ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-682-2480
TDD/TTY: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers – All Providers**

DATE: **July 1, 2014**

SUBJECT: **Provider Manual Update Transmittal SecI-2-14**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
_____	_____	105.300	7-1-2014

Explanation of Updates

Section 105.300 is added to include information regarding the Arkansas Delta Primary Care Case Management Pilot Program.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at 501-320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director

TOC required

105.300 Arkansas Delta Primary Care Case Management Pilot Program 7-1-14

The purpose of the Arkansas Delta Primary Care Case Management Pilot program is to establish a contract with a vendor who meets criteria through a request for qualifications (RFQ) process. The vendor will provide case management by recruiting an adequate number of primary care clinics in the Arkansas Delta Region for a two-year program beginning 7/1/14. Thirty-nine (39) of Arkansas' seventy-five (75) counties have been selected to participate in the pilot; and within those counties, a minimum of five thousand (5,000) beneficiaries meeting certain criteria must be enrolled in the program. However, if enrollment falls below five thousand (5,000) beneficiaries, DMS will apply actuarially sound modifications to the shared savings calculations. The vendor will be responsible for enrolling enough clinics to satisfy the beneficiary requirements. This goal of this program is to lower the total cost of care, enhance a patient's health care experience, and improve health outcomes.

The Delta Primary Care Case Management Pilot program excludes:

A. Beneficiaries who are currently in the Arkansas Beneficiary Centered Medical Home (PCMH) Program

B. Beneficiaries who are currently in the federal Comprehensive Primary Care Initiative (CPCI)

C. Beneficiaries who are currently in a home health program that is similar to PCMH and CPCI (For the purposes of this pilot, these programs are those designed by DMS to provide care coordination services for beneficiaries meeting the health home criteria set out in the Affordable Care Act Section 2703.)

D. Beneficiaries who are in the Alternatives for Persons with Disabilities

E. Beneficiaries who are in the Division of Developmental Disabilities Services Alternative Community Services

F. Beneficiaries who are in the Elder Choices

G. Beneficiaries who are in the Living Choices Assisted Living waivers

H. Beneficiaries who are in the Program of All-Inclusive Care for the Elderly

One hundred percent of the dollar value of care coordination payments is included in the per beneficiary cost of care calculation.

The following costs are excluded from the calculation of per beneficiary cost of care:

A. All costs in excess of $100,000 for any individual beneficiary

B. Behavioral health costs for patients with the most complex behavioral health needs

C. Select costs associated with developmental disabilities (DD) services, identified on the basis of DD provider types

D. Select direct costs associated with Long-Term Support and Services (LTSS)

E. Select costs associated with nursing home fees, transportation fees, dental, and vision

F. Select neonatal costs

G. Other costs as determined by DMS

Detailed information on specific exclusions can be found at **www.paymentinitiative.org**.

The following adjustments are made to costs for calculation of per beneficiary cost of care:

A. Inpatient hospital claims will be adjusted to reflect a standard per diem.

B. Inpatient hospital claims will be adjusted to reflect a standard per diem.

C. Pharmacy costs will be adjusted to reflect all supplemental and OBRA rebates.

D. The per beneficiary cost of care for the PCCM Program is adjusted by the amount of supplemental payment incentives, both positive and negative, made under Episodes of Care for the beneficiaries attributed to the PCCM Program.

E. Technical adjustments may be made by DHS and will be posted at **www.paymentinitiative.org.**

Citation	Condition or Requirement

1932(a)(1)(A)

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

The Delta Primary Care Case Management Pilot program was mandated by Act 1453 of the Arkansas General Assembly in the 2013 Session. This is a 2 year pilot program that will be re-evaluated no later than July 1, 2016 to determine if it will continue to exist. It is expected that the case management services offered by the PCCM contractor will have a positive effect beyond the two (2) year span of the program. It is expected that case management services provided by the PCCM contractor will set an example that clinics will follow in the future. If successful and further authorized by the Arkansas Legislature, the pilot's duration may be extended.

