ARKANSAS REGISTER

Transmittal Sheet

Mark Martin
Secretary of State
State Capitol Room 026
Little Rock, Arkansas 72201-1094
(501) 682-3527

For Office Use Only: Effective Date _____ Code Number 016.06.12-029

Name of Agency Department of Human Services.

Department Division of Medical Services.

Contact Robbie Nix E-mail robert.nix@arkansas.gov Phone 682-8577.

Statutory Authority for Promulgating Rule _____.

Rule Title: Episode performance payments for Ambulatory URI, ADHD and Perinatal care

Intended Effective Date

☐ Emergency

☒ 30 Days After Filing

☐ Other _____

Date

Legal Notice Published..... 06/11/12 – 06/13/12.

Final Date for Public Comment..... 07/10/12.

Reviewed by Legislative Council..... _____

Adopted by State Agency..... 10/01/12.

☒ Electronic Copy of Rule Provided (per Act 1478 of 2003)

☒ Electronic Copy of Rule to be e-mailed from: Becky Murphy (Contact Person) becky.Murphy@arkansas.gov (Email Address)

CERTIFICATION OF AUTHORIZED OFFICER
I Hereby Certify That The Attached Rules Were Adopted
In Compliance with Act 434 of 1967 As Amended

Andy Allison /vg
Signature

(501) 682-8292 (Phone Number) andy.allison@arkansas.gov (E-mail Address)

Director
Title

September 17, 2012
Date

MARK MARTIN
SECRETARY OF STATE
STATE OF ARKANSAS

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FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services
DIVISION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Randy Helms
TELEPHONE NO. 682-1857 **FAX NO.** 682-2480 **EMAIL:** randy.helms@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 performance payments for Ambulatory URI, ADHD and Perinatal care

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 Does this proposed, amended, or repealed rule have a financial impact?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 Does this proposed, amended, or repealed rule affect small businesses?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.

Current Fiscal Year	**Next Fiscal Year**
General Revenue_____	General Revenue_____
Federal Funds_____	Federal Funds_____
Cash Funds_____	Cash Funds_____
Special Revenue_____	Special Revenue_____
Other (Identify)_____	Other (Identify)_____
Total_____	Total_____

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.

Current Fiscal Year	**Next Fiscal Year**

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)**

Current Fiscal Year (2013)	**Next Fiscal Year (2014)**
($ 1,325,884) State	($ 2,735,028) State
($ 3,118,916) Federal	($ 6,598,434) Federal
($ 4,444,800) Total Savings	($ 9,333,462) Total Savings

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance
P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – Episodes of Care**

DATE: **October 1, 2012**

SUBJECT: **Provider Manual Update Transmittal EPISODE-New-12**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
____	____	ALL	10-1-12

Explanation of Updates

The Episodes of Care provider policy manual is now available to participating Arkansas Medicaid providers as part of the new payment improvement initiative, which uses episode-based data to incentivize improved care quality, efficiency and economy.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-6453 (Local); 1-800-482-5850, extension 2-6453 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Andy Allison, PhD
Director

SECTION II – EPISODES OF CARE

CONTENTS

200.000 EPISODES OF CARE GENERAL INFORMATION

200.100 Episode Definition/Scope of Services 10-1-12

This section describes, for each episode type, the rules for determining the specific services included in a particular episode.

A. *Episode subtypes:* Episode types may be divided into two or more subtypes distinguished by more specific diagnostic criteria or other clinical information.

B. *Episode triggers:* Services or events that may initiate an episode.

C. *Episode duration:* The time before and after an episode trigger during which medical assistance may be included in an episode.

D. *Episode services:* Criteria used to determine which medical assistance is included or excluded in an episode when delivered within the episode duration. Services excluded

across all episode types are: nursing home claims, EPSDT claims and managed care claims and fees.

200.200 Principal Accountable Provider 10-1-12

This section specifies, for each episode type, the types of providers eligible to be Principal Accountable Providers (PAPs) for an episode type and the algorithm used to determine the PAP(s) for an individual episode. For each episode of care, providers designated as PAPs hold the main responsibility for ensuring that the episode is delivered with appropriate quality and efficiency.

200.300 Exclusions 10-1-12

This section describes, for each episode type, criteria to exclude an episode from calculation of a PAP's average performance.

Across all episode types, episodes are excluded for dual-eligible Medicaid and Medicare beneficiaries and for Third Party Liability (TPL) beneficiaries.

200.400 Adjustments 10-1-12

This section describes, for each episode type, adjustments to the reimbursement amount attributable to a PAP for the purpose of calculating performance and determining supplemental payment incentives.

Across all episode types, the reimbursement amount attributable to a PAP for facility claims for acute inpatient hospitalizations is adjusted to a per diem rate of $850.

200.500 Quality Measures 10-1-12

This section describes, for each episode type, the data and measures which Medicaid will track and evaluate to ensure provision of high-quality care for each episode type.

A. *Quality measures "to pass":* Measures for which a PAP must meet or exceed a minimum threshold in order to qualify for a full positive supplemental payment for that episode type.

B. *Quality measures "to track":* Measures for which a PAP's performance is not linked to supplemental payments. Performance on these measures may result in a program integrity review.

For quality measures "to pass" and quality measures "to track" that require data not available from claims, PAPs must submit data through the provider portal in order to qualify for a full positive supplemental payment.

200.600 Reimbursement Thresholds 10-1-12

This section describes, for each episode type, the specific values used to calculate positive or negative supplemental payments. This includes an acceptable threshold, a commendable threshold, a gain sharing limit and a risk sharing percentage.

200.700 Minimum Case Volume 10-1-12

This section describes, for each episode type, the minimum case volume required for a PAP to qualify for positive or negative supplemental payments. PAPs who do not meet the minimum case volume for an episode type will not be eligible for positive or negative supplemental payments for that episode type.

210.000 ACUTE AMBULATORY UPPER RESPIRATORY INFECTION (URI) EPISODES

210.100 Episode Definition/Scope of Services 10-1-12

A. *Episode subtypes:*

1. Acute Nonspecific URI
2. Acute Pharyngitis and similar conditions
3. Acute Sinusitis

B. *Episode trigger:*

Office visits, clinic visits or emergency department visits with a primary diagnosis of an Acute Ambulatory URI ("URI") that do not fall within the time window of a previous URI episode.

