TOC required

200.000 DEFINITIONS 1-1-~~18~~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 ~~shared savings~~ incentive payments.
~~Benchmark cost~~	~~The projected cost of care for a specific shared savings entity against which savings are measured. Benchmark costs are expressed as an average amount per beneficiary.~~
~~Benchmark trend~~	~~The fixed percentage growth applied to PCMH practices' historical baseline fixed costs of care to project benchmark cost.~~
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.
~~Cost thresholds~~	~~Cost thresholds are the per beneficiary cost of care values (high and medium) against which a shared savings entity's per beneficiary cost is measured.~~
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.
~~Historical baseline cost of care~~	~~A multi-year weighted average of a shared savings entity's per beneficiary cost of care.~~
Medical neighborhood barriers	Obstacles to the delivery of coordinated care that exist in areas of the health system external to PCMH.
~~Minimum savings rate~~	~~A fixed percentage set by DMS. In order to receive shared savings incentive payments for performance improvement described in Section 237.000, part A, a shared savings entity must achieve a per beneficiary cost of care that is below its benchmark cost by at least the minimum savings rate.~~
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.
~~Per beneficiary cost of care~~	~~The risk- and time-adjusted average of attributed beneficiaries' total Medicaid fee-for-service claims (based on the published reimbursement methodology) during the performance period, net of exclusions.~~
~~Per beneficiary cost of care floor~~	~~The lowest per beneficiary cost of care for which practices within a shared savings entity can receive shared savings incentive payments.~~
~~Per beneficiary savings~~	~~The difference between a shared savings entity's benchmark cost and its per beneficiary cost of care in a given performance period.~~
Performance-based incentive payments	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 ~~savings~~ performance entity; or B. The action of aggregating beneficiaries for the purposes of ~~shared savings~~performance-based incentive payment calculations (i.e., the action of forming a shared ~~savings~~ performance entity).
Practice support	Support provided by Medicaid in the form of care coordination payments to a participating practice ~~and practice transformation support provided by a DMS contracted vendor.~~
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.
~~Risk adjustment~~	~~An adjustment to the cost of beneficiary care to account for patient risk.~~
Same-day appointment request	A beneficiary request to be seen by a clinician within 24 hours.
Shared ~~savings~~ performance entity	A PCMH or pooled PCMHs that, contingent on performance, may receive ~~shared savings~~performance-based incentive payments.
~~Shared savings incentive payment cap~~	~~The maximum shared savings incentive payment that DMS will pay to a shared savings entity, expressed as a percentage of that entity's benchmark cost for the performance period.~~
~~Shared savings incentive payments~~	~~Annual payments made to reward cost-efficient and quality care.~~
~~Shared savings percentage~~	~~The percentage of a shared savings entity's total savings that is paid to the PCMH in a shared savings entity.~~
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-~~16~~19

Enrollment is open for approximately ~~3 months~~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-~~18~~19

Practice support is ~~includes both~~ care coordination payments made to a PCMH ~~and practice transformation support provided by a Division of Medical Services (DMS) contracted vendor and is subject to funding limitations on the part of DMS~~ 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 will contract with a practice transformation vendor on behalf of PCMHs that require additional support to catalyze practice transformation and retain and use such vendor. PCMHs must maintain documentation of the months they have contracted with a practice transformation vendor. Practice transformation vendors must report to DMS the level and type of service delivered to each PCMH. Payments to a practice transformation vendor on behalf of a participating practice may continue for up to 24 months.~~

Division of Medical Services (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.

~~However, no practice transformation may extend beyond December 31, 2018, regardless of the number of months practice support was received by a practice.~~

222.000 Practice Support Eligibility 1-1-~~16~~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 ~~savings~~ performance entity does not qualify for practice support.

230.000 ~~SHARED SAVINGS~~PERFORMANCE-BASED INCENTIVE PAYMENTS (PBIP)

231.000 ~~Shared Savings~~Performance-Based Incentive Payments ~~Scope~~ 1-1-~~14~~19

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

232.000 ~~Shared Savings~~Performance-Based Incentive Payments Eligibility 1-1-~~18~~19

To receive ~~shared savings~~performance-based incentive payments, a shared ~~savings~~ performance entity must have a minimum of ~~5~~1,000 attributed beneficiaries once the exclusions listed below have been applied. A shared ~~savings~~ 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 ~~5~~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 ~~from per beneficiary cost of care~~ (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. ~~Shared savings~~Performance-based incentive payments are conditioned upon a shared ~~savings~~ 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 ~~shared savings~~performance-based incentive payments in Section 243.000 based on the performance for beneficiaries attributed to the shared ~~savings~~ performance entity for the majority of the performance period; and
4. Maintaining eligibility for practice support as described in Section 222.000.

