MEMORANDUM

TO: Interested Persons and Providers
FROM: Janet Mann, Director, Division of Medical Services
DATE: 06/23/20
SUBJ: Episode 1-19; Section I 3-19; and State Plan # 20-0002

As a part of the Arkansas Administrative Procedure Act process, attached for your review and comment are proposed rule revisions.

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter’s name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you have any comments, please submit those comments in writing, no later than July 25, 2020.
NOTICE OF RULE MAKING

The Director of the Division of Medical Services of the Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-76-201, 20-77-107, and 25-10-129.

Effective October 1, 2020:

The Division of Medical Services (DMS) announces it will amend the Arkansas Medicaid State Plan to sunset the Episode of Care Program.

Background: The Episode of Care (EOC) program has been successful as each episode is now reporting stability in cost and quality. Financially, the positive incentives now outweigh negative incentives. The program has exhausted any practical selection of new or additional conditions or procedures for which to study. The proposed rule provides that the EOC Program will sunset over a period of two state fiscal years. State fiscal year 2020 (July 1, 2019 – June 31, 2020) will be the last reporting period for each episode’s performance period. In State fiscal year 2021, the final reconciliation episode report will be generated. The reconciliation report period allows Principal Accountable Providers the opportunity to improve their gain share/risk share or incentive position. The report will reconcile the payment report for a final determination of possible risk share or gain share. The reporting timeframe below identifies the episode programs and the timeframe for each EOC.

Arkansas Medicaid State Plan changes: The Arkansas Medicaid State Plan is being revised to announce the sunset of the Episode of Care Program gradually over SFY 2020 and SFY 2021. Section I, 180.000, Episodes of Care, of the Medicaid provider manual, is being revised to announce the conclusion of the Episode of Care Program gradually over SFY 2020 and SFY 2021. Section II, 200.000, Episodes of Care General Information, of the Episodes of Care Provider Manual, is being revised to announce the conclusion of the Episode of Care Program gradually over SFY 2020 and SFY 2021. Included in the section is a timeframe of the gradual sunset for each episode of care. Section II, 210.000 – 223.000, Episodes of Care Provider Manual, are being revised to reflect the final payment report date and the final reconciliation report date of each episode of care.

The EOC program is a retroactive, financial program of Arkansas fee-for-service Medicaid. The episodes were launched quarterly and, as a result, have different performance periods. Each EOC will sunset as follows:

- Coronary Arterial Bypass Graft (CABG) will have a final payment report produced on July 31, 2019 and final reconciliation report produced on July 31, 2020
- Asthma will have a final payment report produced on October 31, 2019 and final reconciliation report produced on October 31, 2020
- Acute Ambulatory Upper Respiratory Infection (URI) will have a final payment report produced on January 31, 2020 and final reconciliation report produced on January 31, 2021
- Cholecystectomy (CHOLE) will have a final payment report produced on January 31, 2020 and final reconciliation report produced on January 31, 2021
- Perinatal will have a final payment report produced on January 31, 2020 and final reconciliation report produced on January 31, 2021
- Chronic Obstructive Pulmonary Disease (COPD) will have a final payment report produced on April 30, 2020 and final reconciliation report produced on April 30, 2021
- Congestive Heart Failure (CHF) will have a final payment report produced on April 30, 2020 and final reconciliation report produced on April 30, 2021
- Colonoscopy (COLON) will have a final payment report produced on April 30, 2020 and final reconciliation report produced on April 30, 2021
- Tonsillectomy (TONSIL) will have a final payment report produced on April 30, 2020 and final reconciliation report produced on April 30, 2021
- Total Joint Replacement (TJR) will have a final payment report produced on April 30, 2020 and final reconciliation report produced on April 30, 2021

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule on the Medicaid website at https://medicaid.mmis.arkansas.gov/General/Comment/Comment.aspx. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than July 25, 2020. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter’s name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-320-6266.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4501888131

Janet Mann, Director
Division of Medical Services
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021, the final reconciliation report will be generated. The reconciliation report period allows Principal Accountable Providers the opportunity to improve their gain share/risk share or incentive position. (See the Reporting Timeframe table below.)

