ARKANSAS REGISTER

Transmittal Sheet

Use only for **FINAL** and **EMERGENCY RULES**

Secretary of State
Mark Martin
500 Woodlane, Suite 026
Little Rock, Arkansas 72201-1094
(501) 682-5070
www.sos.arkansas.gov

For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

Contact Isaac Linam E-mail Isaac.Linam@dhs.arkansas.gov Phone 501-320-6570

Statutory Authority for Promulgating Rules Arkansas Code Annotated §§20-76-201, 20-77-107,and 25-10-129

Rule Title: PCMH-1-18 (Patient-Centered Medical Home) and SPA 2018-013

Intended Effective Date (Check One)		Date
☐ Emergency (ACA 25-15-204)	Legal Notice Published	October 8-10,2018
☐ 10 Days After Filing (ACA 25-15-204)	Final Date for Public Comment	November 11, 2018
☑ Other January 1, 2019 (Must be more than 10 days after filing date.)	Reviewed by Legislative Council	December 21,2018
	Adopted by State Agency	January 1,2019

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Lisa Smith	Lisa.Smith.DMS.dhs@arkansas.gov	12/21/2018
Contact Person	E-mail Address	Date

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Signature

628-8330	tami.harlan @dhs.arkansas.gov
Phone Number	E-mail Address
Tami Harlan	Director
	Title
December 21, 2018	
Date	

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Office of Policy Coordination & Promulgation

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers – Patient-Centered Medical Home**

EFFECTIVE DATE: **January 1, 2019**

SUBJECT: **Provider Manual Update Transmittal PCMH-1-19**

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
200.000	1-1-18	200.000	1-1-19
213.000	1-1-16	213.000	1-1-19
221.000	1-1-18	221.000	1-1-19
222.000	1-1-18	222.000	1-1-19
230.000	—	230.000	—
231.000	1-1-14	231.000	1-1-19
232.000	1-1-18	232.000	1-1-19
233.000	1-1-18	233.000	1-1-19
234.000	1-1-18	234.000	1-1-19
235.000	1-1-18	235.000	1-1-19
236.000	1-1-18	236.000	1-1-19
237.000	1-1-18	237.000	1-1-19
241.000	1-1-18	241.000	1-1-19
243.000	1-1-18	243.000	1-1-19
244.000	1-1-18	244.000	1-1-19

Explanation of Updates

Section 200.000, PCMH Definitions, has been updated.

Section 213.000 has been updated to change the PCMH enrollment period from three (3) months to six (6) weeks.

Section 221.000 has been updated to change Practice Support Scope.

Section 222.000 has been updated to change shared savings entity to shared risk entity.

Sections 230.000, 231.000, and 232.000 have been updated to change Shared Savings Incentive Payments to Performance-Based Incentive Payments (PBIP).

Section 235.000 has been renamed to Performance-Based Incentive Payment Methodology and its related information updated.

Section 236.000 has been renamed to Focus Measure and its related information updated.

Section 237.000 has been renamed to Performance-Based Incentive Payment Amounts and its related information updated.

Section 241.000 has been updated to add information regarding Activities Tracked for Practice Support.

Section 243.000 has been updated to change its title to Quality Metrics Tracked for Performance-Based Inventive Payments.

Section 244.000 has been updated to change shared savings incentive payments to performance based incentive payments.

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 Arkansas Payment Improvement Initiative Center at 1-866-322-4696 (Toll-Free) within Arkansas or locally and out-of-state at (501) 301-8311.

If you need this material in an alternative format, such as large print, please contact the Office of Policy Coordination and Promulgation 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: https://medicaid.mmis.arkansas.gov/.

Thank you for your participation in the Arkansas Medicaid Program.

