

Statement of Necessity and Rule Summary

PCCM—SPA #18-0013

Statement of Necessity

When DHS submitted SPA #18-0013 for changes to the PCMH (Patient-Centered Medical Home) program in 2018, the Centers for Medicare and Medicaid Services (CMS) required that we complete a new preprint (template) for the PCCM (Primary Care Case Manager) program. Although there was no change to the PCCM program, CMS stated that they would not approve PCMH until the new PCCM preprint was submitted. The public notice period for the promulgation of PCMH was already completed when we were informed of this, so the PCCM is promulgated separately.

Rule Summary

There are no changes to the PCCM program. The formatting of the PCCM Medicaid State Plan changed, but the information and program remains the same. The PCCM portion was submitted to CMS on January 7, 2019, and was approved along with the PCMH on February 28, 2019. Although there are no programmatic changes to the PCCM program, the formatting has changed and is thus being promulgated.

State: Arkansas

Citation	Condition or Requirement
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<u>1932(a)(1)(A)</u>	<u>A. Section 1932(a)(1)(A) of the Social Security Act.</u>
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The State of Arkansas enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization [MCOs], primary care case managers [PCCMs], and/or PCCM entities) in the absence of section 1115 or section 1915(b) waiver authority. 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).

This authority may **not** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future. **Please see Appendix A of this document for compliance dates for various sections of 42 CFR 438.**

<u>1932(a)(1)(B)(i)</u>	<u>B. Managed Care Delivery System.</u>
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<u>1932(a)(1)(B)(ii)</u>	
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<u>42 CFR 438.2</u>	
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<u>42 CFR 438.6</u>	
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<u>42 CFR 438.50(b)(1)-(2)</u>	
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The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. ☐ MCO

a. ☐ Capitation

b. ☐ The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.

2. ☒ PCCM (individual practitioners)

a. ☒ Case management fee

b. ☐ Other (please explain below)

Reimbursement is a set per member per month rate paid through MMIS. There are no performance-based incentive payments in PCCM.

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 PCCM provider will assist enrollees with locating medical services and coordinate and monitor their enrollees prescribed

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medical and rehabilitation services. PCCM will be mandatory for most Medicaid beneficiaries.

The beneficiaries have a free choice of specialists within the state and bordering states. A beneficiary must enroll with a PCCM whose practice is in the beneficiary's county of residence, a county adjacent to the beneficiary's county of residence or a county adjoining a county adjacent to the beneficiary's county of residence. PCCM providers have free choice of referrals specialists and ancillary providers

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

- 1) 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 ConnectCare 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 ConnectCare enrollees to an emergency department for non-emergency conditions during the PCP's regular office hours.

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| | <p>3) <u>Increases to the beneficiaries' and/or their caregivers' understanding of their disease so that they are:</u></p> <ul style="list-style-type: none"><u>Better able to understand their disease</u><u>Better able to access regular preventative health care by improving their self-management skills</u><u>Better able to understand the appropriate use of resources needed to care for their disease</u><u>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.</u> |
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	<p>b. <u>Arkansas Department of Human Services engages a network of credentialed primary care physicians to meet medical needs for enrolled beneficiaries. The PCCM provider is responsible for overall health care services for beneficiaries.</u></p>
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| 3. | <p><input type="checkbox"/> <u>PCCM entity</u></p> <p>a. <input type="checkbox"/> <u>Case management fee</u></p> <p>b. <input type="checkbox"/> <u>Shared savings, incentive payments, and/or financial rewards (see 42 CFR 438.310(c)(2))</u></p> <p>c. <input type="checkbox"/> <u>Other (please explain below)</u></p> |
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If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as in 42 CFR 438.2), in addition to PCCM services:

- ☐ Provision of intensive telephonic case management
- ☐ Provision of face-to-face case management
- ☐ Operation of a nurse triage advice line
- ☐ Development of enrollee care plans.
- ☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program
- ☐ Oversight responsibilities for the activities of FFS providers in the FFS program
- ☐ Provision of payments to FFS providers on behalf of the State.
- ☐ Provision of enrollee outreach and education activities.
- ☐ Operation of a customer service call center.
- ☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement.
- ☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.

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- ☐ Coordination with behavioral health systems/providers.
☐ Coordination with long-term services and supports systems/providers.
☐ Other (please describe):

42 CFR 438.50(b)(4) C. Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the managed care program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan managed care program has been implemented. (Example: public meeting, advisory groups.)

