TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 2009-001

2. STATE: ARKANSAS

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2010

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 438.50(b)

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 $ 17,389.00
b. FFY 2011 $294,744.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F, Pages 1 - 14

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
None, New Pages

10. SUBJECT OF AMENDMENT:

The Arkansas Title XIX State Plan has been amended to define the enhanced PCCM (E-PCCM) program targeted to beneficiaries who meet nursing home level of care criteria.

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Eugene I. Gessow

14. TITLE:
Director, Division of Medical Services

15. DATE SUBMITTED:
September 3, 2009

16. RETURN TO:

Division of Medical Services
PO Box 1437, Slot S295
Little Rock, AR 72203-1437

Attention: LeAnn Edwards

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 3 September, 2009

18. DATE APPROVED: 31 August, 2010

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 July, 2010

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: BILL BROOKS

22. TITLE: Associate Regional Administrator
Div of Medicaid & Children's Health

23. REMARKS:

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 voluntary basis into enhanced primary care case management (E-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. In the existing Arkansas PCCM program, known as ConnectCare, 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, and maintains 24-hour availability to beneficiaries. PCCM is mandatory for most Medicaid beneficiaries, but dual eligibles are not included

The new "enhanced" PCCM (E-PCCM) program is targeted to beneficiaries who meet nursing home level of care criteria, including dual eligibles. This program will be voluntary.

Under this additional E-PCCM program called the Service Options Using Resources in Community Environments (SOURCE) program, the E-PCCM provider manages the enrolled beneficiary's health by working directly with beneficiaries and their physicians on their treatment plans regarding diet, adherence to medicine schedules and other self-management techniques by:

1. Increasing the beneficiaries' and/or their caregivers' understanding of their disease so that they are:
   - Better able to understand their disease

Citation	Condition or Requirement

- 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.

2. Providing coordination between case managers and health care providers

3. Improving adherence to national, evidence-based guidelines to improve beneficiaries' health status

4. Reducing the need for long-term institutional placement and increasing options for aged and disabled beneficiaries

5. Preventing the level of disability and disease from increasing in chronically ill beneficiaries

6. Eliminating fragmented service delivery through managed care principles and outcome-based case management

7. Increasing the cost-efficiency and value of Medicaid LTC funding by reducing inappropriate emergency room use, multiple hospitalizations and nursing home placement caused by preventable medical complications; also by promoting self-care and informal support when possible for individual beneficiaries

b. The Department contracts with a SOURCE E-PCCM organization in this demonstration in one area of the State that engages a network of credentialed primary care physicians, medical personnel, service providers and hospitals to work closely with the case managers to meet program goals for enrolled beneficiaries. This effective enhanced case management model requires a commitment of time, energy and focus from all providers and a standardized set of expected outcomes for the member, with an individualized plan to achieve each outcome.

SOURCE differs from conventional HCBS in Arkansas in part by including health care providers as partners in "enhanced case management." The SOURCE site is responsible for coordinating overall

Citation	Condition or Requirement

health care services for beneficiaries. Sites must work with local health care facilities in collaborative arrangements to reduce conflicting and duplicative efforts. Coordination between the site and health care organizations ensures that decisions for nursing home placement of beneficiaries will not occur without:

- Exploration of all possible routes to a community-based plan
- Primary Care Physician consultation
- Advocacy efforts by case managers in coordination with family/informal caregivers

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;
____iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____vi. other. (Please provide a description below).

The SOURCE site (E-PCCM) receives a standard per member per month case management fee. Providers that render services to beneficiaries will continue to receive payment for services under the current fee for service methodology.

Reimbursement is a set rate of $170 per member per month through MMIS.

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.

Citation	Condition or Requirement
	____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.
	__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. *(Example: public meeting, advisory groups.)* The Arkansas Division of Aging and Adult Services and the Division of Medical Services have utilized Georgia's SOURCE program and approved State Plan as a basic guide for the Arkansas program. In addition, an advisory group made up of state personnel, the Arkansas AARP, Area Agencies on Aging, area physicians and community providers was assembled to meet with interested, potential SOURCE providers in Arkansas and consultants from the State of Georgia. Those consultants included a primary care physician and SOURCE medical director, case managers, Georgia Medicaid personnel and SOURCE beneficiaries. Once the SOURCE program is implemented, ongoing public involvement will take place through intense provider training, monitoring of SOURCE providers and SOURCE beneficiaries, public marketing and advisory group meetings.
1932(a)(1)(A)	5. The state plan program will___/will not_X__ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary___X__ enrollment will be implemented in the following couties::

Citation	Condition or Requirement

i. county/counties (mandatory) _____

ii. county/counties (voluntary) Boone, Benton, Newton, and Washington

iii. area/areas (mandatory)_____

iv. 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. N/A___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)
42 CFR 438.50(c)(3)

3. _N/A___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. N/A___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. _N/A___The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.

