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State/Territory Name: Arkansas

State Plan Amendment (SPA) #: 13-26

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

January 30, 2014

Our Reference: SPA-AR-13-26

Dr. Andrew Allison
State Medicaid Director
Arkansas Department of Health and Human Services
P.O. Box 1437
Little Rock, Arkansas 72203

Dear Dr. Allison:

We have reviewed the proposed amendment to your Medicaid State Plan submitted under Transmittal Number (TN) 13-26. Under the authority of Section 1932(a)(1)(A) of the Social Security Act, Arkansas is approved to implement a Patient Centered Medical Home (PCMH) which aims to improve efficiency, economy and quality of care by rewarding high-quality care and outcomes; encouraging clinical effectiveness; promoting early intervention and coordination to reduce complications and associated costs; and when provider referrals are necessary, by encouraging referral to efficient and economic providers who deliver high-quality care.

Transmittal Number 13-26 is approved with an effective date of January 1, 2014 as requested. A copy of the HCFA-179, Transmittal No. 13-26 dated November 6, 2013 is enclosed along with the approved plan pages.

If you have any questions, please contact Stacey Shuman at (214) 767-6479.

Sincerely,

Bill Brooks
Associate Regional Administrator
Division of Medicaid and Children's Health

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

NATRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: 2013-026	2. STATE ARKANSAS
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE January 1, 2014	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 1905(t)(1)	7. FEDERAL BUDGET IMPACT: a. FFY 2014 $2,203,228 b. FFY 2015 $2,356,589
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-F, Pages 15-31	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: None, New Pages

10. SUBJECT OF AMENDMENT:
The Arkansas Title XIX State Plan has been amended to add Patient Centered Medical Home (PCMH).

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: Division of Medical Services PO Box 1437, Slot S295 Little Rock, AR 72203-1437 Attention: Glenda Higgs
13. TYPED NAME: Andrew Allison, PhD	
14. TITLE: Director, Division of Medical Services	
15. DATE SUBMITTED: November 6, 2013	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 6 November, 2013	18. DATE APPROVED: January 30, 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2014	20. SIGNA[illegible]FFICIAL:
21. TYPED NAME: Bill Brooks	22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

Citation	Condition or Requirement

1932(a) (1) (A)

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

Arkansas Patient Centered Medical Home (PCMH) program aims to improve efficiency, economy and quality of care by rewarding high-quality care and outcomes, encouraging clinical effectiveness, promoting early intervention and coordination to reduce complications and associated costs, and, when provider referrals are necessary, by encouraging referral to efficient and economic providers who deliver high-quality care.

Initially, participation in the PCMH program is open to practices as described in the DMS PCMH Provider Manual that have physicians who are primary care case managers as defined by the DMS Primary Care Case Management (ConnectCare) program. In addition, practices must meet the eligibility requirements described in the DMS PCMH Provider Manual. Practices that participate in the Comprehensive Primary Care Initiative (CPC) are eligible to receive shared savings incentive payments.

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 PCMH provider will assist enrollees with locating medical services and coordinate and monitor their enrollees prescribed medical and rehabilitation services.

The beneficiaries have a free choice of specialists within the state and bordering states. PCMH providers have free choice of referrals specialists and ancillary providers

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

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 PCMH 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 PCMH 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**

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- **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.**

b. Arkansas Department of Human Services engages a network of credentialed primary care physicians to meet medical needs for enrolled beneficiaries. The PCMH 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;
_X_ iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____vi. other. (Please provide a description below).

DMS offers two types of payments to Arkansas Patient Centered Medical Homes (PCMHs): (1) care coordination payments and (2) shared savings incentive payments. A shared savings entity is eligible to receive a shared savings incentive payment that is the greater of: (a) an incentive for performance improvement; and (b) an incentive for absolute performance.

The care coordination payment may be used by participating practices for care coordination efforts, whether these are executed by a vendor on behalf of the practice or directly by the practice. Care coordination payments are risk adjusted to account for the varying levels of care coordination services needed for patients with different risk profiles.

Shared savings incentive payments are annual payments made to a shared savings entity for delivery of economic, efficient and quality care.

Each year the per beneficiary cost of care performance is aggregated and assessed across a shared savings entity. Per beneficiary cost of care is calculated as the risk- and time-adjusted average of such entity's attributed beneficiaries' total fee-for-service claims (based on the published reimbursement methodology) during the annual performance period. DMS will make adjustments to per beneficiary cost of care to account for care coordination payments and supplemental payment incentives made under Episodes of Care as well as other adjustments. DMS will exclude certain costs from the per beneficiary cost of care, based on clinical or other factors as described in the DMS PCMH Provider Manual.

DMS has established thresholds for medium cost and high cost per beneficiary cost of care, as described in the DMS PCMH Provider Manual. These thresholds will help

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determine rewards for economic, efficient and quality care according to the rules below.

DMS will calculate benchmark costs for each shared savings entity by applying a benchmark trend to the entity's historical baseline per beneficiary cost of care. DMS may reevaluate the value of this benchmark trend if the annual, system-average per beneficiary cost or care growth rate differs significantly from a benchmark, determined by DMS.

A shared savings entity may be eligible to receive a shared savings incentive payment that is the greater of (1) a shared savings incentive payment for performance improvement and (2) a shared savings incentive payment for absolute performance.

(1) Performance improvement: During each performance period, each shared savings entity's per beneficiary savings is calculated as: [benchmark cost for that performance period] – [per beneficiary cost of care for that performance period]. If the shared savings entity's per beneficiary cost of care falls below that entity's benchmark cost for that performance period by at least the amount of the minimum savings rate, the shared savings entity may be eligible for a shared savings incentive payment for performance improvement. The minimum savings rate is determined by DMS.

