

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-A
Page 1e

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

October 1, 2012

CATEGORICALLY NEEDED

2.b. Rural Health Clinic Services

Rural health clinic services are limited to twelve (12) visits a year for beneficiaries age 21 and older. This yearly limit is based on the State Fiscal Year (July 1 through June 30). The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist and certified nurse midwife services. Beneficiaries will be allowed twelve (12) visits per State Fiscal Year for rural health clinic services, physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services or a combination of the five. For physicians' services, medical services provided by a dentist, office medical services furnished by an optometrist certified nurse midwife services or rural health clinic core services beyond the 12 visit limit, extensions will be provided if medically necessary. **Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit.** Beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

Rural Health Clinic core services are defined as follows:

1. Physicians' services including required physician supervisory services of nurse practitioners and physician assistants;
2. Services and supplies furnished as an incident to a physician's professional services;

Services and supplies "incident to" the professional services of physicians, physician assistants and/or nurse practitioners are those which are commonly furnished in connection with these professional services, are generally furnished in the physician's office and are ordinarily rendered without charge or included in the clinic's bills; e.g., laboratory services, ordinary medications and other services and supplies used in patient primary care services.

3. Clinical psychologist services;
4. Clinical social worker services;

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SUPERSEDES: TN- 09-12

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AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

October 1, 2012

CATEOGORICALLY NEEDY

2.b. Rural Health Clinic Services

5. Services of physician assistants, nurse practitioners; nurse midwives and specialized nurse practitioners;
6. Services and supplies furnished as an incident to a nurse practitioner's or physician assistant's services; and
7. Visiting nurse services on a part-time or intermittent basis to home-bound patients) limited to areas in which there is a shortage of home health agencies).

Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the Rural Health Clinic offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the Rural Health Clinic will count against the limit established in the plan for that service.

- 2.c. Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual)NCFA – Pub. 45-4).

Effective for claims with dates of service on or after July 1, 1995, federally qualified health center (FQHC) services are limited to twelve (12) encounters per beneficiary, per State Fiscal Year (July 1 through June 30) for beneficiaries age 21 and older. For federally qualified health center core services beyond the 12 visit limit, extensions will be provided if medically necessary. Beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

FQHC hospital visits are limited to one day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

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SUPERSEDES: TN- 95-06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-A
Page 6c

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

October 1, 2012

CATEGORICALLY NEEDY

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

d. **Rehabilitative Services (Continued)**

2. **Rehabilitative Services for Persons with Physical Disabilities (RSPD)**

a. **Extended Rehabilitative Hospital Services**

Extended Rehabilitative Hospital Services are services for the rehabilitation of patients with various neurological, musculo-skeletal, orthopedic and other medical conditions following stabilization of their acute medical conditions. Extended Rehabilitative Hospital Services are a global service, covering all rehabilitative, psychological and/or social services required of the admitting facility for licensure, certification and/or accreditation.

The following services are included in the global coverage of an Extended Rehabilitative Hospital:

- 1) Restorative Therapies
- 2) Behavioral Rehabilitation
- 3) Life Skills Training
- 4) Individual and Group Counseling
- 5) Assessment Services
- 6) Nursing Care

Persons eligible for admission must have at least one of the following neurological conditions: Post acute traumatic or acquired brain injury. This includes and is limited to viral encephalitis, meningitis, aneurysms, cerebral vascular accident/stroke, post-operative tumors, anoxia, hypoxias, toxic encephalopathies, refractory seizure disorders and congenital neurological brain disorders. These conditions can be with or without moderate to severe behavioral disorders secondary to a brain injury.

An Extended Rehabilitative Hospital must be licensed by the Division of Health as a Rehabilitative Hospital. An Extended Rehabilitative Hospital must also be certified as a Title XVIII (Medicare) Rehabilitative Hospital provider. Extended Rehabilitative Hospital services are provided by a licensed practitioner who is directly related to the beneficiary's rehabilitative adjustment.

Extended Rehabilitative Hospital services provided are limited to thirty (30) days per state fiscal year, July 1 through June 30, for ages 21 and older. No extensions will be considered. However, beneficiaries who are under the age of 21 years and in the Child Health Services (EPSDT) Program are not limited to the thirty (30) day annual benefit limit. The thirty (30) day annual benefit limit only applies to services provided in an RSPD facility and does not include days counted toward any other Medicaid Program benefit limit, e.g., hospital, nursing home, etc.

