Appendix 7
PCMH Manual 2019-2020

RFP #710-22-0034

SECTION II - PATIENT CENTERED MEDICAL HOME (PCMH)

CONTENTS

200.000 DEFINITIONS 1-1-19

Attributed beneficiaries	The Medicaid beneficiaries for whom primary care physicians and participating practices have accountability under the PCMH program. A primary care physician's attributed beneficiaries are determined by the ConnectCare Primary Care Case Management (PCCM) program. Attributed beneficiaries do not include dual eligible beneficiaries.
Attribution	The methodology by which Medicaid determines beneficiaries for whom a participating practice may receive practice support and incentive payments.
Care coordination	The ongoing work of engaging beneficiaries and organizing their care needs across providers and care settings.
Care coordination payment	Quarterly payments made to participating practices to support care coordination services. Payment amount is calculated per attributed beneficiary, per month.
Default pool	A pool of beneficiaries who are attributed to participating practices that do not meet the requirements in Section 233.000, part A or part B.
Medical neighborhood barriers	Obstacles to the delivery of coordinated care that exist in areas of the health system external to PCMH.

Participating practice	A physician practice that is enrolled in the PCMH program, which must be one of the following: A. An individual primary care physician (Provider Type 01 or 03); B. A physician group of primary care providers who are affiliated, with a common group identification number (Provider Type 02, 04 or 81); C. A Rural Health Clinic (Provider Type 29) as defined in the Rural Health Clinic Provider Manual Section 201.000; or D. An Area Health Education Center (Provider type 69).
Patient-Centered Medical Home (PCMH)	A team-based care delivery model led by Primary Care Physicians (PCPs) who comprehensively manage beneficiaries' health needs with an emphasis on health care value.
Performance-based incentive payments	Performance-based incentive payments are payments made to a shared performance entity for delivery of economic, efficient and quality care.
Performance adjustment	An adjustment to the cost of beneficiary care to account for patient risk.
Performance period	The period of time over which performance is aggregated and assessed.
Petite pool	Pool reserved for practices with less than 300 attributed beneficiaries that do not wish to participate in a voluntary pool.
Pool	A. The beneficiaries who are attributed to one or more participating practice(s) for the purpose of forming a shared performance entity; or B. The action of aggregating beneficiaries for the purposes of performance-based incentive payment calculations (i.e., the action of forming a shared performance entity).
Practice support	Support provided by Medicaid in the form of care coordination payments to a participating practice.
Practice transformation	The adoption, implementation and maintenance of approaches, activities, capabilities and tools that enable a participating practice to serve as a PCMH.
Primary Care Physician (PCP)	See Section 171.000 of the Arkansas Medicaid provider manual.
Provider portal	The website that participating practices use for purposes of enrollment, reporting to the Division of Medical Services (DMS) and receiving information from DMS.
Quality Improvement Plan (QIP)	QIP is a plan of improvement that practices must submit to PCMH Quality Assurance team after receiving notice of attestation failure or validation failure.

Recover	To deduct an amount from a participating practice's future Medicaid receivables, including without limitation, PCMH payments, or fee-for-service reimbursements, to recoup such amount through legal process, or both.
Remediation time	The period during which participating practices that fail to meet deadlines, targets or both on relevant activities and metrics tracked for practice support may continue to receive care coordination payments while improving performance.
Same-day appointment request	A beneficiary request to be seen by a clinician within 24 hours.
Shared performance entity	A PCMH or pooled PCMHs that, contingent on performance, may receive performance-based incentive payments.
State Health Alliance for Records Exchange (SHARE)	The Arkansas Health Information Exchange. For more information, go to **http://ohit.arkansas.gov**.

210.000 ENROLLMENT AND CASELOAD MANAGEMENT

211.000 Enrollment Eligibility 1-1-18

To be eligible to enroll in the PCMH program:

A. The entity must be a participating practice as defined in Section 200.000.

B. The practice must include PCPs enrolled in the ConnectCare Primary Care Case Management (PCCM) Program.

C. The practice may not participate in the PCCM shared savings pilot established under Act 1453 of 2013.

D. Beginning in January 2018, practices participating in PCMH should work towards adopting an Electronic Health Record (EHR). The EHR adopted must be one that is certified by Office of the National Coordinator for Health Information Technology. Practices should adopt the certified health IT modules which meet the definition of CEHRT according to the timeline and requirements finalized for use in CMS programs supporting certified EHR use. DMS reserves the right to identify and implement EHR metrics in future performance periods.