The State of Arkansas enrolls Medicaid beneficiaries on a voluntary basis into enhanced primary care case management (E-PCCM) called the Arkansas Delta Primary Care Case Management Pilot program. 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 purpose of the Arkansas Delta Primary Care Case Management Pilot program is to establish a contract with a vendor who meets criteria through a request for qualifications (RFQ) process. The successful respondent will provide case management by recruiting an adequate number of primary care clinics in the Arkansas Delta Region for a two (2) year program. Thirty-nine (39) of Arkansas' seventy-five (75) counties have been selected to participate in the pilot and within those counties beneficiaries meeting certain criteria must be enrolled in the program. The PCCM contractor will be responsible for enrolling enough clinics to satisfy the beneficiary requirements. The enrollment must be completed within ninety (90) days of contract start date. The vendor will

Citation | Condition or Requirement

make best efforts to recruit enough clinics to reach a target of a minimum of five-thousand (5,000) beneficiaries who meet all pilot eligibility criteria. If enrollment falls below five-thousand (5,000) beneficiaries, then the DMS will apply actuarially sound modifications to the shared savings calculations pursuant to CMS approval. For example, DMS may introduce a minimum savings rate (MSR) that will behave to be met prior to shared savings calculation.

The PCCM contractor, the Division of Medical Services (DMS) and the participating clinics will be eligible to share in actual savings in the total cost of care that have been obtained as a direct result of the case management services. The PCCM contractor will be compensated for services based on a Per Beneficiary Per Month (PBPM) fee payment. The PCCM contractor will be at risk if the case management services do not produce savings in the total cost of care and if there are no savings in the first performance period, the PBPM payback shall be the lesser of 1) twenty-five percent (25%) of all PBPM fees paid during the period, or 2) difference between the actual cost and the benchmark cost for the performance period. If there are no savings in the second performance period, then twenty-five percent (25%) of all PBPM fees paid for during this period will be subject to recoupment.

In order to qualify for participation in the program, beneficiaries must have one (1) or more of the following conditions and must have healthcare costs associated with them that are in the top quartile for their defined population:

1. Catastrophic condition as defined by a prospective risk score of 6 or more on the John Hopkins Adjusted Clinical Groups System and have costs associated with them that are in the top quartile for their defined population;

2. Complex condition as defined by a prospective risk score of 6 through 10 on the John Hopkins Adjusted Clinical Groups System and have costs associated with them that are in the top quartile for their defined population;

3. Chronic condition as defined by a prospective risk score of 3 through 6 on the John Hopkins Adjusted Clinical Groups System and have costs associated with them that are in the top quartile for their defined population.

4. History of past high risk pregnancies and have costs associated with them that are in the top quartile for their defined population;

Citation | Condition or Requirement

5. History of past poor birth outcomes and have costs associated with them that are in the top quartile for their defined population; and/or

6. History of past preterm deliveries and costs associated with them that are in the top quartile for their defined population.

b. DMS will contract with the vendor to provide care coordination services to the beneficiary. A successful vendor must be able to demonstrate:
- Experience with the PCCM model described in the RFQ in the type of geographic area specified as the thirty-nine (39) Delta counties.
- Customer satisfaction as documented through independent consumer assessment of healthcare providers and systems surveys
- That a Utilization Review Accreditation Commission accreditation for its Health Utilization Management and Case Management programs is maintained.

c. While the care coordination will be provided by the vendor, such service will not be possible without full cooperation and support from all participating clinics. Consequently, the vendor must establish a distinct network of participating clinics which will work with the vendor to create necessary access to the clinic's patients and their medical records and to support execution of care coordination plans outlined by the vendor.

d. The following beneficiaries will be excluded from participation in the pilot:

1. Beneficiaries who are currently in the Arkansas Beneficiary Centered Medical Home (PCMH) Program
2. Beneficiaries who are currently in the federal Comprehensive Primary Care Initiative (CPCI)
3. Beneficiaries who are currently in a home health program that is similar to PCMH and CPCI. (For the purposes of this RFQ and contract, these programs are those designed by DMS to provide care coordination services for beneficiaries meeting the health home criteria set out in the Affordable Care Act Section 2703)
4. Beneficiaries who are in the Alternatives for Persons with Disabilities