C. *Episode duration:*

Episodes begin on the day of the triggering visit and conclude after 21 days.

D. *Episode services:*

All services relating to the treatment of a URI within the duration of the episode are included. The following services are excluded:

1. Surgical procedures
2. Transport
3. Immunizations commonly administered for preventative care
4. Non-prescription medications

210.200 Principal Accountable Provider 10-1-12

The Principal Accountable Provider (PAP) for an episode is the first Arkansas Medicaid enrolled and qualified provider to diagnose a beneficiary with an Acute Ambulatory URI during an in-person visit within the time window for the episode.

210.300 Exclusions 10-1-12

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

A. Children younger than 1 year of age

B. Beneficiaries with inpatient stays or hospital monitoring during the episode duration

C. Beneficiaries with surgical procedures related to the URI (tonsillectomy, adenoidectomy)

D. Beneficiaries with the following comorbidities diagnosed at least twice in the one year period before the episode end date: 1) asthma; 2) cancer; 3) chronic URI; 4) end-stage renal disease; 5) HIV and other immunocompromised conditions; 6) post-procedural state for transplants, pulmonary disorders, rare genetic diseases, and sickle cell anemia

E. Beneficiaries with the following comorbid diagnoses during the episode: 1) croup, 2) epiglottitis, 3) URI with obstruction, 4) pneumonia, 5) influenza, 6) otitis media

F. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode

210.400 Adjustments 10-1-12

The reimbursement for the initial visit that is attributable to the PAP is normalized across different places of service (e.g., "Level 2" visits will count equally toward average reimbursement regardless of place of service). Reimbursements for the facility claim associated with the initial visit are not counted in the total reimbursements attributed to a PAP for calculation of performance.

Reimbursement attributed to the calculation of a PAP's performance for beneficiaries 10 and under is adjusted to reflect age-related variations in treatment using a multiplier determined by regression.

210.500 Quality Measures 10-1-12

A. *Quality measures "to pass":*

1. Frequency of strep testing for beneficiaries who receive antibiotics (for Acute Pharyngitis episode only) – must meet minimum threshold of 47%

B. *Quality measures "to track":*

1. Frequency of antibiotic usage
2. Frequency of multiple courses of antibiotics during one episode
3. Average number of visits per episode

210.600 Thresholds for Incentive Payments 10-1-12

A. *Acute Nonspecific URI*

1. The acceptable threshold is $67.00.
2. The commendable threshold is $46.00.
3. The gain sharing limit is $14.70.
4. The gain sharing percentage is 50%.
5. The risk sharing percentage is 50%.

B. *Acute Pharyngitis and similar conditions*

1. The acceptable threshold is $80.00.
2. The commendable threshold is $60.00.
3. The gain sharing limit is $14.70.
4. The gain sharing percentage is 50%
5. The risk sharing percentage is 50%.

C. *Acute Sinusitis*

1. The acceptable threshold is $87.00.
2. The commendable threshold is $68.00.
3. The gain sharing limit is $14.70.
4. The gain sharing percentage is 50%.
5. The risk sharing percentage is 50%.

210.700 Minimum Case Volume 10-1-12

The minimum case volume is 5 total cases for each episode subtype per 12 month period.

211.000 PERINATAL CARE EPISODES

211.100 Episode Definition/Scope of Services 10-1-12

A. *Episode trigger:*

A live birth on a facility claim

B. *Episode duration:*

Episode begins 40 weeks prior to delivery and ends 60 days after delivery

C. *Episode services:*

All medical assistance with a pregnancy-related ICD-9 diagnosis code is included. Medical assistance related to neonatal care is not included.

211.200 Principal Accountable Provider 10-1-12

For each episode, the Principal Accountable Provider (PAP) is the provider or provider group that performs the delivery.

211.300 Exclusions 10-1-12

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

A. Limited prenatal care (i.e., pregnancy-related claims) provided between start of episode and 60 days prior to delivery

B. Delivering provider did not provide any prenatal services

C. Episode has no professional claim for delivery

D. Pregnancy-related conditions: amniotic fluid embolism, obstetric blood clot embolism, placenta previa, severe preeclampsia, multiple gestation ≥3, late effect complications of pregnancy/childbirth, puerperal sepsis, suspected damage to fetus from viral disease in mother

E. Comorbidities: cancer, cystic fibrosis, congenital cardiovascular disorders, DVT/pulmonary embolism, other phlebitis and thrombosis, end-stage renal disease, sickle cell, Type I diabetes

211.400 Adjustments 10-1-12

For the purposes of determining a PAP's performance, the total reimbursement attributable to the PAP is adjusted to reflect risk and/or severity factors captured in the claims data for each episode in order to be fair to providers with high-risk patients, to avoid any incentive for adverse selection of patients and to encourage high-quality, efficient care. Medicaid, with clinical input from Arkansas providers, will identify risk factors via literature, Arkansas experience and clinical expertise. Using standard statistical techniques and clinical review, risk factors will be tested for statistical and clinical significance to identify a reasonable number of factors that have meaningful explanatory power ($p < 0.01$) for predicting total reimbursement per episode. Some factors which have meaningful explanatory power may be excluded from the set of selected risk factors where necessary to avoid potential for manipulation through coding practices. Episode reimbursement attributable to a PAP for calculating average adjusted episode reimbursement are adjusted based on selected risk factors. Over time, Medicaid may add or subtract risk factors in line with new research and/or empirical evidence.