Service delivery is the same as inpatient hospital services described in Attachment 3.1-A, Page 1a, Item 1, minus the room and board component.

Extended Rehabilitative Hospital Services are available to eligible Medicaid recipients of all ages when medically necessary as determined by the PRO. Services are limited to 30 days per State Fiscal Year for beneficiaries age 21 and older. Recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

SUPERSEDES: TEL 95-01

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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STATE ARKANSAS

ATTACHMENT 3.1-B
Page 2e

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

October 1, 2012

MEDICALLY NEEDY

2.b. Rural Health Clinic Services

Rural health clinic services are limited to twelve (12) visits a year for beneficiaries age 21 and older. This yearly limit is based on the State Fiscal Year (July 1 through June 30). The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist and certified nurse midwife services. Beneficiaries will be allowed twelve (12) visits per State Fiscal Year for rural health clinic services, physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services or a combination of the five. For physicians' services, medical services provided by a dentist, office medical services furnished by an optometrist certified nurse midwife services or rural health clinic core services beyond the 12 visit limit, extensions will be provided if medically necessary. **Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit.** Beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

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2. Services and supplies furnished as an incident to a physician's professional services;

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4. Clinical social worker services;

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SUPERSEDES: 09-12

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

October 1, 2012

MEDICALLY NEEDY

2.b. Rural Health Clinic Services

5. Services of physician assistants, nurse practitioners; nurse midwives and specialized nurse practitioners;
6. Services and supplies furnished as an incident to a nurse practitioner's or physician assistant's services; and
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SUPERSEDED: TN- 95-06

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AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

October 1, 2012

MEDICALLY NEEDY

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

d. **Rehabilitative Services (Continued)**

2. **Rehabilitative Services for Persons with Physical Disabilities (RSPD)**

a. **Extended Rehabilitative Hospital Services**

Extended Rehabilitative Hospital Services are services for the rehabilitation of patients with various neurological, musculo-skeletal, orthopedic and other medical conditions following stabilization of their acute medical conditions. Extended Rehabilitative Hospital Services are a global service, covering all rehabilitative, psychological and/or social services required of the admitting facility for licensure, certification and/or accreditation.

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- 1) Restorative Therapies
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- 3) Life Skills Training
- 4) Individual and Group Counseling
- 5) Assessment Services
- 6) Nursing Care

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An Extended Rehabilitative Hospital must be licensed by the Division of Health as a Rehabilitative Hospital. An Extended Rehabilitative Hospital must also be certified as a Title XVIII (Medicare) Rehabilitative Hospital provider. Extended Rehabilitative Hospital services are provided by a licensed practitioner who is directly related to the beneficiary's rehabilitative adjustment.

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Service delivery is delivery is the same as inpatient hospital services described in Attachment 3.1-A, Page 1a, Item 1, minus the room and board component.

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State/Territory: ARKANSAS

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).
- Provided:** No limitations With limitations* **with Prior Authorization**
- Not provided.
23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
- a. Transportation.
- Provided:** No limitations with limitations*
- Not provided.
- b. Services of Christian Science nurses.
- Provided:** No limitations with limitations*
- Not provided.**
- c. Care and services provided in Christian Science sanatoria.
- Provided:** No limitations with limitations*
- Not provided.**
- d. Nursing facility services for patients under 21 years of age.
- Provided:** No limitations with limitations*
- Not provided.
- e. Emergency hospital services.
- Provided:** No limitations with limitations*
- Not provided.
- f. Critical Access Hospital (CAH).
- Provided:** No limitations with limitations*
- Not provided.

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SUPERSEDES: TN-09-02

*Description provided on attachment.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

October 1, 2012

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>.

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.

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SUPERSEDES: NONE - NEW PAGE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

October 1, 2012

1. Inpatient Hospital Services (continued)

A. 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 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 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 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.

SUPERSEDES: NONE - NEW PAGE

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 4.19-A
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

October 1, 2012

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://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

SUPERSEDES: NONE - NEW PAGE

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

October 1, 2012

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.

SUPERSEDES: 12-08

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

October 1, 2012

2.a. Outpatient Hospital Services (continued)

A. 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 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 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 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.

