ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

DATE: **January 1, 2014**

SUBJECT: **Provider Manual Update Transmittal SecI-5-13**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
181.000	10-1-13	181.000	1-1-14

Explanation of Updates

Section 181.000 is updated to clarify stop-loss protection policy for episodes of care incentive adjustments.

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 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

1. Inpatient Hospital Services (continued)

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

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 episode of care **adjustments made** during any **calendar year** shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements **received by the provider** during that **calendar year**.

2.a. Outpatient Hospital Services (continued)

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

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 episode of care **adjustments made** during any **calendar year** shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements **received by the provider** during that **calendar year**.

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)

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 episode of care **adjustments made** during any **calendar year** shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements **received by the provider** during that **calendar year**.

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 (Continued)

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 episode of care **adjustments made** during any **calendar year** shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements **received by the provider** during that **calendar year**.

5. Physicians' Services (continued)

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

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 episode of care **adjustments made** during any **calendar year** shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements **received by the provider** during that **calendar year**.

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 (Continued):

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 episode of care **adjustments made** during any **calendar year** shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements **received by the provider** during that **calendar year**.

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)

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 episode of care **adjustments made** during any **calendar year** shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements **received by the provider** during that **calendar year**.

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)

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 episode of care **adjustments made** during any **calendar year** shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements **received by the provider** during that **calendar year**.

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)

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 episode of care **adjustments made** during any **calendar year** shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements **received by the provider** during that **calendar year**.

TOC not required

181.000 Incentives to Improve Care Quality, Efficiency and Economy 10-1-134

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. 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 adjustments made during any calendar year ~~performance period~~ shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements received by the provider during that calendar year~~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 qualify 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.