QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS
WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY  Department of Human Services
DIVISION Division of Medical Services
DIVISION DIRECTOR  Andrew Allison, PhD
CONTACT PERSON  Robbie Nix
ADDRESS  P.O Box 1437, Slot S295, Little Rock, AR 72203
PHONE NO.  320-86527  FAX NO.  682-2480  E-MAIL  Robert.nix@arkansas.gov
NAME OF PRESENTER AT COMMITTEE MEETING  Marilyn Strickland
PRESENTER E-MAIL  marilyn.strickland@arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after “Short Title of this Rule” below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

    Donna K. Davis
    Administrative Rules Review Section
    Arkansas Legislative Council
    Bureau of Legislative Research
    Room 315, State Capitol
    Little Rock, AR 72201

******************************************************************************

1. What is the short title of this rule?

    EPISODE-2-13 and State Plan Amendment #2013-005

2. What is the subject of the proposed rule?

    To add Oppositional Defiant Disorder (ODD) episodes, Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) episodes, Percutaneous Coronary Intervention (PCI) episodes, Acute Exacerbation of Asthma episodes and Coronary Arterial Bypass Graft (CABG) episodes to both the Episodes of Care Medicaid manual and the Arkansas State Plan.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ____  No  ____X__.  

    If yes, please provide the federal rule, regulation, and/or statute citation.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act?  Yes _____  No  ____X__.  

    If yes, what is the effective date of the emergency rule?  _____________________________

    When does the emergency rule expire?  _____________________________

    Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act?  Yes _____  No  ____
5. Is this a new rule? Yes ______ No  X  If yes, please provide a brief summary explaining the regulation.

Does this repeal an existing rule? Yes ____ No  X  If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does.

Is this an amendment to an existing rule? Yes  X  No ____ If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled “mark-up.”

6. Cite the state law that grants the authority for this proposed rule? If codified, please give Arkansas Code citation.

Arkansas Statute 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary?

The purpose of the proposed rule is to add Oppositional Defiant Disorder (ODD) episodes, Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) episodes, Percutaneous Coronary Intervention (PCI) episodes, Acute Exacerbation of Asthma episodes and Coronary Arterial Bypass Graft (CABG) episodes to both the Episode of Care Medicaid manual and the Arkansas State Plan. Medicaid has established a payment improvement initiative to incentivize improved care quality, efficiency, and economy. The program uses episode-based data to evaluate the quality, efficiency, and economy of care delivered in the course of the episode, and to apply payment incentives.

The proposed rule is necessary so that providers are aware of Arkansas Medicaid requirements for Oppositional Defiant Disorder (ODD) episodes, Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) episodes, Percutaneous Coronary Intervention (PCI) episodes, Acute Exacerbation of Asthma episodes and Coronary Arterial Bypass Graft (CABG) episodes.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).

https://www.medicaid.state.ar.us/InternetSolution/general/comment/comment.aspx

9. Will a public hearing be held on this proposed rule? Yes  X  No ____
   If yes, please complete the following:
   Date:  June 7, 2013
   Time:  2:00 PM – 4:00 PM
   Place:  Donaghey Plaza South, 700 East Main Street, Little Rock - Conference Room A

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
    June 13, 2013

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
    October 1, 2013

12. Do you expect this rule to be controversial? Yes  X  No ____ If yes, please explain.
    While the episode based payment improvement initiative does not change current reimbursement, there is risk that providers could incur a negative incentive adjustment that would require them to remit money back to Medicaid
13. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known.

Medical associations, interested providers, and advocacy organizations. Their positions for or against is not known at this time.
FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services
DIVISION Division of Medical Services
PERSON COMPLETING THIS STATEMENT: Lynn Burton

TELEPHONE NO. 501-682-1857  FAX NO. 682-3889  EMAIL: Lynn.Burton@Arkansas.gov

To comply with Act 1104 of 1995, please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE – EPISODE-2-13 and State Plan Amendment #2013-005

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes X  No ___.

2. Does this proposed, amended, or repealed rule affect small businesses?
   Yes X  No ___.
   If yes, please attach a copy of the economic impact statement required to be filed with the Arkansas Economic Development Commission under Arkansas Code § 25-15-301 et seq.

3. If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please give the incremental cost for implementing the rule. Please indicate if the cost provided is the cost of the program.

<table>
<thead>
<tr>
<th>Current Fiscal Year</th>
<th>Next Fiscal Year</th>
</tr>
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<tbody>
<tr>
<td>General Revenue</td>
<td>General Revenue</td>
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<tr>
<td>Federal Funds</td>
<td>Federal Funds</td>
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<tr>
<td>Cash Funds</td>
<td>Cash Funds</td>
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<tr>
<td>Special Revenue</td>
<td>Special Revenue</td>
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<tr>
<td>Other (Identify)</td>
<td>Other (Identify)</td>
</tr>
<tr>
<td>Total</td>
<td>Total</td>
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5. What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule? Identify the party subject to the proposed rule and explain how they are affected.

