EXHIBIT H

DHS, MEDICAL SERVICES (2077)

SUBJECT: Episode Performance Payments for Ambulatory URI, ADHD & Perinatal Care

DESCRIPTION: Effective October 1, 2012, Arkansas Medicaid proposed to establish a payment improvement initiative 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. The proposed rule will establish a Episode of Care Manual for Arkansas Medicaid, insert general information regarding Episodes of Care into Section 1 of the current Arkansas Medicaid manuals as well as the Arkansas Medicaid State Plan.

PUBLIC COMMENT: A public hearing was held on July 5, 2012, and the public comment period expired July 10, 2012.

Public comments were as follows:

General Comments:

1. Comment: Will supplemental payment amounts vary based on the principle accountable providers' quality scores?
Response: No. To receive a supplemental payment, providers must achieve qualifying cost and quality benchmarks. Providers will either qualify or not. Medicaid will not adjust supplemental payments based on relative scores of qualifying providers. In short, Medicaid will make supplemental payments on an all-or-nothing basis.

2. Comment: Will episodes always be promulgated in the same way they are now being promulgated?
Response: We intend to establish every episode of care in compliance with controlling laws as those laws exist when the episode is created.

3. Comment: The comment process is not organized well for hospitals or physicians to be able to effectively participate. The website is cumbersome and not user friendly. For instance, the meetings held a year ago all are listed by date while the meetings held this year and associated materials are not evident by looking at the Medicaid payment initiative site. The criteria for episodes of care, what are potential inclusion / exclusion criteria, or for specific ICD-9 or DRG code groupings all are important items that the public should be able to easily find, and then submit comments about. The current process has not allowed that to occur. The sessions that have been held have not adequately allowed for participation from the people who are remote. It has been difficult for those participating remotely to break into the discussions to ask questions. Future meetings need to allow for better open comment ability for those participating remotely. Participation in these discussion groups should not be construed as support for the findings.
Response: Thank you for your comment.

4. Comment: The web site is confusing and difficult to locate the most recent information and it is not consistent in format or organization between the work groups in some cases. There should be links to specifications for each workgroup criteria including tables that define the inclusion and exclusion criteria for each workgroup population.
Response: Thank you for your comment. The initiative launched a new website on July 1st that we are hopeful is easier to use and read.

5. Comment: The program began on July 1st, however, the process for notification to a hospital or provider that they are selected as the PAP on a visit has not been made clear. It is unclear how providers will be able to follow-up those patients for continuity of care purposes.
Response: In general, providers will not be notified in real time that they are the PAP for a specific episode. Rather, providers will be responsible for understanding the PAP criteria and therefore for which patients they will serve as PAP. Note, however, that for long-term episodes, provider reporting will include ongoing episodes, to assist providers.

6. Comment: We propose that efforts be made to use publicly reported data for all proposed measures that apply because the proposed data for collection and reporting through the portal are all existing CMS measures with the exception of one. This data is collected and reported for the hospital inpatient measures already. It seems reasonable that the data for this program could pull from that data shared from CMS rather than burden the hospital with duplicated data entry. There are many programs beyond this program, such as the Hospital Engagement Network that are also requiring data collection and reporting and the burden to track and collect multiple measures or the same measure to multiple different programs is an unnecessary burden on providers and is extremely labor intensive. Instructions for use of the portal should be made available now since the program has already begun.
Response: Thank you for the comment. We anticipate that as technology and systems compatibility evolve we will have opportunity to further reduce administrative burden while promoting high quality care and providing the potential for gain sharing. In the current context and with stakeholder input from workgroups, we have considered both the importance of promoting high quality care as well as the potential administrative burden of long lists of metrics requiring provider data entry.

As a result, we have focused on metrics with a strong base of clinical evidence, have limited the total number of metrics per episode, and where appropriate have used claims-based metrics.

7. Comment: In Section 181.000.J.2. The sentence reads "The acceptable threshold is set such than underperforming the acceptable threshold reflects unacceptable performance . . . ". This confuses me as I thought the only way to get down to the commendable threshold would be to underperform the acceptable threshold. Was the intent to mean having a more costly profile than the acceptable threshold?
Response: Thank you for the comment. The section is vague, and will be corrected in the revised submission. The new sentence will read: "The acceptable threshold is set such that reimbursement above the acceptable threshold reflects unacceptable performance...."

ADHD Episode:

Before answering the questions below, it is important to clarify one point: all currently allowed services remain reimbursable for any episode, regardless of level and provider type. The episode model does not restrict services or require any specific number of services for any recipient.