~~Shared savings~~Performance-based incentive payments are made to the individual PCMHs which are part of a shared ~~savings~~ 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-~~18~~19

Shared ~~savings~~ performance entities will meet the minimum pool size of ~~5~~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 ~~both per beneficiary cost of care and~~ quality metrics tracked for ~~shared savings~~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 ~~measured together by aggregating~~ performance aggregated together; ~~of the per beneficiary cost of care~~ however, the ~~Q~~quality metrics ~~are~~ tracked for ~~shared savings~~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 ~~both per beneficiary cost of care~~ the utilization measures, focus measure, and quality metrics tracked for ~~shared savings~~performance-based incentive payments across all practices in the pool. ~~For the 2018 performance year, all practices with less than 300 beneficiaries will be assigned to the petite pool. In subsequent years, practices with less than 300 beneficiaries may be able to voluntarily pool with other PCMHs to reach the 5,000 minimum requirement.~~

A shared ~~savings~~ 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-~~18~~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 ~~5~~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.

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 ~~savings~~ 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 ~~savings~~ 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 ~~which~~ 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 ~~Per Beneficiary Cost of Care Calculation~~Performance-Based Incentive Payment (PBIP) Methodology 1-1-~~18~~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. ~~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, with adjustments and exclusions as defined below.~~

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

~~As described in Section 232.000, beneficiaries not counted toward the minimum number of attributed beneficiaries for shared savings incentive payments will be excluded from the calculation of per beneficiary cost of care.~~

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

236.000 ~~Baseline and Benchmark Cost Calculations~~Focus Measure 1-1-~~18~~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.~~DMS will calculate a historical baseline per beneficiary cost of care for each shared savings entity. This shared savings entity-specific historical baseline will be calculated as a multi-year blended average of each shared savings entity's per beneficiary cost of care.~~

Each year, DMS will announce which area has been selected as a focus measure ~~DMS will calculate benchmark costs for each shared savings entity by applying a 2.6% 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 of care growth rate differs significantly from a benchmark, to be specified by DMS. DMS will publish any modification to the benchmark trend~~ on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**.

237.000 ~~Shared Savings~~Performance-Based Incentive Payment Amounts 1-1-~~18~~19

A shared ~~savings~~ performance entity is eligible to receive ~~a shared savings~~performance-based incentive payments ~~that is the greater of: (A) a shared savings incentive payment for performance improvement; or (B) a shared savings incentive payment for absolute performance.~~ 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.~~Shared savings incentive payments for performance improvement are calculated as follows:~~

~~1. 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].~~

~~2. 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 minimum savings rate, only then may the shared savings entity be eligible for a shared savings incentive payment for performance improvement.~~

~~3. 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 savings entity's shared savings percentage for that performance period].~~

~~4. To establish shared savings percentages for performance improvement in a given performance period, DMS will compare the entity's previous year per beneficiary cost of care to the previous year's medium and high cost thresholds.~~

~~5. If, in the previous performance period, a shared savings entity's per beneficiary cost of care was:~~

~~a. Below the medium cost threshold, then the shared savings entity may receive 50% of per beneficiary savings created in the current performance period (i.e., the entity's shared savings percentage will be 50%);~~

~~b. Between the medium and high cost thresholds, then the shared savings entity may receive 30% of per beneficiary savings created in the current performance period (i.e., the entity's shared savings percentage will be 30%);~~

~~c. Above the high cost threshold, the shared savings entity may receive 10% of per beneficiary savings created in the current performance period (i.e., the entity's shared~~

~~savings percentage will be 10%) unless the shared savings entity's per beneficiary cost of care falls above the current performance period high cost incentive payment for that performance period.~~

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.