Tami Harlan
Interim Director

TOC required

200.000 DEFINITIONS 1-1-19

Attributed beneficiaries	The Medicaid beneficiaries for whom primary care physicians and participating practices have accountability under the PCMH program. A primary care physician's attributed beneficiaries are determined by the ConnectCare Primary Care Case Management (PCCM) program. Attributed beneficiaries do not include dual eligible beneficiaries.
Attribution	The methodology by which Medicaid determines beneficiaries for whom a participating practice may receive practice support and incentive payments.
Care coordination	The ongoing work of engaging beneficiaries and organizing their care needs across providers and care settings.
Care coordination payment	Quarterly payments made to participating practices to support care coordination services. Payment amount is calculated per attributed beneficiary, per month.
Default pool	A pool of beneficiaries who are attributed to participating practices that do not meet the requirements in Section 233.000, part A or part B.
Medical neighborhood barriers	Obstacles to the delivery of coordinated care that exist in areas of the health system external to PCMH.
Participating practice	A physician practice that is enrolled in the PCMH program, which must be one of the following: A. An individual primary care physician (Provider Type 01 or 03); B. A physician group of primary care providers who are affiliated, with a common group identification number (Provider Type 02, 04 or 81); C. A Rural Health Clinic (Provider Type 29) as defined in the Rural Health Clinic Provider Manual Section 201.000; or D. An Area Health Education Center (Provider type 69).
Patient-Centered Medical Home (PCMH)	A team-based care delivery model led by Primary Care Physicians (PCPs) who comprehensively manage beneficiaries' health needs with an emphasis on health care value.
Performance-based incentive payments	Performance-based incentive payments are payments made to a shared performance entity for delivery of economic, efficient and quality care
Performance adjustment	An adjustment to the cost of beneficiary care to account for patient risk.
Performance period	The period of time over which performance is aggregated

	and assessed.
Petite pool	Pool reserved for practices with less than 300 attributed beneficiaries that do not wish to participate in a voluntary pool.
Pool	A. The beneficiaries who are attributed to one or more participating practice(s) for the purpose of forming a shared performance entity; or B. The action of aggregating beneficiaries for the purposes of performance-based incentive payment calculations (i.e., the action of forming a shared performance entity).
Practice support	Support provided by Medicaid in the form of care coordination payments to a participating practice .
Practice transformation	The adoption, implementation and maintenance of approaches, activities, capabilities and tools that enable a participating practice to serve as a PCMH.
Primary Care Physician (PCP)	See Section 171.000 of the Arkansas Medicaid provider manual.
Provider portal	The website that participating practices use for purposes of enrollment, reporting to the Division of Medical Services (DMS) and receiving information from DMS.
Quality Improvement Plan (QIP)	QIP is a plan of improvement that practices must submit to PCMH Quality Assurance team after receiving notice of attestation failure or validation failure.
Recover	To deduct an amount from a participating practice's future Medicaid receivables, including without limitation, PCMH payments, or fee-for-service reimbursements, to recoup such amount through legal process, or both.
Remediation time	The period during which participating practices that fail to meet deadlines, targets or both on relevant activities and metrics tracked for practice support may continue to receive care coordination payments while improving performance.
Same-day appointment request	A beneficiary request to be seen by a clinician within 24 hours.
Shared performance entity	A PCMH or pooled PCMHs that, contingent on performance, may receive performance-based incentive payments.
State Health Alliance for Records Exchange (SHARE)	The Arkansas Health Information Exchange. For more information, go to **http://ohit.arkansas.gov**.

213.000 Enrollment Schedule 1-1-19

Enrollment is open for approximately six (6) weeks in Quarter 3 and Quarter 4 of the preceding calendar year.

DMS will not accept any enrollment documents received other than during an enrollment period.

221.000 Practice Support Scope 1-1-19

Pooling is effective for a single performance period and must be renewed for each subsequent year.

When a PCMH has voluntarily pooled, its performance is measured in the associated shared performance entity throughout the duration of the performance period unless it withdraws from the PCMH program during the performance period. When a PCMH in a voluntary pool withdraws, is suspended, or otherwise leaves the PCMH program, any and all PCMHs in the shared performance entity will have their performance measured as if the withdrawn or suspended PCMH had never participated in the pool. This provision does not apply to PCMHs that leave the program in the last calendar quarter. If the PCMH leaves the program in the last calendar quarter, the departing PCMH, and its performance will be treated as if the PCMH has not left the program.