1. Comment: (Assumption that RSPMI provider is the PAP) - under current RSPMI regulations, recipients whom are under the age of 21 are required to have a referral from their PCP for the majority of RSPMI services. PCP referrals are valid for 6 months from the date it was issued from the primary care provider. Due to an ADHD "Episode" being one year in length, it is fair to assume that the Medicaid recipient would be required to receive two (2) PCP referrals during the length of an episode. Due to this fact, under the ADHD Episode, why make PCP referrals a requirement for services inside the episode? The large majority of PCP's require that the recipient be seen prior to issuing an updated prior authorization, in which the PCP will bill and Evaluation and Management fee; this only increases the episode cost for providers whom are the PAP, yet are not the PCP.
Response: Initially, for providers to bill services under the RSPMI program all current regulations except for the PA requirement will remain in place. Thus, PCP referral will continue as a requirement for services delivered under RSPMI. When billed, the PCP E&M code – most often $36.30 – is not a substantial driver of episode cost.

2. Comment: Since, under the ADHD episode design, Level One (1) is Medication Management only, for all new recipients whom enter the "episode" after promulgation, why not require the PCP to take care of this population? PCP's are reimbursed at a greater rate than an RSPMI provider (due to their MD only being able to bill for a medication management visit). Then, reserve referrals to RSPMI and other providers for recipients the PCP feels need either Level Two (2) services or need screened for possible co-morbid conditions, yet if no co-morbid condition is found the provider sends the recipient back to the referring PCP for continued medication management. As current situations exist, the PCP will be seeing the recipient at minimum twice a year, in order for an RSPMI provider to get a PCP referral.
Response: In the workgroup feedback process, we heard from numerous providers describing entry into the RSPMI provider via school or other non-medical referrals. Thus, it was important to preserve the ability of all providers to deliver services to any ADHD patient. While the PCP may be best-suited to deliver Level I care, the episode model will allow any eligible provider to deliver care in the setting they serve.

3. Comment: The initial certification requires a non-PCP to verify with the PCP that a vision/hearing screening has been performed within the following year. What is a non-PCP physician supposed to do if they find out that the vision/hearing screening has not been performed within the following year?
a. Can they still certify the recipient and prescribe medication and request the parents/guardian to make an appointment for the vision/hearing screening?
b. Do the not certify the recipient until they have gone to their PCP and can verify they have an updated vision/hearing screening?

Response: Yes, the provider should certify the recipient and deliver services. Guidelines and the Arkansas workgroups described the need for a vision / hearing screening. If such screening has not been completed, the provider should complete the screening themselves or ensure that it is completed at a PCP's office, school, or other place of service.

4. Comment: What is encompassed in the support provided to the school and parent? What are qualifications are required of the staff required to provide this and what are reimbursement rates.
Response: The clinical guidelines reviewed describe school and / or parent support as important functions of comprehensive ADHD treatment. In a coordinated-care environment, the lead provider may choose to offer parent training or teacher support – as such supports will allow the provider to better treat the condition and earn gain-sharing. However, there are no new reimbursable services associated with this training.

5. Comment: Is crisis work reimbursable.
Response: Yes. All currently billable services are reimbursable.

6. Comment: Define what is encompassed in the therapeutic component.
Response: Clinical guidelines identify behavioral therapy as important and appropriate treatment for patients that do not experience an adequate response to medication. Given individual patient circumstances and presentation, the model does not define or restrict services.

7. Comment: Who VO or UAMS be providing approval and oversight of level determination and approval. If not VO, will they continue to review services in Plan of Care Inspections. Who and when will training be provided to Providers and PCPs.
Response: Training to RSPMI providers will be delivered by Value Options. Training to PCPs and other physicians will be delivered by AFMC. The 'Severity' certification – identifying the episode level – does not require approval from Medicaid, VO, or UAMS. Rather, it is a provider's designation that the recipient is severe and immediately begins a level II episode. However, the certifications will all be subject to audit by Medicaid and will be available to Value Options.

8. Comment: If physician can have 4 visits per year, will they give refills and how will medication effectiveness and side effects be monitored. Will extended visits be allowed for adjustments of medication?
Response: Please see the initial clarification. The episode model does not restrict or control the number or duration of visits.

9. Comment: Who has notified all PCPs and schools of upcoming changes and limitations of RSPMI Providers?
Response: All Medicaid PCPs will be notified about the episode model and provided information via their existing relationship with AFMC. Providers are also welcome to communicate directly with the PCPs or schools that refer them beneficiaries.