Citation	Condition or Requirement

5. Beneficiaries who are in the Division of Developmental Disabilities Services Alternative Community Services
6. Beneficiaries who are in the Elder Choices
7. Beneficiaries who are in the Living Choices Assisted Living waivers
8. Beneficiaries who are in the Program of All-Inclusive Care for the Elderly

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;
___ iii. a case management fee;
____iv. a bonus/incentive payment;
____ v. a supplemental payment, or
_X__vi. other. (Please provide a description below).

The E-PCCM Arkansas Delta Primary Care Case Management Pilot program vendor receives a per beneficiary per month (PMPM) fee. The PMPM payment will be predicated on satisfaction of specified quality metrics and activities. The vendor must also meet all other program deliverables in order to be eligible to receive PMPM fees. Providers that render services to beneficiaries will continue to receive payment for services under the current fee for service methodology.

The PCCM pilot PBPM fees will be stratified based on RUB (resource utilization bands) scores as defined by Johns Hopkins ACG. They will be as follows:

RUB 5 - $30.00

RUB 4 - $10.00

RUB 3 - $5.00

Because the pilot's objective is to reach the highest acuity beneficiaries whose cost of care is in the top quartile of the total cost of care, it is expected that beneficiaries within RUB 5, RUB 4, and RUB 3 will be eligible for PBPMs in this program. PBPMs will not be paid to the PCCM contractor for individuals that have no claims experience in the eligibility period or those that have RUB scores less than 3.

Citation	Condition or Requirement

The vendor will be reimbursed $30.00 PBPM fee for all attributed RUB 5 beneficiaries, a $10.00 PBPM fee for all attributed RUB 4 beneficiaries and a $5.00 PBPM fee for all attributed RUB 3 beneficiaries.

PBPM payments will be made to the PCCM contractor based on its monthly submission of a complete and accurate invoice which reflects the proper payment for the number of attributed beneficiaries and their respective score. A retrospective reconciliation will occur annually for any beneficiary that lost Medicaid eligibility or died within the timeframe for which the PCCM contractor received a PBPM or otherwise failed to meet the specified eligibility criteria. However, the PCCM contractor shall monitor eligibility to ensure that invoices are only submitted for eligible beneficiaries.

Throughout the duration of the program, the vendor will be receiving PBPM fees, with the exception that the PCCM Contractor will not receive any payments during the enrollment period.

The pilot program is intended to produce savings as compared to the Benchmark Period. If the result of total costs for eligible beneficiaries in the pilot program during each Performance Period plus PBPM fees paid during the same period less any excluded costs for the same period does not produce a savings when compared to the benchmark period, then vendor will have to pay back twenty-five percent (25%) or portion thereof PBPM fees received by the vendor during the Performance Period. Specifically, if there are no savings in the first performance period, the PBPM payback shall be the lesser of 1) twenty-five percent (25%) of all PBPM fees paid during the period, or 2) difference between the actual cost and the benchmark cost for the performance period.

If there are no savings in the second performance period, then twenty-five percent (25%) of all PBPM fees paid for during this period will be subject to recoupment.

The PCCM Contractor is required to generate savings in comparison to the Arkansas Fee-For-Service benchmark.

In order for DMS to calculate and make shared savings payments, the PCCM pilot must encompass a minimum of five thousand (5,000) beneficiaries who were part of the pilot for at least 6 months of the performance period. If enrollment falls below five-thousand (5,000) beneficiaries, then the DMS will apply actuarially sound modifications to the shared savings calculations pursuant to CMS approval. For example, DMS may introduce a minimum savings rate (MSR) that will be have to be met prior to shared savings calculation.