E. The practice must have at least 150 attributed beneficiaries at the time of enrollment.

DMS may modify the number of attributed beneficiaries required for enrollment based on provider experience and will publish at **www.paymentinitiative.org** any such modification.

212.000 Practice Enrollment 1-1-18

Enrollment in the PCMH program is voluntary and practices must re-enroll annually. To enroll, practices must access the Advanced Health Information Network (AHIN) provider portal and submit a complete and accurate Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement (DMS-844). The AHIN portal can be accessed at **http://www.paymentinitiative.org/enrollment**.

Once enrolled, a participating PCMH remains in the PCMH program until:

A. The PCMH withdraws;

B. The practice or provider changes ownership, becomes ineligible, is suspended or terminated from the Medicaid program or the PCMH program; or

C. DMS terminates the PCMH program.

A physician may be affiliated with only one participating practice. A participating practice must update the Department of Human Services (DHS) on changes to the list of physicians who are part of the practice. Physicians who are no longer participating with a practice are required to update in writing via email at **ARKPCMH@DXC.com** within 30 days of the change.

All practice site locations associated with a PCMH must be listed on the PCMH Program enrollment application. Each site listed on the enrollment application must complete practice support requirements as described in Section 241.000. If a site does not meet deadlines and targets for activities tracked for practice support, then the site must remediate its performance to avoid suspension or termination of practice support for the entire PCMH.

To withdraw from the PCMH program, the participating practice must email a complete and accurate Arkansas Patient-Centered Medical Home Withdrawal Form (DMS-846) to **ARKPCMH@DCX.com**. View or print the Arkansas Patient-Centered Medical Home Withdrawal Form (DMS-846) on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources** or download the form from the AHIN provider portal.

A practice may return to the PCMH Program beginning on the first day of the following performance year (January 1st) after suspension or termination of practice support. Such application for reinstatement is contingent on documentation of successful implementation of all previously deficient requirements and upon meeting the following requirements:

A. Submitting a complete PCMH Program enrollment application during the designated enrollment period

B. Successful implementation of the activity(s) which the practice failed and which resulted in suspension or termination from the program

Practices who withdraw while on remediation will also have to meet the re-instatement requirements. Successful implementation of the activity(s) will be determined by the Quality Assurance Team.

213.000 Enrollment Schedule 1-1-19

Enrollment is open for approximately six (6) weeks in Quarter 3 and Quarter 4 of the preceding calendar year.

DMS will not accept any enrollment documents received other than during an enrollment period.

214.000 Caseload Management 1-1-16

A participating practice must manage its caseload of attributed beneficiaries, including removal of a beneficiary from its panel. DMS retains the right to disallow beneficiary removals if it was determined it was done so to dismiss high costs and/or high-risk patients from the panel.

220.000 PRACTICE SUPPORT

221.000 Practice Support Scope 1-1-19

Practice support is care coordination payments made to a PCMH to support the practices' transformations.

Receipt and use of the care coordination payments is not conditioned on the PCMH engaging a care coordination vendor, as payment can be used to support participating practices' investments (e.g., time and energy) in enacting changes to achieve PCMH goals. Care coordination payments are risk-adjusted to account for the varying levels of care coordination services needed for beneficiaries with different risk profiles.

DMS may pay, recover or offset overpayment or underpayment of care coordination payments.

DMS will also support PCMHs through improved access to information through the reports described in Section 244.000.

222.000 Practice Support Eligibility 1-1-19

In addition to the enrollment eligibility requirements listed in Section 211.000, in order for PCMHs to receive practice support, DMS measures PCMH performance against activities tracked for practice support identified in Section 241.000. PCMHs must meet the requirements of this section to receive practice support.

Each PCMH in a shared performance entity will, if individually qualified, receive practice support even if another PCMH in a shared performance entity does not qualify for practice support.