235.000 Performance-Based Incentive Payment (PBIP) Methodology 1-1-19

Each year, a Practice's performance in emergency department rates and inpatient rates will be measured and ranked. Shared performance entities that achieve the top 35th percentile of performance in the measures will be eligible to receive PBIP.

Certain conditions are excluded from the calculation of emergency room and inpatient rates. Each year, DMS will announce which exclusions it has applied on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**.

236.000 Focus Measure 1-1-19

Each year, DMS will select a focus measure to improve quality and provide incentive to shared performance entities. The focus measure will focus on an area for which Arkansas ranks much lower than the national average. Shared performance entities that are ranked in the top 35th percentile of the focus measure will be eligible to receive PBIP.

Each year, DMS will announce which area has been selected as a focus measure on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**.

237.000 Performance-Based Incentive Payment Amounts 1-1-19

A shared performance entity is eligible to receive performance-based incentive payments in one of the following ways:

A. Shared performance entities that are ranked on the top 10th percentile of performance in emergency room rates, inpatient stay rates, and focus measures will be eligible for 100% of incentive bonus.

B. Shared performance entitles that rank in the top 35th percentile of performance in emergency room rates, inpatient stay rates, and focus measures will be eligible for 50% of incentive bonus.

Performance-based incentive payments will be calculated by multiplying the incentive amount by the number of member months attributed to each PCMH. PCMHs are eligible to receive incentive payments for either ranking in the top 10th or top 35th percentile for each measure. Measures are independent of one another, and practices are not required to achieve the same ranking across all measures to qualify for incentive bonus payments.

If participating practices have pooled their attributed beneficiaries together, then performance-based incentive payments will be allocated to those practices based on risk- and time-adjustment and in proportion to the number of attributed beneficiaries that each PCMH contributed to such pool.

1. A shared performance entity will not receive performance-based incentive payments unless it meets all the conditions described in Section 232.000.

Practice support is care coordination payments made to a PCMH to support the practices' transformations.

Receipt and use of the care coordination payments is not conditioned on the PCMH engaging a care coordination vendor, as payment can be used to support participating practices' investments (e.g., time and energy) in enacting changes to achieve PCMH goals. Care coordination payments are risk-adjusted to account for the varying levels of care coordination services needed for beneficiaries with different risk profiles.

DMS may pay, recover or offset overpayment or underpayment of care coordination payments.

DMS will also support PCMHs through improved access to information through the reports described in Section 244.000.

222.000 Practice Support Eligibility 1-1-19

In addition to the enrollment eligibility requirements listed in Section 211.000, in order for PCMHs to receive practice support, DMS measures PCMH performance against activities tracked for practice support identified in Section 241.000. PCMHs must meet the requirements of this section to receive practice support.

Each PCMH in a shared performance entity will, if individually qualified, receive practice support even if another PCMH in a shared performance entity does not qualify for practice support.

230.000 PERFORMANCE-BASED INCENTIVE PAYMENTS (PBIP)

231.000 Performance-Based Incentive Payments 1-1-19

Performance-based incentive payments are payments made to a shared performance entity for delivery of economic, efficient and quality care that meets the requirements in Section 232.000.

232.000 Performance-Based Incentive Payments Eligibility 1-1-19

To receive performance-based incentive payments, a shared performance entity must have a minimum of 1,000 attributed beneficiaries once the exclusions listed below have been applied. A shared performance entity may meet this requirement as a single PCMH or by pooling attributed beneficiaries across more than one PCMH as described in Section 233.000.

A. The following beneficiaries shall not be counted toward the 1,000 attributed beneficiary requirements.

   1. Beneficiaries that have been attributed to that entity's PCMH(s) for less than half of the performance period.
   2. Beneficiaries that a PCMH prospectively designates for exclusion (also known as physician-selected exclusions) on or before the 90th day of the performance period. Once a beneficiary is designated for exclusion, a PCMH may not update selection for the duration of the performance period. The total number of physician-selected exclusions will be directly proportional to the PCMH's total number of attributed beneficiaries (e.g., up to one exclusion for every 1,000 attributed beneficiaries).
   3. Beneficiaries for whom DMS has identified another payer that is legally liable for all or part of the cost of Medicaid care and services provided to the beneficiary.