Citation	Condition or Requirement

The Department of Medical Services (DMS), the vendor, and participating clinics will share in total cost of care savings that result from case management. After the PCCM shared-savings pilot program has operated for at least fifteen (15) months, the department shall utilize an agreed upon savings algorithm to calculate savings based on the first twelve (12) months of operations, allowing at least three (3) months of run-out. These savings shall be disbursed within thirty (30) calendar days of final calculation.

After the initial year of operation, savings will be calculated and reported on a quarterly basis. However, quarterly calculations will be reconciled on an annual basis and then such annual reconciled amount will be the basis for the second performance period's shared savings payout or twenty-five percent (25%) PBPM fee payback.

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)).

_X_ 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.

_X_ ii. Incentives will be based upon specific activities and targets.

_X_ iii. Incentives will be based upon a fixed period of time.

_X_ iv. Incentives will not be renewed automatically.

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

_X_ vi. Incentives will not be conditioned on intergovernmental transfer agreements.

____ vii. Not applicable to this 1932 state plan amendment.

Citation	Condition or Requirement

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. *(Example: public meeting, advisory groups.)*

   The Delta Primary Care Case Management Pilot program was mandated by Act 1453 of the Arkansas General Assembly in the 2013 Session.

   A steering committee has been formed to guide the development of the Arkansas Delta Primary Care Case Management Pilot program and will continue to meet and involve the public during the pilot.

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___X__ enrollment will be implemented in the following counties:

   i. county/counties (mandatory) _____

   ii. county/counties (voluntary) Arkansas, Ashley, Baxter, Bradley, Calhoun, Chicot, Clay, Cleveland, Crittenden, Cross, Dallas, Desha, Drew, Fulton, Grant, Greene, Independence, Izard, Jackson, Jefferson, Lawrence, Lee, Lincoln, Lonoke, Marion, Mississippi, Monroe, Ouachita, Phillips, Poinsett, Prairie, Randolph, Searcy, Sharp, St. Francis, Stone, Union, Van Buren and Woodruff

   iii. area/areas (mandatory)_____

   iv. 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.	N/A____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) 42 CFR 438.50(c)(3)	3.	_N/A___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.	N/A____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.	_X___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.	_N/A__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. Enrollment in the Arkansas Delta Primary Care Case Management Pilot program is voluntary.

Citation	Condition or Requirement

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. __X__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.)*

Beneficiaries who are also eligible for Medicare may voluntarily enroll into the Arkansas Delta Primary Care Case Management Pilot program if they meet the targeted groups' criteria and are not being served in Targeted Case Management.

1932(a)(2)(C) when
42 CFR 438(d)(2)

ii. __X__Indians who are beneficiaries of Federally recognized Tribes except 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.

Citation	Condition or Requirement

1932(a)(2)(A)(ii)
42 CFR 438.50(3)(v)

vii. __X__ Children under the age of 19 years who are receiving services through a 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.

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.)*

Children enrolled in programs that are Title V funded

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;

Eligibility database

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

Eligibility database

iii. Children under 19 years of age who are in foster care or other out-

Citation	Condition or Requirement
	of-home placement; Eligibility database
	iv. Children under 19 years of age who are receiving foster care or adoption assistance. Eligibility database
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)* There is no mandatory enrollment in the Arkansas Delta Primary Care Case Management Pilot program.
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: *(Examples: usage of aid codes in the eligibility system, self- identification)* i. Beneficiaries who are also eligible for Medicare. There is no mandatory enrollment in the Arkansas Delta Primary Care Case Management Pilot program. 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. There is no mandatory enrollment in the Arkansas Delta Primary Care Case Management Pilot program.
42 CFR 438.50	F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u>

Citation | Condition or Requirement

There is no mandatory enrollment in the Arkansas Delta Primary Care Case Management Pilot program.