<table>
<thead>
<tr>
<th>EOC</th>
<th>Final Reconciliation Report Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CORONARY ARTERIAL BYPASS GRAFT (CABG)</td>
<td>7/31/2020</td>
</tr>
<tr>
<td>ASTHMA</td>
<td>10/31/2020</td>
</tr>
<tr>
<td>UPPER RESPIRATORY INFECTION NON-SPECIFIC, SINUSITIS, PHARYNGITIS (URI)</td>
<td>1/31/2021</td>
</tr>
<tr>
<td>CHOLECYSTECTOMY (CHOLE)</td>
<td>1/31/2021</td>
</tr>
<tr>
<td>PERINATAL</td>
<td>1/31/2021</td>
</tr>
<tr>
<td>CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)</td>
<td>4/30/2021</td>
</tr>
<tr>
<td>CONGESTIVE HEART FAILURE (CHF)</td>
<td>4/30/2021</td>
</tr>
<tr>
<td>COLONOSCOPY (COLON)</td>
<td>4/30/2021</td>
</tr>
<tr>
<td>TONSILLECTOMY (TONSIL)</td>
<td>4/30/2021</td>
</tr>
<tr>
<td>TOTAL JOINT REPLACEMENT (TJR)</td>
<td>4/30/2021</td>
</tr>
</tbody>
</table>

The transition process to sunset Episodes of Care will result in a final payment report for Acute Ambulatory Upper Respiratory Infection (URI) Episode to be produced on January 31, 2020 and a final reconciliation report to be produced on January 31, 2021.

The transition process to sunset Episodes of Care will result in a final payment report for Perinatal Episode to be produced on January 31, 2020 and a final reconciliation report to be produced on January 31, 2021.

The transition process to sunset Episodes of Care will result in a final payment report for Congestive Heart Failure (CHF) Episode to be produced on April 30, 2020 and a final reconciliation report to be produced on April 30, 2021.
The transition process to sunset Episodes of Care will result in a final payment report for Total Joint Replacement (TJR) Episode to be produced on April 30, 2020 and a final reconciliation report to be produced on April 30, 2021.

The transition process to sunset Episodes of Care will result in a final payment report for Colonoscopy (COLON) Episode to be produced on April 30, 2020 and a final reconciliation report to be produced on April 30, 2021.

The transition process to sunset Episodes of Care will result in a final payment report for Tonsillectomy (TONSIL) Episode to be produced on April 30, 2020 and a final reconciliation report to be produced on April 30, 2021.

The transition process to sunset Episodes of Care will result in a final payment report for Cholecystectomy (CHOLE) Episode to be produced on January 31, 2020 and a final reconciliation report to be produced on January 31, 2021.

The transition process to sunset Episodes of Care will result in a final payment report for Asthma Episode to be produced on October 31, 2019 and a final reconciliation report to be produced on October 31, 2020.

The transition process to sunset Episodes of Care will result in a final payment report for Chronic Obstructive Pulmonary Disease (COPD) Episode to be produced on April 30, 2020 and a final reconciliation report to be produced on April 30, 2021.

The transition process to sunset Episodes of Care will result in a final payment report for Coronary arterial bypass graft (CABG) Episode to be produced on July 31, 2019 and a final reconciliation report to be produced on July 31, 2020.
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021, the final reconciliation report will be generated. The reconciliation report period allows Principal Accountable Providers the opportunity to improve their gain share/risk share or incentive position.
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated as provided in the chart.