<table>
<thead>
<tr>
<th>Current Fiscal Year</th>
<th>Next Fiscal Year</th>
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6. What is the total estimated cost by fiscal year to the agency to implement this rule? Is this the cost of the program or grant? Please explain. (The Medicaid program projects program savings resulting from the Healthcare Payment Improvement Initiative in the following amounts)

<table>
<thead>
<tr>
<th>First Fiscal Year (2014)</th>
<th>Next Fiscal Year (2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 255,502 State</td>
<td>$ 343,856 State</td>
</tr>
<tr>
<td>$ 605,065 Federal</td>
<td>$ 814,296 Federal</td>
</tr>
<tr>
<td>$ 860,567 Total Savings</td>
<td>$1,158,152 Total Savings</td>
</tr>
</tbody>
</table>
ECONOMIC IMPACT STATEMENT
(As Required under Arkansas Code § 25-15-301)

Department:  Arkansas Department of Human Services
Division:  Medical Services
Person Completing this Statement:  Lynn Burton
Telephone Number:  501-682-1857  Fax Number:  501-682-3889
EMAIL:  Lynn.Burton@Arkansas.gov

Short Title of this Rule:  EPISODE-2-13 and State Plan Amendment #2013-005

(1) The type or types of small businesses that will be directly affected by the proposed rule, bear the cost of the proposed rule, or directly benefit from the proposed rule.

Health Care providers providing services for conditions covered under episodes included in the Arkansas Health Care Payment Improvement Initiative.

(2) A description of how small businesses will be adversely affected.

Some health care providers may benefit from the episode performance payment model, while those providing services that do not meet certain cost and quality standards will see reduced provider revenue. Impact to any individual provider will depend on the provider’s behavior and performance.

(3) A reasonable determination of the dollar amounts the proposed rule will cost small businesses in terms of fees, administrative penalties, reporting, recordkeeping, equipment, construction labor, professional services, revenue loss, or other costs associated with compliance.

No additional incremental costs to providers are expected. The net revenue impact to any individual provider will depend on their current standard of care and any improvement they make.

(4) A reasonable determination of the dollar amounts of the costs to the agency of implementing the proposed rule, as well as the financial benefit to the agency of implementing the rule.

The Department projects savings resulting from implementation of this initiative to be $1,158,152 in SFY 2015. 2015 is the first year that the full impact of this initiative would be realized.

(5) Whether and to what extent alternative means exist for accomplishing the objectives of the proposed rule that might be less burdensome to small businesses and why such alternatives are not being proposed.

Not Applicable

(6) A comparison of the proposed rule with federal and state counterparts.

Not Applicable
Effective October 1, 2013 Arkansas Medicaid proposes to add Oppositional Defiant Disorder (ODD) episodes, Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) episodes, Percutaneous Coronary Intervention (PCI) episodes, Acute Exacerbation of Asthma episodes and Coronary Arterial Bypass Graft (CABG) episodes to the Episodes of Care Medicaid manual and Arkansas State Plan to incentivize improved care quality, efficiency, and economy. The program uses episode-based data to evaluate the quality, efficiency, and economy of care delivered in the course of the episode, and to apply payment incentives.
1. Inpatient Hospital Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at [https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx](https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx) and also at the Arkansas Health Care Payment Improvement Initiative website at [http://www.paymentinitiative.org/Pages/default.aspx](http://www.paymentinitiative.org/Pages/default.aspx).

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Perinatal Care Episodes

Effective for dates of service on or after February 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Congestive Heart Failure (CHF) Episodes
(2) Total Joint Replacement Episodes

Effective for dates of service on or after October 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) Episodes
(2) Acute Exacerbation of Asthma Episodes
B. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Perinatal Care Episodes

Effective for dates of service on or after February 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Congestive Heart Failure (CHF) Episodes
(2) Total Joint Replacement Episodes

Effective for dates of service on or after October 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) Episodes
(2) Acute Exacerbation of Asthma Episodes
2.b. Rural Health Clinic Services and other ambulatory services that are covered under the plan and furnished by a rural health clinic (continued)

C. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Perinatal Care Episodes

Effective for dates of service on or after October 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) Episodes
(2) Acute Exacerbation of Asthma Episodes
4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(17) Psychology Services (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

   (1) Attention Deficit Hyperactivity Disorder (ADHD) Episodes

Effective for dates of service on or after October 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

   (1) Oppositional Defiant Disorder (ODD) Episodes
   (2) Attention Deficit Hyperactivity Disorder (ADHD) / Oppositional Defiant Disorder (ODD) Comorbid Episodes
5. Physicians’ Services (continued)

D. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

1. Acute Ambulatory Upper Respiratory Infection (URI) Episodes
2. Perinatal Care Episodes
3. Attention Deficit Hyperactivity Disorder (ADHD) Episodes

Effective for dates of service on or after February 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

1. Congestive Heart Failure (CHF) Episodes
2. Total Joint Replacement Episodes

Effective for dates of service on or after October 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

1. Tonsillectomy Episodes
2. Cholecystectomy Episodes
3. Colonoscopy Episodes
4. Oppositional Defiant Disorder (ODD) Episodes
5. Attention Deficit Hyperactivity Disorder (ADHD) / Oppositional Defiant Disorder (ODD) Comorbid Episodes
6. Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) Episodes
7. Percutaneous Coronary Intervention (PCI) Episodes
8. Acute Exacerbation of Asthma Episodes
9. Coronary Arterial Bypass Graft (CABG) episodes
13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan
   (Continued)
   (d) Rehabilitative Services (Continued)

   (1) Rehabilitative Services for Persons with Mental Illness (RSPMI) (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY
   (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

   (1) Attention Deficit Hyperactivity Disorder (ADHD) Episodes

Effective for dates of service on or after October 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

   (1) Oppositional Defiant Disorder (ODD) Episodes
   (2) Attention Deficit Hyperactivity Disorder (ADHD) / Oppositional Defiant Disorder (ODD) Comorbid Episodes
23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

(Continued)

e. Emergency Hospital Services (Continued)

E. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

1. Perinatal Care Episodes

Effective for dates of service on or after February 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

1. Congestive Heart Failure (CHF) Episodes

Effective for dates of service on or after October 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

1. Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) Episodes

2. Acute Exacerbation of Asthma Episodes
23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
   (Continued)

   f. Critical Access Hospitals (CAH) (continued)

F. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

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1) Perinatal Care Episodes

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1) Congestive Heart Failure (CHF) Episodes

Effective for dates of service on or after October 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

1) Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) Episodes
2) Acute Exacerbation of Asthma Episodes
Dan Sullivan - Arkansas Comprehensive Health Care Providers Association

Comment: 1.) I would like to urge DHS not to proceed with implementation of the ADHD/ODD Comorbid Episode. We would further recommend holding off on the ODD Episode until there is more information of progress with the ADHD Episode.

2.) There are several aspects of the ADHD Episode that DHS agrees need to be modified. Please hold off moving forward with additional episodes until we have a clear picture of the Episode impact on patients and providers before moving forward with another Episode.

3.) Why is there such a rush to move forward? Before the state moved forward with the Private Option they set triggers and safeguards in place. How can the state justify moving forward with additional episodes with no data that indicates we are moving in the right direction.

Response (to the prior 3 comments above): DHS has developed a rigorous approach in close collaboration with providers and a clinical advisory group (which includes providers and consumers) to develop the episodes in a manner that is thoughtful and conscious of broad impact to improve quality and efficiency of the care provided to Medicaid patients. Arkansas is on the leading edge of designing a sustainable health program for all Medicaid members and behavioral health is a critical component of this effort.

While episodes are being introduced in waves, they are part of the multi-pronged episodic approach to impacting behavioral health care delivered.

4.) I understand the state is also moving forward with Health Homes. Some have suggested the Health Homes and Episodes include redundancies? Is that correct? If so, what are they and what is the anticipated impact?

Response: Behavioral Health Homes are intended to be complementary to episodes, providing additional support for clients with the greatest needs across behavioral health and medical care. More specifically, Behavioral Health Homes will provide care management activities that allow coordination across multiple systems (behavioral health, long term services and supports, justice system, etc.) for individuals with chronic and persistent behavioral health conditions.

5.) Is there year over year data to support the projections made by DHS? If yes, why are we using only one year's data?

Response: DHS uses the most recent reliable data available to provide a view of current average costs for each episode of care. The process to develop thresholds uses a wide range of inputs including this data and advice from the clinical advisory group on the evidence-based care for each episode.

DHS works with several scenarios as to the potential future impact of episodes of care on quality and cost.

6.) What does current data indicate for ADHD Episodes? What's the impact on patient? On providers? Fiscal impact for state?

Response: DHS is currently reviewing the first few months of data since the start of the performance period for the ADHD episode. DHS looks forward to sharing this information when the review is completed.

Paul Bokker, C.E.O., Hope Behavioral Healthcare

Comment: I strongly oppose the episode of care system for the following reasons:

1.) I have been involved in peer review research efforts and have some understanding how one can research which agrees with one’s position and refuting research that disagrees with one’s position.

2.) The “episode of care” system puts people in need of care into a system of “non-care” as evidenced by gaps in medication usage because some PCP’s will not write psychotropics because they are not psychiatrists and fear recoupment due to restricted funding and people in need are denied services.

