

**SECTION I - GENERAL POLICY
CONTENTS**

TOC Not Required

180.000 EPISODES OF CARE 10-1-20

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.

*TOC not required***200.000 EPISODES OF CARE GENERAL INFORMATION****10-1-20**

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.)

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

210.000 ACUTE AMBULATORY UPPER RESPIRATORY INFECTION (URI) EPISODES**10-1-20**

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.

211.000 PERINATAL CARE EPISODES**10-1-20**

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.

213.000 CONGESTIVE HEART FAILURE (CHF) EPISODES**10-1-20**

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.

214.000 TOTAL JOINT REPLACEMENT EPISODES 10-1-20

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.

216.000 COLONOSCOPY EPISODES 10-1-20

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.

217.000 TONSILLECTOMY EPISODES 10-1-20

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.

218.000 CHOLECYSTECTOMY EPISODES 10-1-20

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.

220.000 ACUTE EXACERBATION OF ASTHMA EPISODES 10-1-20

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.

221.000 ACUTE EXACERBATION OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) EPISODES 10-1-20

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.

223.000 CORONARY ARTERIAL BYPASS GRAFT (CABG) EPISODES 10-1-20

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.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
 INPATIENT HOSPITAL SERVICES**

Revised: October 1, 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 as provided in the chart.

Episodes of Care	Final Reconciliation Episode Report Date
CORONARY ARTERIAL BYPASS GRAFT (CABG)	7/31/2020
ASTHMA	10/31/2020
UPPER RESPIRATORY INFECTION - NON SPECIFIC, SINUSITIS, PHARYNGITIS (URINS, URIS, URIP)	1/31/2021
CHOLECYSTECTOMY (CHOLE)	1/31/2021
PERINATAL	1/31/2021
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)	4/30/2021
CONGESTIVE HEART FAILURE (CHF)	4/30/2021
COLONOSCOPY (COLON)	4/30/2021
TONSILLECTOMY (TONSIL)	4/30/2021
TOTAL JOINT REPLACEMENT (TJR)	4/30/2021

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> and also at the Arkansas Health Care Payment Improvement Initiative website at <http://www.paymentinitiative.org/Pages/default.aspx>.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

Revised: October 1, 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)

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.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

Revised: October 1, 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)

1. Inpatient Hospital 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://medicaid.mmis.arkansas.gov/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**
(2) Total Joint Replacement Episodes - **Sunset date for final reconciliation report 4/30/2021**

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 18-010

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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)

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.

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 12-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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)

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.

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 13-25

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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)

2.a. Outpatient Hospital 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://medicaid.mmis.arkansas.gov/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**
- (2) Total Joint Replacement Episodes - **Sunset date for final reconciliation report 4/30/2021**

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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)

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.

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 13-25

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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)

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 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 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.

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 13-25

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1,2020

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)

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)

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://medicaid.mmis.arkansas.gov/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 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**

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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)

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.

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 12-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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)

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.

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 13-25

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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)

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

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 17-008

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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)

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.

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 12-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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)

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.

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 13-25

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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)

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) Acute Exacerbation of Asthma Episodes - **Sunset date for final reconciliation report 10/31/2020**
- (6) Coronary Arterial Bypass Graft (CABG) episodes - **Sunset date for final reconciliation report 07/31/2020**

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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
(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.

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 13-25

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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)

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

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

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

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

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 17-008

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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)

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.

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 12-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYEPS OF CARE

Revised: October 1, 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)

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

e. Emergency Hospital Services (continued)

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

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by **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.

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 13-25

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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)

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)

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://medicaid.mmis.arkansas.gov/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**

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 18-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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)

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.

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 12-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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)

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.

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 13-25

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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)

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**

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 13-05

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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.

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 12-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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 (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.

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 13-25

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 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 (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**

TN: 20-0002

APPROVAL: 8/31/20

EFFECTIVE: October 01, 2020

SUPERSEDES TN: 12-10

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT _____
DIVISION _____
PERSON COMPLETING THIS STATEMENT _____
TELEPHONE NO. _____ **FAX NO.** _____ **EMAIL:** _____

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

SHORT TITLE OF THIS RULE _____

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

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

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes _____ No _____
If an agency is proposing a more costly rule, please state the following:
 - (a) How the additional benefits of the more costly rule justify its additional cost;

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

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

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

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:
 - (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year

Next Fiscal Year

General Revenue _____
Federal Funds _____
Cash Funds _____
Special Revenue _____

General Revenue _____
Federal Funds _____
Cash Funds _____
Special Revenue _____

Other (Identify)_____

Other (Identify)_____

Total_____

Total_____

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

Current Fiscal Year

Next Fiscal Year

General Revenue_____

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 private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year

Next Fiscal Year

\$_____

\$_____

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

Current Fiscal Year

Next Fiscal Year

\$_____

\$_____

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

Yes_____ No_____

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously

with the financial impact statement and shall include, without limitation, the following:

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

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

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

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

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

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

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