<table>
<thead>
<tr>
<th>Episodes of Care</th>
<th>Final Reconciliation Episode Report Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CORONARY ARTERIAL BYPASS GRAFT (CABG)</td>
<td>7/31/2020</td>
</tr>
<tr>
<td>ASTHMA</td>
<td>10/31/2020</td>
</tr>
<tr>
<td>UPPER RESPIRATORY INFECTION - NON SPRECIFIC, SINUSITIS, PHARYNGITIS (URINS, URIS, URIP)</td>
<td>1/31/2021</td>
</tr>
<tr>
<td>CHOLECYSTECTOMY (CHOLE)</td>
<td>1/31/2021</td>
</tr>
<tr>
<td>PERINATAL</td>
<td>1/31/2021</td>
</tr>
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<td>CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)</td>
<td>4/30/2021</td>
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<tr>
<td>COLONOSCOPY (COLON)</td>
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<td>TONSILLECTOMY (TONSIL)</td>
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</tr>
<tr>
<td>TOTAL JOINT REPLACEMENT (TJR)</td>
<td>4/30/2021</td>
</tr>
</tbody>
</table>

1. Inpatient Hospital Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative (“Payment Improvement Program,” or “Program”). The Program:

1. Establishes Principle Accountable Providers (“PAPs”) for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at [https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx](https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx) and also at the Arkansas Health Care Payment Improvement Initiative website at [http://www.paymentinitiative.org/Pages/default.aspx](http://www.paymentinitiative.org/Pages/default.aspx).
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

1. Inpatient Hospital Services (continued)

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

   II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

   III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

   2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by fifty percent (50%) or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider’s net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episode of care adjustments made during any calendar year shall not exceed ten percent (10%) of the provider’s gross Medicaid reimbursements received by the provider during that calendar year.
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

1. Inpatient Hospital Services (continued)

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


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

   (1) Perinatal Care Episodes - Sunset date for final reconciliation report 1/31/2021

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

   (1) Congestive Heart Failure (CHF) Episodes - Sunset date for final reconciliation report 4/30/2021
   (2) Total Joint Replacement Episodes - Sunset date for final reconciliation report 4/30/2021
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021. (see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

2.a. Outpatient Hospital Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative (“Payment Improvement Program,” or “Program”). The Program:

1. Establishes Principle Accountable Providers (“PAPs”) for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

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

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

2.a. Outpatient Hospital Services (continued)

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

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by fifty percent (50%) or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider’s net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episode of care adjustments made during any calendar year shall not exceed ten percent (10%) of the provider’s gross Medicaid reimbursements received by the provider during that calendar year.
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11c for specific sunset dates)

2.a. Outpatient Hospital Services (continued)

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


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

- Perinatal Care Episodes - **Sunset date for final reconciliation report 1/31/2021**

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

- Congestive Heart Failure (CHF) Episodes - **Sunset date for final reconciliation report 4/30/2021**
- Total Joint Replacement Episodes - **Sunset date for final reconciliation report 4/30/2021**
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

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

A. ALTERNATE PAYMENT METHODOLOGY TO INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative (“Payment Improvement Program,” or “Program”). The Program:

1. Establishes Principle Accountable Providers (“PAPs”) for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

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

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

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

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

IV. INCENTIVE ADJUSTMENTS: The Program promotes efficient and economic care utilization by making incentive adjustments based on the aggregate valid and paid claims (“paid claims”) across a PAP’s episodes of care ending during the twelve (12) month performance period specified for the episode. Unless provided otherwise for a specific episode of care, incentive adjustments are made annually in the form of gain sharing (positive incentive adjustments) or provider risk sharing payments to Medicaid (negative incentive adjustments), and equal fifty percent (50%) of the difference between the average adjusted episode expenditures and the applicable threshold as described below. Incentive adjustments will occur no later than ninety (90) days after the end of the performance period. Because the incentive adjustments are based on aggregated and averaged claims data for a particular performance period, adjustments cannot be apportioned to specific provider claims.

1. Positive Incentive Adjustments: If the PAP’s average adjusted episode paid claims are lower than the commendable threshold and the PAP meets the quality requirements established by Medicaid for each episode type, Medicaid will remit an incentive adjustment to the PAP equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation, multiplied by fifty percent (50%) or the gain sharing percentage specified for the episode of care. To avoid incentivizing underutilization, Medicaid may establish a gain sharing limit. PAPs with average adjusted episode expenditures lower than the gain sharing limit will receive an incentive adjustment calculated as though the PAP’s average adjusted episode of care paid claims equal the gain sharing limit.