223.000 Care Coordination Payment Amount 1-1-18

The care coordination payment is risk adjusted based on factors including demographics (age, sex), diagnoses and utilization. DMS will publish the current payment scale on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**.

After each quarter, DMS may pay, recover or offset the care coordination payments to ensure that a PCMH did not receive a care coordination payment for any beneficiary who died, lost eligibility or if the practice lost eligibility during the quarter.

If a PCMH withdraws from the PCMH program, then the PCMH is only eligible for care coordination payments based on a complete quarter's participation in the PCMH program.

230.000 PERFORMANCE-BASED INCENTIVE PAYMENTS (PBIP)

231.000 Performance-Based Incentive Payments 1-1-19

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

232.000 Performance-Based Incentive Payments Eligibility 1-1-19

To receive performance-based incentive payments, a shared performance entity must have a minimum of 1,000 attributed beneficiaries once the exclusions listed below have been applied. A shared performance entity may meet this requirement as a single PCMH or by pooling attributed beneficiaries across more than one PCMH as described in Section 233.000.

A. The following beneficiaries shall not be counted toward the 1,000 attributed beneficiary requirements.

1. Beneficiaries that have been attributed to that entity's PCMH(s) for less than half of the performance period.

2. Beneficiaries that a PCMH prospectively designates for exclusion (also known as physician-selected exclusions) on or before the 90th day of the performance period. Once a beneficiary is designated for exclusion, a PCMH may not update selection for the duration of the performance period. The total number of physician-selected

exclusions will be directly proportional to the PCMH's total number of attributed beneficiaries (e.g., up to one exclusion for every 1,000 attributed beneficiaries).

3. Beneficiaries for whom DMS has identified another payer that is legally liable for all or part of the cost of Medicaid care and services provided to the beneficiary.

DMS may add, remove or adjust these exclusions based on new research, empirical evidence, provider experience with select beneficiary populations or inclusion of new payers. DMS will publish such an addition, removal or modification on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**.

B. Performance-based incentive payments are conditioned upon a shared performance entity:

1. Enrolling during the enrollment period prior to the beginning of the performance period;
2. Meeting Section 241.000 requirements for activities tracked for practice support;
3. Meeting requirements for metrics tracked for performance-based incentive payments in Section 243.000 based on the performance for beneficiaries attributed to the shared performance entity for the majority of the performance period; and
4. Maintaining eligibility for practice support as described in Section 222.000.

Performance-based incentive payments are made to the individual PCMHs which are part of a shared performance entity. These payments are risk- and time- adjusted and prorated based on the number of beneficiaries of each PCMH. These payments are predicated on each PCMH maintaining eligibility for practice support as described in Section 222.000.

233.000 Pools of Attributed Beneficiaries 1-1-19

Shared performance entities will meet the minimum pool size of 1,000 attributed beneficiaries as described in Section 232.000 in one of four ways:

A. Meet minimum pool size independently;

B. Pool attributed beneficiaries voluntarily with other participating PCMHs as described in Section 234.000. In this method, practices voluntarily agree to have their performance measured together by aggregating quality metrics tracked for performance-based incentive payments across the practices; or

C. Be assigned to the default pool as described in Section 234.000. Practices with beneficiaries in this pool will have their utilization performance and focus measure performance aggregated together; however, the quality metrics tracked for performance-based incentive payments are measured at the individual PCMH level; or

D. Be assigned to the petite pool as described in Section 234.000. In this method, practices will have their performance measured together by aggregating the utilization measures, focus measure, and quality metrics tracked for performance-based incentive payments across all practices in the pool.

A shared performance entity's pool configuration (A, B, C, or D) is established during the enrollment period and cannot be changed after the end of the enrollment period.

234.000 Requirements for Joining and Leaving Pools 1-1-19

PCMHs may voluntarily pool for purposes described in Section 233.000 before the end of the enrollment period that precedes the start of the performance period. To pool, the participating practice must email a complete and accurate Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form (DMS-845) to **ARKPCMH@DXC.com**. View or print the Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form on the APII

website at http://www.paymentinitiative.org/pcmh-manual-and-additional-resources. You can also download the form from the AHIN provider portal.