The per beneficiary shared savings incentive payment for performance improvement for which the shared savings entity may be eligible is calculated as follows: [per beneficiary savings for that performance period] * [shared saving entity's shared savings percentage for that performance period]. A shared savings entity's shared savings percentage in a given performance period will be based on such entity's per beneficiary cost of care in the previous performance period compared to the previous performance period high and medium cost thresholds.

(2) Absolute performance: If the shared savings entity's per beneficiary cost of care falls below the current performance period medium cost threshold, the shared savings entity may be eligible for a shared savings incentive payment for absolute performance. The per beneficiary shared savings incentive payment for absolute performance for which the entity may be eligible is calculated as follows: ([medium cost threshold for that performance period] – [per beneficiary cost of care for that performance period]) * [50%]

A shared savings entity's total shared savings incentive payment will be calculated as the per beneficiary shared savings incentive payment for which it is eligible multiplied by the number of attributed beneficiaries as described in (g)(1), adjusted based on the amount of time beneficiaries were attributed to such entity's participating practice(s) and the risk profile of the attributed beneficiaries.

Three years from effective date of the program, Arkansas DMS will review and renew thresholds and submit any modifications to the State Amendment Plan as needed.

Citation	Condition or Requirement

As a condition of continuance beyond December 31, 2016, DMS will evaluate the PCMH program to demonstrate improvement against past performance and the performance of comparable states (to the extent available) using cost and quality data to determine whether the PCMH payment methodology has achieved or needs revisions to achieve the goals of improving health, increasing quality and lowering the growth of health care costs.
DMS will:

- **Provide CMS, at least annually, with data and reports supporting achievements in the goals of improving health, increasing quality and lowering the growth of health care costs.**
- **Provide CMS with updates, as conducted, to the state's metrics.**
- **Review and renew the payment methodology as part of the evaluation.**
- **Make all necessary modifications to the methodology, including those determined based on the evaluation and program success, through State Plan Amendment submissions.**

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.

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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.

The State established a website (www.paymentinitiative.org) to keep the public informed during the design of the PCMH program and provide current information on progress towards implementation. The website is a 'one stop shop' for documents and information PCMH and includes an email address for interested parties to send suggestions. The State also established a toll free number manned by service representatives to answer public/provider questions on PCMH program. These service representatives triage and escalate as needed, and catalogue questions for changes to the technical design, operational processes, or communications.

The PCMH Provider Manual explaining the program in detail is posted on the website. Webinars on program overview, enrollment process, benefits and requirements are also posted on the website along with FAQs on relevant topics.

PCMH town halls were held across Arkansas, led by Medicaid Managed Care Services (MMCS), a division of Arkansas Foundation For Medical Care (AFMC) that operates under contract with the DHS Division of Medical Services (DMS) and serves as a liaison between DMS and Medicaid providers. Monthly meetings were held with the Arkansas Hospital Association (AHA) and Arkansas Medical Society (AMS) to engage providers on developments in PCMH design and implementation. A Strategic Advisory Group of providers was formed and meets every other week to provide detailed feedback on program design and implementation. Statewide webinars were conducted to educate and receive feedback from providers and other stakeholders. A calendar of past and upcoming events and announcements is available to the public at http://www.paymentinitiative.org/calendar/Pages/default.aspx.

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There was a state wide promulgation process, whereby there was a 30 day public comment period, after which feedback was incorporated into version that was submitted for State legislative approval. PCMH program passed the Public Health Committee meeting on 9/19 and then passed Rules and Regulations committee on 10/9. The state also assures that it will consult with the State Medical Care Advisory Committee. The

Citation		Condition or Requirement
		beneficiary has the right to appeal or grieve through the Division of Medical Services, Office of Chief Counsel.
		Several informational sessions were conducted to provide an overview of the PCMH program and details around enrollment process and requirements to participate in the program. First informational session was conducted on 10/16 at UAMS, Little Rock and telecast live through video conference at AHEC locations around the state. Another informational session was help at Mercy Health Systems, Rogers on 10/30.
		Meaningful updates to the provider manual will be shared with CMS to enable continued collaboration and open lines of communication
1932(a)(1)(A)	5.	The state plan program will___/will not_X_ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary___ __ enrollment will be implemented in the following couties::

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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.

Citation		Condition or Requirement
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) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2.	__X__The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A)	3.	_ __The state assures that all the applicable requirements of section 1932

Citation		Condition or Requirement
42 CFR 438.50(c)(3)		(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

Citation		Condition or Requirement
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, 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)		i. _____Beneficiaries who are also eligible for Medicare.

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Citation	Condition or Requirement
42 CFR 438(d)(1)	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) of Title V, and is defined by the state in terms of either program participation or special health care needs. Note: Voluntary provider enrollment is allowed under the PCMH program. This program no way impacts direct services to Arkansas Medicaid beneficiaries.

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E. Identification of Mandatory Exempt Groups

Citation	Condition or Requirement
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

Citation		Condition or Requirement
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.

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.

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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)* **PCMH follows the PCCM process in which 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 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.**

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42 CFR 438.50	F.	<u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u> 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

Citation	Condition or Requirement

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 PCMH or transfer between PCMHs.**

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

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

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 a PCMH at the office of the PCMH, at the regional district state office, through Connectcare or through the emergency room. The PCMH'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**

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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

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

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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

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Citation	Condition or Requirement

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).

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).

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Citation		Condition or Requirement
		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) 1905(t)	L.	List all services that are excluded for each model (MCO & PCCM)

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

Citation	Condition or Requirement

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.

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.

N/A

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