EXHIBIT F

DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES (3485)

SUBJECT: PCMH 1-18 (Patient-Centered Medical Home)

DESCRIPTION: Effective January 1, 2019, Arkansas Patient-Centered Medical Homes will use performance-based incentive payments instead of shared savings incentive payments.

DMS is proposing the following changes to the 2019 PCMH Program Manual:

1. Remove definitions related to total cost of care and shared savings and add definition for Performance-Based Incentive Payments.
2. Define performance-based incentive payment methodology.
3. Define focus measure.
4. Define performance-based payment amounts.
5. Remove total cost of care calculations.
6. Reduce the number of weeks enrollment is open.
7. Clarify practice transformation payments.
8. Revise shared-savings incentive payments to performance-based incentive payments.
9. Decrease pool size to 1000.
10. Change savings to performance based.
11. Change per beneficiary cost to utilization measures and focus measures.
12. Add core measure requirement.
13. Replace shared savings with performance based and total cost of care with utilization rates.
14. Replace shared savings entities with performance risk entities.

PUBLIC COMMENT: A public hearing was held on November 2, 2018. The public comment period expired on November 11, 2018. The Department of Human Services provided the following comments and its responses:

Chimere Ashley, Pratapji Thakor, Sejal Thakor, Stephen Pirtle (all writing separately)

Comment: It has come to my attention that in the proposed 2019 PCMH manual a practice transformation coach is no longer provided for a new PCMH at no cost to them. In previous manuals a transformation coach was provided at no charge for the first 24 months of participating in the state PCMH program. I am in a group with 3 other providers, separated into 3 clinics that fall into the state default pool. The group I am in was new to PCMH in 2016 and having three clinics to transform has to say the least been quite an undertaking for our care coordinator, four providers and our clinic staff members. With that being said, practice transformation is a huge undertaking for a practice(s). A state funded transformation coach is very beneficial to a care coordinator when beginning the state program. There are so many guidelines to understand, policies and procedures to write, as well as reports to maintain. It is my opinion that the policy remains as written in previous manuals and a transformation coach is provided to a new PCMH for the first 24 months of their program.

Response: The agency wants to thank you for your feedback and concerns regarding practice transformation. We understand the importance of this resource tool and how it has impacted clinics within the PCMH community and for that reason this is why DMS extended the contract, because of the outreach on so many clinics. The agency will keep your concerns in mind and if there is any other feedback in the future please feel free to share.

Public Hearing, Little Rock, 11/2/18

Dr. Curt Patton, East Arkansas Children's Clinic
Oral comments

Comment: First of all, let me apologize for responding to something that is not true. You know, when you are outside of central Arkansas and you are not in policy development and you don't read manuals for a living, you know, some of what I have heard and been told may not be accurate. So, if some of my remarks seem pointed towards some particular item and they are incorrect, I apologize for that on the front end. My concern about the new manual and the changes in it have to do with how smaller clinics outside of central Arkansas and northwest Arkansas, for those of us that are trying to make PCMH work, how it affects us. I have been in the program for five years, and I'm generally committed toward -- I mean, our clinic is committed to excellence and quality. We try not to tell people, because we are in a small town, that we do a less good job. And I believe that the twin goals of PCMH of improved quality of care and cost savings are admirable. Just for background, I'm not just a country doctor, but I serve on the board of Arkansas Children's Care Network, ACCN, an institution initiated by Arkansas Children's Hospital. I am a past president of the Arkansas Academy of Pediatrics for the state. And so, I have some experience in this area.

The first thing I will start out with -- and again, these are more stream of consciousness that I typed up than an organized paper. So, I apologize for any duplications or poor grammar. My first concern when I read the new manual is that the design for '19 appears to put two-thirds of clinics that participate in PCMH in the position of not getting any incentive payments. Yes, the top 30 percent will get some and the top ten percent will get the most. But considering the challenges to smaller clinics, we start out kind of behind, in my opinion. Part of it is, is that as physicians, we really don't have much control over when people go to the emergency room or get admitted because there are other players involved, and there are so many factors at play: Availability of transportation, clinic hours that I can operate as a 64-year-old pediatrician who has had a stroke, and the difficulty of recruiting help to the Delta to have a larger clinic to do that. But we are trying to do what we can. But I believe that the way it is designed inadvertently penalizes the smaller rural clinics. And so, I'm not necessarily prepared -- I'm not expecting to get some of the incentives as they are currently designed.