If the program will include long term services and supports (LTSS), please indicate how the views of stakeholders have been, and will continue to be, solicited and addressed during the design, implementation, and oversight of the program, including plans for a member advisory committee (42 CFR 438.70 and 438.110)

A statewide promulgation process was completed in 2013, which allowed for a 30-day public comment period. At the time the state consulted with the State Medical Care Advisory Committee. The beneficiary has the right to appeal or grieve through the Division of Medical Services or Office of Chief Counsel.

D. 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) 1. ☐ The state assures that all of the applicable requirements of
1903(m) section 1903(m) of the Act, for MCOs and MCO contracts will be met.
- 42 CFR 438.50(c)(1)
- 1932(a)(1)(A)(i)(I) 2. ☒ The state assures that all the applicable requirements of section 1905(t)
1905(t) of the Act for PCCMs and PCCM contracts (including for PCCM entities) will
be met.
- 42 CFR 438.50(c)(2)
1902(a)(23)(A)
- 1932(a)(1)(A) 3. ☐ The state assures that all the applicable requirements of section 1932
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) 4. ☒ The state assures that all the applicable requirements of 42 CFR 431.51
42 CFR 431.51 regarding freedom of choice for family planning services and supplies as
1905(a)(4)(C) defined in section 1905(a)(4)(C) will be met.

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42 CFR 438.10(g)(2)(vii)

<u>1932(a)(1)(A)</u>	5. <input type="checkbox"/> The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
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<u>1932(a)(1)(A)</u> <u>42 CFR 438</u> <u>1903(m)</u>	6. <input checked="" type="checkbox"/> The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs, PCCMs, and PCCM entities will be met.
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<u>1932(a)(1)(A)</u>	7. <input type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.4, 438.5, 438.7, 438.8, and 438.74 for payments under any risk contracts will be met.
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42 CFR 438.4
42 CFR 438.5
42 CFR 438.7
42 CFR 438.8
42 CFR 438.74
42 CFR 438.50(c)(6)

<u>1932(a)(1)(A)</u> <u>42 CFR 447.362</u> <u>42 CFR 438.50(c)(6)</u>	8. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
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<u>45 CFR 75.326</u>	9. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 45 CFR 75.326 for procurement of contracts will be met.
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<u>42 CFR 438.66</u>	10. Assurances regarding state monitoring requirements:
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☒ The state assures that all applicable requirements of 42 CFR 438.66(a), (b), and (c), regarding a monitoring system and using data to improve the performance of its managed care program, will be met.

☒ The state assures that all applicable requirements of 42 CFR 438.66(d), regarding readiness assessment, will be met.

☒ The state assures that all applicable requirements of 42 CFR 438.66(e), regarding reporting to CMS about the managed care program, will be met.

<u>1932(a)(1)(A)</u> <u>1932(a)(2)</u>	E. <u>Populations and Geographic Area.</u>
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1. **Included Populations.** Please check which eligibility groups are included, if they are enrolled on a **Mandatory (M)** or **Voluntary (V)** basis (as defined in 42 CFR 438.54(b)) or **Excluded (E)**, and the geographic scope of enrollment. Under the **Geographic Area** column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions. Also, if type of enrollment varies by geographic area (for example, mandatory in some areas and voluntary in other areas), please note specifics in the **Geographic Area** column. Under the **Notes** column, please note any additional relevant details about the population or enrollment.

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A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage)

1. Family/Adult

<u>Eligibility Group</u>	<u>Citation (Regulation [42 CFR] or SSA)</u>	<u>M</u>	<u>V</u>	<u>E</u>	<u>Geographic Area (include specifics if M/V/E varies by area)</u>	<u>Notes</u>
<u>1. Parents and Other Caretaker Relatives</u>	<u>§435.110</u>	<u>X</u>			<u>Statewide</u>	
<u>2. Pregnant Women</u>	<u>§435.116</u>	<u>X</u>			<u>Statewide</u>	<u>Required to enroll with a PCCM only if they need non- obstetrical services which require a PCP referral.</u>
<u>3. Children Under Age 19 (Inclusive of Deemed Newborns under §435.117)</u>	<u>§435.118</u>	<u>X</u>			<u>Statewide</u>	
<u>4. Former Foster Care Youth (up to age 26)</u>	<u>§435.150</u>	<u>X</u>			<u>Statewide</u>	
<u>5. Adult Group (Non-pregnant individuals age 19-64 not eligible for Medicare with income no more than 133% FPL)</u>	<u>§435.119</u>	<u>X</u>				<u>Required only if deemed frail and receiving</u>
						<u>Traditional Medicaid.</u>
<u>6. Transitional Medical Assistance (Includes adults and children, if not eligible under §435.116, §435.118, or §435.119)</u>	<u>1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA</u>	<u>X</u>			<u>Statewide</u>	
<u>7. Extended Medicaid Due to Spousal Support Collections</u>	<u>§435.115</u>	<u>X</u>			<u>Statewide</u>	

