State: Arkansas
Date Received: 7/10/13
Date Approved: 9/30/13
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Transmittal Number AR 13-08

Citation	Condition or Requirement

1932(a) (1) (A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Arkansas enrolls most Medicaid beneficiaries into mandatory primary care case management (PCCM). This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
X ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

a. The Medicaid beneficiary chooses a primary care physician (PCP) who, through an on-going provider/beneficiary relationship, coordinates health care services, including referrals for necessary specialty services, physician's services, hospital care and other services. The PCCM provider will assist enrollees with locating medical services and coordinate and monitor their enrollees prescribed medical and rehabilitation services. PCCM will be mandatory for most Medicaid beneficiaries.

The beneficiaries have a free choice of specialists within the state and bordering states. A beneficiary must enroll with a PCCM whose practice is in the beneficiary's county of residence, a county adjacent to the beneficiary's county of residence or a county adjoining a county adjacent to the beneficiary's county of residence. PCCM providers have free choice of referrals specialists and ancillary providers

Under this PCCM program, the PCCM provider manages the enrolled beneficiary's health by working directly with beneficiaries and their treatment by providing:

Citation	Condition or Requirement

1. A PCP must make available 24-hour, 7 days per week telephone access to a live voice (an employee of the primary care physician or an answering service) Reasonable 24- hour availability and adequate hours of operation, referral and treatment with respect to medical emergencies.
2. Response to after-hours calls regarding non-emergencies must be within 30 minutes.

   PCPs must make the after-hours telephone number as widely available as possible to their patients.

   When employing an answering machine with recorded instructions for after-hours callers, PCPs should regularly check to ensure that the machine functions correctly and that the instructions are up to date.

   PCPs in underserved and sparsely populated areas may refer their patients to the nearest facility available, but enrollees must be able to obtain the necessary instructions by telephone.

   As regards access to services, PCPs are required to provide the same level of service for their ConnectCare enrollees as they provide for their insured and private-pay patients.

   Physicians and facilities treating a PCP's enrollees after hours must report diagnosis, treatment, significant findings, recommendations and any other pertinent information to the PCP for inclusion in the patient's medical record.

   A PCP may not refer ConnectCare enrollees to an emergency department for non-emergency conditions during the PCP's regular office hours.

3. Increasing the beneficiaries' and/or their caregivers' understanding of their disease so that they are:
   - Better able to understand their disease
   - Better able to access regular preventative health care by improving their self-management skills
   - Better able to understand the appropriate use of resources needed to care for their disease
   - Better able to improve the beneficiary's quality of life by assisting them in self-managing their disease and in accessing regular preventative health care.

Citation	Condition or Requirement

b. Arkansas Department of Human Services engages a network of credentialed primary care physicians to meet medical needs for enrolled beneficiaries. The PCCM provider is responsible for overall health care services for beneficiaries.

42 CFR 438.50(b) (2)
42 CFR 438.50(b) (3)

2. The payment method to the contracting entity will be:

____i. fee for service;
____ii. capitation;
__X__ iii. a case management fee;
____iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____vi. other. (Please provide a description below).

Reimbursement is a set rate of $ 3.00 per member per month through MMIS.

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

____ii. Incentives will be based upon specific activities and targets.

____iii. Incentives will be based upon a fixed period of time.

____iv. Incentives will not be renewed automatically.

____v. Incentives will be made available to both public and private PCCMs.

____vi. Incentives will not be conditioned on intergovernmental transfer agreements.

Citation	Condition or Requirement

__X_vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented.
There will be a state wide promulgation process, whereby there will be a 30 day public comment period. The state also assures that it will consult with the State Medical Care Advisory Committee. The beneficiary has the right to appeal or grieve through the Division of Medical Services, Office of Chief Counsel.

1932(a)(1)(A)

5. The state plan program will_X__/will not_ __ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary___ __ enrollment will be implemented in the following couties::

i. county/counties (mandatory) _____

ii. area/areas (mandatory)_____

iii. area/areas (voluntary)_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ___The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)

2. __X__The state assures that all the applicable requirements of section 1905(t)

Citation		Condition or Requirement
1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)		of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3.	_ __The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4.	_X___The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5.	__X__The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6.	___The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) for 42 CFR 447.362 42 CFR 438.50(c)(6)	7.	_X__ The state assures that all applicable requirements of 42 CFR 447.362 payments under any nonrisk contracts will be met.
45 CFR 74.40	8.	__X__The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

1932(a)(1)(A)(i)

1. List all eligible groups that will be enrolled on a mandatory basis.

Section 1931 children and related populations, pregnant women under SOBRA **(SOBRA women are required to enroll with a Primary Care Case Manger only if they need non-obstetrical services which require a PCP referral).**, Section 1931 Adults and Related populations, poverty level, Blind/Disabled Adults and related populations age 18 or older, Blind/Disabled Children, Aged and related populations. Ages 65 or older who are not Medicare beneficiaries. Foster Care Children, ARKids First B children,

Citation	Condition or Requirement
	pregnant women and infants, Blind/Disabled adults 18 and older, Foster Care children.
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment in any of the following mandatory exempt groups.
1932(a)(2)(B) 42 CFR 438(d)(1)	i. _____Beneficiaries who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Beneficiaries who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*
1932(a)(2)(C)	ii. _X___Indians who are beneficiaries of Federally recognized Tribes except when 42 CFR 438(d)(2) the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii _X__Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under Title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. __X_ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) of- 42 CFR 438.50(3)(iii)	v. _X__Children under the age of 19 years who are in foster care or other out- the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. _X___Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii)	vii. _X ___Children under the age of 19 years who are receiving services through a 42 CFR 438.50(3)(v) family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D)

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of Title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

N/A

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

____i. program participation,
____ii. special health care needs, or
_ X_iii. both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

__X_i. yes
___ _ii. no

1932(a)(2)
42 CFR 438.50 (d)

4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)*

i. Children under 19 years of age who are eligible for SSI under title XVI;

The state identifies this group as defined by categories at time of enrollment or reenrollment via the eligibility data base.