Amongst my colleagues, I sometimes have a reputation as a bomb thrower, but I usually won't come up with a criticism unless I have a suggestion. And so, I would consider spreading out the incentive payments percentage-wise to a larger number of clinics. I don't think you need to incentivize the lowest performing percentage, whether it's the

lowest ten percent or the lowest 30 percent. But I think the middle third consists of clinics like mine who are honestly trying to make the program work. And I don't necessarily think that I should get the same amount of incentive as a top ten percent clinic, but I think an adjusted amount ought to be considered.

If the numbers of incentive payments are accurate, from what I have been told, then we are talking about quite a significant amount of money that the department and the taxpayers of the state are investing in it, and I certainly applaud that. But as it is now, it's going to be the rich getting richer, the poor getting poorer, and the middle class getting poorer. So, I really would like to consider adjusting those percentages to incentivize those of us that are kind of in the middle. One reason that clinics like mine are in the middle is because we have several barriers, and they are outlined in the following comments. I'm across the street from a hospital that is using the rules and bending the rules and being dishonest with the rules as currently promulgated by Medicaid to create an income-generating center in the emergency room and their fast track version within the emergency room. I used to sit on the hospital board of my local small hospital, and I would hear financial reports over and over and over, year after year, that we are doing well as a small rural hospital because our lab and our x-ray in our ER is generating a lot of income. And when I got into it as a board member, it was because they were flaunting the rules. Several ways that they do that is, first of all, they market against supporting clinics. They have spent a large operating budget on marketing in radio and TV and billboards telling my patients that they will be seen within 30 minutes in the emergency room. And so, I have had people walk into my office at 2:00 o'clock on a Friday afternoon, look at how full it is, and walk out and go across the street to the emergency room. And I cannot stop that. So, I think that we really need to think about some policy changes to give me more control. Yes, I might make some people unhappy, but again, I'm in a private practice, I'm not a rural clinic, I'm not government-funded. And so, I want to keep my patients happy and receiving good care. My malpractice attorney friends see to it that I provide good care. And so, I don't think that a change would really harm the quality of care that much.

I had one mother tell me that the reason she likes to go to the emergency room for non-emergencies is, "I can get all the lab and all the x-rays that I think my child needs." Whereas we are known, as a clinic, I'm a board certified pediatrician, trained at the university in Memphis, and I was not trained to get every lab I can think of on every patient that shows up in my clinic sick, whether they have flu, whether they have pneumonia, or whatever. And as a result, because the screening policy of Medicaid as it is currently set up for emergency rooms allows an inexperienced moonlighting dermatologist in the ER to get all the lab and x-ray that he thinks is necessary. And, in fact, the software for my local hospital emergency room makes suggestions to the physician or the PA that is seeing the child on what labs and x-rays to get. You type in "abdominal pain" and a whole list comes up, and the majority of the time the inexperienced ER physicians get all of that, and it is covered under the guise of screening lab and imaging. Because, as one PA told me, "Doctor Patton, we have to do this to figure out if they are an emergency." And I said, "I respect that, but I'm telling you I don't need all that to decide if it's an emergency."

So, the hospitals outside of the major ones in the urban centers do not have an incentive to triage appropriately. In other words, they triage as many of their patients as they can as emergent. And their attitude in their Billing Department is they look at it like being a white collar tax cheat, "I'm cheating on my taxes every year, but I only got caught one year. But think of those nine years that I got away with it." And so, as a result, there is an inadvertent incentive to get more lab, to classify things as emergency when they are not. A less educated population tends to use the ER more even when the clinic educates them and is open, which we have tried to do. My suggestion on that is to consider an incentive for both the ER and for patients for not using the ER for non-emergencies. It's not as radical as it sounds. Many programs that have been funded by grants are paying young teenage mothers to not get pregnant. And I cannot quote statistics, but they seem to be helping. Again, anything we can do at an administrator level to give us the tools to help us succeed in the rural areas will help. And then, of course, the opposite is to consider disincentives for both ER and patients. One of the problems with the definition of an emergency currently under Social Security, I believe, is that an emergency is a medical condition that is judged by a prudent lay person to be an emergency. Well, is that prudent lay person the son of -- the daughter-in-law of a pediatrician who gets plenty of free advice, is that a prudent lay person, or is a prudent lay person a 16-year-old mother with her second child, raising the child by herself with no fund of health information, and, of course, then there are all sorts of in between. But again, the definition and the administrative policies kind of handicap us to make this successful, in my opinion. So, both incentives and disincentives should be considered, in my opinion. One thing about the prior manuals, if you will look at my "C", is that there was quite a bit of information sharing, in fact, I was asked to speak five years ago when the program first started because my cost per patient and my policies were felt to be in line with what PCMH was intending to do, and that I had been doing it for years. So, again, I'm not an expert in the true sense of the word, but I have a lot of experience. And so, we -- different clinics would go to PCMH meetings and we would say, "Well, how are you dealing with this outbreak of excessive ER usage?" "Well, we do this, this, and this." Now the clinics are competing against others. In other words, we are not trying to be the standard. This clinic is competing against this clinic to be in the top third to incentivize. There will be absolutely no sharing of best practices. And so far, our PCMH reps have been hesitant to give us more than general guidelines on best practices. But that information sharing is going out the window come January 1 because no clinic is going to help me improve if it kicks them out of the top third. It's another reason to expand the reward percentage of clinics. So, one obvious suggestion is to set a standard percentage like current metrics do for us to try to meet, that your ER utilization be, you know, like I say, in maybe the bottom 50 percent or less than "X" number of visits per year. Something like that we can hang our hat on and we can information share clinic to clinic on what we are doing to help that.

