4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(17) Psychology Services (Continued)

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

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

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

(1) **Attention Deficit Hyperactivity Disorder (ADHD) Episodes**

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

(1) **Oppositional Defiant Disorder (ODD) Episodes**

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**

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

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

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

(1) **Tonsillectomy Episodes**
(2) **Cholecystectomy Episodes**
(3) **Colonoscopy Episodes**
(4) **Oppositional Defiant Disorder (ODD) Episodes**

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

(d) Rehabilitative Services (Continued)

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

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

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

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

(1) **Attention Deficit Hyperactivity Disorder (ADHD) Episodes**

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

(1) **Oppositional Defiant Disorder (ODD) Episodes**

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, 2013**

SUBJECT: **Provider Manual Update Transmittal EPISODE-1-13**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
211.100	10-1-12	211.100	10-1-13
211.300	10-1-12	211.300	10-1-13
212.300	10-1-12	212.300	10-1-13
213.100	2-1-13	213.100	10-1-13
214.100	2-1-13	214.100	10-1-13
—	—	215.000	10-1-13
—	—	215.100	10-1-13
—	—	215.200	10-1-13
—	—	215.300	10-1-13
—	—	215.400	10-1-13
—	—	215.500	10-1-13
—	—	215.600	10-1-13
—	—	215.700	10-1-13
—	—	216.000	10-1-13
—	—	216.100	10-1-13
—	—	216.200	10-1-13
—	—	216.300	10-1-13
—	—	216.400	10-1-13
—	—	216.500	10-1-13
—	—	216.600	10-1-13
—	—	216.700	10-1-13
—	—	217.000	10-1-13
—	—	217.100	10-1-13
—	—	217.200	10-1-13
—	—	217.300	10-1-13
—	—	217.400	10-1-13
—	—	217.500	10-1-13
—	—	217.600	10-1-13
—	—	217.700	10-1-13

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__	__	218.100	10-1-13
__	__	218.200	10-1-13
__	__	218.300	10-1-13
__	__	218.400	10-1-13
__	__	218.500	10-1-13
__	__	218.600	10-1-13
__	__	218.700	10-1-13

Explanation of Updates

Section 211.100 is updated to clarify that there are no subtypes for the Perinatal episode of care.

Section 211.300 is updated to clarify the exclusions for the Perinatal Care episode of care.

Section 212.300 is updated to clarify the exclusions for the Attention Deficit Hyperactivity Disorder (ADHD) episode of care.

Section 213.100 is updated to clarify the episode services and to add continuous Medicaid enrollment information for the Congestive Heart Failure (CHF) episode of care. It is also reformatted to match the established manual style.

Section 214.100 is updated to clarify the episode services for the Total Joint Replacement episode of care. It is also reformatted to match the established manual style.

Sections 215.000, 215.100, 215.200, 215.300, 215.400, 215.500, 215.600, and 215.700 are added to provide information pertaining to the Oppositional Defiant Disorder (ODD) episode of care.

Sections 216.000, 216.100, 216.200, 216.300, 216.400, 216.500, 216.600, and 216.700 are added to provide information pertaining to the Colonoscopy episode of care.

Sections 217.000, 217.100, 217.200, 217.300, 217.400, 217.500, 217.600, and 217.700 are added to provide information pertaining to the Tonsillectomy episode of care.

Sections 218.000, 218.100, 218.200, 218.300, 218.400, 218.500, 218.600, and 218.700 are added to provide information pertaining to the Cholecystectomy episode of care.

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 Arkansas Payment Improvement Initiative Center at 1-866-322-4696 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 301-8311.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at 501-320-6429.

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.

_____

Andrew Allison, PhD
Director

TOC required

211.100 Episode Definition/Scope of Services 10-1-13

A. *Episode subtypes:*

There are no subtypes for this episode type.

B. *Episode trigger:*

A live birth on a facility claim

C. *Episode duration:*

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

D. *Episode services:*

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

211.300 Exclusions 10-1-13

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, cerebrovascular disorders

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

212.300 Exclusions 10-1-13

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 comorbid behavioral health condition or developmental disability

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

213.100 Episode Definition/Scope of Services 10-1-13

A. *Episode subtypes:*

There are no subtypes for this episode type.

B. *Episode trigger:*

Inpatient admission with a primary diagnosis code for heart failure

C. *Episode duration:*

Episodes begin at inpatient admission for heart failure. Episodes end at the latter of 30 days after the date of discharge for the triggering admission or the date of discharge for any inpatient readmission initiated within 30 days of the initial discharge. Episodes shall not exceed 45 days post-discharge from the triggering admission.