Response: Thank you for your comment. DHS is currently reviewing the first few months of data since the start of the performance period for the ADHD episode. DHS looks forward to sharing this information when the review is completed.

DHS has developed a rigorous approach in close collaboration with providers and a clinical advisory group (which includes providers and consumers) to develop the episodes in a manner that is thoughtful and conscious of broad impact to improve quality and efficiency of the care provided to Medicaid patients.

Shella Pounds, Compliance Officer, Life Strategies of Arkansas, LLC

Comment: Since the inception of the Episode of Care for Attention Deficit Hyperactivity Disorder (ADHD), Life Strategies of Arkansas has had to make substantial changes in its operation. Prior to removing the fee-for-service model and moving to the episode of care model, LSA had 238 ADHD clients in the billing system. Sixty of the clients were reassessed and an
additional diagnosis was added. Sixty-eight clients were discharged. By February 28, 2013 LSA had 23 ADHD clients being served. The establishment of the episode of care has adversely impacted quality of care provided by LSA. Most ADHD clients were attending group and were provided mental health paraprofessional services. 29% of the Parents of the patients we serve decided to discontinue needed services. The decline in patients has had a 5% negative impact agency wide as of March 8, 2013. This negative impact can be seen in increased school suspensions and court related occurrences in the communities we serve.

Response: The episode of care for ADHD is designed to improve the accuracy of diagnosis and the delivery of evidence-based care in a guideline-concordant manner. It is designed with clinical advice to support and reward providers who deliver guideline-concordant care.

DHS has developed a rigorous approach in close collaboration with providers and a clinical advisory group (which includes providers and consumers) to develop the episodes in a manner that is thoughtful and conscious of broad impact to improve quality and efficiency of the care provided to Medicaid patients. Arkansas is on the leading edge of designing a sustainable health program for all Medicaid members and behavioral health is a critical component of this effort.

If you are aware of data showing a direct connection to an increase in school suspensions and court-related occurrences, DHS would like to evaluate it. We appreciate your comment.

Jason Turner, Director of Quality Assurance, Families, Inc.

Comment: I have three concerns which I hope your team will consider:

1). We are still concerned about the complexity and risk of the simple ADHD episode of care. In our location we experienced a marked increase of cases referred to mental health that seemed to be simpler cases than those we typically received. This resulted in a physician manpower problem.

Response: The episode of care model allows any eligible provider to deliver care in the setting they serve. For ADHD, there are a range of eligible primary accountable providers, including physicians, RSPMI provider organizations, and clinical psychologists.

2). The evidence based treatment of ODD including a high degree of parent participation is certainly appropriate; but will be very hard to reach at the intensity level. This will be especially true when the clients are rural and do not have means for transportation. Also, it seems fairly rare in our population that only one child is affected with some type of mental health needs, so that when more than one child needs Rx, it becomes very complex to get all the parts together to actually deliver services to the family. Could some realistic modification of the treatment plans when the issue is one of working out time, cost and availability of transportation is the barrier (rather than the parent being simply non-compliant)

Response: The clinical guidelines for ODD describe parental involvement as an important component of treatment. DHS understands the complexity of family involvement. Therefore, the episode model links intensity of family therapy to gain sharing only and does not affect payment for services. It is important to note that the issues described above are present - with or without episodic based treatment.

3). In a fairly newly diagnosed ODD case, it seems totally reasonable to apply the evidence-based stands (with some practical modifications such as very described in 2) above. But what about the child who has been refractory to intervention (or whose family refused to cooperate with mental health providers), who now accesses services due to severe and dangerous school, home, or in-the-community behaviors. Such children, unless some slack in letting them get into intensive services (such as day treatment care) will only result in them being kicked out of school and ultimately enter the juvenile justice system. This group of children are usually over 10. The early teen period, without treatment, is the time when the begin to add drug/alcohol issues. Also, if they have been childhood victims of sexual and severe trauma in early childhood, their dealing with hormonal influences is to act out sexually or physically. It is clear that this is a very ill, very high risk, and very expensive social costs when they pass on to the late teen and adult years. To use criteria that would exclude this groups access to care (albeit it not as
well responding as the simpler younger cases where the criteria apply. Those ODD teens who begin to show increased anti-social symptoms, except for those children who develop severe conduct disorder prior to the age of 10, still have significant benefit from treatments (especially when it is combined with the work of the local legal, school, and probation services).

**Response:** DHS and the clinical advisory board considered the needs of older youths as well as younger children in designing the ODD episode. It is important to note that the episode does not exclude any specific behavioral health services. Providers should continue to provide the most appropriate, guidance-concordant care for their clients.