The DMS-845 Pooling form must be executed by all PCMHs participating in the pool. Before the end of the enrollment period, PCMHs that are on their own or through pooling do not reach a minimum of 1,000 attributed beneficiaries will be assigned to the default pool. Practices with less than 300 attributed beneficiaries that do not wish to participate in a voluntary pool will be placed in the petite pool. Individual PCMHs whose attribution changes during the performance period will be classified as standalone, default, or petite pool members according to their attribution count at the end of the performance period.

Pooling is effective for a single performance period and must be renewed for each subsequent year.

When a PCMH has voluntarily pooled, its performance is measured in the associated shared performance entity throughout the duration of the performance period unless it withdraws from the PCMH program during the performance period. When a PCMH in a voluntary pool withdraws, is suspended, or otherwise leaves the PCMH program, any and all PCMHs in the shared performance entity will have their performance measured as if the withdrawn or suspended PCMH had never participated in the pool. This provision does not apply to PCMHs that leave the program in the last calendar quarter. If the PCMH leaves the program in the last calendar quarter, the departing PCMH, and its performance will be treated as if the PCMH has not left the program.

235.000 Performance-Based Incentive Payment (PBIP) Methodology 1-1-19

Each year, a Practice's performance in emergency department rates and inpatient rates will be measured and ranked. Shared performance entities that achieve the top 35th percentile of performance in the measures will be eligible to receive PBIP.

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

236.000 Focus Measure 1-1-19

Each year, DMS will select a focus measure to improve quality and provide incentive to shared performance entities. The focus measure will focus on an area for which Arkansas ranks much lower than the national average. Shared performance entities that are ranked in the top 35th percentile of the focus measure will be eligible to receive PBIP.

Each year, DMS will announce which area has been selected as a focus measure on the APII website at http://www.paymentinitiative.org/pcmh-manual-and-additional-resources.

237.000 Performance-Based Incentive Payment Amounts 1-1-19

A shared performance entity is eligible to receive performance-based incentive payments in one of the following ways:

A. Shared performance entities that are ranked on the top 10th percentile of performance in emergency room rates, inpatient stay rates, and focus measures will be eligible for 100% of incentive bonus.

B. Shared performance entitles that rank in the top 35th percentile of performance in emergency room rates, inpatient stay rates, and focus measures will be eligible for 50% of incentive bonus.

Performance-based incentive payments will be calculated by multiplying the incentive amount by the number of member months attributed to each PCMH. PCMHs are eligible to receive incentive payments for either ranking in the top 10th or top 35th percentile for

each measure. Measures are independent of one another, and practices are not required to achieve the same ranking across all measures to qualify for incentive bonus payments.

If participating practices have pooled their attributed beneficiaries together, then performance-based incentive payments will be allocated to those practices based on risk- and time-adjustment and in proportion to the number of attributed beneficiaries that each PCMH contributed to such pool.

1. A shared performance entity will not receive performance-based incentive payments unless it meets all the conditions described in Section 232.000.
2. DMS pays performance-based incentive payments on an annual basis for the most recently completed performance period and may withhold a portion of performance-based incentive payments to allow for final payment adjustment after a year of claims data is available.
3. Final payment will include any adjustments required in order to account for all claims for dates of service within the performance period. If the final payment adjustment is negative, then DMS may recover the payment adjustment from the participating PCMH.

240.000 METRICS AND ACCOUNTABILITY FOR PAYMENT INCENTIVES

241.000 Activities Tracked for Practice Support 1-1-19

Using the provider portal, participating PCMHs must complete and document the activities as announced by DMS on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**. The reference point for the deadlines is the first day of the calendar year.

In addition to activities tracked for practice support, DMS will assess a practice's low performance of core metrics. The selected core metrics will be announced at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources.** It is incumbent upon the PCMH to review the selected core metrics that have been announced.

Each year a Core Metric will be chosen to have its Minimal Performance assessed. For example, in 2019 the Core Metric may be infant wellness. A PCMH will be placed in remediation for the Infant Wellness Metric if 15% or greater of the patient panel (0-15 months), have 0-1 wellness visits and the PCMH does not meet the 2019 Quality Metric Target for 5 or more wellness visits.