On "D", whereas adolescent wellness as an incentivized metric can mostly be controlled by us with getting kids in, doing wellness metrics when they come in for things they didn't realize would be a wellness. Like a sports physical, camp physical, we are gung ho about doing wellness visits any time we have the patient in, and then if they are on a refill protocol for something like AD/HD where they have to get medicine from us in order to be compliant, then we internally set up things like, "It's time for your AD/HD checkup,

and, oh, by the way, your wellness visit is due." So, we try not to miss opportunities. And I suspect most clinics trying to make it work are the same way. However, emergency room visits and admissions cannot be controlled by us. Current policy, if I'm correct, allows any admission from an emergency room to the hospital without a referral because it's an emergency; right? Well, that goes back to my definition that an emergency for a moonlighting dermatologist in a 40-bed rural hospital is not the same as an emergency for me or for an experienced pediatrician here at Arkansas Children's. Sometimes one of the problems of having, you know, monocular or tunnel vision when you are in central Arkansas is that the standard of care throughout the state is what Children's does. And that's obviously not correct. You know, they are way ahead of us in many ways. Their budget also allows them to have a lot of support people that we can't afford. And although we are grateful for the per member per month payments, some of which we use to get some help -- for example, I will probably be purchasing care management services from ACCN next year, in addition to services from my current AFMC rep. The bottom line is that the incentives are not going to help us do that unless we are in the top third. So, we cannot control who gets admitted if they go through the emergency room. We cannot control who goes to the emergency room except for education and/or for firing the patient from our practice.

One suggestion I heard from another clinic that I'm close enough to that we do information share is they are now sending letters to frequent ER utilizers, and the first one is a gentle reminder that, "Based on record review, two of your six emergency room visits in the last six months could have been handled in the office." One of the six we were actually open, and one more of the six was actually something they should have gone elsewhere for, like Children's or UT in Memphis. So, this policy could be fixed by a simple administrative change, and that's to require a referral from a PCP and PCMH, or all PCPs to submit a referral if someone wants to admit from the emergency room. Keeping in mind that all emergency rooms are not created equal and neither are the ER docs. I made a comment, indeed, that one doctor's emergency is another doctor's, "Go home and see you tomorrow." And I do that quite a bit. You know, I will get a call from the emergency room to request a referral for a non-emergency visit, which is very rare, by the way. I never get called by my local facility, I never get called by surrounding facilities 15 miles up the road in Wynne, 50 miles up the road in Jonesboro, and 40 miles south of me in Helena. So, between those four hospitals, I never get a call from them saying, "We have a non- emergency, do you want us to treat it?" They treat them, assume a referral, and then I get a list a week later that says, "Doctor Patton, will you approve these referrals for non-emergency care?" I routinely don't do it, but that doesn't mean they quit sending me the list. So, again, one recommendation would be to require referral for admission, whether it's ER or from a clinic. And "E", my local emergency room is one of these, they code an excessive number of visits as emergent because they are not on a hundred percent review and it's a revenue center for the hospital. And even if they feel like they got away with it the other time and made a lot of money. So, I would suggest taking some of these funds, which I have heard anywhere from $9 million to $13 million to $15 million that may be disbursed this next year, and using a little bit of that to get some extra reviewers to do more hundred percent reviews specifically for the ER utilization.

