EXHIBIT H

DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES

SUBJECT: Patient Centered Medical Home (PCMH) 2-17 and Section V-4-17

DESCRIPTION: The following changes are proposed to the 2018 manual:

200.000 – Added the definition of Quality Improvement Plan (QIP).

211.000 – Reduced the number of minimum beneficiaries required to participate, added EHR certification requirements, and clarified how a previously suspended/terminated practice may return to the PCMH program.

221.000 – Updated dated for Practice Transformation sunset.

232.000 – Removed eligibility requirements pertaining to Comprehensive Primary Care (CPC) Program.

233.000 – Added a new pooling option (petite pool) to accommodate practices with fewer than 300 beneficiaries.

234.000 – Removed exception disallowing voluntary pools to move to default pool when attribution gets below 5000 beneficiaries, added petite pool definition, and clarified how a practice leaving the pool during Q4 affects performance.

237.000 – Updated floor, medium and high threshold amounts as required in the state plan amendment.

244.000 – Added instructions pertaining to provider reports and updated, added guidelines for practice support payments during appeals and reconsiderations, and corrected address for reconsiderations.

250.000 – Deleted section regarding CPC as the program ended on 12/31/2016.

PUBLIC COMMENT: No public hearings were held. The public comment period expired on October 13, 2017. The Department provided the following comments and its response:

Commenter: Dr. Culber Mack Shotts, Medical Director, Paragould Doctors' Clinic

We wish to submit comments addressing a few concerns with the 2018 Arkansas PCMH Manual and Addendum. Our first and primary concern centers on the proposed per-beneficiary medium cost threshold for shared savings. According to the manual, the medium cost threshold per beneficiary is only increasing 1.5% to $2150.00. We do not feel that this is a realistic medium cost threshold, especially considering that the cost threshold is directly tied to whether or not PCMHs are eligible for shared savings incentives. In researching our clinic cost from 2015 to 2016, we found that there are many factors which are out of our direct control that affected our cost, and we question whether or not these factors are considered when the cost threshold is determined. We also question whether or not a realistic approach is being taken when considering the often high cost of providing high quality healthcare.

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For example, as a rural health clinic, we are paid an all-inclusive rate of $83.61 for office visits rather than being paid according to the physician fee schedule. If a patient is seen 12 times in a year as patients with chronic issues often are, that totals $1003.32. This is nearly half of the total medium cost threshold in primary care office visits alone. This leaves very little room for cost of care for things such as specialist visits, pharmacy claims, or inpatient physician or facility claims, all of which are pertinent costs associated with a patient's overall care. One inpatient stay or a handful of specialist visits can easily put the beneficiary over the medium cost threshold for the entire year. While it's understandable that a goal of the PCHM program is for PCPs to strive to improve overall health of their patients and reduce the need for excessive specialist and emergency room visits and inpatient stays and thereby lower costs, it is not realistic to expect that lower healthcare costs necessarily correlates to improved quality of patient health or that PCPs can necessarily directly lower cost of these additional necessary services. Considering that we are the ones held responsible for the total cost of care of these patients, we feel that the threshold is too low and should be reevaluated and raised to a more realistic amount.

As it relates to cost, we understand that the reasoning behind the lower medium cost threshold might be that patients who exceed this threshold might be the exception and not the rule. If that is the case, we feel that only allowing one cost exclusion per 1,000 beneficiaries is currently not much of an asset to lowering our calculated cost in the PCMH program. Even if higher cost patients are not considered typical, surely DMS realizes that high cost patients who often require additional services at additional cost to improve overall health represent a greater demographic than the 0.001% of our total patients that we are allowed to exclude.

The other concern we have with the program relates to care plans. This is a complaint that we have found to be common among PCMHs over the last several years in the program. We do not select our high-priority patients until the end of March of each year, yet we must attest that we have two valid care plans on these patients by the end of December each year, yet we must attest that we have two valid care plans on these patients by the end of December each year. This means that in reality, we only have nine months to complete the car plans on these patients, not a full year. We have been told that the logic behind this is that we can still complete care plans on these patients between January and March prior to selecting them, so we still technically have a full year to compete the care plans. However, this logic is flawed because it makes no sense to complete care plans on patients in advance if we don't know that we will select them as high-priority patients in March because other patients might be considered more high-priority and selected instead. A more efficient way of handling this would be to either allow us to select the high-priority patients by the end of the December the year before the new PCMH year or to allow us until the end of March the following year to attest that two care plans for each high-priority patient have been obtained. Either of these options would give PCMHs a full year with the currently-selected high-priority list in order to obtain valid care plans.

RESPONSE:
We are writing in response to your October 6, 2017 letter regarding the proposed changes for the 2018 PCMH Program, specifically the medium cost threshold and Care Plan requirements.