211.500 Quality Measures 10-1-12

A. *Quality measures "to pass":*

1. HIV screening – must meet minimum threshold of 80% of episodes
2. Group B streptococcus screening (GBS) – must meet minimum threshold of 80% of episodes
3. Chlamydia screening – must meet minimum threshold of 80% of episodes

B. *Quality measures "to track":*

1. Ultrasound screening
2. Screening for Gestational Diabetes
3. Screening for Asymptomatic Bacteriuria
4. Hepatitis B specific antigen screening
5. C-Section Rate

211.600 Thresholds for Incentive Payments 10-1-12

A. The acceptable threshold is $3,906.00.

B. The commendable threshold is $3,394.00.

C. The gain sharing limit is $2,000.00.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

211.700 Minimum Case Volume 10-1-12

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

212.000 ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) EPISODES

212.100 Episode Definition/Scope of Services 10-1-12

A. *Episode subtypes:*

1. Level I: Episode of care for an ADHD beneficiary with no behavioral health comorbid conditions and for whom no qualifying Severity Certification has been completed.
2. Level II: Episode of care for an ADHD beneficiary with no behavioral health comorbid conditions who has had an inadequate response to medication management. Providers must complete a Severity Certification through the provider portal to qualify beneficiaries for a Level II designation.

B. *Episode trigger:*

Level I subtype episodes are triggered by either two medical claims with a primary diagnosis of ADHD or a medical claim with a primary diagnosis of ADHD as well as a pharmacy claim for medication used to treat ADHD. Level II subtype episodes are triggered by a completed Severity Certification followed by either two medical claims with a primary diagnosis of ADHD or a medical claim with a primary diagnosis of ADHD as well as a pharmacy claim for medication used to treat ADHD.

C. *Episode duration:*

The standard episode duration is a 12-month period beginning at the time of the first trigger claim. A Level I episode will conclude at the initiation of a new Level II episode if a Severity Certification is completed during the 12-month period.

D. *Episode services:*

All claims with a primary diagnosis of ADHD as well as all medications indicated for ADHD or used in the treatment of ADHD.

Notwithstanding any other provisions in the provider manual, medical assistance included in an ADHD episode shall not be subject to prior authorization requirements.

212.200 Principal Accountable Provider **10-1-12**

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

If the provider responsible for the largest number of claims is a physician or an RSPMI provider organization, that provider 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.

If the provider responsible for the largest number of claims is a licensed clinical psychologist operating outside of an RSPMI provider organization, that provider is a co-PAP with the physician or RSPMI provider providing the next largest number of claims within the episode. 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 co-PAP.

Where there are co-PAPs for an episode, the positive or negative supplemental payments are divided equally between the co-PAPs.

212.300 Exclusions **10-1-12**

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

A. Duration of less than 4 months

B. Small number of medical and/or pharmacy claims during the episode

C. Beneficiaries with any behavioral health comorbid condition

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

212.400 Adjustments **10-1-12**

Total reimbursement attributable to the PAP for episodes with a duration of less than 12 months will be scaled linearly to determine a reimbursement per 12-months for the purpose of calculating the PAP's performance.

212.500 Quality Measures **10-1-12**

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

B. *Quality measures "to track":*

1. In order to track and evaluate selected quality measures, providers are asked to complete a "Quality Assessment" certification (for beneficiaries new to the provider) or a "Continuing Care" certification (for beneficiaries previously receiving services from the provider)
2. Percentage of episodes classified as Level II
3. Average number of physician visits/episode
4. Percentage of episodes with medication
5. Percentage of episodes certified as non-guideline concordant
6. Percentage of episodes certified as non-guideline concordant with no rationale

212.600 Thresholds for Incentive Payments **10-1-12**

A. *ADHD Level I*

1. The acceptable threshold is $2,223.
2. The commendable threshold is $1,547.
3. The gain sharing limit is $700.
4. The gain sharing percentage is 50%.
5. The risk sharing percentage is 50%.

B. *ADHD Level II*

1. The acceptable threshold is $7,112.
2. The commendable threshold is $5,403.
3. The gain sharing limit is $2,223.
4. The gain sharing percentage is 50%.
5. The risk sharing percentage is 50%.

212.700 Minimum Case Volume **10-1-12**

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

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – All Providers**

DATE: **October 1, 2012**

SUBJECT: **Provider Manual Update Transmittal SecI-3-12**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
___	___	180.000	___
___	___	181.000	10-1-12

Explanation of Updates

Section 180.000 is added as the new Episodes of Care section heading.

Section 181.000 is added to describe the new payment improvement initiative for Arkansas Medicaid providers.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

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Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director

TOC required

180.000 EPISODES OF CARE

181.000 INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY AND ECONOMY

10-1-12

A. Definitions

1. An "episode" refers to a defined collection of related Medicaid-covered health care services provided to a specific Medicaid beneficiary.

2. An "episode type" is defined by a diagnosis, health care intervention, or condition during a specific timeframe (or performance period).

3. "Thresholds" are the upper and lower reimbursement benchmarks for an episode of care.

B. Medicaid has established a payment improvement initiative ("payment improvement program") 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. **Please refer to the Episodes of Care Medicaid Manual for information about specific episodes.**

C. The payment improvement program is separate from, and does not alter, current methods for reimbursement.

D. The payment improvement program promotes efficiency, economy and quality of care by rewarding high-quality care and outcomes, encouraging clinical effectiveness, promoting early intervention and coordination to reduce complications and associated costs, and, when provider referrals are necessary, by encouraging referral to efficient and economic providers who furnish high-quality care.

E. All medical assistance provided in the delivery of care for an episode may be included in the determination of a supplemental payment incentive under the payment improvement program.

F. Payment incentives may be positive or negative. Incentive payments are calculated and made retrospectively after care has been completed and reimbursed in accordance with the published reimbursement methodology. Incentive payments are based on the aggregate of valid, paid claims across a provider's episodes and are not relatable to any individual provider claim for payment.

G. Medicaid establishes episode definitions, levels of supplemental incentive payments and appropriate quality measures based on evidence-based practices. To identify evidence-based practices, Medicaid shall consider clinical information furnished by Arkansas providers of the care and services typically rendered during the episode of care, and may also consider input from one or more quality improvement organizations ("QIO's") or QIO-like entities, peer-reviewed medical literature, or any combination thereof.

H. Principal Accountable Providers

The principal accountable provider(s) (PAPs) for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAPs after an episode is complete using algorithms described in the episode definition.

I. Supplemental Payment Incentives

For each PAP for each applicable episode type:

1. Performance will be aggregated and assessed over a specified period of time ("performance period"). For each PAP, the average reimbursement across all relevant episodes completed during the performance period will be calculated, based on the set of services included in the episode definition published and made available to providers.