EXHIBIT F

My last two comments are more questions, which I, now that I know the routine, won't get answered, but I will say them anyway. The first is that the reports don't yet reflect where we stand on the metrics of admission, ER utilization, and adolescent wellness. We can guess from the raw numbers that are on the current report, but hopefully those will be forthcoming soon in 2019. And then, the manual's comment about excluding one patient per a thousand who is maybe an excessive utilizer. And of my top five, I know what that means, my top one has 39 ER visits this past year. They go to St. Jude, he has brain cancer, and so he will need a lot of care. And I am under no illusion that I need to restrict that unduly, but I don't know why the process at St. Jude is set up to see them in the emergency room this often. I get the feeling that maybe chemo is being administered outpatient but they are billing it as an ER rather than as a clinic visit. I can only tell you what fun it is to call the business office at a big facility like St. Jude and start asking questions. It is impossible to get a straight answer from a knowledgeable person. So, I personally think that the exclusion of one per thousand is unduly strict. I have about 15 patients that have been to the ER six times this past year, 15 that have been there seven times, and then quite a few that are three and four. And to me, that's still too many based on their problem list.

However, I do have ten that are high utilizers, and of the ten, I can only not explain why in two of them. In addition to my two kids with cancer, I have -- I'm in an area that's highly African-American, and so, I have five sickle cell children who frequently go to the emergency room to get pain relief because their only car is not available until 6:00 o'clock at night, so they cannot make it to the clinic. Even with Medicaid-paid transportation, if it's a non-emergency, you require 48 to 72 hours' notice to get a ride. And most of my uneducated, ill-informed low health information families do not use that transportation in a realistic way. If I certify them as an emergency, I can get them there the same day, but I have to know about the patient in order to certify it. And if an uneducated Medicaid mom with more than she can handle doesn't call me and say, "I really need to come to the clinic, but I can't get there," then I can't help them. So, I would consider increasing that exclusion to five to ten per a thousand. No big secret, I have a caseload, since my whole practice is Medicaid, essentially, of 3,000. So, under the current policy, that means I can exclude three high utilizers. So, I get to decide between the two cancer patients and my four sickle cell who I can exclude. So, I really think that number should be considered to go up. That's really all my prepared comments. And I didn't want to take up excessive time. But this just gives you a smattering of the concerns we have outside of the larger clinics. I know that physicians were involved in the input of some of this through, I believe, a governor-appointed group, I have been told. And, of course, there is always politics. I am a loyal Democrat, so I did not expect to get appointed to a group by a Republican governor. No hard feelings there, it's just a fact of life. But that does cut out a group of people who might have a different view from some of the people that did get appointed. Any time a group is set up by appointees, the outcome is pre-determined. For example, the Board of Medicine, three, four, five, six of their membership is appointed by the medical society. Now, you cannot tell me that the medical society does not control the medical board. So, that's not DHS' problem. I'm just using that as an example to say, the recommendations you get from advisors depends on who you appoint. And I must say, to quote one of my favorite movies, most physician advisers these days in the State of Arkansas are from a list of usual suspects, and it's the

same people over and over and over. People that don't have three colleagues, at least, like I have, never would have the time to come in and give their comments. So, the next time a major overhaul is made, maybe consider regional meetings. You still might not get a huge turnout, but at least you would hear some alternative ideas. That's all I've got.

Dr. Curt Patton, East Arkansas Children's Clinic
Written comments

Comment: 1. The program's design for 2019 is 2/3 of clinic will get no incentive payments. Consider a lesser amount for the middle 3rd to encourage at least a simple majority to get gain share.
Challenges:

A. Clinics near a small hospital have to compete with their "fast track" program for patients ("guarantee 30 min wait, all of the lab and x-rays mom wants, can go at night")
B. Less educated population tend to use ER more even when clinic educates them and is open.
   - Consider an incentive for hospital ER and/or patients for not using ER for non-emergencies.
   - Consider disincentives for both ER and patients.
C. Clinics competing against each other for any incentive means best practices will not be shared
   - One suggestion would be to set a standard percentage like current metrics for clinics to meet.
D. Whereas adolescent wellness can be controlled by the clinic, ER visits and admissions cannot be controlled by the clinic. Current ER policy allows any admission from an ER to be done without PCP referral.
   - One recommendation would be to change this policy to require a referral when admitted from ER. (One doctor's emergency is another doctor's "go home and follow up tomorrow").
E. Some emergency rooms code an excessive number of visits as "emergent" because they are not on 100% review and these visits are a revenue center for the hospital.
   - Consider spending some of the funds for extra reviewers to do more 100% reviews.