~~Shared savings incentive payments for absolute performance are calculated as follows:~~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 the shared savings entity's per beneficiary cost of care falls below the current performance period medium cost threshold, then 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%].~~

~~Shared savings calculations under absolute performance and performance improvements are subject to the following criteria:~~

~~Cost thresholds reflect an annual increase of 1.5% from the base year 2018 (base year medium cost threshold: $2,150; base year high cost threshold: $2,444) and will increase by 1.5% each subsequent year. Adjustments to the thresholds will be posted on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**.~~

1. ~~The minimum savings rate is 2%. DMS may adjust this rate based on new research, empirical evidence or experience from initial provider experience with shared savings incentive payments. DMS will publish any such modification of the minimum savings rate on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**.~~
2. ~~If the per beneficiary shared savings incentive payment for which the shared savings entity is eligible exceeds the shared savings incentive payment cap, expressed as 10% of the shared savings entity's benchmark cost for that performance period, the shared savings entity will be eligible for a per beneficiary shared savings incentive payment equal to 10% of its benchmark cost for that performance period.~~
3. ~~If the shared savings entity's per beneficiary cost of care falls below the current performance period total cost of care floor, then the shared savings entity's per beneficiary cost of care will be set as the total cost of care floor, for purposes of calculating shared savings incentive payments. The 2018 cost of care floor is set at $1,481and will increase by 1.5% each subsequent year, or as specified at **www.paymentinitiative.org**.~~
4. ~~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 Section 232.000, adjusted based on the amount of time beneficiaries were attributed to such PCMHs and the risk profile of the attributed beneficiaries.~~

If participating practices have pooled their attributed beneficiaries together, then ~~shared savings~~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 ~~savings~~ performance entity will not receive ~~shared savings~~performance-based incentive payments unless it meets all the conditions described in Section 232.000.
2. DMS pays ~~shared savings~~performance-based incentive payments on an annual basis for the most recently completed performance period and may withhold a portion of ~~shared savings~~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-~~18~~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 ~~Shared Savings~~Performance-Based Incentive Payments 1-1-~~18~~19

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

244.000 Provider Reports 1-1-~~18~~19

DMS provides participating PCMH provider reports containing information about their PCMH performance on activities tracked for practice support, quality metrics tracked for ~~shared~~

~~savings~~performance-based incentive payments and their ~~per beneficiary cost of care~~ 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 ~~Division~~ Department of ~~Medical~~ Human Services must receive written request for reconsideration within (30) calendar days of the ~~D~~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

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

Citation	Condition or Requirement

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**

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) ~~shared savings~~performance based 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~~
~~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~~Performance based incentive payments are annual payments made to a ~~shared savings entity~~PCMH 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~~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.~~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~~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. ~~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~~ top performance thresholds for ~~-~~utilization measures~~medium cost and high cost per beneficiary cost of care~~, as described in the DMS PCMH Provider Manual. These thresholds will help determine rewards for efficient, economic, and quality care.

Citation | Condition or Requirement

~~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.

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.**~~ **There ~~was~~ is a state wide promulgation process including ~~s, 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::

   i. county/counties (mandatory) _____

   ii. area/areas (mandatory)_____

   iii. area/areas (voluntary)_____

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

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

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

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

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

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.

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.

E. Identification of Mandatory Exempt Groups

1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)* N/A

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.

Citation	Condition or Requirement

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.

42 CFR 438.50

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

Medicare dual eligible, poverty level pregnant women (SOBRA ;SOBRA women are required to enroll with a Primary Care Case Manger only if they need non-obstetrical services which require a PCP referral), Beneficiaries who reside in a nursing facilities or intermediate care facilities for the mentally retarded, Home

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

Citation	Condition or Requirement
	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 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

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).

Summary

2019 Patient-Centered Medical Home (PCMH) Manual

DMS is proposing the following changes to the 2019 PCMH Program Manual and SPA:

1. Remove definitions related to total cost of care and shared savings and add definition for Performance-Based Incentive Payments.
2. Define performance-based incentive payment methodology.
3. Define focus measure.
4. Define performance-based payment amounts.
5. Remove total cost of care calculations.
6. Reduce the number of weeks enrollment is open.
7. Clarify practice transformation payments.
8. Revise shared-savings incentive payments to performance-based incentive payments.
9. Decrease pool size to 1000.
10. Change savings to performance based.
11. Change per beneficiary cost to utilization measures and focus measures.
12. Add core measure requirement.
13. Replace shared savings with performance based and total cost of care with utilization rates.
14. Replace shared savings entities with performance risk entities.