2. Some episodes may be excluded and reimbursement for some episodes may be adjusted in this calculation, based on clinical or other factors, as described in the definition of each episode.

3. The average adjusted reimbursement of all episodes for the PAP during the performance period will be compared to thresholds established by Medicaid with advice from providers.

4. If the average adjusted episode reimbursement is lower than the commendable threshold and the PAP has documented that the quality requirements established by Medicaid for each episode type have been met, Medicaid will make a positive supplemental payment to the PAP. This payment will be equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation and multiplied by a gain sharing percentage for the episode. Where necessary, a gain sharing limit will be established to avoid incentives for underutilization. PAPs with average adjusted episode reimbursement lower than the gain sharing limit will receive a supplemental payment calculated as though their average adjusted episode reimbursement were equal to the gain sharing limit.

5. If the average episode reimbursement is higher than the acceptable threshold, the PAP will incur a negative supplemental payment. This payment to Medicaid will be equal to the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation and multiplied by a risk sharing percentage defined by Medicaid for the episode.

J. Principles for determining "thresholds"

1. The threshold process aims to incentivize high-quality clinical care delivered efficiently, and to consider several factors including the potential to improve patient access, the impact on provider economics and the level and type of practice pattern changes required for performance improvement.

2. The acceptable threshold is set such that average cost per episode above the acceptable threshold reflects unacceptable performance, which could result from a large variation from typical performance without clinical justification (e.g., individual provider variation) or from system-wide variance from widely accepted clinical standards.

3. The commendable threshold is set such that outperforming the commendable threshold represents quality care provided at a lower total reimbursement, which would result from care at meaningfully better than current average reimbursement in Arkansas, consistent with good medical outcomes. Medicaid may take into consideration what a clinically feasible target would be, as demonstrated by historical reimbursement variance in Arkansas.

4. The gain-sharing limit is set to avoid the risk of incentivizing care delivery at a cost that could compromise quality.

5. The gain and risk sharing percentages aim to recognize required provider investment in practice change and will be set at a sustainable level for Medicaid.

K. Outlier Patient Exclusions

Calculation of average adjusted episode reimbursement for each PAP will exclude outlier patients who have extraordinarily high risk/severity so that one or a few cases do not meaningfully misrepresent a provider's performance across the provider's broader patient population.

L. Provider-level adjustments

1. Supplemental payment incentives for each PAP take into account provider-level adjustments, which may include stop-loss provisions, adjustments for cost-based facilities, adjustments or exclusions for providers with low case volume or any combination thereof.

2. Medicaid has modeled the potential impact of thresholds on individual providers given historical treatment patterns, and under a number of scenarios representing meaningful improvement toward a more consistent provision of evidence-based care, and have identified a number of providers of ADHD services that far exceed clinical expectations in the volume of services reimbursed for Medicaid beneficiaries, and for whom reimbursement for ADHD services represents a significant percentage of total Medicaid reimbursement. To help sustain these providers for a reasonable period of transition as they seek to achieve acceptable levels of reimbursement and a clinically appropriate volume of services for the treatment of ADHD, Medicaid will apply stop-loss protection across all episodes for one year such that the net negative supplemental payment payable in a period (i.e., the total of all negative supplemental payments in a period minus the total of all positive supplemental payments in the same period) is capped at 10% of Medicaid reimbursement in the period.

3. Temporary stop-loss provisions may apply when necessary to ensure access to care.

4. Providers that receive cost-based or PPS-based reimbursement are reimbursed as specified in the corresponding provider manual(s), but are subject to positive and negative supplemental payment incentives in order to achieve statewide improvement in quality and efficiency. For episodes including services furnished by providers who receive at exceptional reimbursement levels, reimbursements attributed to PAPs for the purpose of calculating performance are computed as if the provider did not receive exceptional reimbursement.

5. Minimum case volume thresholds exclude from supplemental payment incentives those providers whose case volume includes too few cases to generate a robust measure of performance. Medicaid will set a minimum case volume for each episode type. PAPs who do not meet the minimum case volume for an episode type will not be eligible for positive or negative supplemental payments for that episode type.

M. Quality

1. For each episode type, there will be a set of quality metrics "to pass" and a set of quality metrics "to track." These quality metrics may be based on claims data or based on additional data specified by Medicaid, which PAPs will be required to report.

2. To quality for positive supplemental payments, PAPs must report all required data and meet specific thresholds for the quality metrics "to pass."

3. Providers who do not report data or who do not meet minimum quality thresholds may still incur negative supplemental payments if their average adjusted episode reimbursement exceeds the acceptable threshold.

N. Consideration of the aggregate cost and quality of care is not a retrospective review of the medical necessity of care rendered to any particular patient, nor is such consideration intended to supplant any retrospective review or other program integrity activity.

2.b. Rural Health Clinic Services

Rural health clinic services are limited to twelve (12) visits a year for beneficiaries age 21 and older. This yearly limit is based on the State Fiscal Year (July I through June 30). The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist and certified nurse midwife services. Beneficiaries will be allowed twelve (12) visits per State Fiscal Year for rural health clinic services, physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services or a combination of the five. For physicians' services, medical services provided by a dentist, office medical services furnished by an optometrist certified nurse midwife services or rural health clinic core services beyond the 12 visit limit, extensions will be provided if medically necessary. **Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit.** Beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

Rural Health Clinic core services are defined as follows:

1. Physicians' services including required physician supervisory services of nurse practitioners and physician assistants;

2. Services and supplies furnished as an incident to a physician's professional services;

   Services and supplies "incident to" the professional services of physicians, physician assistants and/or nurse practitioners are those which are commonly furnished in connection with these professional services, are generally furnished in the physician's office and are ordinarily rendered without charge or included in the clinic's bills; e.g., laboratory services, ordinary medications and other services and supplies used in patient primary care services.