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2. Aged/Blind/Disabled Individuals						
<u>Eligibility Group</u>	<u>Citation</u> (Regulation [42 CFR] or SSA)	<u>M</u>	<u>V</u>	<u>E</u>	<u>Geographic Area</u> (include specifics if M/V/E varies by area)	<u>Notes</u>
8. <u>Individuals Receiving SSI age 19 and over only (See E.2. below regarding age <19)</u>	<u>§435.120</u>	<u>X</u>			<u>Statewide</u>	<u>Exclude Medicare Beneficiaries.</u>
9. <u>Aged and Disabled Individuals in 209(b) States</u>	<u>§435.121</u>					<u>N/A—AR is a 1634 State.</u>
10. <u>Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increase since April, 1977</u>	<u>§435.135</u>	<u>X</u>			<u>Statewide</u>	<u>Exclude Medicare Beneficiaries.</u>
11. <u>Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI</u>	<u>§435.137</u>	<u>X</u>			<u>Statewide</u>	<u>Exclude Medicare Beneficiaries.</u>
12. <u>Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security</u>	<u>§435.138</u>	<u>X</u>			<u>Statewide</u>	<u>Exclude Medicare Beneficiaries.</u>
13. <u>Working Disabled under 1619(b)</u>	<u>1619(b), 1902(a)(10)(A)(i)(II), and 1905(q) of SSA</u>	<u>X</u>			<u>Statewide</u>	<u>Exclude Medicare Beneficiaries.</u>
14. <u>Disabled Adult Children</u>	<u>1634(c) of SSA</u>	<u>X</u>			<u>Statewide</u>	

B. Optional Eligibility Groups
1. Family/Adult

<u>Eligibility Group</u>	<u>Citation</u> (Regulation [42 CFR] or SSA)	<u>M</u>	<u>V</u>	<u>E</u>	<u>Geographic Area</u> (include specifics if M/V/E varies by area)	<u>Notes</u>
1. <u>Optional Parents and Other Caretaker Relatives</u>	<u>§435.220</u>					<u>N/A</u>
2. <u>Optional Targeted Low-Income Children</u>	<u>§435.229</u>					<u>N/A</u>
3. <u>Independent Foster Care Adolescents Under Age 21</u>	<u>§435.226</u>					<u>N/A</u>
4. <u>Individuals Under Age 65 with Income Over 133%</u>	<u>§435.218</u>					<u>N/A</u>
5. <u>Optional Reasonable Classifications of Children Under Age 21</u>	<u>§435.222</u>					<u>N/A</u>
6. <u>Individuals Electing COBRA Continuation Coverage</u>	<u>1902(a)(10)(F) of SSA</u>					<u>N/A</u>

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2. Aged/Blind/Disabled Individuals