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the average adjusted episode reimbursement, multiplied by fifty percent (50%) or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider’s net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episodes of care during any performance period shall not exceed ten percent (10%) of the provider’s gross Medicaid reimbursements during that performance period.

For Rural Health Centers (RHCs), the negative incentive adjustment will not result in payment at less than the rate required under the PPS methodology, but Medicaid reserves the right to adjust total reimbursements to RHCs based on appropriate utilization under our utilization control responsibility to safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments consistent with regulations at 42 CFR Part 456.
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

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

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


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

(1) Perinatal Care Episodes - Sunset date for final reconciliation report 1/31/2021

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

(1) Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) Episodes - Sunset date for final reconciliation report 4/30/2021
(2) Acute Exacerbation of Asthma Episodes - Sunset date for final reconciliation report 10/31/2020

Effective for dates of service on or after March 14, 2014, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Acute Ambulatory Upper Respiratory Infection (URI) Episodes - Sunset date for final reconciliation report 1/31/2021
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021. (see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

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

(17) Psychology Services (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative (“Payment Improvement Program,” or “Program”). The Program:

1. Establishes Principle Accountable Providers (“PAPs”) for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

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

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

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

(17) Psychology Services (Continued)

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

IV. INCENTIVE ADJUSTMENTS (Continued)

1. Positive Incentive Adjustments: If the PAP’s average adjusted episode paid claims are lower than the commendable threshold and the PAP meets the quality requirements established by Medicaid for each episode type, Medicaid will remit an incentive adjustment to the PAP equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation, multiplied by fifty percent (50%) or the gain sharing percentage specified for the episode of care. To avoid incentivizing underutilization, Medicaid may establish a gain sharing limit. PAPs with average adjusted episode expenditures lower than the gain sharing limit will receive an incentive adjustment calculated as though the PAP’s average adjusted episode of care paid claims equal the gain sharing limit.

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by fifty percent (50%) or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider’s net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episode of care adjustments made during any calendar year shall not exceed ten percent (10%) of the provider’s gross Medicaid reimbursements received by the provider during that calendar year.
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

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

(17) Psychology Services (Continued)

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

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

Reserved for the potential addition of Episodes of Care subject to incentive adjustments
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

5. Physicians’ Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative (“Payment Improvement Program,” or “Program”). The Program:

1. Establishes Principle Accountable Providers (“PAPs”) for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

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

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

5. Physicians’ Services (continued)

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

   2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by fifty percent (50%) or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider’s net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episode of care adjustments made during any calendar year shall not exceed ten percent (10%) of the provider’s gross Medicaid reimbursements received by the provider during that calendar year.
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

5. Physicians’ Services (continued)

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

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

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

1. Acute Ambulatory Upper Respiratory Infection (URI) Episodes - Sunset date for final reconciliation report 1/31/2021
2. Perinatal Care Episodes - Sunset date for final reconciliation report 1/31/2021

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

1. Congestive Heart Failure (CHF) Episodes - Sunset date for final reconciliation report 4/30/2021
2. Total Joint Replacement Episodes - Sunset date for final reconciliation report 4/30/2021

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

1. Tonsillectomy Episodes - Sunset date for final reconciliation report 4/30/2021
2. Cholecystectomy Episodes - Sunset date for final reconciliation report 1/31/2021
3. Colonoscopy Episodes - Sunset date for final reconciliation report 4/30/2021
4. Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) Episodes - Sunset date for final reconciliation report 4/30/2021
5. Percutaneous Coronary Intervention (PCI) Episodes
6. Acute Exacerbation of Asthma Episodes - Sunset date for final reconciliation report 10/31/2020
7. Coronary Arterial Bypass Graft (CABG) episodes - Sunset date for final reconciliation report 07/31/2020
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

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

(d) Rehabilitative Services (Continued)