3. Clinical psychologist services;

4. Clinical social worker services;

2.b. Rural Health Clinic Services

5. Services of physician assistants, nurse practitioners; nurse midwives and specialized nurse practitioners;

6. Services and supplies furnished as an incident to a nurse practitioner's or physician assistant's services; and

7. Visiting nurse services on a part-time or intermittent basis to home-bound patients) limited to areas in which there is a shortage of home health agencies).

Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the Rural Health Clinic offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the Rural Health Clinic will count against the limit established in the plan for that service.

2.c. Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual)NCFA – Pub. 45-4).

Effective for claims with dates of service on or after July 1, 1995, federally qualified health center (FQHC) services are limited to twelve (12) encounters per beneficiary, per State Fiscal Year (July 1 through June 30) for beneficiaries age 21 and older. For federally qualified health center core services beyond the 12 visit limit, extensions will be provided if medically necessary. Beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

FQHC hospital visits are limited to one day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (Continued)

2. Rehabilitative Services for Persons with Physical Disabilities (RSPD)

a. Extended Rehabilitative Hospital Services

Extended Rehabilitative Hospital Services are services for the rehabilitation of patients with various neurological, musculo-skeletal, orthopedic and other medical conditions following stabilization of their acute medical conditions. Extended Rehabilitative Hospital Services are a global service, covering all rehabilitative, psychological and/or social services required of the admitting facility for licensure, certification and/or accreditation.

The following services are included in the global coverage of an Extended Rehabilitative Hospital:

1) Restorative Therapies
2) Behavioral Rehabilitation
3) Life Skills Training
4) Individual and Group Counseling
5) Assessment Services
6) Nursing Care

Persons eligible for admission must have at least one of the following neurological conditions: Post acute traumatic or acquired brain injury. This includes and is limited to viral encephalitis, meningitis, aneurysms, cerebral vascular accident/stroke, post-operative tumors, anoxia, hypoxias, toxic encephalopathies, refractory seizure disorders and congenital neurological brain disorders. These conditions can be with or without moderate to severe behavioral disorders secondary to a brain injury.

An Extended Rehabilitative Hospital must be licensed by the Division of Health as a Rehabilitative Hospital. An Extended Rehabilitative Hospital must also be certified as a Title XVIII (Medicare) Rehabilitative Hospital provider. Extended Rehabilitative Hospital services are provided by a licensed practitioner who is directly related to the beneficiary's rehabilitative adjustment.

Extended Rehabilitative Hospital services provided are limited to thirty (30) days per state fiscal year, July 1 through June 30, for ages 21 and older. No extensions will be considered. However, beneficiaries who are under the age of 21 years and in the Child Health Services (EPSDT) Program are not limited to the thirty (30) day annual benefit limit. The thirty (30) day annual benefit limit only applies to services provided in an RSPD facility and does not include days counted toward any other Medicaid Program benefit limit, e.g., hospital, nursing home, etc.

Service delivery is delivery is the same as inpatient hospital services described in Attachment 3.1-A, Page 1a, Item 1, minus the room and board component.

Extended Rehabilitative Hospital Services are available to eligible Medicaid recipients of all ages when medically necessary as determined by the PRO. Services are limited to 30 days per State Fiscal Year for beneficiaries age 21 and older. Recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

2.b. Rural Health Clinic Services

Rural health clinic services are limited to twelve (12) visits a year for beneficiaries age 21 and older. This yearly limit is based on the State Fiscal Year (July I through June 30). The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist and certified nurse midwife services. Beneficiaries will be allowed twelve (12) visits per State Fiscal Year for rural health clinic services, physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services or a combination of the five. For physicians' services, medical services provided by a dentist, office medical services furnished by an optometrist certified nurse midwife services or rural health clinic core services beyond the 12 visit limit, extensions will be provided if medically necessary. **Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit.** Beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

Rural Health Clinic core services are defined as follows:

1. Physicians' services including required physician supervisory services of nurse practitioners and physician assistants;

2. Services and supplies furnished as an incident to a physician's professional services;

   Services and supplies "incident to" the professional services of physicians, physician assistants and/or nurse practitioners are those which are commonly furnished in connection with these professional services, are generally furnished in the physician's office and are ordinarily rendered without charge or included in the clinic's bills; e.g., laboratory services, ordinary medications and other services and supplies used in patient primary care services.

3. Clinical psychologist services;

4. Clinical social worker services;

2.b. Rural Health Clinic Services

5. Services of physician assistants, nurse practitioners; nurse midwives and specialized nurse practitioners;

6. Services and supplies furnished as an incident to a nurse practitioner's or physician assistant's services; and

7. Visiting nurse services on a part-time or intermittent basis to home-bound patients) limited to areas in which there is a shortage of home health agencies).

Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the Rural Health Clinic offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the Rural Health Clinic will count against the limit established in the plan for that service.

2.c. Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual)NCFA – Pub. 45-4).

Effective for claims with dates of service on or after July 1, 1995, federally qualified health center (FQHC) services are limited to twelve (12) encounters per beneficiary, per State Fiscal Year (July 1 through June 30) for beneficiaries age 21 and older. For federally qualified health center core services beyond the 12 visit limit, extensions will be provided if medically necessary. Beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

FQHC hospital visits are limited to one day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (Continued)

2. Rehabilitative Services for Persons with Physical Disabilities (RSPD)

a. Extended Rehabilitative Hospital Services

Extended Rehabilitative Hospital Services are services for the rehabilitation of patients with various neurological, musculo-skeletal, orthopedic and other medical conditions following stabilization of their acute medical conditions. Extended Rehabilitative Hospital Services are a global service, covering all rehabilitative, psychological and/or social services required of the admitting facility for licensure, certification and/or accreditation.

The following services are included in the global coverage of an Extended Rehabilitative Hospital:

1) Restorative Therapies
2) Behavioral Rehabilitation
3) Life Skills Training
4) Individual and Group Counseling
5) Assessment Services
6) Nursing Care

Persons eligible for admission must have at least one of the following neurological conditions: Post acute traumatic or acquired brain injury. This includes and is limited to viral encephalitis, meningitis, aneurysms, cerebral vascular accident/stroke, post-operative tumors, anoxia, hypoxias, toxic encephalopathies, refractory seizure disorders and congenital neurological brain disorders. These conditions can be with or without moderate to severe behavioral disorders secondary to a brain injury.