<u>Eligibility Group</u>	<u>Citation (Regulation [42 CFR] or SSA)</u>	<u>M</u>	<u>V</u>	<u>E</u>	<u>Geographic Area (include specifics if M/V/E varies by area)</u>	<u>Notes</u>
7. <u>Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash</u>	<u>§435.210 and §435.230</u>					<u>N/A</u>
8. <u>Individuals eligible for Cash except for Institutionalized Status</u>	<u>§435.211</u>			<u>X</u>		
9. <u>Individuals Receiving Home and Community-Based Waiver Services Under Institutional Rules</u>	<u>§435.217</u>			<u>X</u>		
10. <u>Optional State Supplement Recipients - 1634 and SSI Criteria States – with 1616 Agreements</u>	<u>§435.232</u>					<u>N/A</u>
11. <u>Optional State Supplemental Recipients- 209(b) States and SSI criteria States without 1616 Agreements</u>	<u>§435.234</u>					<u>N/A</u>
12. <u>Institutionalized Individuals Eligible under a Special Income Level</u>	<u>§435.236</u>			<u>X</u>		
13. <u>Individuals Participating in a PACE Program under Institutional Rules</u>	<u>1934 of the SSA</u>			<u>X</u>		
14. <u>Individuals Receiving Hospice Care</u>	<u>1902(a)(10)(A)(ii) (VII) and 1905(o) of the SSA</u>			<u>X</u>		<u>Institutionalized</u>
15. <u>Poverty Level Aged or Disabled</u>	<u>1902(a)(10)(A)(ii) (X) and 1902(m)(1) of the SSA</u>	<u>X</u>			<u>Statewide</u>	<u>Exclude Medicare Beneficiaries. (AR entitles ARSeniors)</u>
16. <u>Work Incentive Group</u>	<u>1902(a)(10)(A)(ii) (XIII) of the SSA</u>					<u>N/A</u>
17. <u>Ticket to Work Basic Group</u>	<u>1902(a)(10)(A)(ii) (XV) of the SSA</u>	<u>X</u>			<u>Statewide</u>	<u>Exclude Medicare Beneficiaries. (AR entitles Workers with Disabilities)</u>
18. <u>Ticket to Work Medically Improved Group</u>	<u>1902(a)(10)(A)(ii) (XVI) of the SSA</u>					<u>N/A</u>
19. <u>Family Opportunity Act Children with Disabilities</u>	<u>1902(a)(10)(A)(ii) (XIX) of the SSA</u>					<u>N/A</u>
20. <u>Individuals Eligible for State Plan Home and Community-Based Services</u>	<u>§435.219</u>			<u>X</u>		

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3. Partial Benefits

<u>Eligibility Group</u>	<u>Citation</u> (Regulation [42 CFR] or SSA)	<u>M</u>	<u>V</u>	<u>E</u>	<u>Geographic Area</u> (include specifics if M/V/E varies by area)	<u>Notes</u>
21. <u>Family Planning Services</u>	<u>§435.214</u>					<u>N/A</u>
22. <u>Individuals with Tuberculosis</u>	<u>§435.215</u>					<u>N/A</u>
23. <u>Individuals Needing Treatment for Breast or Cervical Cancer (under age 65)</u>	<u>§435.213</u>					<u>N/A</u>

C. Medically Needy

<u>Eligibility Group</u>	<u>Citation</u> (Regulation [42 CFR] or SSA)	<u>M</u>	<u>V</u>	<u>E</u>	<u>Geographic Area</u> (include specifics if M/V/E varies by area)	<u>Notes</u>
1. <u>Medically Needy Pregnant Women</u>	<u>§435.301(b)(1)(i) and (iv)</u>			<u>X</u>		
2. <u>Medically Needy Children under Age 18</u>	<u>§435.301(b)(1)(ii)</u>			<u>X</u>		
3. <u>Medically Needy Children Age 18 through 20</u>	<u>§435.308</u>					<u>N/A</u>
4. <u>Medically Needy Parents and Other Caretaker Relatives</u>	<u>§435.310</u>			<u>X</u>		
5. <u>Medically Needy Aged</u>	<u>§435.320</u>			<u>X</u>		
6. <u>Medically Needy Blind</u>	<u>§435.322</u>			<u>X</u>		
7. <u>Medically Needy Disabled</u>	<u>§435.324</u>			<u>X</u>		
8. <u>Medically Needy Aged, Blind and Disabled in 209(b) States</u>	<u>§435.330</u>					<u>N/A</u>

2. Voluntary Only or Excluded Populations. Under this managed care authority, some populations cannot be subject to mandatory enrollment in an MCO, PCCM, or PCCM entity (per 42 CFR 438.50(d)). Some such populations are Eligibility Groups separate from those listed above in E.1., while others (such as American Indians/Alaskan Natives) can be part of multiple Eligibility Groups identified in E.1. above.

Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

<u>Population</u>	<u>Citation (Regulation [42 CFR] or SSA)</u>	<u>V</u>	<u>E</u>	<u>Geographic Area</u>	<u>Notes</u>
<u>Medicare Savings Program – Qualified Medicare Beneficiaries, Qualified Disabled Working Individuals, Specified Low Income Medicare Beneficiaries, and/or Qualifying Individuals</u>	<u>1902(a)(10)(E), 1905(p), 1905(s) of the SSA</u>		<u>X</u>		