URI Episode:

1. Comment: Principal accountable provider is proposed to be identified as the initial treating physician. For communities and regions in Arkansas where there is limited access to general practice or family care providers, the hospital emergency department many times serves as the urgent care facility which makes the emergency physicians many times to be the initial treating physician. Care is handed off to the primary care physician. The principal accountable provider should not be assigned to the hospital physicians in this case because they do not perform follow-up or on-going care.
Response: The hospital itself will never be the Principal Accountable Provider. However, the ED physician is eligible to be a PAP. The general criteria for identifying Principal Accountable Providers identified the physician treating the patient at their first visit as the best fit to PAP criteria, regardless of location of service. Further, the follow-up visit rate is approximately 10%.

2. Comment: Exclusions: Asthma, HIV, sickle cell, chronic URI conditions, COPD, tracheostomy, Cystic Fibrosis, comorbid Anemia and ERSD, inpatient hospitalization during the episode, children under 6 months old. The exclusions list appears to represent valid populations that should be excluded, however as the program is ongoing there should be allowable changes to the exclusions as we all see data from the program.
Response: The program will allow and encourage continued feedback on exclusions as the initial data is received and reviewed.

3. Comment: Population selection: Primary diagnosis code of 460-465, excluding 464.4 (Croup). In many cases what a community care provider submits as a primary diagnosis varies from what may ultimately be submitted by an outpatient or emergency hospital visit. Nothing in the initiative plan addresses these billing discrepancies or how they will be adjudicated. There does not seem to be anything in the initiative plan that addresses the non-compliant patient. The typical patient in this category that presents to the hospital usually is in distress because they have not seen or been treated by a primary care physician or they have not responded to treatment and are in distress. The hospitals course of action may or may not include antibiotic administration; however, the ED physician has little influence over the treatments by any follow up providers. Assuming that the PAP is deemed to be an ED physician, and the patient subsequently sees another physician who prescribes (inappropriately) an antibiotic regimen, the ED physician will have little impact on that decision making, but as the PAP will suffer the consequences of inappropriate antibiotic administration by subsequent providers.
Response: Thank you. The episode sub-type will be assigned based upon the primary diagnosis code on the final ED or office visit within an episode.

4. Comment: We agree that claims based measurement is best so that there is no additional burden and cost on the PAP having to access the portal.
Response: Thank you.

Perinatal Episode:

1. Comment: Principal accountable provider is proposed to be identified as the physician who delivers the baby. In many cases due to call group coverage the delivering physician may not be the primary physician involved in the case. This needs to be clarified. In

other cases, in certain populations, women present to the hospital for delivery with little or no prenatal care. These are high risk.
If a provider delivers the baby is part of the same
Response: An episode will only be included if it meets both of the following conditions: (1) A minimum level of prenatal care was delivered and (2) The delivery billing provider was involved in the prenatal care. Thus, a women who presents to the hospital with no prenatal care or a woman who delivers with a completely different provider than her prenatal provider will not fall in to an eligible episode. However, when multiple physicians bill under the same billing ID, the episode will be included.

2. Comment: The exclusions list appears to represent valid populations that should be excluded, however as the program is ongoing there should be allowable changes to the exclusions as we all see data from the program.
Response: The program will allow and encourage continued feedback on exclusions as the initial data is received and reviewed.

3. Comment: Risk adjustment is complex and multifactorial. It is unclear from the proposed rule how this process will work, who will be convening these meetings, and how the information from those meetings will be made available for comment and refinement. The process for obtaining "clinical input from Arkansas providers" should be transparent, should allow for adequate input from adequate numbers of physicians providing these services as well as input from professional organizations with expertise in these areas. It is unclear why certain risk factors would be excluded based upon "coding practices". This approach would potentially punish all providers, by removing valid risk adjustors, to prevent the possibility of miscoding by a few providers. Medicaid has the statutory ability and responsibility through its fiscal intermediary to audit claims for suspicious patterns of coding, and should use that approach to prevent abuse of the coding system.
Response: Thank you for the comment. The program will allow and encourage continued feedback on exclusions as the initial data is received and reviewed.

Ozark Guidance Questions

Question: The Rule has the date October 1, 2012, on every page. Does that mean it will be effective Oct. 1, 2012? Will it be retroactive to July 1, 2012?

Answer: The rule will go into effect on October 1st. The infrastructure of the payment system will be in place prior to October 1st to allow providers the opportunity to view historical data and begin entering data via the Provider Portal, if desired

Question: On the effective date, does the Rule apply to current open clients who meet the ADHD definitions under Level I and II or only to new clients who begin an episode after the effective date of the rule?

Answer: The rule will apply to all clients beginning on October 1st. For ADHD, providers will be allowed to immediately submit the severity certification for existing clients who are Level II.