D. *Episode services:*

The episode will include all of the following services rendered within the episode's duration:

1. Inpatient facility and professional fees for the initial hospitalization and for all cause readmissions (excluding those defined by Bundled Payments for Care Improvement (BPCI))
2. Emergency or observation care
3. Home health services
4. Skilled nursing facility care due to acute exacerbation of CHF (services not included in episode for patients with SNF care in 30 days prior to episode start)
5. Durable medical equipment

E. *Continuous Medicaid Enrollment*

For the purpose of the CHF episode, the beneficiary must be enrolled in Medicaid beginning at least 30 days before the start of the episode and maintain continuous enrollment in Medicaid for the duration of the episode.

214.100 Episode Definition/Scope of Services 10-1-13

A. *Episode subtypes:*

There are no subtypes for this episode type.

B. *Episode trigger:*

A surgical procedure for total hip replacement or total knee replacement

C. *Episode duration:*

Episodes begin 30 days prior to the date of admission for the inpatient hospitalization for the total joint replacement surgery and end 90 days after the date of discharge.

D. *Episode services:*

The following services are included in the episode:

1. From 30 days prior to the date of admission to the date of the surgery: All evaluation and management, hip- or knee-related radiology and all labs/imaging/other outpatient services
2. During the triggering procedure: all medical, inpatient and outpatient services
3. From the date of the surgery to 30 days after the date of discharge: All cause readmissions (excluding those defined by Bundled Payments for Care Improvement (BPCI)), non-traumatic revisions, complications, all follow-up evaluation & management, all emergency services, all home health and therapy, hip/knee radiology and all labs/imaging/other outpatient procedures
4. From 31 days to 90 days after the date of discharge: Readmissions (excluding those defined by BPCI) due to infections and complications as well as hip or knee-related

follow-up evaluation and management, home health and therapy and labs/imaging/other outpatient procedures

215.000 OPPOSITIONAL DEFIANT DISORDER (ODD) EPISODES

215.100 Episode Definition/Scope of Services 10-1-13

A. *Episode subtypes:*

There are no subtypes for this episode type.

B. *Episode trigger:*

ODD episodes are triggered by three medical claims with a primary diagnosis of ODD.

C. *Episode duration:*

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

D. *Episode services:*

All claims with a primary diagnosis of ODD. Behavioral health medications will be excluded from the episode, but utilization of medications will be tracked as a quality metric for providers "to pass."

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

215.200 Principal Accountable Provider 10-1-13

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

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

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

215.300 Exclusions 10-1-13

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

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

B. Beneficiaries with any comorbid behavioral health condition

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

215.400 Adjustments 10-1-13

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

215.500 Quality Measures 10-1-13

A. *Quality measures "to pass":*

1. Percentage of episodes with completion of either Continuing Care or Quality Assessment certification – must meet minimum threshold of 90% of episodes.
2. Percentage of new episodes (i.e., a PAP's first ODD episode for this beneficiary) in which the beneficiary received behavioral health medications – must be under maximum threshold of 20%.
3. Percentage of repeat episodes (i.e., all episodes other than a PAP's first ODD episode for this beneficiary) for which the beneficiary received behavioral health medications – must be equal to 0%.
4. Percentage of episodes resulting in beneficiary remission (no repeat ODD episode for this beneficiary within 180 days after the end of the episode) – must meet minimum threshold of 40%. If a PAP has <5 episodes used for the calculation in a performance period, the metric becomes a quality measure "to track" – not "to pass".

B. *Quality measures "to track":*

1. Percentage of episodes with >9 visits over >30 days
2. Percentage of episodes certified as non-guideline concordant care
3. Average number of visits per episode
4. Average number of behavioral therapy visits per episode
5. Percentage of episodes with >9 therapy sessions over a period of 30+ days and of which >7 are family therapy sessions (CPT 90846 OR CPT 90847)

215.600 Thresholds for Incentive Payments 10-1-13

A. The acceptable threshold is $2,671.

B. The commendable threshold is $1,642.

C. The gain sharing limit is $984.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

215.700 Minimum Case Volume 10-1-13

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

216.000 COLONOSCOPY EPISODES

216.100 Episode Definition/Scope of Services 10-1-13

A. *Episode subtypes:*

There are no subtypes for this episode type.

B. *Episode trigger:*

Outpatient colonoscopy procedure (including balloon, biopsy, polypectomy, etc.) and primary or secondary diagnosis indicating conditions that require a colonoscopy (e.g., colorectal bleeding, hemorrhoids, anal fistula, neoplasm of unspecified nature). For a complete list of diagnoses, please see the code sheet associated with the episode.

C. *Episode duration:*

Episodes begin with the initial consult with the performing provider (within 30 days prior to procedure) and end 30 days after the procedure.