42 CFR 438.50

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

The Arkansas Delta Primary Care Case Management Pilot program will be offered as a demonstration in Arkansas, Ashley, Baxter, Bradley, Calhoun, Chicot, Clay, Cleveland, Crittenden, Cross, Dallas, Desha, Drew, Fulton, Grant, Greene, Independence, Izard, Jackson, Jefferson, Lawrence, Lee, Lincoln, Lonoke, Marion, Mississippi, Monroe, Ouachita, Phillips, Poinsett, Prairie, Randolph, Searcy, Sharp, St. Francis, Stone, Union, Van Buren and Woodruff counties in Arkansas on a voluntary basis for the following groups:

1. Catastrophic condition as defined by a prospective risk score of 6 or more on the John Hopkins Adjusted Clinical Groups System and have costs associated with them that are in the top quartile for their defined population;

2. Complex condition as defined by a prospective risk score of 6 through 10 on the John Hopkins Adjusted Clinical Groups System and have costs associated with them that are in the top quartile for their defined population;

3. Chronic condition as defined by a prospective risk score of 3 through 6 on the John Hopkins Adjusted Clinical Groups System and have costs associated with them that are in the top quartile for their defined population.

4. History of past high risk pregnancies and have costs associated with them that are in the top quartile for their defined population;

5. History of past poor birth outcomes and have costs associated with them that are in the top quartile for their defined population; and/or

6. History of past preterm deliveries and costs associated with them that are in the top quartile for their defined population.

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 recipient

Citation	Condition or Requirement

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.

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).

The Arkansas Delta Primary Care Case Management Pilot program is voluntary and will not utilize default enrollment. The vendor shall recruit an adequate number of clinics to initiate the program who will then continue their existing provider/beneficiary relationship. Providers will be required to inform beneficiaries that they are participating in the Arkansas Delta Primary Care Case Management Pilot program.

ii. the relationship with providers that have traditionally served Medicaid beneficiaries (as defined in H.2.ii).

The Arkansas Delta Primary Care Case Management Pilot program is voluntary and will not utilize default enrollment. The vendor shall recruit an adequate number of clinics to initiate the program who will then continue their existing provider/beneficiary relationship. Providers will be required to inform beneficiaries that they are participating in the Arkansas Delta Primary Care Case Management Pilot program.

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). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

The Arkansas Delta Primary Care Case Management Pilot program is voluntary and will not utilize default enrollment. The vendor shall recruit an adequate number of clinics to initiate the program who will

Citation	Condition or Requirement
	then continue their existing provider/beneficiary relationship. Providers will be required to inform beneficiaries that they are participating in the Arkansas Delta Primary Care Case Management Pilot program.
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 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

Citation	Condition or Requirement

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. _X_ 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).

Citation	Condition or Requirement

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

Enrollment in the Arkansas Delta Primary Care Case Management Pilot program is voluntary. The vendor will make all feasible efforts to meet the reported and observed needs of persons in service. A voluntary discharge will be effective immediately as of the date requested by the member, guardian or custodial caregiver.

Only after thorough efforts by the Arkansas Delta Primary Care Case Management Pilot program vendor to resolve patterns of non-compliance with Arkansas Delta Primary Care Case Management Pilot program beneficiaries be involuntarily discharged. Examples of non-compliance include:

- Moving out of the Arkansas Delta Primary Care Case Management Pilot program service area
- Failing to keep scheduled Primary Care Physician appointments
- Avoiding or refusing Case Manager visits or other contacts
- Showing physical aggression toward providers, Case Managers or PCPs

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)

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 X will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option.

Citation	Condition or Requirement

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. *(Example: a limited number of providers and/or enrollees.)*

   An Arkansas Delta Primary Care Case Management Pilot program vendor will provide intensive care coordination by recruiting an adequate number of primary care clinics in the Arkansas Delta Region for a two (2) year program beginning 7/1/14. Thirty-nine (39) of Arkansas' seventy-five (75) counties have been selected to participate in the pilot and within those counties the vendor will make best efforts to recruit enough clinics to reach a target of a minimum of five-thousand (5,000) beneficiaries who meet all pilot eligibility criteria. If enrollment falls below five-thousand (5,000) beneficiaries, then the DMS will apply actuarially sound modifications to the shared savings calculations pursuant to CMS approval.