**Laura Prondzinski, CEO, Hometown Behavioral Health Services of Arkansas, Inc.**

**Comment:** Based upon our research of the thresholds put in place for episodes of care, we do not believe the thresholds are realistic. Clinically, we agree that there is a need for intensive services for these clients, however, we do not believe that you can provide the brief intensive services that are needed for clients diagnosed with ADHD/ODD based upon the thresholds provided. This would be especially true for new clients when you have to include the Medicaid required initial services. We are concerned with the rush to initiate the ADHD/ODD Comorbid episode without concrete evidence that the ADHD episode of care is effectively working.

Many questions remain for the current ADHD episode.

1.) How do you educate the schools? Has anyone contacted the board of education to see how they train the teacher with how to deal with ADHD?

**Response:** DHS is continuously working with stakeholders and other State agencies to educate them on the Episode of Care model. Providers are also welcome to communicate directly with the PCPs or schools that refer them beneficiaries. While teacher training on handling students with ADHD is crucial to care, the ADHD episode does not change their current practices.

2.) How are we monitoring the children to see how they are dealing with the changes made to their treatment based upon recommendations made through the episodes of care?

**Response:** DHS is currently reviewing the first few months of data since the start of the performance period for the ADHD episode. DHS looks forward to sharing the data once this review is completed.

3.) Has data been collected to see if the children are maintaining effectively with medication management only?

**Response:** Data reviewed by DHS and the clinical working group showed that prior to the establishment of the ADHD episode, children had been maintaining effectively with medication management only. DHS has assured providers that continuous monitoring of data will drive future decisions in adjustment of current episodes.

4.) Has data been reviewed from the first quarter of the ADHD episode of care to see if anyone is meeting the threshold amounts?

**Response:** DHS is currently reviewing the first few months of data since the start of the performance period for the ADHD episode. DHS looks forward to sharing the data once this review is completed. Thresholds were developed using the most recent reliable data available to provide a view of current average costs for each episode of care.

At this time we implore you to table this until further discussion can be taken until current questions can be answered.

**TOC required**

### 215.000 OPPOSITIONAL DEFIANT DISORDER (ODD) EPISODES

#### 215.100 Episode Definition/Scope of Services

**A. Episode subtypes:**

There are no subtypes for this episode type.

**B. Episode trigger:**

ODD episodes are triggered by three medical claims with a primary diagnosis of ODD.
C. **Episode duration:**

The standard episode duration is a 90-day period beginning at the time of the first trigger claim. Claims for a beneficiary are tracked for 180 days following the closure of the 90-day standard episode to determine the episode remission rate quality metric.

D. **Episode services:**

All claims with a primary diagnosis of ODD. Behavioral health medications will be excluded from the episode, but utilization of medications will be tracked as a quality metric for providers “to pass.” Notwithstanding any other provisions in the provider manual, medical assistance included in an ODD episode shall not be subject to prior authorization requirements.

215.200 **Principal Accountable Provider**

Determination of the Principal Accountable Provider (PAP) is based upon which provider is responsible for the largest number of claims within the episode.

The provider responsible for the largest number of claims is designated the PAP. In instances in which two providers are responsible for an equal number of claims within the episode, the provider whose claims accounted for a greater proportion of total reimbursement will be designated PAP.

Providers eligible to be PAPs include primary care physicians, psychiatrists, clinical psychologists, and RSPMI provider organizations.

215.300 **Exclusions**

Episodes meeting one or more of the following criteria will be excluded:

A. Beneficiaries not continuously enrolled in Medicaid during the 90-day episode

B. Beneficiaries with any comorbid behavioral health condition

C. Beneficiaries age 5 or younger and beneficiaries age 18 or older at the time of the initial claim

215.400 **Adjustments**

An episode with fewer than 10 therapy visits over 30+ days will not be applied to reduce a PAP’s average episode cost but may count toward risk sharing. PAPs who in an entire performance period have no episodes with 10 or more therapy visits over 30+ days will not be eligible for gain sharing.

215.500 **Quality Measures**

A. **Quality measures “to pass”:**

1. Percentage of episodes with completion of either Continuing Care or Quality Assessment certification – must meet minimum threshold of 90% of episodes.

2. Percentage of new episodes (i.e., a PAP’s first ODD episode for this beneficiary) in which the beneficiary received behavioral health medications – must be under maximum threshold of 20%.

3. Percentage of repeat episodes (i.e., all episodes other than a PAP’s first ODD episode for this beneficiary) for which the beneficiary received behavioral health medications – must be equal to 0%.

4. Percentage of episodes resulting in beneficiary remission (no repeat ODD episode for this beneficiary within 180 days after the end of the episode) – must meet minimum threshold of 40%. If a PAP has <5 episodes used for the calculation in a performance period, the metric becomes a quality measure “to track” – not “to pass”.

