ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

EFFECTIVE DATE: **June 1, 2017**

SUBJECT: **Provider Manual Update Transmittal EPISODE-7-16**

REMOVE		**INSERT**	
Section	**Effective Date**	**Section**	**Effective Date**
200.300	7-1-16	200.300	6-1-17

Explanation of Updates

Section 200.300 is updated to add an episode-specific exclusion.

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.

Dawn Stehle
Director

TOC not required

200.300 Exclusions

~~7-1-16~~6-1-17

There are two types of exclusions. Global Exclusions are either policy related or clinically pertinent medical conditions that will exclude a beneficiary from all Episodes of Care.

Global Exclusions (applied to all Episodes of Care):

A. Medicaid and Medicare dual eligibility

B. Beneficiaries with non-continuous Medicaid enrollment for the duration of the episode

C. Beneficiaries with Third Party Liability

D. Beneficiaries with one or more of the following:

1. End-Stage Renal Disease
2. Clinically pertinent metabolic, nutritional, immunity disorders
3. Clinically pertinent disorders of blood and blood forming organs
4. Clinically pertinent cancers
5. Active chemotherapy treatments
6. Clinically pertinent organ transplants
7. Acute Leukemia
8. Cystic Fibrosis

E. Beneficiaries leaving against medical advice

F. Beneficiaries expiring during the episode duration

G. Beneficiaries admitted to hospice care

H. Episodes that are a result from trauma

I. Beneficiaries who are pregnant during episode duration with the following episode-specific exclusions:

1. Perinatal

The second type of exclusions, referred to as Episode-Specific Exclusions, are at the episode type level. These exclusions are determined through consultation with providers and are identified as a significant impact on a particular episode. Episode-Specific Exclusions are identified for each episode of care.

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

EFFECTIVE DATE: **June 1, 2017**

SUBJECT: **Provider Manual Update Transmittal SecI-2-16**

REMOVE		**INSERT**	
Section	**Effective Date**	**Section**	**Effective Date**
181.000	7-1-16	181.000	6-1-17

Explanation of Updates

Section 181.000 is updated to change the Principles for Determining Thresholds for Episodes 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 Hewlett Packard Enterprise 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.

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TOC not required

181.000 Incentives to Improve Care Quality, Efficiency and Economy

~~7-1-16~~6-1-17

A. Definitions

1. An "episode" refers to a defined bundle 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.
4. A “valid episode” is defined as any episode that meets criteria for inclusion in a calculation of cost and quality measures for which a PAP is accountable during a performance period.
5. An ”invalid (excluded) episode” refers to an episode in which the services or the patient do not meet standard criteria for inclusion set by the definition of each episode type. (Refer to the Episodes of Care Medicaid Manual for episode-specific criteria.)
6. An “incentive” can either be positive (gain-share) or negative (risk-share).

B. Medicaid has established a payment improvement initiative (“payment improvement program”) to incentivize improved care quality, efficiency and economy. The program uses Medicaid paid claims 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 of Care.**

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, encouraging referrals 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 an incentive under the payment improvement program.

F. Incentives may be positive (gain share) or negative (risk share). Incentives are calculated and made retrospectively, after care has been completed and reimbursed in accordance with the published reimbursement methodology. Incentives 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 incentives and appropriate quality measures based on evidence-based practices. To identify evidence-based practices, Medicaid shall consider clinical practices information furnished by Arkansas providers of the care and services typically rendered during the episode of care, and may also consider input from quality measurement organizations, 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. 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 valid episodes completed during the performance period will be calculated, based on the set of services included in the episode definition. Please refer to the Episodes of Care Medicaid Manual for information about specific Episodes of Care.
2. Some episodes may be excluded based on clinical factors derived from paid claims. Other exclusions may be determined from coverage factors for each individual patient.
3. Reimbursement for some episodes may be adjusted as described in the definition of each episode. The average adjusted reimbursement of all episodes for the PAP during the performance period will be compared to thresholds which are established by Medicaid in consultation with providers.
4. If a PAP's average adjusted episode reimbursement is lower than the commendable threshold and the PAP has met the quality measures established by Medicaid for each episode type, the PAP is eligible for gain share and Medicaid will make a positive incentive to the PAP. This 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 an incentive calculated as though their average adjusted episode reimbursement were equal to the gain-sharing limit.
5. If the average adjusted episode reimbursement is higher than the acceptable threshold, the PAP will incur a negative (risk-share) incentive. This incentive 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. Medicaid may take into consideration what a clinically feasible target would be, as demonstrated by historical variance in Arkansas. DMS will continuously review episodes of care thresholds to monitor the impact of provider economics/resource costs on thresholds and take action as deemed appropriate. Current tools such as quarter episode milestone reports and EOC report cards are monitored after each payment release.
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 or low cost episodes and/or comorbid conditions so that one or a few cases do not misrepresent a provider's overall performance across the provider's broader patient population.

L. Provider-Level Adjustments

1. 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 shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements received by the provider during that calendar year.

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 (gain-share) and negative (risk-share) 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. Each episode has a designated minimum case volume that must be reached in order for the PAP to be eligible for incentives. PAPs who do not meet the minimum case volume for an episode type will not be eligible for positive (gain-share) or negative (risk-share) incentives for that episode type.

M. Quality Measures

1. For each episode type, there is a set of quality measures "to pass" and/or a set of quality measures "to track." These quality measures are based on paid claims data or based on additional data when specified by Medicaid and which PAPs are required to report through the Advanced Health Information Network (AHIN) provider portal.

2. To qualify for positive (gain-share) incentives, PAPs must report required data and meet specific quality measures "to pass."

3. Providers who do not report data or who do not meet minimum quality measures may still incur negative (risk-share) incentives 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.