2. When will reports reflect our status of Inpatient Admission, ER Utilization and Adolescent Wellness compared to other clinics? Current reports only give us raw numbers without any ideas of where our current ranking is.
3. Excluding 1 patient per 1000 who is an "excessive utilizer" is excessively strict.
   - Consider an exclusion of 5-10 patients per 1000

Response: The Patient-Centered Medical Homes (PCMH) program appreciates your comments and concerns about the proposed 2019 Medicaid PCMH Manual. It is concerns expressed by providers like yourself that have been the driving force in the new proposed direction for PCMH.
Under the proposed 2019 PCMH Manual, Medicaid will potentially pay incentive payments to the top 35% of PCMH's in three independent measures (Emergency Room

Rates, Inpatient Stay Rates, Adolescent Wellness). Since each measure is independent of how a PCMH performs in each of the other measures, the potential is greater than 35% of PCMH's will be eligible for incentive payments. To give a comparison over how many PCMH's have receive incentive payments since the beginning of this program:

2014 24% of PCMH's received Shared Savings
2015 38% of PCMH's received Shared Savings
2016 7% of PCMH's received Shared Savings
2017 the trend seems to be following the same as 2016

We understand that there are obstacles that providers and clinics face when it comes to hospitalization. For that reason, ER Rates and Inpatient Rates will be risk adjusted based on attribution, regions, age of population and other factors that are unique to Arkansas. PCMH wants to make sure that all providers are on as equal of a playing field as possible.

We know that ER and Inpatient Stays will not be eliminated. The purpose of these measures are to possibly reduce the Non-Emergency ER visits, as well as catching some physical conditions before they require inpatient stays. We do this by tracking and rewarding those practices and PCP's that have voluntarily contracted and are participating in the Medicaid PCMH program.

Although it is true that this program will create a little competition amongst practices and providers, even after presenting these proposed changes to the provider community, over 300 of these same providers came together at the October 2018 CPC+ learning Session. During this session they discussed successes, obstacles, and ideas to improve in these same measures that they will also be competing in for incentive payment.

PCMH has released a new report this past October called the Provider Health Metric (PHM) Monthly Report. This will provide monthly data and updates on how a PCMH is performing in both Quality Metrics as well as Performance Measures tracked for Incentive Payments. This monthly report along with the quarterly PCMH report, a provider should be able to get a picture of how they are performing compared to other providers and their cohorts.

The Physician Exclusion of 1 patient per 1,000 has been part of the PCMH program from the beginning. This has always allowed a physician to exclude a patient that could adversely affect the performance of their clinic due to cost of care. With addition to this exclusion we also capped the cost of any individual beneficiary at $100,000, so that we could evaluate the provider on what they could control instead of what is out of their control. Likewise, in the new proposed manual for 2019 in addition to the physician exclusion of 1 patient per 1,000, we have added exclusions unique to each measure, as well as capping the number of ER visits to 12 per year, any additional visits over 12 per calendar year will not be counted against the provider.

EXHIBIT F

Kathryn Henry, an attorney with the Bureau of Legislative Research, asked the following question: What is the reason for the change from shared-savings incentive payments to performance-based incentive payments? **Response**: Shared Savings is paid based upon Total Cost of Care Methodology averaged out over the provider's annual attribution. Over time, this has proven difficult to sustain in a fair and reliable manner. Escalating pharmacy costs, changes to reimbursement for ambulatory surgery, fluctuation within the Medicaid population, creation of the PASSE program, and implementation of a new DHS medical information system have led to time consuming difficulties in editing and sustaining a fair and consistent measurement of the total cost of care for and enrolled PCMH. Performance based incentive payments will focus on areas that have statistically shown to have a high correlation to cost, such as inpatient stays and ER rates and reward the providers with lowest rates in these measures. Those with lower rates in these areas show to have lower average total cost of care than those with higher utilization rates. By encouraging providers to decrease these numbers it in return will decrease cost.

Per the agency, CMS is not required for the PCMH manual updates. There is a corresponding state-plan amendment, as to which CMS approval is required and currently is pending. The state-plan amendment, however, is being promulgated separately from the manual and is expected to be on the agenda at a later date.

The proposed effective date is January 1, 2019.

FINANCIAL IMPACT: The estimated savings for the current fiscal year is $7,725,000 ($2,271,150 in general revenue and $5,453,850 in federal funds) and $15,450,000 for the next fiscal year ($4,542,300 in general revenue and $10,907,700 in federal funds).