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<u>Population</u>	<u>Citation (Regulation [42 CFR] or SSA)</u>	<u>V</u>	<u>E</u>	<u>Geographic Area</u>	<u>Notes</u>
<u>“Dual Eligibles” not described under Medicare Savings Program - Medicaid beneficiaries enrolled in an eligibility group other than one of the Medicare Savings Program groups who are also eligible for Medicare</u>			<u>X</u>		
<u>American Indian/Alaskan Native— Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes</u>	<u>§438.14</u>	<u>X</u>		<u>Statewide</u>	
<u>Children Receiving SSI who are Under Age 19 - Children under 19 years of age who are eligible for SSI under title XVI</u>	<u>§435.120</u>	<u>X</u>		<u>Statewide</u>	
<u>Qualified Disabled Children Under Age 19 - Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.</u>	<u>§435.225 1902(e)(3) of the SSA</u>	<u>X</u>		<u>Statewide</u>	<u>This population is covered under 1115 TEFRA Waiver</u>
<u>Title IV-E Children - Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E *</u>	<u>§435.145</u>	<u>X</u>		<u>Statewide</u>	
<u>Non-Title IV-E Adoption Assistance Under Age 21*</u>	<u>§435.227</u>	<u>X</u>		<u>Statewide</u>	
<u>Children with Special Health Care Needs - Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the State in terms of either program participation or special health care needs.</u>		<u>X</u>		<u>Statewide</u>	

* = Note – Individuals in these two Eligibility Groups who are age 19 and 20 can have mandatory enrollment in managed care, while those under age 19 cannot have mandatory enrollment. Use the Notes column to indicate if you plan to mandatorily enroll 19 and 20 year olds in these Eligibility Groups.

3. (Optional) Other Exceptions. The following populations (which can be part of various Eligibility Groups) can be subject to mandatory enrollment in managed care, but states may elect to make exceptions for these or other individuals. Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

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Population	V	E	Notes
<u>Other Insurance--Medicaid beneficiaries who have other health insurance</u>		<u>X</u>	
<u>Reside in Nursing Facility or ICF/IID--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).</u>		<u>X</u>	
<u>Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program</u>		<u>X</u>	
<u>Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program</u>		<u>X</u>	
<u>Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).</u>		<u>X</u>	
<u>Retroactive Eligibility--Medicaid beneficiaries for the period of retroactive eligibility.</u>		<u>X</u>	
<u>Other (Please define):</u>			

1932(a)(4)

42 CFR 438.54

F. Enrollment Process.

Based on whether mandatory and/or voluntary enrollment are applicable to your program (see E. Populations and Geographic Area and definitions in 42 CFR 438.54(b)), please complete the below:

1. For **voluntary** enrollment: (see 42 CFR 438.54(c))

a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(c)(3).

State with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program:

b. ☐ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(c)(1)(i) and 42 CFR 438.54(c)(2)(i), during which individuals who are subject to voluntary enrollment may make an active choice to enroll in the managed care program, or will otherwise continue to receive covered services through the fee-for-service delivery system.

i. Please indicate the length of the enrollment choice period:

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- c. ☐ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(c)(1)(ii) and 438.54(c)(2)(ii), for individuals who are subject to voluntary enrollment.
- i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8).
- ii. Please indicate how long the enrollee will have to disenroll from the plan and return to the fee-for-service delivery system:

2. For **mandatory** enrollment: (see 42 CFR 438.54(d))
- a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3).
- Medicaid provides the Arkansas Medicaid Handbook online through Medicaid.mmis.arkansas.gov as well as by simply typing in AR Medicaid handbook. This handbook provides information on how to enroll in Medicaid and how to contact ConnectCare, who assists our beneficiaries as well as providers in enrollment, and change of primary care provider. The Handbook provides all information that may be needed as to definitions, coverage, and how to reach a customer representative. Our contractor AFMC, who also holds the contract for ConnectCare, provides education sessions across the state for Medicaid beneficiaries through AFMC Medicaid Beneficiary Education. Each enrollee also receives notification by either mail or email of rights and processes to choose or change providers as well as how to access coverage and definitions.
- b. ☐ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(d)(2)(i), during which individuals who are subject to mandatory enrollment may make an active choice to select a managed care plan, or will otherwise be enrolled in a plan selected by the State's default enrollment process.
- i. Please indicate the length of the enrollment choice period:

- c. ☐ If applicable, please check here to indicate that the state uses a **default** enrollment process, as described in 42 CFR 438.54(d)(5), for individuals who are subject to mandatory enrollment.
- i. If so, please describe the algorithm used for default enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (5), (7), and (8).

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- d. ☐ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(d)(2), for individuals who are subject to mandatory enrollment.
- i. If so, please describe the algorithm used for passive enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (6), (7), and (8).