Citation	Condition or Requirement
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.

Enrollment in the SOURCE E-PCCM is voluntary.

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)
42 CFR 438(d)(1)

i. __X__Beneficiaries who are also eligible for Medicare.

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.)*

Beneficiaries who are also eligible for Medicare may voluntarily enroll into the SOURCE E-PCCM if they meet the targeted groups' criteria and are not being served in Targeted Case Management.

1932(a)(2)(C) when
42 CFR 438(d)(2)

ii. ____Indians who are beneficiaries of Federally recognized Tribes except 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

Citation	Condition or Requirement
	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. ____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. ____Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. ____Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. ____Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. ____Children under the age of 19 years who are 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.

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

Citation	Condition or Requirement
	____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; N/A ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; N/A iii. Children under 19 years of age who are in foster care or other out-of-home placement; N/A iv. Children under 19 years of age who are receiving foster care or adoption assistance. N/A
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)* N/A
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: *(Examples: usage of aid codes in the eligibility system, self- identification)* i. Beneficiaries who are also eligible for Medicare. There is no mandatory enrollment in SOURCE E-PCCM.

Citation	Condition or Requirement

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.

There is no mandatory enrollment in SOURCE E-PCCM.

42 CFR 438.50

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

There is no mandatory enrollment in SOURCE E-PCCM.

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

The SOURCE E-PCCM will be offered as a demonstration in Boone, Benton, Newton and Washington counties in Arkansas on a voluntary basis for the following groups:

- ElderChoices Home and Community-Based Services (HCBS) Waiver participants aged 65 and older. If chosen by the waiver participant, SOURCE will be included on their waiver plan of care developed by DAAS as a non-waiver service.
- Alternatives for Adults with Physical Disabilities HCBS Waiver participants. If chosen by the waiver participant, SOURCE will be included on their waiver plan of care as a non-waiver service.
- Persons identified in the targeted groups residing in a SOURCE site's designated service area.
- Persons identified in the targeted groups, with the assistance from SOURCE and/or informal caregivers, capable of safely residing in the community (with consideration for a recipient's right to take calculated risks in how and where he or she lives).

Citation	Condition or Requirement

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient 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.

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).

The SOURCE E-PCCM is voluntary and will not utilize default enrollment.

ii. the relationship with providers that have traditionally served Medicaid beneficiaries (as defined in H.2.ii).

The SOURCE E-PCCM is voluntary and will not utilize default enrollment.

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). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

The SOURCE E-PCCM is voluntary and will not utilize default enrollment.

Citation	Condition or Requirement

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

STATE Arkansas
DATE REC'D 9-3-09
DATE APP'VD 8-31-10
DATE EFF 7-1-10
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SUPERSEDES: NONE - NEW PAGE

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. ___X_ 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.

Citation	Condition or Requirement

X The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

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

Enrollment in SOURCE is voluntary. Case Managers will make all feasible efforts to meet the reported and observed needs of persons in service. A voluntary discharge will be effective immediately as of the date requested by the member, guardian or custodial caregiver.

Only after thorough efforts by the SOURCE site to resolve patterns of non-compliance will SOURCE beneficiaries be involuntarily discharged. Examples of non-compliance include:

- Moving out of the SOURCE service area
- Failing to keep scheduled Primary Care Physician appointments
- Avoiding or refusing Case Manager visits or other contacts
- Refusing to allow or facilitate the delivery of community services as agreed on the Carepath plan
- Failing to provide essential information affecting the ability of SOURCE to help beneficiaries live in healthy and functionally independent ways
- Refusing to participate in problem solving discussions and efforts with Case Managers, PCPs, physicians or other providers regarding Carepath variance, delivery or clinical issues
- Failing to use designated SOURCE providers affiliates
- Showing physical aggression toward providers, Case Managers or PCPs

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)
1905(t)

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

Citation	Condition or Requirement

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 X will not _____ 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. *(Example: a limited number of providers and/or enrollees.)*

SOURCE E-PCCM entities are selected based on the following criteria:

- A case management agency certified by the Division of Aging and Adult services that includes a network of primary care physicians, medical personnel, service providers and hospital affiliations within the targeted geographic area for the pilot program
- Willing and able to meet requirements of SOURCE program as designed by the Arkansas Department of Human Services
- A minimum of five years experience providing case management to the frail elderly and/or adults with physical disabilities
- The ability to meet the State's electronic data reporting requirements

SUPERSEDES: NONE - NEW PAGE

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