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

The state identifies this group as defined by categories at time of enrollment or reenrollment via the eligibility data base.

Citation	Condition or Requirement
	iii. Children under 19 years of age who are in foster care or other out-of-home placement; The state identifies this group as defined by categories at time of enrollment or reenrollment via the eligibility data base.
	iv. Children under 19 years of age who are receiving foster care or adoption assistance. The state identifies this group as defined by categories at time of enrollment or reenrollment via the eligibility data base.
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* The state requires PCCM's to allow enrollees to self–refer under certain circumstances. Arkansas Medicaid has no special definition for" special needs" children who are Medicaid beneficiaries. Connectcare includes mandatory enrollment for all of them who are not excluded for some other reason, such as having Medicare as their primary insurance.
1932(a)(2) 42 CFR 438.50(d)	**6.** Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: i. Beneficiaries who are also eligible for Medicare. The state uses aid categories on the eligibility system and the MMIS claims processing system to identify groups who are exempt from mandatory enrollment.
	ii. Indians who are beneficiaries of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating

Citation	Condition or Requirement

under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

The state uses aid categories on the eligibility system and the MMIS claims processing system to identify groups who are exempt from mandatory enrollment.

42 CFR 438.50

F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

Medicare dual eligible, poverty level pregnant women (SOBRA ;**SOBRA women are required to enroll with a Primary Care Case Manger only if they need non-obstetrical services which require a PCP referral**), Beneficiaries who reside in a nursing facilities or intermediate care facilities for the mentally retarded, Home and Community Based Waiver beneficiaries, Medicaid beneficiaries for the period of retroactive eligibility, medically needy spend down, family planning waiver, pregnant women: presumptive eligibility

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

N/A

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-beneficiary relationship is one in which the provider was the main source of Medicaid services for the beneficiary during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience or through contact with the recipient. Enrollees are permitted to disenroll from their PCCM or transfer between PCCMs.

ii. A provider is considered to have “traditionally served” Medicaid beneficiaries if it has experience in serving the Medicaid population.

1932(a)(4)

2. State process for enrollment by default.

Citation		Condition or Requirement
42 CFR 438.50		Describe how the state's default enrollment process will preserve:
		i. the existing provider-recipient relationship (as defined in H.1.i). A beneficiary may enroll with at PCCM at the office of the PCCM, at the regional district state office, through Connectcare or through the emergency room. The PCCM's staff telephones a Voice Response System; the entire process is automated via proprietary hardware and software;
		ii. the relationship with providers that have traditionally served Medicaid beneficiaries (as defined in H.2.ii).
		iii. the equitable distribution of Medicaid beneficiaries among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). The state has set enrollment limits for each PCCM provider. The PCCM provider is limited to 2500 enrollees. If that limitation creates a hardship for the practitioner, threatens the PCCM's practice or creates a problem of access and availability for beneficiaries, the PCCM may request in writing to the Director of Medical Services additional case load.
1932(a)(4) 42 CFR 438.50	3.	As part of the state's discussion on the default enrollment process, include the following information:
		i. The state will____/will not x use a lock-in for managed care.
		ii. The time frame for beneficiaries to choose a health plan before being auto-assigned will be N/A .
		iii. Describe the state's process for notifying Medicaid beneficiaries of their auto-assignment. *(Example: state generated correspondence.)* N/A

Citation	Condition or Requirement

iv. Describe the state's process for notifying the Medicaid beneficiaries who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

N/A

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

N/A

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

N/A

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. X The state assures it has an enrollment system that allows beneficiaries who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. X The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid beneficiaries enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

Citation	Condition or Requirement

3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

This provision is not applicable to this 1932 State Plan Amendment.

4. ____The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

X This provision is not applicable to this 1932 State Plan Amendment.

5. ____ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

X This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will___/will not X use lock-in for managed care.

2. The lock-in will apply for _N/A_ months (up to 12 months).

3. Place a check mark to affirm state compliance.

X The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

X The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)

L. List all services that are excluded for each model (MCO & PCCM)

Citation		Condition or Requirement
1905(t)		The following PCCM exempt services do not require PCP authorization: Dental Services Emergency hospital care Alternatives for Adults with Physical Disabilities waiver services. DDS Alternative Community Services Family Planning Anesthesia Alternative Waiver Programs Developmental Day Treatment Services Core Services only Disease Control Services for Communicable Diseases Domiciliary care ElderChoices waiver services Gynecological care Inpatient Hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment Mental health services as follows: a. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practice as an individual practitioner b. Rehabilitative services for persons with mental illness aged 21 or older or for specified procedures for persons under age 21 c. Rehabilitative Services for Youth and Children Nurse Midwife services ICF/MR services Nursing Facility services Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment. Ophthalmology and Optometry services Obstetric (antepartum, deliver and postpartum) services Pharmacy Physician Services for inpatients acute care. Transportation Sexual Abuse Examination. Targeted case management provided by the Division of Youth Services or the Division of Children and Family services under an interagency agreement with the Division of Medical Services.
1932 (a)(1)(A)(ii)	M.	Selective contracting under a 1932 state plan option To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

Citation	Condition or Requirement

1. The state will___will not___X___ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. X The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option.

A PCCM must establish his or her Medicaid caseload limit, of a maximum of 2500. The state will permit higher maximums in areas the federal government has designated as medically underserved. The state may permit higher maximum caseloads for Primary Care Providers who so request if the limit would create a hardship on their practice.