B. **Quality measures “to track”:**

1. Percentage of episodes with >9 visits over >30 days

2. Percentage of episodes certified as non-guideline concordant care

3. Average number of visits per episode
4. Average number of behavioral therapy visits per episode
5. Percentage of episodes with >9 therapy sessions over a period of 30+ days and of which >7 are family therapy sessions (CPT 90846 OR CPT 90847)

215.600 Thresholds for Incentive Payments
A. The acceptable threshold is $2,671.
B. The commendable threshold is $1,642.
C. The gain sharing limit is $984.
D. The gain sharing percentage is 50%.
E. The risk sharing percentage is 50%.

215.700 Minimum Case Volume
The minimum case volume is 5 cases per 12-month period.

220.000 ACUTE EXACERBATION OF ASTHMA EPISODES

220.100 Episode Definition/Scope of Services
A. Episode subtypes:
   There are no subtypes for this episode type.
B. Episode trigger:
   Asthma episodes are triggered by medical claims with a primary diagnosis related to an asthma acute exacerbation on an emergency department or inpatient claim. Trigger must be preceded by 30-day clean period with no triggers or repeat exacerbations.
C. Episode duration:
   Episodes begin with a trigger diagnosis in a hospital setting and end 30 days after discharge or until the end of a readmission where the patient had entered the hospital within the 30 day post-discharge period.
D. Episode services:
   The following services are included in the episode:
   1. During the trigger window (i.e., date of emergency room visit or entire inpatient stay): all services and claims received by the beneficiary
   2. Within 30-day post-trigger window: related services including inpatient and outpatient facility services, professional services, related medications, treatment for post-procedure complications, and readmissions or repeat visits to the Emergency Department.

220.200 Principle Accountable Provider
The PAP is the facility (i.e., hospital) where the initial trigger event occurred.

220.300 Exclusions
Episodes with one or more of the following criteria will be excluded:
A. Beneficiaries with select comorbid conditions
B. Beneficiaries who are intubated or have home oxygen usage at any point during the episode
C. Beneficiaries with ICU admissions greater than 72 hours
D. Beneficiaries who die in the hospital during episode
E. Beneficiaries with status of “left against medical advice” during episode
F. Beneficiaries under the age of 5 on the trigger date
G. Beneficiaries with dual enrollment in Medicare/Medicaid (i.e., dual-eligible)
H. Beneficiaries with third party liabilities in the episode
I. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode

220.400 Adjustments
For the purposes of determining a PAP’s performance, the total reimbursement attributable to the PAP for an acute exacerbation episode is adjusted based on:
A. Patient comorbidities which may be risk factors that influence episode cost
B. Age
C. High cost or low cost outliers, applied after other cost adjustments

220.500 Quality Measures
A. Quality measures “to pass”:
   1. Rate of corticosteroid and/or inhaled corticosteroid usage determined by filled prescription rate for medication within +/- 30 days of trigger start date – must meet minimum threshold of 38%
   2. Percent of episodes where patient visits outpatient physician within 30 days post initial discharge – must meet minimum threshold of 59%
B. Quality measures “to track”:
   1. Rate of repeat acute exacerbation within 30 days post initial discharge

220.600 Thresholds for Incentive Payments
A. The acceptable threshold is $575.
B. The commendable threshold is $427.
C. The gain sharing limit is $299.
D. The gain sharing percentage is 50%.
E. The risk sharing percentage is 50%.

220.700 Minimum Case Volume
The minimum case volume is 5 valid cases per 12-month period.

221.000 ACUTE EXACERBATION OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) EPISODES

221.100 Episode Definition/Scope of Services
A. Episode subtypes:
   There are no subtypes for this episode type.
B. Episode trigger:
COPD episodes are triggered by medical claims with a primary diagnosis related to a COPD acute exacerbation on an emergency department or inpatient claim. Trigger must be preceded by 30-day clean period with no triggers or repeat exacerbations.

C. **Episode duration:**

Episodes begin with a trigger diagnosis in a hospital setting and end 30 days after discharge or until the end of a readmission where the patient had entered the hospital within the 30 day post-discharge period.

D. **Episode services:**

The following services are included in the episode:

1. During the trigger window (i.e., date of emergency room visit or entire inpatient stay): all services and claims received by the beneficiary
2. Within 30-day post-trigger window: related services including inpatient and outpatient facility services, professional services, related medications, treatment for post-procedure complications, and readmissions or repeat visits to the Emergency Department.

221.200 **Principal Accountable Provider**

The PAP is the facility (i.e., hospital) where the initial trigger event occurred.