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

October 1, 2012

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://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>.

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(1) Perinatal Care Episodes

SUPERSEDES: NONE - NEW PAGE

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

October 1, 2012

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. 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:

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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.

SUPERSEDES: NONE - NEW PAGE

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

October 1, 2012

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. 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 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 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 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.

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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. 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

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

(17) Psychology Services (Continued)

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

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.

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

(17) Psychology Services (Continued)

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

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 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 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 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.

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

(17) Psychology Services (Continued)

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

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

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) **Attention Deficit Hyperactivity Disorder (ADHD) Episodes**

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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.

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5. Physicians' Services (continued)

A. 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 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 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 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.

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5. Physicians' Services (continued)

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

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

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

- (1) Acute Ambulatory Upper Respiratory Infection (URI) Episodes
- (2) Perinatal Care Episodes
- (3) Attention Deficit Hyperactivity Disorder (ADHD) Episodes

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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

d. Eyeglasses

Negotiated statewide contract bid.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e. **STATE** Arkansas **Arkansas** those provided elsewhere in this plan

- a. Diagnostic Services - Not provided.
- b. Screening Services - Not provided.
- c. Preventive Services - Not provided.
- d. Rehabilitative Services

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

Reimbursement is based on the lower of the amount billed or the Title XIX (Medicaid) maximum allowable. Except as otherwise noted in the state plan, state developed fee schedule rates are the same for both governmental and private providers of RSPMI services. The agency's fee schedule rates were set as of April 1, 1988 and are effective for services provided on or after that date. All rates are published on the agency's website at www.medicaid.state.ar.us.

Effective for dates of service on or after April 1, 2004, reimbursement rates (payments) for inpatient visits in acute care hospitals by board certified psychiatrists shall be as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds. Refer to Attachment 4.19-B, Item 5, for physician reimbursement.

The State shall not claim FFP for any non institutional service provided to individuals who are residents of facilities that meet the Federal definition of an institution for mental diseases or a psychiatric residential treatment facility as described in Federal regulations at 42 CFR 1440 and 14460 and 42 CFR 441 Subparts C and D. Reimbursement of RSPMI services that are provided in IMD's will be discontinued for services provided on or after September 1, 2011.

For RSPMI services provided in clinics operated by State operated teaching hospitals.

Effective for claims with dates of service on or after March 1, 2002, Arkansas State Operated Teaching Hospital psychiatric clinics that are not part of a hospital outpatient department shall be reimbursed based on reasonable costs with interim payments at the RSPMI fee schedule rates and a year-end cost settlement. The provider will be paid the lesser of actual costs identified using a CMS approved cost report or customary charges. Each Arkansas State Operated Teaching Hospital with qualifying psychiatric clinics shall submit an annual cost report. Said cost report shall be submitted within five (5) months after the close of the hospital's fiscal year. Failure to file the cost report within the prescribed period, except as expressly extended by the State Medicaid Agency, may result in suspension of reimbursement until the cost report is filed. The State Medicaid Agency will review the submitted cost report and make a tentative settlement within 60 days of the receipt of the cost report and will make final settlement in the following year after all Medicaid charges and payments have been processed. The final settlement will be calculated and made at the same time as the next year's tentative settlement is calculated and made.

Medical professionals affiliated with Arkansas State Operated Teaching Hospitals are not eligible for additional reimbursement for services provided in these clinics.

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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.inedicaid.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.

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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: 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 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 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 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.

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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)**

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) **Attention Deficit Hyperactivity Disorder (ADHD) Episodes**

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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.

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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)**

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 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 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 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.

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

October 1, 2012

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://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

SUPERSEDES: NONE - NEW PAGE

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DATE REC'D	6-8-12
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

October 1, 2012

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.

SUPERSEDES: NONE - NEW PAGE

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

October 1, 2012

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)

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 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 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 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.

SUPERSEDES: NONE - NEW PAGE

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

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

October 1, 2012

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**

SUPERSEDES: NONE - NEW PAGE

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

October 1, 2012

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.

SUPERSEDES: NONE - NEW PAGE

STATE	<u>Arkansas</u>
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

October 1, 2012

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)

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 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 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 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.

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OTHER TYPES OF CARE

October 1, 2012

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
- (2) Perinatal Care Episodes

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