The PCMH program has always had per member per year thresholds and target inflation rate in place since the beginning of the program. We are actively reviewing the program thresholds as well as monitoring provider program performance and cost. In your letter, you also mention the one cost exclusion per 1,000 beneficiaries is currently not much of an asset to lowering the calculated cost in the PCMH program. This exclusion of 0.1%, was set by Medicaid's previous Director. We now have a new Medicaid Director in place and one of her interests is the next iteration of the PCMH program. We will bring your concern to her attention for further review.

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At this time, no additional standards are being added to care plan requirements. We are reviewing all comments and suggestions for improvement for future PCMH performance periods. It is important to remember, that many of mature PCMH practices have mostly the same high priority beneficiaries each year and it is expected that these patients have existing care plans on file that can be updated with regular visits.

The proposed effective date is January 1, 2018.

FINANCIAL IMPACT: The estimated additional cost to implement the rule for the current fiscal year is $184,890 ($54,395 in general revenue and $130,495 in federal funds). For the next fiscal year, the agency anticipates a savings of $1,015,621 ($298,796 in general revenue and $716,825 in federal funds).

LEGAL AUTHORIZATION: The amendment to an existing rule is necessary to update the Patient Centered Medical Home (PCMH) provider manual to implement the Health Task Force's recommendations and to update thresholds after Medical Services review as required by the PCMH Medicaid State Plan Amendment.

The Department of Human Services is authorized to "make rules and regulations and take actions as are necessary or desirable to carry out the provisions of this chapter [Public Assistance] and that are not inconsistent therewith." Arkansas Code Annotated § 20-76-201 (12). Arkansas Code §20-77-107 specifically authorizes the department to "establish and maintain an indigent medical care program."

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL

DEPARTMENT/AGENCY Department of Human Services

DIVISION Division of Medical Services

DIVISION DIRECTOR Rose M. Naff

CONTACT PERSON Anne Santifer

ADDRESS PO Box 1437, Slot S295 Little Rock AR.72203

PHONE NO. 501-320-6177 **FAX NO.** 501-404-4626 **E-MAIL** Anne.Santifer@dhs.arkansas.go

NAME OF PRESENTER AT COMMITTEE MEETING Tami Harlan

PRESENTER E-MAIL tami.harlan@dhs.arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

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1. What is the short title of this rule? Patient Centered Medical Home (PCMH) 2-17 and Section V-4-17

2. What is the subject of the proposed rule? The purpose of the proposed rule is to update the PCMH provider manual to implement the Health Reform Task Force's recommendations to remove language regarding program that ende on 12/31/16 (CPCi) and to update thresholds as required the PCMH State Plan Amendment.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☐ No ☒
If yes, please provide the federal rule, regulation, and/or statute citation.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ☐ No ☒
If yes, what is the effective date of the emergency rule?

When does the emergency rule expire? ______________________________

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act?

Yes ☐ No ☐

5. Is this a new rule? Yes ☐ No ☒
   If yes, please provide a brief summary explaining the regulation. Task force has recommended PCMH program to be expanded and SPA requires thresholds to be reviewed and renewed.

   Does this repeal an existing rule? Yes ☐ No ☒
   If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. Currently practices must have 300 beneficiaries to enroll; we would like to reduce the min requirement to 150 beneficiaries.

   Is this an amendment to an existing rule? Yes ☒ No ☐
   If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. AR Statute 20-76-201

7. What is the purpose of this proposed rule? The purpose of the proposed rule is to update the PCMH provider manual to expand the program and allow additional practices to enroll. Why is it necessary? PCMH program has proven to be successful at cost avoiding Medicaid funds, expanding the program and allowing additional practices to participate, will most likely reduce Medicaid spending within those practice.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b). www.medicaid.state.ar.us/general/comment/comment.aspx

9. Will a public hearing be held on this proposed rule? Yes ☐ No ☒
   If yes, please complete the following:

   Date: ______________________________

   Time: ______________________________

   Place: ______________________________

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)

    October 13, 2018

11. What is the proposed effective date of this proposed rule? (Must provide a date.)

    January 1st 2018

12. Please provide a copy of the notice required under Ark. Code Ann. § 25-15-204(a), and proof of the publication of said notice. See attached

13. Please provide proof of filing the rule with the Secretary of State and the Arkansas State Library as required pursuant to Ark. Code Ann. § 25-15-204(e). see attached

14. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known. Primary care providers will be supportive of this rule change

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Medical Services

PERSON COMPLETING THIS STATEMENT Lynn Burton

TELEPHONE 501-682-1857 **FAX** 501-682-3889 **EMAIL:** Lynn.burton@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Patient Centered Medical Home (PCMH) -2-17 and Section V-4-17

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐
2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐
3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   ____

   (b) The reason for adoption of the more costly rule;

   ____

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   ____

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

   ____

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
   (a) the rule is achieving the statutory objectives;
   (b) the benefits of the rule continue to justify its costs; and
   (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.