221.300 **Exclusions**

Episodes with one or more of the following criteria will be excluded:

A. Beneficiaries with select comorbid conditions
B. Beneficiaries who are intubated
C. Beneficiaries with ICU admissions greater than 72 hours
D. Beneficiaries who die in the hospital during episode
E. Beneficiary with status of “left against medical advice” during episode
F. Beneficiaries under the age of 35 on the trigger date
G. Beneficiaries with dual enrollment in Medicare/Medicaid (i.e., dual-eligible)
H. Beneficiaries with third party liabilities in the episode
I. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode

221.400 **Adjustments**

For the purposes of determining a PAP's performance, the total reimbursement attributable to the PAP for an acute exacerbation episode is adjusted based on:

A. Patient comorbidities, which may be risk factors that influence episode cost
B. Age
C. High cost or low cost outliers, applied after other cost adjustments

221.500 **Quality Measures**

A. **Quality measures “to pass”:**
   1. Percent of episodes where patient visits outpatient physician within 30 days post initial discharge – must meet minimum threshold of 36%

B. **Quality measures “to track”:**
1. Rate of repeat acute exacerbation within 30 days post initial discharge

### 221.600 Thresholds for Incentive Payments

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>A.</strong></td>
<td>The acceptable threshold is $1,469.</td>
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<tr>
<td><strong>B.</strong></td>
<td>The commendable threshold is $1,046.</td>
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<tr>
<td><strong>C.</strong></td>
<td>The gain sharing limit is $859.</td>
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<td><strong>D.</strong></td>
<td>The gain sharing percentage is 50%.</td>
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<tr>
<td><strong>E.</strong></td>
<td>The risk sharing percentage is 50%.</td>
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</table>

### 221.700 Minimum Case Volume

The minimum case volume is 5 valid cases per 12-month period.

### 222.000 PERCUTANEOUS CORONARY INTERVENTIONS (PCI) EPISODES

#### 222.100 Episode Definition/Scope of Services

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<tr>
<td><strong>A.</strong></td>
<td><strong>Episode subtypes:</strong> There are no subtypes for this episode type.</td>
</tr>
<tr>
<td><strong>B.</strong></td>
<td><strong>Episode trigger:</strong> Episode is triggered by a professional claim for PCI (angioplasty, stent, thrombectomy, arterectomy, injection or transfusion of thrombolytic agent, transcatheter placement of radiation delivery device).</td>
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<tr>
<td><strong>C.</strong></td>
<td><strong>Episode duration:</strong> The episode duration is the timeframe from the diagnostic angiogram (within 30 days pre-trigger) through 30 days post discharge from the facility stay during which the procedure occurred.</td>
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<td><strong>D.</strong></td>
<td><strong>Episode services:</strong> The following services are included in the episode:</td>
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1. Before the PCI procedure (only applies if the diagnostic angiogram occurs before the PCI procedure): All related services including inpatient and outpatient facility services, professional services, medications, and treatment for complications related to conditions affecting the coronary arterial system
2. During procedure: All services (i.e., inpatient and outpatient facility services, professional services, medications, treatment for complications) |
3. Within 30 days post discharge for the procedure: All related services defined as inpatient and outpatient facility services, professional services, medications, treatment for complications related to conditions affecting the coronary arterial system and readmissions or repeat visits to the Emergency Department.

#### 222.200 Principle Accountable Provider

For each episode, the Principal Accountable Provider (PAP) is the physician performing the PCI.

#### 222.300 Exclusions

Episodes meeting one or more of the following criteria will be excluded:

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<tbody>
<tr>
<td><strong>A.</strong></td>
<td>Beneficiaries with PCIs that convert to CABG within 1 day</td>
</tr>
</tbody>
</table>
B. Beneficiaries with select comorbid conditions within previous 365 days through end of episode
C. Beneficiaries who die in the hospital during episode
D. Beneficiaries with status of “left against medical advice” during episode
E. Beneficiaries under the age of 18 on the trigger date
F. Beneficiaries with dual enrollment in Medicare/Medicaid (i.e., dual-eligible)
G. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode
H. Beneficiaries with third party liabilities in the episode

222.400 Adjustments 10-1-13
For the purposes of determining a PAP’s performance, the total reimbursement attributable to the PAP is adjusted based on:
A. Severity, as determined by historical patient information
B. High cost or low cost outliers, applied after other cost adjustments
C. Number of vessel interventions performed in single procedure
D. Changes to fee schedules and reimbursements originating from changes to provider procedure coding and billing practices