DMS may add, remove or adjust these exclusions based on new research, empirical evidence, provider experience with select beneficiary populations or inclusion of new payers. DMS will publish such an addition, removal or modification on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**.

B. Performance-based incentive payments are conditioned upon a shared performance entity:

1. Enrolling during the enrollment period prior to the beginning of the performance period;
2. Meeting Section 241.000 requirements for activities tracked for practice support;
3. Meeting requirements for metrics tracked for performance-based incentive payments in Section 243.000 based on the performance for beneficiaries attributed to the shared performance entity for the majority of the performance period; and
4. Maintaining eligibility for practice support as described in Section 222.000.

Performance-based incentive payments are made to the individual PCMHs which are part of a shared performance entity. These payments are risk- and time- adjusted and prorated based on the number of beneficiaries of each PCMH. These payments are predicated on each PCMH maintaining eligibility for practice support as described in Section 222.000.

233.000 Pools of Attributed Beneficiaries 1-1-19

Shared performance entities will meet the minimum pool size of 1,000 attributed beneficiaries as described in Section 232.000 in one of four ways:

A. Meet minimum pool size independently;

B. Pool attributed beneficiaries voluntarily with other participating PCMHs as described in Section 234.000. In this method, practices voluntarily agree to have their performance measured together by aggregating quality metrics tracked for performance-based incentive payments across the practices; or

C. Be assigned to the default pool as described in Section 234.000. Practices with beneficiaries in this pool will have their utilization performance and focus measure performance aggregated together; however, the quality metrics tracked for performance-based incentive payments are measured at the individual PCMH level; or

D. Be assigned to the petite pool as described in Section 234.000. In this method, practices will have their performance measured together by aggregating the utilization measures, focus measure, and quality metrics tracked for performance-based incentive payments across all practices in the pool.

A shared performance entity's pool configuration (A, B, C, or D) is established during the enrollment period and cannot be changed after the end of the enrollment period.

234.000 Requirements for Joining and Leaving Pools 1-1-19

PCMHs may voluntarily pool for purposes described in Section 233.000 before the end of the enrollment period that precedes the start of the performance period. To pool, the participating practice must email a complete and accurate Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form (DMS-845) to **ARKPCMH@DXC.com**. View or print the Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**. You can also download the form from the AHIN provider portal.

The DMS-845 Pooling form must be executed by all PCMHs participating in the pool. Before the end of the enrollment period, PCMHs that are on their own or through pooling do not reach a minimum of 1,000 attributed beneficiaries will be assigned to the default pool. Practices with less than 300 attributed beneficiaries that do not wish to participate in a voluntary pool will be placed in the petite pool. Individual PCMHs whose attribution changes during the performance period will be classified as standalone, default, or petite pool members according to their attribution count at the end of the performance period.

2. DMS pays performance-based incentive payments on an annual basis for the most recently completed performance period and may withhold a portion of performance-based incentive payments to allow for final payment adjustment after a year of claims data is available.

3. Final payment will include any adjustments required in order to account for all claims for dates of service within the performance period. If the final payment adjustment is negative, then DMS may recover the payment adjustment from the participating PCMH.

241.000 Activities Tracked for Practice Support 1-1-19

Using the provider portal, participating PCMHs must complete and document the activities as announced by DMS on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**. The reference point for the deadlines is the first day of the calendar year.

In addition to activities tracked for practice support, DMS will assess a practice's low performance of core metrics. The selected core metrics will be announced at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources.** It is incumbent upon the PCMH to review the selected core metrics that have been announced.

Each year a Core Metric will be chosen to have its Minimal Performance assessed. For example, in 2019 the Core Metric may be infant wellness. A PCMH will be placed in remediation for the Infant Wellness Metric if 15% or greater of the patient panel (0-15 months), have 0-1 wellness visits and the PCMH does not meet the 2019 Quality Metric Target for 5 or more wellness visits.