Question: What is the Severity Certification Form? Where can we obtain it (assume on the Medicaid website)? Who can or should complete it? Does it need to be completed on all current open clients or only those opened after the effective date of the Rule?

Answer: The Severity Certification is accessible through the Provider Portal, and is used to determine the rationale for Level II care. As with all ADHD Provider Portal entries, the certification must be e-signed by the MD, PhD or PsyD psychologist involved with the client's care. However, providers may designate other staff to complete the form online.

The specific question language is available on the Payment Initiative website at www.paymentinitiative.org. The Severity Certification must be completed on all clients in order to designate them as Level II.

Question: The rule references a form that will have to be filled out to have someone moved from Level I to Level II, but nowhere is the form provided for us to review and comment on the criteria

Answer: This form is the Severity Certification. Please see the answer to question 3 for more information.

Question: Section 212.500 discusses the quality metrics "to pass" and the quality metrics "to track." There are six quality metrics "to track." How are these to be counted – individually, in the aggregate, as an average? How are they to be reported by PAPs?

Answer: All quality metrics are measured as an average across all of the PAP's eligible episodes. They are provided to the PAPs on quarterly reports.

Question: How do the quality metrics to pass or track relate to positive or negative supplemental payments?

Answer: To receive positive supplemental payments, providers must meet a benchmark in the quality metrics labeled "to pass." These benchmarks are provided in the Episode Manual submitted for promulgation. Quality metrics labeled "to track' do not affect supplemental payments.

Question: Is the "provider portal" open and ready to accept client data? What and where is the provider portal and does it require a certain secure connection with a connection fee?

Answer: The Provider Portal is accessible through the Initiative website, www.paymentinitiative.org. It is open as of July 1st, though registration may be required if a provider is not currently enrolled.

Question: Do we submit claims for services to HP the same way we are doing now utilizing discrete Fee for Services (FFS) codes and units? If yes, will claims be paid FFS and then reconciled (positive or negative) against the total cost of the 12 month episode OR will discrete services/claims remain pending (i.e. unpaid) and be paid by an episode lump sum payment?

Answer: Yes, providers will submit claims to HP going forward and will be paid according to the existing fee schedules in the same way that you are today. At the conclusion of a twelve-month period, an average cost will be calculated across all of the provider's episodes in order to determine any supplemental payment (positive or negative).

Question: How are we going to get paid for parent or school training that is recommended in Level I care? The AAP policy statement says 7-10 group parent/teacher sessions. We cannot currently bill for services without the client present unless it is "Family therapy without the client present".

Answer: Medicaid is not changing its reimbursable services or the structure of the RSPMI program. However, the costs of parent / teacher support were included calculating the episode thresholds, with the hope that providers investing in training parents or teachers will qualify for positive supplemental payments.

Question: The chart Draft Thresholds for ADHD shows acceptable, commendable and gain sharing levels. Is the level for "negative supplemental payments" anything above the acceptable level? Does a "negative supplemental" simply mean that if the cost of an episode of care exceeds the Level II acceptable level of $7,112 per episode, then only $7,112 will be paid for that episode or will we be required to pay back to the State amounts in excess of $7,112 per episode?

Answer: Providers with an average episode cost higher than the acceptable threshold will be required to share in the excess costs above the threshold. Medicaid and the provider will share those excess costs at a 50% - 50% split. Thus, for example, a provider with an average cost of $8,112 per episode -- $1000 above the acceptable threshold -- would owe the state $500 per episode.

Question: Will children with ADHD be required to have an annual Psychiatric Diagnostic Assessment? That is a fairly large expense given the proposed reimbursement models.

Answer: Initially, the structure and regulations of the RSPMI program will not change.

Question: Possible disparate pay levels – Pay is based off a Level 3 office visit. Our understanding is that a PCP can bill as many of these office visits as they want per hour. They are not unit or time based. Under RSPMI regulations, we cannot bill more than 4 units per hour. A PCP could potentially see 8-10 Level I clients per hour, but an RSPMI provider can see only 4 per hour.

Answer: As in many episodes, different provider types are currently reimbursed in different ways. The episode thresholds incorporate all of these factors.

Question: Where do the children that have ADHD and co-morbidities such as a learning disability fit in? Currently, there is not a good way to identify those children because Medicaid does not pay for psycho-educational testing since it should be done by schools. Recommend adding psycho-ed testing as part of the service episode.

Answer: Initially, only Medicaid-reimbursable services will qualify as comorbid conditions.

Due to public comments, one change was made. Section 1 was changed to read in Section 181.000, J, 2...., as follows:

"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."