An Extended Rehabilitative Hospital must be licensed by the Division of Health as a Rehabilitative Hospital. An Extended Rehabilitative Hospital must also be certified as a Title XVIII (Medicare) Rehabilitative Hospital provider. Extended Rehabilitative Hospital services are provided by a licensed practitioner who is directly related to the beneficiary's rehabilitative adjustment.

Extended Rehabilitative Hospital services provided are limited to thirty (30) days per state fiscal year, July 1 through June 30, for ages 21 and older. No extensions will be considered. However, beneficiaries who are under the age of 21 years and in the Child Health Services (EPSDT) Program are not limited to the thirty (30) day annual benefit limit. The thirty (30) day annual benefit limit only applies to services provided in an RSPD facility and does not include days counted toward any other Medicaid Program benefit limit, e.g., hospital, nursing home, etc.

Service delivery is delivery is the same as inpatient hospital services described in Attachment 3.1-A, Page 1a, Item 1, minus the room and board component.

Extended Rehabilitative Hospital Services are available to eligible Medicaid recipients of all ages when medically necessary as determined by the PRO. Services are limited to 30 days per State Fiscal Year for beneficiaries age 21 and older. Recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

State/Territory: ARKANSAS

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

☒ **Provided:** ☐ No limitations ☒ With limitations* **with Prior Authorization**

☐ Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ with limitations*

☐ Not provided.

b. Services of Christian Science nurses.

☐ Provided: ☐ No limitations ☐ with limitations*

☒ Not provided.

c. Care and services provided in Christian Science sanitoria.

☐ Provided: ☐ No limitations ☐ with limitations*

☒ Not provided.

d. Nursing facility services for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ with limitations*

☐ Not provided.

e. Emergency hospital services.

☒ Provided: ☐ No limitations ☒ with limitations*

☐ Not provided.

f. Critical Access Hospital (CAH).

☒ Provided: ☐ No limitations ☒ with limitations*

☐ Not provided.

*Description provided on attachment.

1. Inpatient Hospital Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

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.

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

1. Inpatient Hospital Services (continued)

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

IV. INCENTIVE ADJUSTMENTS: The Program promotes efficient and economic care utilization by making incentive adjustments based on the aggregate valid and paid claims ("paid claims") across a PAP's episodes of care ending during the twelve (12) month performance period specified for the episode. Unless provided otherwise for a specific episode of care, incentive adjustments are made annually in the form of gain sharing (positive incentive adjustments) or provider risk sharing payments to Medicaid (negative incentive adjustments), and equal 50% of the difference between the average adjusted episode expenditures and the applicable threshold as described below. Incentive adjustments will occur no later than ninety (90) days after the end of the performance period. Because the incentive adjustments are based on aggregated and averaged claims data for a particular performance period, adjustments cannot be apportioned to specific provider claims.

1. Positive Incentive Adjustments: If the PAP's average adjusted episode paid claims are lower than the commendable threshold and the PAP meets the quality requirements established by Medicaid for each episode type, Medicaid will remit an incentive adjustment to the PAP equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation, multiplied by 50% or the gain sharing percentage specified for the episode of care. To avoid incentivizing underutilization, Medicaid may establish a gain sharing limit. PAPs with average adjusted episode expenditures lower than the gain sharing limit will receive an incentive adjustment calculated as though the PAP's average adjusted episode of care paid claims equal the gain sharing limit.

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by 50% or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episodes of care during any performance period shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements during that performance period.

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 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**

2.a. Outpatient Hospital Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

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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III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

2.a. Outpatient Hospital Services (continued)

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

IV. INCENTIVE ADJUSTMENTS: The Program promotes efficient and economic care utilization by making incentive adjustments based on the aggregate valid and paid claims ("paid claims") across a PAP's episodes of care ending during the twelve (12) month performance period specified for the episode. Unless provided otherwise for a specific episode of care, incentive adjustments are made annually in the form of gain sharing (positive incentive adjustments) or provider risk sharing payments to Medicaid (negative incentive adjustments), and equal 50% of the difference between the average adjusted episode expenditures and the applicable threshold as described below. Incentive adjustments will occur no later than ninety (90) days after the end of the performance period. Because the incentive adjustments are based on aggregated and averaged claims data for a particular performance period, adjustments cannot be apportioned to specific provider claims.

1. Positive Incentive Adjustments: If the PAP's average adjusted episode paid claims are lower than the commendable threshold and the PAP meets the quality requirements established by Medicaid for each episode type, Medicaid will remit an incentive adjustment to the PAP equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation, multiplied by 50% or the gain sharing percentage specified for the episode of care. To avoid incentivizing underutilization, Medicaid may establish a gain sharing limit. PAPs with average adjusted episode expenditures lower than the gain sharing limit will receive an incentive adjustment calculated as though the PAP's average adjusted episode of care paid claims equal the gain sharing limit.

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by 50% or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episodes of care during any performance period shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements during that performance period.

2.a. Outpatient 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 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**

2.b. Rural Health Clinic Services and other ambulatory services that are covered under the plan and furnished by a rural health clinic (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

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.

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

2.b. Rural Health Clinic Services and other ambulatory services that are covered under the plan and furnished by a rural health clinic (continued)

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

IV. INCENTIVE ADJUSTMENTS: The Program promotes efficient and economic care utilization by making incentive adjustments based on the aggregate valid and paid claims ("paid claims") across a PAP's episodes of care ending during the twelve (12) month performance period specified for the episode. Unless provided otherwise for a specific episode of care, incentive adjustments are made annually in the form of gain sharing (positive incentive adjustments) or provider risk sharing payments to Medicaid (negative incentive adjustments), and equal 50% of the difference between the average adjusted episode expenditures and the applicable threshold as described below. Incentive adjustments will occur no later than ninety (90) days after the end of the performance period. Because the incentive adjustments are based on aggregated and averaged claims data for a particular performance period, adjustments cannot be apportioned to specific provider claims.