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 20-76-201, DHS shall administer assigned forms of public assistance, supervise agencies and institutions caring for dependent or aged adults or adults with mental or physical disabilities, and administer other welfare activities or services that may be vested in it. *See* Ark. Code Ann. § 20-76-201(1). DHS shall also make rules and regulations and take actions as are necessary or desirable to carry out the provisions of Title 20, Chapter 76, Public Assistance Generally, of the Arkansas Code. *See* Ark. Code Ann. § 20-76-201(12). Additionally, Ark. Code Ann. § 20-77-107(a)(1) specifically authorizes DHS to "establish and maintain an indigent medical care program." DHS and its various divisions also are authorized to promulgate rules, as necessary to conform to federal statutes, rules, and regulations as may now or in the future affect programs administered or funded by or through the department or its various divisions, as necessary to receive any federal funds which may now or in the future be available to the department or its various divisions. *See* Ark. Code Ann. § 25-10-129(b).

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 Tami Harlan

CONTACT PERSON Isaac Linam

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

PHONE NO. 501-682-8330 **FAX NO.** 501-404-4619 **E-MAIL.** Isaac.Iinam @dhs.arkansas.gov

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? PCMH-1-18 (Patient-Centered Medical Home) SPA 2018-013

2. What is the subject of the proposed rule? Effective January 1, 2019 Arkansas Patient-Centered Medical Homes will use performance-based incentive payments instead of shared savings incentive payments.

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 ☒

Does this repeal an existing rule? Yes ☐ No ☒

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.

Arkansas Code § 20-76-201, 20-77-107, and 25-10-129

7. What is the purpose of this proposed rule? The purpose of this rule, which is effective January 1, 2019, is to allow Arkansas Patient-Centered Medical Homes to use performance-based incentive payments on an annual basis. Performance-based incentive payments will be risk and time adjusted, dependent on the selected thresholds of cost utilization measures.

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: November 2, 2018

Time: 2:30-4:30 PM

Place: 7th and Main Street Conference Rooms A & B
Little Rock, AR.

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

November 6, 2018

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

January 1. 2019

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 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. At this point in time we are unaware if Physicians, Hospitals, and other Medicaid providers will be for this change or against this change.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Brian Jones

TELEPHONE 501-537-2064 **FAX** 501-404-4619 **EMAIL:** Brian Jones @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 PCMH-1-18 Patient-Centered Medical Home (PCMH); SPA 2018-013

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	0	General Revenue	0
Federal Funds	0	Federal Funds	0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total	0	Total	0

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	(2,271,150)	General Revenue	(4,542,300)
Federal Funds	(5,453,850)	Federal Funds	(10,907,700)
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	(7,725,000)	Total	(15,450,000)

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year **Next Fiscal Year**

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6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year
$ (2,271,150)

Next Fiscal Year
$ (4,542,300)

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7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
   (a) justifies the agency's need for the proposed rule; and
   (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(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.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Brian Jones

TELEPHONE 501-537-2064 **FAX** 501-404-4619 **EMAIL:** Brian Jones @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 PCMH-1-18 Patient-Centered Medical Home (PCMH); SPA 2018-013

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	0	General Revenue	0
Federal Funds	0	Federal Funds	0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total	0	Total	0

(b) What is the additional cost of the state rule?

Current Fiscal Year		Next Fiscal Year	
General Revenue	(2,271,150)	General Revenue	(4,542,300)
Federal Funds	(5,453,850)	Federal Funds	(10,907,700)
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	(7,725,000)	Total	(15,450,000)

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year	Next Fiscal Year

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	Next Fiscal Year
$ (2,271,150)	$ (4,542,300)

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
   (a) justifies the agency's need for the proposed rule; and
   (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(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.

Summary

2019 Patient-Centered Medical Home (PCMH) Manual

DMS is proposing the following changes to the 2019 PCMH Program Manual and SPA:

1. Remove definitions related to total cost of care and shared savings and add definition for Performance-Based Incentive Payments.
2. Define performance-based incentive payment methodology.
3. Define focus measure.
4. Define performance-based payment amounts.
5. Remove total cost of care calculations.
6. Reduce the number of weeks enrollment is open.
7. Clarify practice transformation payments.
8. Revise shared-savings incentive payments to performance-based incentive payments.
9. Decrease pool size to 1000.
10. Change savings to performance based.
11. Change per beneficiary cost to utilization measures and focus measures.
12. Add core measure requirement.
13. Replace shared savings with performance based and total cost of care with utilization rates.
14. Replace shared savings entities with performance risk entities.