The proposed effective date is October 1, 2012.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: The Medicaid Program projects program savings resulting from the Healthcare Payment Improvement Initiative in the following amounts: $4,444,800 total savings for the current fiscal year (2013) ($1,325,884 state and $3,118,916 federal) and a total savings of $9,333,462 for the next fiscal year (2014) ($2,735,028 state and $6,598,434 federal).

Economic Impact Statement:

1. The type or types of small businesses that will be directly affected by the proposed rule, bear the cost of the rule, or directly benefit from the proposed rule.

Health care providers providing services for conditions covered under episodes included in the Arkansas Health Care Payment Improvement Initiative.

2. A description of how small businesses will be adversely affected.

Some health care providers may benefit from the episode performance payment model, while those providing services that do not meet certain cost and quality standards will see reduced provider revenue. Impact to any individual provider will depend on the provider's behavior and performance.

3. A reasonable determination of the dollar amounts the proposed rule will cost small businesses in terms of fees, administrative penalties, reporting, recordkeeping, equipment, construction labor, professional services, revenue loss, or other costs associated with compliance.

Providers will incur some small additional administrative expense, limited to once yearly input of several questions for each ADHD client. No additional incremental costs to providers are expected. The net revenue impact to any individual provider will depend on their current standard of care and any improvement they make.

4. A reasonable determination of the dollar amounts of the costs to the agency of implementing the proposed rule, as well as the financial benefit to the agency of implementing the rule.

The department projects savings resulting from implementation of this initiative to be $9,333,462 in SFY 2014. 2014 is the first year that the full impact of this initiative would be realized.

5. Whether and to what extent alternative means exist for accomplishing the objectives of the proposed rule that might be less burdensome to small businesses and why such alternatives are not being proposed.

Not applicable.

6. A comparison of the proposed rule with federal and state counterparts.

Not applicable.

LEGAL AUTHORIZATION: Arkansas Code § 20-76-201 authorizes the Department of Human Services to administer programs for the indigent and to "make rules and regulations" pertaining to the administration of those programs. Arkansas Code § 20-77-107 specifically authorizes the department to "establish and maintain an indigent medical care program."

EXHIBIT H

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Department of Human Services
DIVISION Division of Medical Services
DIVISION DIRECTOR Andrew Allison, PhD
CONTACT PERSON Robert Nix
ADDRESS P.O Box 1437, Slot S295, Little Rock, AR 72203
PHONE NO. 682-8362 **FAX NO.** 682-2480 **E-MAIL** robert.nix@arkansas.gov
NAME OF PRESENTER AT COMMITTEE MEETING Marilyn Strickland
PRESENTER E-MAIL marilyn.strickland@arkansas.gov

INSTRUCTIONS

A. **Please make copies of this form for future use.**
B. **Please answer each question completely using layman terms. You may use additional sheets, if necessary.**
C. **If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.**
D. **Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:**

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
Room 315, State Capitol
Little Rock, AR 72201

****

1. What is the short title of this rule?

   Episode performance payments for Ambulatory URI, ADHD and Perinatal care

2. What is the subject of the proposed rule?

   To create an Episode of Care Medicaid manual, update Section 1 to include information regarding Arkansas Medicaid Episodes of Care as well as the Arkansas Medicaid State Plan.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ___ No __X__.
   If yes, please provide the federal rule, regulation, and/or statute citation.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes___ No__X__.

   If yes, what is the effective date of the emergency rule? _____

   When does the emergency rule expire? _____

   Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes____ No__

5. Is this a new rule? Yes X No ____ If yes, please provide a brief summary explaining the regulation.

   Does this repeal an existing rule? Yes____ No X If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does.

   Is this an amendment to an existing rule? Yes____ No X If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give Arkansas Code citation.

   Arkansas Statute 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary?

   The purpose of the proposed rule is to establish an Episode of Care Manual for Arkansas Medicaid as well as insert general information regarding Episodes of Care into Section 1 of the current Arkansas Medicaid manuals. Medicaid has established a payment improvement initiative 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.

   The proposed rule is necessary so that providers are aware of Arkansas Medicaid requirements and expectations involving Episodes of Care.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).

   https://www.medicaid.state.ar.us/InternetSolution/general/comment/comment.aspx

9. Will a public hearing be held on this proposed rule? Yes X No ____.
   If yes, please complete the following:
   Date: July 5, 2012
   Time: 10:00 a.m.
   Place: Blue Flame Room, 400 East Capitol, Little Rock

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)

    July 10, 2012

11. What is the proposed effective date of this proposed rule? (Must provide a date.)

    October 1, 2012

12. Do you expect this rule to be controversial? Yes____ No X If yes, please explain.

13. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known.

