

PATIENT-CENTERED MEDICAL HOME STANDARDS

Table of Contents

Section 1.	Authority
Section 2.	Purpose
Section 3.	Applicability & Scope
Section 4.	Definitions
Section 5.	Requirements
Section 6.	Enforcement
Section 7.	Effective Date

Section 1. Authority

This Rule is issued pursuant to Section One of Act 1498 of 2013 of the Arkansas Eighty-Ninth General Assembly, also known as the “Health Care Independence Act of 2013” (hereafter, the “Health Care Independence Program,” or “HCIP”), now codified in Ark. Code Ann. §§ 20-77-2401 et seq. Pursuant to Ark. Code Ann. § 20-77-2405(g)(1) and Ark. Code Ann. § 20-77-2406(e), the Arkansas Insurance Department (“AID”) and Arkansas Department of Human Services (“ADHS”) are authorized to issue Rules to implement provisions under HCIP. In addition, this Rule is issued pursuant to Ark. Code Ann. § 23-61-108(b)(1) which states that the Arkansas Insurance Commissioner (“Commissioner”) has authority to promulgate rules and regulations necessary for the effective regulation of the business of insurance.

Section 2. Purpose

The purpose of this Rule is to provide standards for patient-centered medical home (“PCMH”) programs for Health Carriers in the Health Insurance Marketplace which issue Qualified Health Plans (“QHPs”) on or after January 1, 2015.

Section 3. Applicability & Scope

This Rule applies to all Health Carriers issuing QHPs in the Health Insurance Marketplace on or after January 1, 2015. Under Ark. Code Ann. § 20-77-2406(d), Health Carriers participating in the Health Insurance Marketplace are required to participate in the Arkansas Payment Improvement Initiative (“APII”) including: (1) Assignment of primary care

clinician; (2) Support for patient-centered medical home; and (3) Access of clinical performance data for providers. The HCIP requires Health Carriers to participate in the APII as multi-payer participants. This Rule requires Health Carriers to participate in PCMH standards as one active or available option in QHP networks on or after January 1, 2015. Additionally, these standards set a floor for participation and do not preclude Health Carriers from developing and implementing standards that exceed the requirements set forth in this Rule.

Section 4. Definitions

The following definitions shall apply in this Rule, unless otherwise defined by HCIP:

- (1) "ADHS" means the Arkansas Department of Human Services;
- (2) "AID" means the Arkansas Insurance Department;
- (3) "APII" means the Arkansas Payment Improvement Initiative, as referenced in Ark. Code Ann. § 20-77-2406(d), which is a multi-payer program that connects medical payment to medical providers to achieve high quality care at an appropriate cost;
- (4) "Arkansas PCMH Model" means the provisions in Section 200 of the Arkansas Medicaid PCMH Provider Manual;
- (5) "DMS" means the Division of Medical Services under ADHS;
- (6) "HCIP" means the Program established under Act 1498 of 2013 by the Arkansas State Legislature known as the "Health Care Independence Act of 2013";
- (7) "Health Carrier" means a private entity certified by AID and offering plans through the Health Insurance Marketplace;
- (8) "Healthcare coverage" shall mean healthcare benefits as defined under Ark. Code Ann. § 20-77-2404(4);
- (9) "Health Insurance Marketplace" means the marketplace as defined by Ark. Code Ann. § 20-77-2404(5);
- (10) "Qualified Health Plan" means an AID certified individual health insurance plan offered by a Health Carrier through the Health Insurance Marketplace;
- (11) "QHP Enrollee" means a person insured under a Qualified Health Plan;
- (12) "Patient Centered Medical Home" ("PCMH") means a "Patient Centered Medical Home" as defined under Section 200 of the Arkansas Medicaid PCMH Provider Manual.
- (13) "Primary Care Physician" means a "Primary Care Physician" as defined under Section 171 of the Arkansas Medicaid PCMH Provider Manual.

Section 5. Requirements

For QHPs issued on or after January 1, 2015, Health Carriers shall adopt the following requirements and provide the opportunity for primary care physicians eligible to

participate in the Arkansas PCMH model to participate in a PCMH program according to these standards:

- (a) A Health Carrier shall follow the requirements of the Arkansas PCMH Model or may develop its own PCMH standards based upon an accepted national PCMH model, as approved by the Commissioner, to the extent that such provisions are consistent with and not in conflict with this Rule or the Arkansas PCMH Model.
- (b) Health Carriers will prospectively attribute QHP enrollees to primary care practices either based on enrollee choice or according to the plurality of professional visits for primary care evaluation and management paid by the Health Carrier over the prior year. Health Carriers may develop their own method for attributing enrollees for whom coverage was discontinuous during the prior year. Health Carriers must attribute QHP enrollees on at least a quarterly basis and provide AID with access to timely and sufficient data upon request to complete an audit of Health Carriers' attribution process and to ensure appropriate QHP enrollee attribution;
- (c) Notwithstanding the PCMH Model chosen by the Health Carrier in Section Five (5) (a) of this Rule, Health Carriers will offer practice support to primary care physician practices that have been identified by Medicaid as participating in the Arkansas PCMH model through the APII. Health Carriers may identify additional PCMH participants with at least three hundred (300) enrollees for inclusion in the Arkansas PCMH Model. Practice support will be provided in the form of care coordination payments equivalent to or greater than an average of five dollars (\$5.00) per enrollee per month. Health Carriers may use a risk adjustment method of their choosing for determining the actual payment, so long as the average payment per enrollee is no less than five dollars (\$5.00) per month;
- (d) Health Carriers may terminate payment of practice support for a primary care physician's failure to meet milestones or deadlines for practice transformation activities and benchmarks or targets for clinical quality. In order to minimize provider administrative burden and encourage meaningful data reporting, quality metrics collected and reported by Health Carriers must incorporate Arkansas PCMH model requirements;
- (e) Health Carriers shall provide performance reports for PCMH practice transformation and quality on a quarterly basis. A standardized report form shall be made available to Health Carriers from the Arkansas Health Care Payment

Improvement Initiative Web Site (www.paymentinitiative.org) and reporting should include total cost of patient care and care categories (not shown in referenced report);

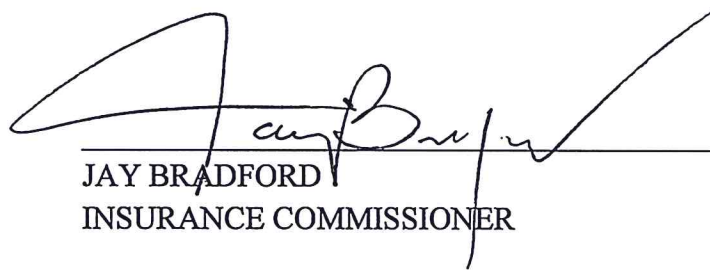
- (f) Health Carriers shall share statistics with AID or its designee(s) (output of analyzed claims data used to create above reports) for streamlined provider use at an aggregate multi-payer level;
- (g) On or after January 1, 2016, Health Carriers should expect to participate in development of mechanisms to share savings with PCMH practices for achieving a per issuer enrollee cost of care that is below its benchmark cost.
- (h) Health Carriers shall educate QHP enrollees about the Health Carrier's PCMH program and indicate which practices are participating in the program.

Section 6. Enforcement

AID shall review a Health Carrier's compliance with the provisions of this Rule in its role of recommending approval or non-approval for certification of qualified health plans sold in the Health Insurance Marketplace.

Section 7. Effective Date

The effective date of this Rule shall be January 1, 2015.



JAY BRADFORD
INSURANCE COMMISSIONER

November 12, 2014
DATE