1. Positive Incentive Adjustments: If the PAP's average adjusted episode paid claims are lower than the commendable threshold and the PAP meets the quality requirements established by Medicaid for each episode type, Medicaid will remit an incentive adjustment to the PAP equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation, multiplied by 50% or the gain sharing percentage specified for the episode of care. To avoid incentivizing underutilization, Medicaid may establish a gain sharing limit. PAPs with average adjusted episode expenditures lower than the gain sharing limit will receive an incentive adjustment calculated as though the PAP's average adjusted episode of care paid claims equal the gain sharing limit.

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by 50% or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episodes of care during any performance period shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements during that performance period.

2.b. Rural Health Clinic Services and other ambulatory services that are covered under the plan and furnished by a rural health clinic (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) **Perinatal Care 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

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

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.

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

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)

IV. INCENTIVE ADJUSTMENTS: The Program promotes efficient and economic care utilization by making incentive adjustments based on the aggregate valid and paid claims ("paid claims") across a PAP's episodes of care ending during the twelve (12) month performance period specified for the episode. Unless provided otherwise for a specific episode of care, incentive adjustments are made annually in the form of gain sharing (positive incentive adjustments) or provider risk sharing payments to Medicaid (negative incentive adjustments), and equal 50% of the difference between the average adjusted episode expenditures and the applicable threshold as described below. Incentive adjustments will occur no later than ninety (90) days after the end of the performance period. Because the incentive adjustments are based on aggregated and averaged claims data for a particular performance period, adjustments cannot be apportioned to specific provider claims.

1. Positive Incentive Adjustments: If the PAP's average adjusted episode paid claims are lower than the commendable threshold and the PAP meets the quality requirements established by Medicaid for each episode type, Medicaid will remit an incentive adjustment to the PAP equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation, multiplied by 50% or the gain sharing percentage specified for the episode of care. To avoid incentivizing underutilization, Medicaid may establish a gain sharing limit. PAPs with average adjusted episode expenditures lower than the gain sharing limit will receive an incentive adjustment calculated as though the PAP's average adjusted episode of care paid claims equal the gain sharing limit.

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by 50% or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episodes of care during any performance period shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements during that performance period.

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**

5. Physicians' Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

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.

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

5. Physicians' Services (continued)

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

IV. INCENTIVE ADJUSTMENTS: The Program promotes efficient and economic care utilization by making incentive adjustments based on the aggregate valid and paid claims ("paid claims") across a PAP's episodes of care ending during the twelve (12) month performance period specified for the episode. Unless provided otherwise for a specific episode of care, incentive adjustments are made annually in the form of gain sharing (positive incentive adjustments) or provider risk sharing payments to Medicaid (negative incentive adjustments), and equal 50% of the difference between the average adjusted episode expenditures and the applicable threshold as described below. Incentive adjustments will occur no later than ninety (90) days after the end of the performance period. Because the incentive adjustments are based on aggregated and averaged claims data for a particular performance period, adjustments cannot be apportioned to specific provider claims.

1. Positive Incentive Adjustments: If the PAP's average adjusted episode paid claims are lower than the commendable threshold and the PAP meets the quality requirements established by Medicaid for each episode type, Medicaid will remit an incentive adjustment to the PAP equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation, multiplied by 50% or the gain sharing percentage specified for the episode of care. To avoid incentivizing underutilization, Medicaid may establish a gain sharing limit. PAPs with average adjusted episode expenditures lower than the gain sharing limit will receive an incentive adjustment calculated as though the PAP's average adjusted episode of care paid claims equal the gain sharing limit.

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by 50% or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episodes of care during any performance period shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements during that performance period.

5. Physicians' 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) **Acute Ambulatory Upper Respiratory Infection (URI) Episodes**
(2) **Perinatal Care Episodes**
(3) **Attention Deficit Hyperactivity Disorder (ADHD) Episodes**

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

d. Eyeglasses

Negotiated statewide contract bid.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan

a. Diagnostic Services - Not provided.
b. Screening Services - Not provided.
c. Preventive Services - Not provided.
d. Rehabilitative Services

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

Reimbursement is based on the lower of the amount billed or the Title XIX (Medicaid) maximum allowable. Except as otherwise noted in the state plan, state developed fee schedule rates are the same for both governmental and private providers of RSPMI services. The agency's fee schedule rates were set as of April 1, 1988 and are effective for services provided on or after that date. All rates are published on the agency's website at www.medicaid.state.ar.us.

Effective for dates of service on or after April 1, 2004, reimbursement rates (payments) for inpatient visits in acute care hospitals by board certified psychiatrists shall be as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds. Refer to Attachment 4.19-B, Item 5, for physician reimbursement.

The State shall not claim FFP for any non institutional service provided to individuals who are residents of facilities that meet the Federal definition of an institution for mental diseases or a psychiatric residential treatment facility as described in Federal regulations at 42 CFR 1440 and 14460 and 42 CFR 441 Subparts C and D. Reimbursement of RSPMI services that are provided in IMD's will be discontinued for services provided on or after September 1, 2011.

For RSPMI services provided in clinics operated by State operated teaching hospitals.

Effective for claims with dates of service on or after March 1, 2002, Arkansas State Operated Teaching Hospital psychiatric clinics that are not part of a hospital outpatient department shall be reimbursed based on reasonable costs with interim payments at the RSPMI fee schedule rates and a year-end cost settlement. The provider will be paid the lesser of actual costs identified using a CMS approved cost report or customary charges. Each Arkansas State Operated Teaching Hospital with qualifying psychiatric clinics shall submit an annual cost report. Said cost report shall be submitted within five (5) months after the close of the hospital's fiscal year. Failure to file the cost report within the prescribed period, except as expressly extended by the State Medicaid Agency, may result in suspension of reimbursement until the cost report is filed. The State Medicaid Agency will review the submitted cost report and make a tentative settlement within 60 days of the receipt of the cost report and will make final settlement in the following year after all Medicaid charges and payments have been processed. The final settlement will be calculated and made at the same time as the next year's tentative settlement is calculated and made.

Medical professionals affiliated with Arkansas State Operated Teaching Hospitals are not eligible for additional reimbursement for services provided in these clinics.

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

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

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.