    Medical associations, interested providers, and advocacy organizations. Their positions for or against is not known at this time.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services
DIVISION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Randy Helms
TELEPHONE NO. 682-1857 **FAX NO.** 682-2480 **EMAIL:** randy.helms@arkansas.gov

To comply with Act 1104 of 1995, please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE – Episode performance payments for Ambulatory URI, ADHD and Perinatal care

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

2. Does this proposed, amended, or repealed rule affect small businesses?
   Yes X No _____.

   If yes, please attach a copy of the economic impact statement required to be filed with the Arkansas Economic Development Commission under Arkansas Code § 25-15-301 et seq.

3. If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please give the incremental cost for implementing the rule. Please indicate if the cost provided is the cost of the program.

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

5. What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule? Identify the party subject to the proposed rule and explain how they are affected.

Current Fiscal Year	Next Fiscal Year

6. What is the total estimated cost by fiscal year to the agency to implement this rule? Is this the cost of the program or grant? Please explain. **(The Medicaid program projects program savings resulting from the Healthcare Payment Improvement Initiative in the following amounts)**

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

ECONOMIC IMPACT STATEMENT
(As Required under Arkansas Code § 25-15-301)

Department: Arkansas Department of Human Services
Division: Medical Services
Person Completing this Statement: Randy Helms
Telephone Number: 501-682-1857 **Fax Number:** 501-682-3889
EMAIL: Randy.Helms@Arkansas.gov

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

(1) The type or types of small businesses that will be directly affected by the proposed rule, bear the cost of the proposed rule, or directly benefit from the proposed rule.

Health Care providers providing services for conditions covered under episodes included in the Arkansas Health Care Payment Improvement Initiative.

(2) A description of how small businesses will be adversely affected.

Some health care providers may benefit from the episode performance payment model, while those providing services that do not meet certain cost and quality standards will see reduced provider revenue. Impact to any individual provider will depend on the provider's behavior and performance.

(3) A reasonable determination of the dollar amounts the proposed rule will cost small businesses in terms of fees, administrative penalties, reporting, recordkeeping, equipment, construction labor, professional services, revenue loss, or other costs associated with compliance.

Providers will incur some small additional administrative expense, limited to once-yearly input of several questions for each ADHD client. No additional incremental costs to providers are expected. The net revenue impact to any individual provider will depend on their current standard of care and any improvement they make.

(4) A reasonable determination of the dollar amounts of the costs to the agency of implementing the proposed rule, as well as the financial benefit to the agency of implementing the rule.

The Department projects savings resulting from implementation of this initiative to be $9,333,462 in SFY 2014. 2014 is the first year that the full impact of this initiative would be realized.

(5) Whether and to what extent alternative means exist for accomplishing the objectives of the proposed rule that might be less burdensome to small businesses and why such alternatives are not being proposed.

Not Applicable

(6) A comparison of the proposed rule with federal and state counterparts.

Not Applicable

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

TO: Arkansas Medicaid Health Care Providers – All Providers

DATE: October 1, 2012

SUBJECT: Provider Manual Update Transmittal Secl-3-12

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

Explanation of Updates

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

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

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

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

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

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

Thank you for your participation in the Arkansas Medicaid Program.

Andy Allison /mg

Andrew Allison, PhD
Director

TOC required

180.000 EPISODES OF CARE

181.000 INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY AND ECONOMY 10-1-12

A. Definitions

1. An "episode" refers to a defined collection of related Medicaid-covered health care services provided to a specific Medicaid beneficiary.
2. An "episode type" is defined by a diagnosis, health care intervention, or condition during a specific timeframe (or performance period).
3. "Thresholds" are the upper and lower reimbursement benchmarks for an episode of care.

B. Medicaid has established a payment improvement initiative ("payment improvement program") to incentivize improved care quality, efficiency and economy. The program uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode, and to apply payment incentives. Please refer to the Episodes of Care Medicaid Manual for information about specific episodes.