1932(a)(4)
42 CFR 438.54

3. 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.

42 CFR 438.52

a. ☒ The state assures that, per the choice requirements in 42 CFR 438.52:

- i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of at least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3);
- ii. Medicaid beneficiaries with mandatory enrollment in a primary care case management system will have a choice of at least two primary care case managers employed by or contracted with the State;
- iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.

42 CFR 438.52

b. ☐ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:

☒ This provision is not applicable to this 1932 State Plan Amendment.

42 CFR 438.56(g)

c. ☐ 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.

☒ This provision is not applicable to this 1932 State Plan Amendment.

State: Arkansas

Citation	Condition or Requirement
42 CFR 438.71	d. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.71 regarding developing and implementing a beneficiary support system that provides support to beneficiaries both prior to and after MCO, PCCM, or PCCM entity enrollment will be met.
1932(a)(4)	G. Disenrollment.
42 CFR 438.56	1. The state will <input type="checkbox"/> / will not <input checked="" type="checkbox"/> limit disenrollment for managed care.
	2. The disenrollment limitation will apply for N/A (up to 12 months).
	3. <input checked="" type="checkbox"/> The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56.
	4. Describe the state's process for notifying the Medicaid beneficiaries of their right to disenroll without cause during the 90 days following the date of their initial enrollment into the MCO, PCCM, or PCCM entity. (Examples: state generated correspondence, enrollment packets, etc.)
	A letter or email (recipient's choice) is sent to the recipient from ConnectCare when the recipient is first enrolled in Medicaid. The letter/email informs the recipient of who their PCP/PCCM is and how to disenroll or change their PCP/PCCM.
	5. Describe any additional circumstances of "cause" for disenrollment (if any).
	H. Information Requirements for Beneficiaries.
1932(a)(5)(c)	<input checked="" type="checkbox"/> The state assures that its state plan program is in compliance with 42 CFR
42 CFR 438.50	438.10 for information requirements specific to MCOs, PCCMs, and PCCM entity
42 CFR 438.10	programs operated under section 1932(a)(1)(A)(i) state plan amendments.
1932(a)(5)(D)(b)	I. List all benefits for which the MCO is responsible.
1903(m)	
1905(i)(3)	
	Complete the chart below to indicate every State Plan-Approved services that will be delivered by the MCO, and where each of those services is described in the state's Medicaid State Plan. For "other practitioner services", list each provider type separately. For rehabilitative services, habilitative services, EPSDT services and 1915(i), (j) and (k) services list each program separately by its own list of services. Add additional rows as necessary.
	In the first column of the chart below, enter the name of each State Plan-Approved service delivered by the MCO. In the second – fourth column of the chart, enter a State Plan citation providing the Attachment number, Page number, and Item number, respectively.

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1932(c)(1)(A) 42 CFR 438.330 42 CFR 438.340	L. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.330 and 438.340, regarding a quality assessment and performance improvement program and State quality strategy, will be met.
---	--

1932(c)(2)(A) 42 CFR 438.350 42 CFR 438.354 42 CFR 438.364	M. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.350, 438.354, and 438.364 regarding an annual external independent review conducted by a qualified independent entity, will be met.
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1932 (a)(1)(A)(ii)	N. Selective Contracting Under a 1932 State Plan Option.
--------------------	--

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will ☐/will not ☒ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. ☒ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. (Example: a limited number of providers and/or enrollees.)

A PCCM must establish his or her Medicaid caseload limit, of a maximum of 2500. The state will permit higher maximums in areas the federal government has designated as medically underserved. The state may permit higher maximum caseloads for Primary Care Providers who so request if the limit would create a hardship on their practice.

4. ☐ The selective contracting provision is not applicable to this state plan.

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Appendix A: Compliance Dates (from Supplementary Information in 81 FR 27497, published 5/6/2016)

States must comply with all provisions in effect as of the issuance of this preprint. Additionally, the following compliance dates apply:

<u>Compliance Dates</u>	<u>Sections</u>
<u>For rating periods for Medicaid managed care contracts beginning before July 1, 2017, States will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in 42 CFR parts 430 to 481, edition revised as of October 1, 2015. States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.</u>	<u>§§ 438.3(h), 438.3(m), 438.3(q) through (u), 438.4(b)(7), 438.4(b)(8), 438.5(b) through (f), 438.6(b)(3), 438.6(c) and (d), 438.7(b), 438.7(c)(1) and (2), 438.8, 438.9, 438.10, 438.14, 438.56(d)(2)(iv), 438.66(a) through (d), 438.70, 438.74, 438.110, 438.208, 438.210, 438.230, 438.242, 438.330, 438.332, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424, 438.602(a), 438.602(c) through (h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d)</u>
<u>For rating periods for Medicaid managed care contracts beginning before July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015. States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2018.</u>	<u>§§ 438.4(b)(3), 438.4(b)(4), 438.7(c)(3), 438.62, 438.68, 438.71, 438.206, 438.207, 438.602(b), 438.608(b), and 438.818</u>
<u>States must be in compliance with the requirements at § 438.4(b)(9) no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2019.</u>	<u>§ 438.4(b)(9)</u>
<u>States must be in compliance with the requirements at § 438.66(e) no later than the rating period for Medicaid managed care contracts starting on or after the date of the publication of CMS guidance.</u>	<u>§ 438.66(e)</u>
<u>States must be in compliance with § 438.334 no later than 3 years from the date of a final notice published in the Federal Register.</u>	<u>§ 438.334</u>
<u>Until July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42</u>	<u>§§ 438.340, 438.350, 438.354, 438.356, 438.358, 438.360, 438.362, and 438.364</u>

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<u>Compliance Dates</u>	<u>Sections</u>
<u>CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.</u>	
<u>States must begin conducting the EQR-related activity described in § 438.358(b)(1)(iv) (relating to the mandatory EQR-related activity of validation of network adequacy) no later than one year from the issuance of the associated EQR protocol.</u>	<u>§ 438.358(b)(1)(iv)</u>
<u>States may begin conducting the EQR-related activity described in § 438.358(c)(6) (relating to the optional EQR-related activity of plan rating) no earlier than the issuance of the associated EQR protocol.</u>	<u>§ 438.358(c)(6)</u>

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

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

~~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)~~ ~~1. The State will contract with an~~

~~1932(a)(1)(B)(ii)~~

~~42 CFR 438.50(b)(1)~~

~~_____ 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 PCCM provider will assist enrollees with locating medical services and coordinate and monitor their enrollees prescribed medical and rehabilitation services. PCCM will be mandatory for most Medicaid beneficiaries.~~

~~The beneficiaries have a free choice of specialists within the state and bordering states. A beneficiary must enroll with a PCCM whose practice is in the beneficiary's county of residence, a county adjacent to the beneficiary's county of residence or a county adjoining a county adjacent to the beneficiary's county of residence. PCCM providers have free choice of referrals specialists and ancillary providers~~

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

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~~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 ConnectCare 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 ConnectCare 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~~
- ~~• 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.~~

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~~b. Arkansas Department of Human Services engages a network of credentialed primary care physicians to meet medical needs for enrolled beneficiaries. The PCCM provider is responsible for overall health care services for beneficiaries.~~

~~42 CFR 438.50(b) (2) 2. The payment method to the contracting entity will be:~~
~~42 CFR 438.50(b) (3)~~

- ~~___ i. fee for service;~~
- ~~___ ii. capitation;~~
- ~~X iii. a case management fee;~~
- ~~___ iv. a bonus/incentive payment;~~
- ~~___ v. a supplemental payment, or~~
- ~~___ vi. other. (Please provide a description below).~~

~~Reimbursement is a set rate of \$ 3.00 per member per month through MMIS.~~

~~1905(t)
42 CFR 440.168
42 CFR 438.6(e)(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(e)(5)(iv)).~~

- ~~___ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.~~
- ~~___ ii. Incentives will be based upon specific activities and targets.~~
- ~~___ iii. Incentives will be based upon a fixed period of time.~~
- ~~___ iv. Incentives will not be renewed automatically.~~
- ~~___ v. Incentives will be made available to both public and private PCCMs.~~
- ~~___ vi. Incentives will not be conditioned on intergovernmental transfer agreements.~~

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~~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.

There will be a state wide promulgation process, whereby there will be a 30-day public comment period. The state also assures that it will consult with the State Medical Care Advisory Committee. The beneficiary has the right to appeal or grieve through the Division of Medical Services, Office of Chief Counsel.