D. *Episode services:*

The episode will include all of the following services rendered within the episode's duration:

1. Within 30-day pre-procedure window: related services beginning on the day of the first consult with the performing provider, including inpatient and outpatient facility services, professional services, related medications, and excluding ER visits on the day of the first visit
2. Within procedure window: colonoscopies with and without additional procedures, including inpatient and outpatient facility services, professional services, and related medications, beginning day of procedure
3. Within 30-day post-procedure window; related services including inpatient and outpatient facility services, professional services, related medications, treatment for post-procedure complications, inpatient post-procedure admission (excluding those defined by Bundled Payments for Care Improvement (BPCI))

216.200 Principal Accountable Provider 10-1-13

The Principal Accountable Provider (PAP) for an episode is the primary provider performing the colonoscopy.

216.300 Exclusions 10-1-13

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

A. Beneficiaries with select comorbid conditions within 365 days prior to procedure or during episode (e.g., inflammatory bowel disease, select cancers, select transplants, etc.). For a complete list of comorbidities, please see the code sheet associated with the episode.

B. Beneficiaries under the age of 18 or over the age of 64 at the time of the procedure

C. Beneficiaries who are pregnant during the episode

D. Beneficiaries with dual enrollment in Medicare/Medicaid (i.e., dual-eligible)

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

F. Beneficiaries who die in the hospital during the episode

G. Beneficiaries with patient status "left against medical advice" during the episode

216.400 Adjustments 10-1-13

The cost of this episode is based on a) risk factors (e.g., renal failure, diabetes) and b) episode types. Episode types include 1) colonoscopies with additional procedures, 2) colonoscopies without additional procedures.

216.500 Quality Measures 10-1-13

A. *Quality measures "to pass":*

1. Cecal intubation rate reported by provider on an aggregated quarterly basis – must meet minimum threshold of 75%.

2. In at least 80% of valid episodes, the withdrawal time must be greater than 6 minutes.

B. *Quality measures "to track":*

1. Perforation rate
2. Post polypectomy/biopsy bleed rate

All of the above quality measures "to pass" require providers to submit data through the provider portal.

216.600 Thresholds for Incentive Payments 10-1-13

A. The acceptable threshold is $886.

B. The commendable threshold is $796.

C. The gain sharing limit is $717.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

216.700 Minimum Case Volume 10-1-13

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

217.000 TONSILLECTOMY EPISODES

217.100 Episode Definition/Scope of Services 10-1-13

A. *Episode subtypes:*

There are no subtypes for this episode type.

B. *Episode trigger:*

Episode is triggered by an outpatient tonsillectomy, adenoidectomy, or adeno-tonsillectomy procedure, and a primary or secondary diagnosis (Dx1 or Dx2) indicating conditions that require tonsillectomy/adenoidectomy (e.g., chronic tonsillitis, chronic adenoiditis, chronic pharyngitis, hypertrophy of tonsils and adenoids, obstructive sleep apnea, insomnia, peritonsillar abscess). For a complete list of diagnoses, please see the code sheet associated with the episode.

C. *Episode duration:*

Episodes begin with the initial consult with the performing provider (within 90 days prior to procedure) and end 30 days after the procedure.

D. *Episode services:*

The following services are included in the episode:

1. Within 90 days prior to procedure: initial consult with performing provider, and any related services including sleep studies, head and neck X-rays, and laryngoscopy
2. The tonsillectomy/adenoidectomy procedure
3. Within 30 days after procedure: related services including inpatient and outpatient facility services, professional services, related medications, treatment for post-procedure complications, and post-procedure admissions (excluding those defined by Bundled Payments for Care Improvement (BPCI))

217.200 Principal Accountable Provider 10-1-13

For each episode, the Principal Accountable Provider (PAP) is the primary provider performing the tonsillectomy/adenoidectomy.

217.300 Exclusions 10-1-13

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

A. Beneficiaries who are under the age of 3 or above the age of 21 at the time of the procedure

B. Beneficiaries with select comorbid conditions (e.g., Down syndrome, cancer, severe asthma, cerebral palsy, muscular dystrophy, myopathies). For a complete list of comorbidities, please see the code sheet associated with the episode.

C. Beneficiaries with an Uvulopalatopharngoplasty (UPPP) on date of procedure

D. Beneficiaries with a BMI>50

E. Beneficiaries with dual enrollment in Medicare/Medicaid (i.e., dual-eligible)

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

G. Beneficiaries who die in the hospital during the episode

H. Beneficiaries with a patient status of “left against medical advice” during the episode

217.400 Adjustments 10-1-13

For the purpose of determining a PAP’s performance, the total reimbursement attributable to the PAP is adjusted for tonsillectomy episodes within certain risk factors (e.g., COPD, asthma), and depending on type. There are two episode types: 1) adenoidectomy and 2) tonsillectomy/adeno-tonsillectomy.