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

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

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

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

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

H. Principal Accountable Providers

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

I. Supplemental Payment Incentives

For each PAP for each applicable episode type:

1. Performance will be aggregated and assessed over a specified period of time ("performance period"). For each PAP, the average reimbursement across all relevant episodes completed during the performance period will be calculated, based on the set of services included in the episode definition published and made available to providers.
2. Some episodes may be excluded and reimbursement for some episodes may be adjusted in this calculation, based on clinical or other factors, as described in the definition of each episode.
3. The average adjusted reimbursement of all episodes for the PAP during the performance period will be compared to thresholds established by Medicaid with advice from providers.
4. If the average adjusted episode reimbursement is lower than the commendable threshold and the PAP has documented that the quality requirements established by Medicaid for each episode type have been met, Medicaid will make a positive supplemental payment to the PAP. This payment will be equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation and multiplied by a gain sharing percentage for the episode. Where necessary, a gain sharing limit will be established to avoid incentives for underutilization. PAPs with average adjusted episode reimbursement lower than the gain sharing limit will receive a supplemental payment calculated as though their average adjusted episode reimbursement were equal to the gain sharing limit.
5. If the average episode reimbursement is higher than the acceptable threshold, the PAP will incur a negative supplemental payment. This payment to Medicaid will be equal to the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation and multiplied by a risk sharing percentage defined by Medicaid for the episode.

J. Principles for determining "thresholds"

1. The threshold process aims to incentivize high-quality clinical care delivered efficiently, and to consider several factors including the potential to improve patient access, the impact on provider economics and the level and type of practice pattern changes required for performance improvement.
2. The acceptable threshold is set such that average cost per episode above the acceptable threshold reflects unacceptable performance, which could result from a large variation from typical performance without clinical justification (e.g., individual provider variation) or from system-wide variance from widely accepted clinical standards.
3. The commendable threshold is set such that outperforming the commendable threshold represents quality care provided at a lower total reimbursement, which would result from care at meaningfully better than current average reimbursement in Arkansas, consistent with good medical outcomes. Medicaid may take into consideration what a clinically feasible target would be, as demonstrated by historical reimbursement variance in Arkansas.
4. The gain-sharing limit is set to avoid the risk of incentivizing care delivery at a cost that could compromise quality.
5. The gain and risk sharing percentages aim to recognize required provider investment in practice change and will be set at a sustainable level for Medicaid.

K. Outlier Patient Exclusions

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

L. Provider-level adjustments

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

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

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

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

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

M. Quality

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

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

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

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

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

TO: Arkansas Medicaid Health Care Providers – Episodes of Care

DATE: October 1, 2012

SUBJECT: Provider Manual Update Transmittal EPISODE-New-12

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

Explanation of Updates

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

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

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

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

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

Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director

SECTION II – EPISODES OF CARE

CONTENTS

200.000 EPISODES OF CARE GENERAL INFORMATION

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

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

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

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

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

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

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

200.200 Principal Accountable Provider 10-1-12

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

200.300 Exclusions 10-1-12

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

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

200.400 Adjustments 10-1-12

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

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

200.500 Quality Measures 10-1-12

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

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

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

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

200.600 Reimbursement Thresholds 10-1-12

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

200.700 Minimum Case Volume 10-1-12

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

210.000 ACUTE AMBULATORY UPPER RESPIRATORY INFECTION (URI) EPISODES

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

A. *Episode subtypes:*

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

B. *Episode trigger:*

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

C. *Episode duration:*

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

D. *Episode services:*

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

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

210.200 Principal Accountable Provider 10-1-12

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

210.300 Exclusions 10-1-12

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

A. Children younger than 1 year of age

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

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

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

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

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

210.400 Adjustments 10-1-12

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

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

210.500 Quality Measures 10-1-12

A. *Quality measures "to pass":*

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

B. *Quality measures "to track":*

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

210.600 Thresholds for Incentive Payments 10-1-12

A. *Acute Nonspecific URI*

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

B. *Acute Pharyngitis and similar conditions*

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

C. *Acute Sinusitis*

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

210.700 Minimum Case Volume 10-1-12

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

211.000 PERINATAL CARE EPISODES

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

A. *Episode trigger:*

A live birth on a facility claim

B. *Episode duration:*

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

C. *Episode services:*

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

211.200 Principal Accountable Provider 10-1-12

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

211.300 Exclusions 10-1-12

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

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

B. Delivering provider did not provide any prenatal services

C. Episode has no professional claim for delivery

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

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

211.400 Adjustments 10-1-12

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

211.500 Quality Measures **10-1-12**

A. *Quality measures "to pass":*

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

B. *Quality measures "to track":*

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

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

A. The acceptable threshold is $3,906.00.

B. The commendable threshold is $3,394.00.

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

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

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

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

212.000 ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) EPISODES

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

A. *Episode subtypes:*

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

B. *Episode trigger:*

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

C. *Episode duration:*

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

D. *Episode services:*

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

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

212.200 Principal Accountable Provider 10-1-12

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

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

If the provider responsible for the largest number of claims is a licensed clinical psychologist operating outside of an RSPMI provider organization, that provider is a co-PAP with the physician or RSPMI provider providing the next largest number of claims within the episode. In instances in which two providers are responsible for an equal number of claims within the episode, the provider whose claims accounted for a greater proportion of total reimbursement will be designated co-PAP.