~~1932(a)(1)(A)~~

5. The state plan program will X /will not___ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory____/ voluntary___ enrollment will be implemented in the following counties::

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)~~

2. ~~X~~ The state assures that all the applicable requirements of section 1905(t)

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1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. <u> </u> The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)	4. <u>X</u> 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. <u>X</u> 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(e) 42 CFR 438.50(c)(6)	6. <u> </u> The state assures that all applicable requirements of 42 CFR 438.6(e) 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. <u>X</u> 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. <u>X</u> 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,

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~~adults 18 and older, Foster Care~~ pregnant women and infants, Blind/Disabled 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.~~
~~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. 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) iii. Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under Title XVI.~~
~~42 CFR 438.50(d)(3)(i)~~

~~1932(a)(2)(A)(iii) iv. Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.~~
~~42 CFR 438.50(d)(3)(ii)~~

~~1932(a)(2)(A)(v) v. Children under the age of 19 years who are in foster care or other out-of-home placement.~~
~~42 CFR 438.50(3)(iii)~~

~~1932(a)(2)(A)(iv) vi. Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.~~
~~42 CFR 438.50(3)(iv)~~

~~1932(a)(2)(A)(ii) vii. 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)~~

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~~of Title V, and is defined by the state in terms of either program participation or special health care needs.~~

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. ~~Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. (Examples: children receiving services at a specific clinic or enrolled in a particular program.)~~

N/A

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.~~

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~~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.~~

~~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)~~

~~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~~

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~~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 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) 1. Definitions~~

~~42 CFR 438.50~~

~~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 PCCM or transfer between PCCMs.~~

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

~~1932(a)(4) 2. State process for enrollment by default.~~

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~~42 CFR 438.50~~

~~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 at PCCM at the office of the PCCM, at the regional district state office, through Connectcare or through the emergency room. The PCCM'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 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~~

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iv. ~~Describe the state's process for notifying the Medicaid beneficiaries who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. (Examples: state-generated correspondence, HMO enrollment packets etc.)~~

N/A

v. ~~Describe the default assignment algorithm used for auto-assignment. (Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)~~

N/A

vi. ~~Describe how the state will monitor any changes in the rate of default assignment. (Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)~~

N/A

~~1932(a)(4)
42 CFR 438.50~~ I. ~~State assurances on the enrollment process~~

~~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).~~

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~~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) _____ J. Disenrollment
42 CFR 438.50~~

~~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(e).~~

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

~~K. Information requirements for beneficiaries~~

~~Place a check mark to affirm state compliance.~~

~~1932(a)(5)
42 CFR 438.50
42 CFR 438.10~~

~~X The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)~~

~~1932(a)(5)(D)~~

~~L. List all services that are excluded for each model (MCO & PCCM)~~

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1905(t) ~~The following PCCM exempt services do not require PCP authorization:~~
~~Dental Services~~
~~Emergency hospital care~~

~~DDS Alternative Community Services~~
~~Family Planning Anesthesia~~
~~Alternative Waiver Programs~~
~~Developmental Day Treatment Services Core Services only Disease Control Services~~
~~for Communicable Diseases Domiciliary care~~
~~ARChoices waiver services~~
~~Gynecological care~~
~~Inpatient Hospital admissions on the effective date of PCP enrollment or on the day~~
~~after the effective date of PCP enrollment~~
~~Mental health services as follows:~~
~~Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and~~
~~practice as an individual practitioner~~
~~Rehabilitative services for persons with mental illness aged 21 or older or for specified~~
~~procedures for persons under age 21~~
~~Rehabilitative Services for Youth and Children Nurse Midwife services~~
~~ICF/IID services Nursing Facility services~~
~~Hospital non-emergency or outpatient clinic services on the effective date of PCP~~
~~enrollment or on the day after the effective date of PCP enrollment.~~
~~Ophthalmology and Optometry services~~
~~Obstetric (antepartum, deliver and postpartum) services Pharmacy~~
~~Physician Services for inpatients acute care. Transportation~~
~~Sexual Abuse Examination.~~
~~Targeted case management provided by the Division of Youth Services or the Division~~
~~of Children and Family services under an interagency agreement with the Division of~~
~~Medical Services.~~

1932 (a)(1)(A)(ii) M. ~~Selective contracting under a 1932 state plan option~~

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

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1. ~~The state will _____ will not X intentionally limit the number of entities it contracts under a 1932 state plan option.~~

2. ~~X The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.~~

3. ~~Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option.~~

~~A PCCM must establish his or her Medicaid caseload limit, of a maximum of 2500. The state will permit higher maximums in areas the federal government has designated as medically underserved. The state may permit higher maximum caseloads for Primary Care Providers who so request if the limit would create a hardship on their practice.~~

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