217.500 Quality Measures 10-1-13

A. *Quality measures “to pass”:*

1. Percent of episode with administration of intra-operative steroids – must meet minimum threshold of 85%

B. *Quality measures “to track”:*

1. Post-operative primary bleed rate (i.e., post-procedure admissions or unplanned return to OR due to bleeding within 24 hours of surgery)
2. Post-operative secondary bleed rate
3. Rate of antibiotic prescription post-surgery

All of the above quality measures “to pass” require providers to submit data through the provider portal.

217.600 Thresholds for Incentive Payments 10-1-13

A. The acceptable threshold is $1,069.

B. The commendable threshold is $1,019.

C. The gain sharing limit is $824.

D, The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

217.700 Minimum Case Volume 10-1-13

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

218.000 CHOLECYSTECTOMY EPISODES

218.100 Episode Definition/Scope of Services 10-1-13

A. *Episode subtypes:*

There are no subtypes for this episode type.

B. *Episode trigger:*

Episode is triggered by open or laparoscopic cholecystectomy procedure, and a primary or secondary diagnosis (Dx1 or Dx2) indicating conditions related to cholecystectomy (e.g., cholelithiasis, cholecystitis). For a complete list of diagnoses, please see the code sheet associated with the episode.

C. *Episode duration:*

Episodes begin with the cholecystectomy procedure and end 90 days post-procedure

D. *Episode services:*

The following services are included in the episode:

1. During procedure: Cholecystectomy surgery and related services (i.e., inpatient and outpatient facility services, professional services, related medications, treatment for complications)
2. Within 90 days post-procedure: related services (i.e., inpatient and outpatient facility services, professional services, related medications, treatment for complications)
3. Within 30-day post-procedure window: related services including inpatient and outpatient facility services, professional services, related medications, treatment for post-procedure complications, inpatient post-procedure admission (excluding those defined by Bundled Payments for Care Improvement (BPCI))

218.200 Principal Accountable Provider 10-1-13

For each episode, the Principal Accountable Provider (PAP) is the primary surgeon performing the cholecystectomy.

218.300 Exclusions 10-1-13

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

A. Beneficiaries who are less than or equal to the age of 1 or greater than or equal to the age of 65 at the time of the procedure

B. Beneficiaries with select comorbid conditions or past procedures within 365 days or 90 days after cholecystectomy (e.g., HIV, cancer, sickle cell anemia, transplants). For a complete list of comorbidities, please see the code sheet associated with the episode.

C. Beneficiaries with a pregnancy 30 days prior to a cholecystectomy procedure to 90 days after said cholecystectomy procedure

D. Beneficiaries with ICU care within 30 days prior to the cholecystectomy procedure

E. Beneficiaries with acute pancreatitis, cirrhosis, or cholangitis concurrent with procedure

F. Beneficiaries with open cholecystectomy procedure (includes laparoscopic converted to open and surgeries initiated open)

G. Beneficiaries who die in the hospital during the episode

H. Beneficiaries with a patient status of "left against medical advice" during the episode

I. Beneficiaries with dual enrollment in Medicare/Medicaid (i.e., dual-eligible)

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

218.400 Adjustments 10-1-13

For the purposes of determining a PAP's performance, the total reimbursement attributable to the PAP is adjusted for: cholecystectomy episodes in which patients have comorbidities, including indirectly related health conditions (e.g., acute cholecystitis, common bile duct stones), and episodes in which patients have an ED admittance prior to procedure.

218.500 Quality Measures 10-1-13

A. *Quality measures "to pass":*

1. Percent of episodes with CT scan prior to cholecystectomy – must be below threshold of 44%

B. *Quality measures "to track":*

1. Rate of major complications that occur in episode, either during procedure or in post-procedure window: common bile duct injury, abdominal blood vessel injury, bowel injury
2. Number of laparoscopic cholecystectomies converted to open surgeries
3. Number of cholecystectomies initiated via open surgery

218.600 Thresholds for Incentive Payments 10-1-13

A. The acceptable threshold is $2,048.

B. The commendable threshold is $1,614.

C. The gain sharing limit is $1,190.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

218.700 Minimum Case Volume 10-1-13

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, 2013**

SUBJECT: **Provider Manual Update Transmittal SecI-2-13**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
181.000	10-1-12	181.000	10-1-13

Explanation of Updates

Section 181.000 is updated to reflect the current stop-loss protection information for provider-level adjustments to the incentives involved in the Arkansas Medicaid Episodes of Care program.

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 not required

181.000 Incentives to Improve Care Quality, Efficiency and Economy 10-1-~~12~~13

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.~~

2. Stop-loss protection: 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.

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.