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

212.300 Exclusions 10-1-12

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

A. Duration of less than 4 months

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

C. Beneficiaries with any behavioral health comorbid condition

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

212.400 Adjustments 10-1-12

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

212.500 Quality Measures 10-1-12

A. *Quality measures "to pass":*

1. Percentage of episodes with completion of either Continuing Care or Quality Assessment certification – must meet minimum threshold of 90% of episodes

B. *Quality measures "to track":*

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

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

A. *ADHD Level I*

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

PROPOSED

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.

1. Inpatient Hospital Services (continued)

PROPOSED

(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 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 underperforming 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.

1. Inpatient Hospital Services (continued)

PROPOSED

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

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

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

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

1. Inpatient Hospital Services (continued)

(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.

PROPOSED

2.a. Outpatient Hospital Services (continued)

PROPOSED

INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

(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) ("PAP's") for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAP's after an episode is complete using algorithms described in the episode definition.

2.a. Outpatient Hospital Services (continued)

PROPOSED

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

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

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

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

2.a. Outpatient Hospital Services (continued)

(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.

PROPOSED

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

INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

(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.

PROPOSED

(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) ("PAP's") for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAP's after an episode is complete using algorithms described in the episode definition.

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

(i) Supplemental Payment Incentives

PROPOSED

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 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 underperforming 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.

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

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

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

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

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

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

(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.

PROPOSED

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4) (continued).

INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

(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) ("PAP's") for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAP's after an episode is complete using algorithms described in the episode definition.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4) (continued).

PROPOSED

(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 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 underperforming 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.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4) (continued).

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

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

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

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

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4) (continued).

(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.

PROPOSED

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

(16) RESERVED

PROPOSED

(17) Psychology Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. Some Medicaid maximums were established at 65% of the Blue Shield customary reflected in their publication dated 10/90. The other Medicaid maximums were established at 50% of the Rehabilitative Services for Persons with Mental Illness (RSPMI) fee schedule per procedure code. Refer to Attachment 4.19-B, Page 5a, Item 13.d.1.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rates were decreased by 20%.

INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

(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.

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

(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) ("PAP's") for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAP's 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 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.

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

(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 underperforming 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 towards 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.

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

(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.

PROPOSED

PROPOSED

5. Physicians' Services (continued)

INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

(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) ("PAP's") for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAP's after an episode is complete using algorithms described in the episode definition.

5. Physicians' Services (continued)

PROPOSED

(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 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 underperforming 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.

5. Physicians' Services (continued)

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

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

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

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

5. Physicians' Services (continued)

(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.

PROPOSED

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

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

INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

(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) ("PAP's") for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAP's after an episode is complete using algorithms described in the episode definition.

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

PROPOSED

(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 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 underperforming 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.

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

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

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

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

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

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

(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.

PROPOSED

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)

INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

(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.

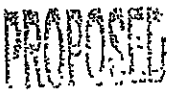
(g) Medicaid establishes episode definitions, levels of supplemental incentive payments, and appropriate quality measures based on evidence-based practices. To identify evidence-based practices, Medicaid shall consider clinical information furnished by Arkansas providers of the care and services typically 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) ("PAP's") for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAP's after an episode is complete using algorithms described in the episode definition.

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)



(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 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 underperforming 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.

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

PROPOSED

e. Emergency Hospital Services (continued)

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

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

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

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)

(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.

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)

INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

(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.

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

PROPOSED

f. Critical Access Hospitals (CAH) (continued)

(h) Principal Accountable Providers

The principal accountable provider(s) ("PAP's") for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAP's 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 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.

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)

PROPOSED

(2) The acceptable threshold is set such that underperforming 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 towards 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.

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)

PROPOSED

(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.

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

Reimbursement is based on the lower of the amount billed or the Title XIX maximum allowable.

The Title XIX maximum is 80% of the physician fee schedule except EPSDT procedure codes. Medicaid maximum allowables are the same for all EPSDT providers. Immunizations and Rhogam RhoD Immune Globulin are reimbursed at the same rate as the physician rate since the cost and administration of the drug does not vary between the advanced practice nurse and physician.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of services provided by Advanced Practice Nurse. The agency's fee schedule rate was set as of April 1, 2004 and is effective for services provided on or after that date. All rates are published on the agency's website@ www.medicaid.state.ar.us.

INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

(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.

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

(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) ("PAP's") for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAP's 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 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.

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

(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 underperforming 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 towards 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.

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

(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.