ARKANSAS REGISTER

Transmittal Sheet

Use only for **FINAL** and **EMERGENCY RULES**

Secretary of State
Mark Martin
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Little Rock, Arkansas 72201-1094
(501) 682-5070
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For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

Contact James Gallaher E-mail james.gallaher@dhs.arkansas.gov Phone 501-396-6364

Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-76-201

Rule Title: State Plan #2017-008 and Episodes of Care #1-17

Intended Effective Date (Check One)

- ☐ Emergency (ACA 25-15-204)
- ☐ 10 Days After Filing (ACA 25-15-204)
- ☑ Other January 1, 2018 (Must be more than 10 days after filing date.)

Date	
Legal Notice Published	10/14/2017
Final Date for Public Comment	11/12/2017
Reviewed by Legislative Council	12/15/2017
Adopted by State Agency	01/01/2018

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Becky Murphy (Contact Person) becky.murphy@dhs.arkansas.gov (E-mail Address) _____ (Date)

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Signature

(501) 371-2165 (Phone Number) rose.naff@dhs.arkansas.gov (E-mail Address)

Director (Title)

12/12/17 (Date)

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT James Gallaher

TELEPHONE 501.396.6364 **FAX** 501.404.4619 **EMAIL:** james.gallaher@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE State Plan #2017-008 and Episodes of Care 1-17

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 Does this proposed, amended, or repealed rule have a financial impact?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

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

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	

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$0.00	General Revenue	$0.00
Federal Funds	$0.00	Federal Funds	$0.00
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$0.00	Total	$0.00

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year
$ _____

Next Fiscal Year
$ _____

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6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year
$ 0.00

Next Fiscal Year
$ $0.00

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7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously
with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
  (a) justifies the agency's need for the proposed rule; and
  (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
  (a) the rule is achieving the statutory objectives;
  (b) the benefits of the rule continue to justify its costs; and
  (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

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.

Reserved for the potential addition of Episodes of Care subject to incentive adjustments

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

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) Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) Episodes
(5) Percutaneous Coronary Intervention (PCI) Episodes
(6) Acute Exacerbation of Asthma Episodes
(7) Coronary Arterial Bypass Graft (CABG) episodes

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

(d) Rehabilitative Services (Continued)

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

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.

Reserved for the potential addition of Episodes of Care subject to incentive adjustments

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: Arkansas Medicaid Health Care Providers – Episodes of Care

EFFECTIVE DATE: January 1, 2018

SUBJECT: Provider Manual Update Transmittal EPISODE-1-17

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
212.000	—	—	—
212.100	10-1-12	—	—
212.200	10-1-12	—	—
212.300	10-1-13	—	—
212.400	10-1-12	—	—
212.500	10-1-12	—	—
212.600	10-1-12	—	—
212.700	10-1-12	—	—
215.000	—	—	—
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	—	—

Explanation of Updates

The Episode of Attention Deficit Hyperactivity Disorder (ADHD) (212.000, 212.100, 212.200, 212.300, 212.400, 212.500, 212.600, and 212.700) has been removed from the Episodes of Care Program.

The Episode of Oppositional Defiant Disorder (ODD) (215.000, 215.100, 215.200, 215.300, 215.400, 215.500, 215.600, and 215.700) has been removed from the 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 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.

Rose M. Naff
Director

TOC required

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 10-1-13

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

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.~~

[redacted]

~~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.~~