Failure to meet the targets will result in a Notice of Failure to Meet Wellness Metrics Tracked for Practice Support. PCMHs which receive this notice will be subject to completion of a Quality Improvement Plan (QIP) and a 90-day remediation period. The PCMH will have 15 calendar days to submit a sufficient QIP. Failure to submit a sufficient QIP within 15 calendar days of receiving the notice will result in suspension of practice support. PCMHs which receive a notice will have 90 calendar days, from the date of the notice, to remediate performance of the metric. Successful completion of remediation will be determined by DMS based on the metric results reported in the monthly PCMH report, posted in the AHIN portal, the following month after remediation ends. If a PCMH fails to meet the deadlines or targets for the wellness metrics tracked for practice support within the specified remediation time, then DMS will suspend practice support.

242.000 Accountability for Practice Support 1-1-16

If a PCMH does not meet deadlines and targets for activities tracked for practice support as described in Section 241.000, then the practice must remediate its performance to avoid suspension or termination of practice support.

DMS will verify whether attestation and required documentation was submitted as required by the PCMH program. Failure to comply with this requirement will result in a Notice of Attestation Failure.

DMS will also validate whether attested activities met the PCMH program requirements. Failure to pass validation will result in a Notice of Validation Failure.

PCMHs which received a Notice of Attestation Failure and/or PCMHs which received a Notice of Validation Failure will have 15 calendar days to submit sufficient QIP. Failure to submit sufficient QIP within 15 days of receiving a Notice of Attestation Failure and/or a Notice of Validation Failure will result in suspension or termination of practice support. PCMHs which receive a Notice of Attestation Failure will have 90 days to remediate their performance from the date of the Notice of Attestation Failure. PCMHs which received a Notice of Validation Failure will have 45 days to remediate their performance from the date of the Notice of Validation Failure.

If a PCMH fails to meet the deadlines or targets for activities within the specified remediation time, then DMS will suspend or terminate practice support.

243.000 Quality Metrics Tracked for Performance-Based Incentive Payments 1-1-19

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

244.000 Provider Reports 1-1-19

DMS provides participating PCMH provider reports containing information about their PCMH performance on activities tracked for practice support, quality metrics tracked for performance-based incentive payments and their utilization rates via the provider portal.

Failing to submit any updated license, address changes or changes to the Provider Id number, may result in provider reports with no beneficiary attribution. Providers may update at any time their licenses, address changes, or changes to their Provider ID number by submitting documentation to the Provider Enrollment unit via fax at (501) 374-0746. Providers who have concerns about information included in their reports should send an email to **PCMH@AFMC.org**. The PCMH Quality Assurance Manager will respond to the provider/practice with a review of their inquiry. If the review leads to a discovery that the provider report is inaccurate or does not reflect actual performance, DMS will take the necessary steps to correct the inaccuracies including those that are a result of a systems and/or algorithm error. Providers can also call the APII help desk at 501-301-8311 or 866-322-4698 and by email at **ARKPII@DXC.com**.

Appeals

If you disagree with DMS' decision regarding program participation, payment or other adverse action, you have the right to request reconsideration and you have the right to request an administrative appeal. During the remediation period, and prior to the notice of adverse action, practices continue receiving practice support payments. However, DMS will not pay practice support payments after the notice of adverse action. If the practice prevails during the appeal, or reconsideration, the practice support payments will resume retroactively from the date of the adverse action notice.

A. Request Reconsideration

The Department of Human Services must receive written request for reconsideration within (30) calendar days of the date of the adverse action, notice. Send your request to the Arkansas Department of Human Services, Division of Medical Services, Health Care Innovation: Attention PCMH – Reconsideration, P.O. Box 1437, Slot S425, Little Rock, AR 72203.

B. Request an Administrative Appeal

The Arkansas Department of Health must receive a written appeals request within (30) calendar days of the date of the adverse action notice, or within (10) calendar days of receiving a reconsideration decision. Send your request to Arkansas Department of Health: Attention: Medicaid Provider Appeals Office, 4815 West Markham Street, Slot 31, Little Rock, AR 72205.