State: Arkansas

Citation	Condition or Requirement

1932(a)(1)(A)

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

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.**

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.2
42 CFR 438.6
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.

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

State: Arkansas

Citation	Condition or Requirement

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.

Citation	Condition or Requirement

3) Increases to 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.

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.

3. ☐ PCCM entity
   a. ☐ Case management fee
   b. ☐ Shared savings, incentive payments, and/or financial rewards (see 42 CFR 438.310(c)(2))
   c. ☐ Other (please explain below)

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.

State: Arkansas

Citation	Condition or Requirement

☐ 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)
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. ☒ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts (including for PCCM entities) will be met.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. ☐ 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. ☒ 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.

State: Arkansas

Citation	Condition or Requirement
42 CFR 438.10(g)(2)(vii)	
1932(a)(1)(A)	5. ☐ The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) 42 CFR 438 1903(m)	6. ☒ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs, PCCMs, and PCCM entities will be met.
1932(a)(1)(A) 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)	7. ☐ 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.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	8. ☒ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
45 CFR 75.326	9. ☒ The state assures that all applicable requirements of 45 CFR 75.326 for procurement of contracts will be met.
42 CFR 438.66	10. Assurances regarding state monitoring requirements: ☒ 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.
1932(a)(1)(A) 1932(a)(2)	E. <u>Populations and Geographic Area.</u> 1. **<u>Included Populations.</u>** 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.

State: Arkansas

Citation | Condition or Requirement

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

1. Family/Adult

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

State: Arkansas

Citation | Condition or Requirement

2. Aged/Blind/Disabled Individuals

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

B. Optional Eligibility Groups

1. Family/Adult

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

State: Arkansas

Citation | Condition or Requirement

2. Aged/Blind/Disabled Individuals

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

State: Arkansas

Citation | Condition or Requirement

3. Partial Benefits

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

C. Medically Needy

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

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):

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

State: Arkansas

Citation Condition or Requirement

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
"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			X		
American Indian/Alaskan Native— Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes	§438.14	X		Statewide	
Children Receiving SSI who are Under Age 19 - Children under 19 years of age who are eligible for SSI under title XVI	§435.120	X		Statewide	
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.	§435.225 1902(e)(3) of the SSA	X		Statewide	This population is covered under 1115 TEFRA Waiver
Title IV-E Children - Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E *	§435.145	X		Statewide	
Non-Title IV-E Adoption Assistance Under Age 21*	§435.227	X		Statewide	
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.		X		Statewide	

* = 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):

State: Arkansas

Citation | Condition or Requirement

Population	V	E	Notes
Other Insurance--Medicaid beneficiaries who have other health insurance		X	
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).		X	
Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program		X	
Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program		X	
Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).		X	
Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.		X	
Other (Please define):			

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 specicifed 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:

Citation | Condition or Requirement

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).

State: Arkansas

Citation	Condition or Requirement

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 casse 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. ☒ 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) 42 CFR 438.56	G. Disenrollment. 1. The state will☐/ will not☒ limit disenrollment for managed care.
	2. The disenrollment limitation will apply for N/A (up to 12 months).
	3. ☒ 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) 42 CFR 438.50 42 CFR 438.10	☒ The state assures that its state plan program is in compliance with 42 CFR 438.10 for information requirements specific to MCOs, PCCMs, and PCCM entity programs operated under section 1932(a)(1)(A)(i) state plan amendments.
1932(a)(5)(D)(b) 1903(m) 1905(t)(3)	I. List all benefits for which the MCO is responsible. 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.

State: Arkansas

Citation | Condition or Requirement

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
Ex. Physical Therapy	*3.1-A*	*4*	*11.a*

1932(a)(5)(D)(b)(4)
42 CFR 438.228

J. ☐ The state assures that each MCO has established an internal grievance and appeal system for enrollees.

1932(a)(5)(D)(b)(5)
42 CFR 438.62
42 CFR 438.68
42 CFR 438.206
42 CFR 438.207
42 CFR 438.208

K. Services, including capacity, network adequacy, coordination, and continuity.

☒ The state assures that all applicable requirements of 42 CFR 438.62, regarding continued service to enrollees, will be met.

☐ The state assures that all applicable requirements of 42 CFR 438.68, regarding network adequacy standards, will be met.