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

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)

IV. INCENTIVE ADJUSTMENTS: The Program promotes efficient and economic care utilization by making incentive adjustments based on the aggregate valid and paid claims ("paid claims") across a PAP's episodes of care ending during the twelve (12) month performance period specified for the episode. Unless provided otherwise for a specific episode of care, incentive adjustments are made annually in the form of gain sharing (positive incentive adjustments) or provider risk sharing payments to Medicaid (negative incentive adjustments), and equal 50% of the difference between the average adjusted episode expenditures and the applicable threshold as described below. Incentive adjustments will occur no later than ninety (90) days after the end of the performance period. Because the incentive adjustments are based on aggregated and averaged claims data for a particular performance period, adjustments cannot be apportioned to specific provider claims.

1. Positive Incentive Adjustments: If the PAP's average adjusted episode paid claims are lower than the commendable threshold and the PAP meets the quality requirements established by Medicaid for each episode type, Medicaid will remit an incentive adjustment to the PAP equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation, multiplied by 50% or the gain sharing percentage specified for the episode of care. To avoid incentivizing underutilization, Medicaid may establish a gain sharing limit. PAPs with average adjusted episode expenditures lower than the gain sharing limit will receive an incentive adjustment calculated as though the PAP's average adjusted episode of care paid claims equal the gain sharing limit.

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by 50% or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episodes of care during any performance period shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements during that performance period.

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

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)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

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.

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

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)

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

IV. INCENTIVE ADJUSTMENTS: The Program promotes efficient and economic care utilization by making incentive adjustments based on the aggregate valid and paid claims ("paid claims") across a PAP's episodes of care ending during the twelve (12) month performance period specified for the episode. Unless provided otherwise for a specific episode of care, incentive adjustments are made annually in the form of gain sharing (positive incentive adjustments) or provider risk sharing payments to Medicaid (negative incentive adjustments), and equal 50% of the difference between the average adjusted episode expenditures and the applicable threshold as described below. Incentive adjustments will occur no later than ninety (90) days after the end of the performance period. Because the incentive adjustments are based on aggregated and averaged claims data for a particular performance period, adjustments cannot be apportioned to specific provider claims.

1. Positive Incentive Adjustments: If the PAP's average adjusted episode paid claims are lower than the commendable threshold and the PAP meets the quality requirements established by Medicaid for each episode type, Medicaid will remit an incentive adjustment to the PAP equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation, multiplied by 50% or the gain sharing percentage specified for the episode of care. To avoid incentivizing underutilization, Medicaid may establish a gain sharing limit. PAPs with average adjusted episode expenditures lower than the gain sharing limit will receive an incentive adjustment calculated as though the PAP's average adjusted episode of care paid claims equal the gain sharing limit.

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by 50% or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episodes of care during any performance period shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements during that performance period.

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)

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) **Perinatal Care 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)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

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.

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

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)

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

IV. INCENTIVE ADJUSTMENTS: The Program promotes efficient and economic care utilization by making incentive adjustments based on the aggregate valid and paid claims ("paid claims") across a PAP's episodes of care ending during the twelve (12) month performance period specified for the episode. Unless provided otherwise for a specific episode of care, incentive adjustments are made annually in the form of gain sharing (positive incentive adjustments) or provider risk sharing payments to Medicaid (negative incentive adjustments), and equal 50% of the difference between the average adjusted episode expenditures and the applicable threshold as described below. Incentive adjustments will occur no later than ninety (90) days after the end of the performance period. Because the incentive adjustments are based on aggregated and averaged claims data for a particular performance period, adjustments cannot be apportioned to specific provider claims.

1. Positive Incentive Adjustments: If the PAP's average adjusted episode paid claims are lower than the commendable threshold and the PAP meets the quality requirements established by Medicaid for each episode type, Medicaid will remit an incentive adjustment to the PAP equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation, multiplied by 50% or the gain sharing percentage specified for the episode of care. To avoid incentivizing underutilization, Medicaid may establish a gain sharing limit. PAPs with average adjusted episode expenditures lower than the gain sharing limit will receive an incentive adjustment calculated as though the PAP's average adjusted episode of care paid claims equal the gain sharing limit.

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by 50% or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episodes of care during any performance period shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements during that performance period.

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)

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) **Perinatal Care Episodes**

27. Advanced Practice Nurse and Registered Nurse Practitioner licensed as such by the Arkansas State Board of Nursing. (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

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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III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

27. Advanced Practice Nurse and Registered Nurse Practitioner licensed as such by the Arkansas State Board of Nursing. (Continued)

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

IV. INCENTIVE ADJUSTMENTS: The Program promotes efficient and economic care utilization by making incentive adjustments based on the aggregate valid and paid claims ("paid claims") across a PAP's episodes of care ending during the twelve (12) month performance period specified for the episode. Unless provided otherwise for a specific episode of care, incentive adjustments are made annually in the form of gain sharing (positive incentive adjustments) or provider risk sharing payments to Medicaid (negative incentive adjustments), and equal 50% of the difference between the average adjusted episode expenditures and the applicable threshold as described below. Incentive adjustments will occur no later than ninety (90) days after the end of the performance period. Because the incentive adjustments are based on aggregated and averaged claims data for a particular performance period, adjustments cannot be apportioned to specific provider claims.

1. Positive Incentive Adjustments: If the PAP's average adjusted episode paid claims are lower than the commendable threshold and the PAP meets the quality requirements established by Medicaid for each episode type, Medicaid will remit an incentive adjustment to the PAP equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation, multiplied by 50% or the gain sharing percentage specified for the episode of care. To avoid incentivizing underutilization, Medicaid may establish a gain sharing limit. PAPs with average adjusted episode expenditures lower than the gain sharing limit will receive an incentive adjustment calculated as though the PAP's average adjusted episode of care paid claims equal the gain sharing limit.

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by 50% or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episodes of care during any performance period shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements during that performance period.

27. Advanced Practice Nurse and Registered Nurse Practitioner licensed as such by the Arkansas State Board of Nursing. (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) **Acute Ambulatory Upper Respiratory Infection (URI) Episodes**
(2) **Perinatal Care Episodes**