Managed Care in Arkansas

This profile reflects state managed care program information as of August 2014, and only includes information on active federal operating authorities, and as such, the program start date may not reflect the earliest date that a program enrolled beneficiaries and provided services. Some states report populations and services available to program participants under the federal authority (e.g. Section 1115 waiver), so these features cannot be easily distinguished for each program.

Overview of Current Managed Care Programs

In July 2011, more than three quarters of Medicaid beneficiaries in Arkansas were enrolled in at least one of three managed care programs. Arkansas began offering managed care in 1994 with the introduction of its **ConnectCare** primary care case management program, which capitalized on the Automated Eligibility Verification and Claims Submission System (AEVCS) in 1992 to modernize payment to physicians. ConnectCare is currently mandatory for most Medicaid beneficiaries in the state and provides them with a medical home to provide primary care, health education, and case management and to coordinate their Medicaid services. ConnectCare also offers Dental Coordinated Care Specialists to assist with the coordination of beneficiaries' dental care.

In 1998, Arkansas introduced its **Non-emergency Transportation Program** to provide transportation services through a limited set of providers to most Medicaid beneficiaries in the state. Arkansas also offers a **Program for All-Inclusive Care for the Elderly (PACE)**, which provides all Medicare and Medicaid services to individuals over age 55 that require a nursing home level of care on a voluntary basis in a select region of the state.

In 2012, Arkansas launched its Health Care Payment Improvement Initiative that expands medical and health homes and institutes a shared-savings/shared-risk model based on providers' average costs for selected episodes of care. Participating practices can receive per member per month payments to support care coordination and practice transformation, which are tied to their ability to meet measures of utilization and quality. On September 30, 2013 CMS gave approval to the State to modify the existing enhanced PCCM program to limit the PCCM benefit to a mandatory group and remove the duals population.

In January 2014, Arkansas launched the PCCM program that limits benefits from their ePCCM program to mandatory and exempt groups minus members with dual coverage. To improve case management the two plans were collapsed to run services granted under one 1932(b) waiver.

Participating Plans, Plan Selection, and Rate Setting

The state contracts with Medicaid Managed Care Services (MMCS), which is a division of the Arkansas Foundation for Medical Care, to administer its ConnectCare program and perform monitoring and reporting functions. In addition, the state contracts with primary care providers to manage care for Medicaid enrollees in the ConnectCare program. Primary care providers are paid a monthly per-member case management fee in addition to regular Medicaid fee-for-service reimbursement for medical services. The state also contracts with six transportation brokers (one per geographic region) to provide non-emergency transportation services. Transportation brokers are paid a flat rate based on the number of beneficiaries in the region they serve.

Quality and Performance Incentives

Arkansas constructs a subset of HEDIS and CAHPS measures to monitor quality of care provided to ARKids (Medicaid and CHIP-eligible) enrollees. The state also uses a physician profiling system for its Medicaid programs, including ConnectCare, which generates reports at the end of each quarter that describe costs and utilization rates for pharmacy, primary care visits, referrals, emergency room use, and hospitalization for the provider and for the whole state on a total and per-enrollee per-month basis. In addition, supplemental payments are made to providers who meet or exceed expected measure targets on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings.

Table: Managed Care Program Features, as of August 2014

Program Name	Non-Emergency Transportation	Arkansas Safety Benefit Program	Program for the All-Inclusive Care for the Elderly (PACE)	Primary Care Case Management	
Program Type	Transportation PAHP	PCCM	PACE	PCCM	
Program Start Date	March 1998	October 1994**	June 2008	January 2014	
Statutory Authorities	1915(b)	1115(a)	PACE	1932(a)	
Geographic Reach of Program	Statewide	Statewide	Single Region	Statewide	
		Populations Enrolled *(Exceptions may apply for certain individuals in each group)*			
Aged	X	X	X	x	
Disabled Children & Adults	X	X	X (age 55+)		
Children	X	X			
Low-Income Adults	X	X		x	
Blind/Disabled Children, Aged and related populations		x		x	
Blind/Disabled Adults and related populations age 18 or older		x		x	
Pregnant Women and Children		x		x	
AR Kids First B Children		x		x	
Medicare-Medicaid Eligibles ("duals")	X		X (age 55+)		
Foster Care Children	X	X		x	
American Indians/Alaska Natives					
Mandatory or Voluntary enrollment?	Mandatory	Mandatory	Voluntary	Mandatory	
		Medicaid Services Covered in Capitation (*Specialized services other than those listed may be covered. Services not marked with an X are excluded or "carved out" of the benefit package.)*			
Inpatient hospital			X		
Primary Care and Outpatient Services		X (case management only)	X		

Program Name	Non-Emergency Transportation	Arkansas Safety Benefit Program	Program for the All-Inclusive Care for the Elderly (PACE)	Primary Care Case Management
Pharmacy			X	
Institutional LTC			X	
Personal care/HCBS			X	
Inpatient Behavioral Health Services			X	
Outpatient Behavioral Health Services			X	
Dental			X	
Transportation	X		X	
Participating Plans	1. Lefleur Transportation* 2. Area Agency on Aging of Western Arkansas* 3. Southeastrans* 4. Central Arkansas Development Council* 5. Area Agency on Aging of Southeast Arkansas* 6. Southwest Arkansas Development Council, Inc.*	1. Connect Care – participating primary care providers	1. Total Life Healthcare	
Uses HEDIS Measures or Similar		X	NA	
Uses CAHPS Measures or Similar		X	NA	
State requires MCOs to submit HEDIS or CAHPS data to NCQA	NA	NA	NA	
State Requires MCO Accreditation	NA	NA	NA	
External Quality Review Organization				
State Publicly Releases Quality Reports				

Sources: Centers for Medicare and Medicaid Services (CMS), National Summary of State Medicaid Managed Care Programs as of July 1, 2011. Kaiser Commission on Medicaid and the Uninsured. Profile of Medicaid Managed Care Programs in 2010. September 2011.

National Committee on Quality Assurance. NCQA Medicaid Managed Care Toolkit 2012 Health Plan Accreditation Standards. State Use of Accreditation as of February 2012.

Notes: Managed Care Organization (MCO); Prepaid Inpatient Health Plans (PIHP); Prepaid Ambulatory Health Plan (PAHP); Mental Health/Substance Use Disorder (MH/SUD); Healthcare Effectiveness Data and Information Set (HEDIS); Consumer Assessment of Healthcare Providers and Systems (CAHPS).

Primary Care and Outpatient Services include physician services, hospice, laboratory, imaging, FQHC, and other specialty services delivered in outpatient offices and clinics. Institutional Long Term Care (LTC) includes Skilled Nursing Facilities (SNF) and/or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDD).

External Quality Review Organization activities are only required for MCOs, PIHPs, PAHPs, and other applicable entities with comprehensive risk contracts.

* According to the state, there are six contracting non-emergency transportation brokers. See http://mmcs.afmc.org/LinkClick.aspx?fileticket=WxpOcgqShr4%3d&tabid=566&portalid=3&mid=1294.

** Though the 2011 National Program Summary Report lists the implementation date for this program as 2006, external sources describe the program as having been in place since 1994. See http://www.chcs.org/usr_doc/EPCCM_Full_Report.pdf.