☐ The state assures that all applicable requirements of 42 CFR 438.206, regarding availability of services, will be met.

☐ The state assures that all applicable requirements of 42 CFR 438.207, regarding assurances of adequate capacity and services, will be met.

☐ The state assures that all applicable requirements of 42 CFR 438.208, regarding coordination and continuity of care, will be met.

State: Arkansas

Citation	Condition or Requirement
1932(c)(1)(A) 42 CFR 438.330 42 CFR 438.340	L. ☒ 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. ☒ 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.
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 in not applicable to this state plan.

State: Arkansas

Citation | Condition or Requirement

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:

Compliance Dates	Sections
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.**	§§ 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)
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.**	§§ 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
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.	§ 438.4(b)(9)
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.	§ 438.66(e)
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.	§ 438.334
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	§§ 438.340, 438.350, 438.354, 438.356, 438.358, 438.360, 438.362, and 438.364

State: Arkansas

Citation | Condition or Requirement

Compliance Dates	Sections
CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	
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.**	§ 438.358(b)(1)(iv)
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.**	§ 438.358(c)(6)

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

CMS-10120 (exp. TBD – currently 4/30/17)

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) **performance-based** incentive payments.

The care coordination payment may be used by participating practices for care coordination efforts, whether these are executed by a vendor on behalf of the practice or directly by the practice. Care coordination payments are risk adjusted to account for the varying levels of care coordination services needed for patients with different risk profiles.

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

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

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

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

<RESERVED>

Citation	Condition or Requirement

DMS will:

· Provide CMS, at least annually, with data and reports supporting achievements in the goals of improving health, increasing quality and lowering the growth of health care costs.

· Provide CMS with updates, as conducted, to the state's metrics.

· Review and renew the payment methodology as part of the evaluation.

· Make all necessary modifications to the methodology, including those determined based on the evaluation and program success, through State Plan Amendment submissions.

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met *all* of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

____ii. Incentives will be based upon specific activities and targets.

____iii. Incentives will be based upon a fixed period of time.

____iv. Incentives will not be renewed automatically.

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

____vi. Incentives will not be conditioned on intergovernmental transfer agreements.

Citation		Condition or Requirement
		__X_vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4.	Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. The State established a website (www.paymentinitiative.org) to keep the public informed during the design of the PCMH program and provide current information on progress towards implementation. The website is a 'one stop shop' for documents and information PCMH and includes an email address for interested parties to send suggestions. The State also established a toll free number manned by service representatives to answer public/provider questions on PCMH program. These service representatives triage and escalate as needed, and catalogue questions for changes to the technical design, operational processes, or communications. The PCMH Provider Manual explaining the program in detail is posted on the website. Webinars on program overview, enrollment process, benefits and requirements are also posted on the website along with FAQs on relevant topics. There **is** a statewide promulgation process **including** a 30 day public comment period, after which feedback is incorporated into **the** version that **is** submitted for State legislative approval.

Citation	Condition or Requirement

Meaningful updates to the provider manual will be shared with CMS to enable continued collaboration and open lines of communication

1932(a)(1)(A)

5. The state plan program will **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 couties::

   i. county/counties (mandatory) _____

   ii. area/areas (mandatory)_____

   iii. area/areas (voluntary)_____

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

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

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

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

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. __X The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1932(a)(1)(A)

3. _ The state assures that all the applicable requirements of section 1932

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. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u>

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).

Citation	Condition or Requirement

1. 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)
CFR 438.50
42 CFR 438.10

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

1932(a)(5)(D)
1905(t)

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

The following PCCM exempt services do not require PCP authorization:
Dental Services
Emergency hospital care
Developmental Disabilities Services Community and Employment Support
Family Planning
Anesthesia
Alternative Waiver Programs
Adult Developmental Day Treatment Services Core Services only
Disease Control Services for Communicable Diseases
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
Medication-Assisted Treatment Services for opioid use disorder when part of a Medication Assisted Treatment plan
Mental health services as follows:
a. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practice as an individual practitioner
b. 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, delivery, and postpartum) services
Pharmacy
Physician Services for inpatients acute care
Transportation

Citation	Condition or Requirement

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.

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.

N/A