Failure to meet the targets will result in a Notice of Failure to Meet Wellness Metrics Tracked for Practice Support. PCMHs which receive this notice will be subject to completion of a Quality Improvement Plan (QIP) and a 90-day remediation period. The PCMH will have 15 calendar days to submit a sufficient QIP. Failure to submit a sufficient QIP within 15 calendar days of receiving the notice will result in suspension of practice support. PCMHs which receive a notice will have 90 calendar days, from the date of the notice, to remediate performance of the metric. Successful completion of remediation will be determined by DMS based on the metric results reported in the monthly PCMH report, posted in the AHIN portal, the following month after remediation ends. If a PCMH fails to meet the deadlines or targets for the wellness metrics tracked for practice support within the specified remediation time, then DMS will suspend practice support.

243.000 Quality Metrics Tracked for Performance-Based Incentive Payments 1-1-19

DMS assesses quality metrics tracked for performance-based incentive payments according to the targets announced by DMS at **www.paymentinitiative.org**. To receive a performance-based incentive payment, the shared performance entity or PCMH must meet the quality metrics by which the entity or PCMH is assessed and published on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**.

244.000 Provider Reports 1-1-19

DMS provides participating PCMH provider reports containing information about their PCMH performance on activities tracked for practice support, quality metrics tracked for performance-based incentive payments and their utilization rates via the provider portal.

Failing to submit any updated license, address changes or changes to the Provider Id number, may result in provider reports with no beneficiary attribution. Providers may update at any time their licenses, address changes, or changes to their Provider ID number by submitting documentation to the Provider Enrollment unit via fax at (501) 374-0746. Providers who have

concerns about information included in their reports should send an email to **PCMH@AFMC.org**. The PCMH Quality Assurance Manager will respond to the provider/practice with a review of their inquiry. If the review leads to a discovery that the provider report is inaccurate or does not reflect actual performance, DMS will take the necessary steps to correct the inaccuracies including those that are a result of a systems and/or algorithm error. Providers can also call the APII help desk at 501-301-8311 or 866-322-4698 and by email at **ARKPII@DXC.com**.

Appeals

If you disagree with DMS' decision regarding program participation, payment or other adverse action, you have the right to request reconsideration and you have the right to request an administrative appeal. During the remediation period, and prior to the notice of adverse action, practices continue receiving practice support payments. However, DMS will not pay practice support payments after the notice of adverse action. If the practice prevails during the appeal, or reconsideration, the practice support payments will resume retroactively from the date of the adverse action notice.

A. Request Reconsideration

The Department of Human Services must receive written request for reconsideration within (30) calendar days of the date of the adverse action, notice. Send your request to the Arkansas Department of Human Services, Division of Medical Services, Health Care Innovation: Attention PCMH – Reconsideration, P.O. Box 1437, Slot S425, Little Rock, AR 72203.

B. Request an Administrative Appeal

The Arkansas Department of Health must receive a written appeals request within (30) calendar days of the date of the adverse action notice, or within (10) calendar days of receiving a reconsideration decision. Send your request to Arkansas Department of Health: Attention: Medicaid Provider Appeals Office, 4815 West Markham Street, Slot 31, Little Rock, AR 72205.

Citation	Condition or Requirement

- 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) **performance-based** incentive payments.

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.

Performance-based incentive payments are annual payments made to a **PCMH** for delivery of economic, efficient and quality care.

Each year the **PCMHs are assessed in cost utilization measures. Those PCMHs that fall into the negotiated threshold of cost utilization measures will be eligible for performance-based incentive payments. Performance-based incentive payments will be risk and time adjusted.**

DMS will also select a yearly focus measure to reward top performing PCMHs. The focus measure will focus on an area in which the state performance is significantly lower than national average.

DMS has established **top performance thresholds** for **utilization measures**, as described in the DMS PCMH Provider Manual. These thresholds will help **determine rewards for efficient, economic, and quality care.**

<RESERVED>

Citation	Condition or Requirement

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.

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. There is a state wide promulgation process including a 30 day public comment period, after which feedback is incorporated into the version that is submitted for State legislative approval.

Citation	Condition or Requirement
	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:: i. county/counties (mandatory) _____ ii. area/areas (mandatory)_____ iii. area/areas (voluntary)_____
	B. 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) 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