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

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative (“Payment Improvement Program,” or “Program”). The Program:

1. Establishes Principle Accountable Providers (“PAPs”) for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

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

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

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

(d) Rehabilitative Services (Continued)

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

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

   IV. INCENTIVE ADJUSTMENTS (Continued):

   1. Positive Incentive Adjustments: If the PAP’s average adjusted episode paid claims are lower than the commendable threshold and the PAP meets the quality requirements established by Medicaid for each episode type, Medicaid will remit an incentive adjustment to the PAP equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation, multiplied by fifty percent (50%) or the gain sharing percentage specified for the episode of care. To avoid incentivizing underutilization, Medicaid may establish a gain sharing limit. PAPs with average adjusted episode expenditures lower than the gain sharing limit will receive an incentive adjustment calculated as though the PAP’s average adjusted episode of care paid claims equal the gain sharing limit.

   2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by fifty percent (50%) or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider’s net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episode of care adjustments made during any calendar year shall not exceed ten percent (10%) of the provider’s gross Medicaid reimbursements received by the provider during that calendar year.
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021. (see chart on Attachment 4.19-A, Page 11c for specific sunset dates)

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

   (d) Rehabilitative Services (Continued)

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

   Incentives to improve care quality, efficiency, and economy (CONTINUED)

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

Reserved for the potential addition of Episodes of Care subject to incentive adjustments
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

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

(Continued)

e. Emergency Hospital Services (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative (“Payment Improvement Program,” or “Program”). The Program:

1. Establishes Principle Accountable Providers (“PAPs”) for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

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

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

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

c. Emergency Hospital Services (continued)

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

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by fifty percent (50%) or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider’s net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episode of care adjustments made during any calendar year shall not exceed ten percent (10%) of the provider’s gross Medicaid reimbursements received by the provider during that calendar year.
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11c for specific sunset dates)

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

(Continued)

e. Emergency Hospital Services (Continued)

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


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

(1) Perinatal Care Episodes - Sunset date for final reconciliation report 1/31/2021

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

(1) Congestive Heart Failure (CHF) Episodes - Sunset date for final reconciliation report 4/30/2021
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

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

   f. Critical Access Hospitals (CAH) (continued)

   A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

      I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative (“Payment Improvement Program,” or “Program”). The Program:

      1. Establishes Principle Accountable Providers (“PAPs”) for defined episodes of care;
      2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
      3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
      4. Encourages clinical effectiveness;
      5. Promotes early intervention and coordination to reduce complications and associated costs; and
      6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

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

      II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

      III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

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

f. Critical Access Hospitals (CAH)(continued)

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

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by fifty percent (50%) or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider’s net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episode of care adjustments made during any calendar year shall not exceed ten percent (10%) of the provider’s gross Medicaid reimbursements received by the provider during that calendar year.
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11c for specific sunset dates)

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

f. Critical Access Hospitals (CAH) (continued)

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

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

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

(1) Perinatal Care Episodes - Sunset date for final reconciliation report 1/31/2021

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

(1) Congestive Heart Failure (CHF) Episodes - Sunset date for final reconciliation report 4/30/2021

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

(1) Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) Episodes - Sunset date for final reconciliation report 4/30/2021
(2) Acute Exacerbation of Asthma Episodes - Sunset date for final reconciliation report 10/31/2020
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

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

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative (“Payment Improvement Program,” or “Program”). The Program:

1. Establishes Principle Accountable Providers (“PAPs”) for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

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

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

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

(Continued)

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

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by fifty percent (50%) or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider’s net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episode of care adjustments made during any calendar year shall not exceed ten percent (10%) of the provider’s gross Medicaid reimbursements received by the provider during that calendar year.
The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode’s performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

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

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

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

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

(1) Acute Ambulatory Upper Respiratory Infection (URI) Episodes - Sunset date for final reconciliation report 1/31/2021
(2) Perinatal Care Episodes - Sunset date for final reconciliation report 1/31/2021