222.500 Quality Measures 10-1-13
A. Quality measures “to pass”:
   NOTE: For PCI quality measures, PAPs must satisfy thresholds PCI appropriateness (metric #1) AND five of the seven adverse outcome metrics (metrics 2-8) in order to qualify for gain sharing.
   1. PCI appropriateness Percent of PCIs performed that are inappropriate according to the American College of Cardiology criteria – cannot exceed the maximum threshold of 2 inappropriate procedures
   2. Percent of patients with myocardial infarction in 30 days post-procedure – must meet maximum threshold of 0%
   3. Percent of patients with stroke in 30 days post-procedure – must meet maximum threshold of 0%
   4. Percent of patients with stent thrombosis in 30 days post-procedure – must meet maximum threshold of 0%
   5. Percent of patients with post-operative hemorrhage in 30 days post-procedure – must meet maximum threshold of 0%
   6. Percent of patients with AV fistula in 30 days post-procedure – must meet maximum threshold of 0%
   7. Percent of patients with pulmonary embolism in 30 days post-procedure – must meet maximum threshold of 0%
   8. Percent of patients with post-operative wound infection in 30 days post-procedure – must meet maximum threshold of 0%
B. Quality measures “to track”:
   1. PCI appropriateness - Percent of PCIs performed that are appropriate, uncertain and unclassified according to the American College of Cardiology criteria
2. Percent of episodes during which at least 1 “adverse outcome” occurs (with adverse outcome defined as patients with either myocardial infarction, stroke, stent thrombosis, post-operative hemorrhage, AV fistula, pulmonary embolism or post-operative wound infection in 30 days post-procedure)

222.600 Thresholds for Incentive Payments

A. The acceptable threshold is $4,572.
B. The commendable threshold is $3,153.
C. The gain sharing limit is $1,656.
D. The gain sharing percentage is 50%.
E. The risk sharing percentage is 50%.

222.700 Minimum Case Volume
The minimum case volume is 5 valid cases per 12-month period.

223.000 CORONARY ARTERIAL BYPASS GRAFT (CABG) EPISODES

223.100 Episode Definition/Scope of Services

A. Episode subtypes:
   There are no subtypes for this episode type.
B. Episode trigger:
   Episode is triggered by a coronary arterial bypass graft (CABG) procedure.
C. Episode duration:
   The episode duration is the timeframe from the date of surgery through 30 days post discharge from the facility stay during which the procedure occurred.
D. Episode services:
   The following services are included in the episode:
   1. During procedure: All services (i.e., inpatient and outpatient facility services, professional services, medication, treatment for complications)
   2. Within 30 days post discharge of the procedure: All related services including inpatient and outpatient facility services, professional services, medications, treatment for complications related to conditions affecting the coronary arterial system, and readmissions or repeat visits to the Emergency Department.

223.200 Principle Accountable Provider
For each episode, the Principal Accountable Provider (PAP) will be the physician performing the CABG.

223.300 Exclusions
Episodes meeting one or more of the following criteria will be excluded:
A. Beneficiaries with select comorbid conditions
B. Beneficiaries undergoing a salvage CABG (from failed or aborted PCI)
C. Beneficiaries who die in the hospital during episode
D. Beneficiaries with status of “left against medical advice” during episode
E. Beneficiaries under the age of 18 on the trigger date
F. Beneficiaries with dual enrollment in Medicare/Medicaid (i.e., dual-eligible)
G. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode
H. Beneficiaries with CABG surgeries that include 2 or more valve procedures
I. Beneficiaries with procedure triggers that do not have a corresponding facility claim
J. Beneficiaries with third party liabilities in the episode

223.400 Adjustments
For the purposes of determining a PAP’s performance, the total reimbursement attributable to the PAP is adjusted based on:

A. Patient comorbidities, including indirectly related health conditions and patient presentation prior to CABG episode
B. High cost or low cost outliers, applied after other cost adjustments
C. Presence of 1 valve procedure during CABG surgery
D. Changes to fee schedules and reimbursements originating from changes to provider procedure coding and billing practices

223.500 Quality Measures

A. Quality measures “to pass”:
   NOTE: For CABG quality measures, PAPs must satisfy thresholds for two of the three adverse outcome metrics in order to qualify for gain sharing
   1. Percent of patients with stroke in 30 days post-procedure – must meet maximum threshold of 0%
   2. Percent of patients with deep sternal wound infection in 30 days post-procedure – must meet maximum threshold of 0%
   3. Percent of patients with post-operative renal failure in 30 days post-procedure – must meet maximum threshold of 0%

B. Quality measures “to track”:
   1. Percent of episodes during which at least 1 adverse outcome occurs (with adverse outcome defined as patients with either stroke, deep sternal wound infection or post-operative renal failure in 30 days post-procedure)
   2. Percent of patients on a ventilator for longer than 24 hours after surgery
   3. Average length of pre-operative inpatient stay
   4. Percent of patients admitted on day of surgery
   5. Percent of patients for whom an internal mammary artery is used

223.600 Thresholds for Incentive Payments

A. The acceptable threshold is $11,017.
B. The commendable threshold is $9,305.
C. The gain sharing limit is $7,550.
D. The gain sharing percentage is 50%.
E. The risk sharing percentage is 50%.

**223.700 Minimum Case Volume**  10-1-13

The minimum case volume is 5 valid cases per 12-month period.