EXHIBIT K

DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES

SUBJECT: Patient-Centered Medical Home 1-15 and Section V-8-15

DESCRIPTION: This rule changes and moves enrollment criteria and total cost of care calculation criteria to the APH website, and it removes a reporting requirement for a participating practice. It clarifies that dates, deadlines, definitions, attestation failure and validation failure, and prescriptive remediation timelines for both are included in the provider manual update.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on November 14, 2015. The Department received the following comments:

COMMENT: The Clarksville Family Medical Center (CFMC) voiced concern over the affects of Metric 1 of the new rule, specifically that it may hinder their ability to see their patients. Metric 1 states "Percentage of a practice's high priority beneficiaries who have been seen by any PCP within their PCMH at least twice in the past 12 months." CFMC asked that the wording be changed to any licensed provider rather than just a PCP.

RESPONSE: Arkansas Medicaid is aware of the workforce challenges in our rural state. Past assessments of Medicaid panels, however, indicated shortage areas for pediatrics only in the Sebastian County region of state. The PCMH program encourages use of health professionals to care for the preventive and chronic care needs of their Medicaid panels. Nurse practitioners and physician assistants are critical components of many busy, effective medical homes. Metric one specifically targets high priority patients with medical or social conditions that put them at risk for medical complications or increased resource consumption related to their health and functional status. Medical homes should organize their workflow to ensure that most of these high priority patients are seen and assessed by physicians twice a year as appropriate for their clinical status.

COMMENT: Arkansas Medical Society:
RE: Quality Metrics 9, 12, 13, 14, and 15. Do not add new Quality Metrics until DHS resolves the horrendous problems with Recipient Eligibility and Redetermination processes.

RE: State-wide Default Pool. Continue to measure per beneficiary cost of care and quality metrics of each PCMH in the default pool individually and not hold them responsible for the performance of all others in the default pool.

RE: Quality Metrics 10. Allow PCMH to enter the metric data in the physician portal on AHIN website or recommend that the PCMH use quality data generated by EHR. Also remove the benefit limit on required QM or not require extension of benefits for payment. We also recommend that the program use quality data generated by EHR or claims data on a month-to-month basis rather than 6 months behind.

RE: Metrics 3, 4, and 5. Include the NP individual Medicaid ID number in the numerator to capture the needed data for the EPSDT/wellness metrics. A referral is allowed and required when a PCP refers to another provider but a referral from a PCP to the ANP will not capture the services unless the ANP's Medicaid ID number is included in the algorithm for the metric.

RE: Review and approval of manual changes and updates. Form a Provider/Legislative board as oversight for the AR PCMH policies to replace the SAG meetings.

RE: Appeal and review process. Accept a reconsideration request before the end of the performance period. Allow PCMH's to request the reconsideration services when an issue appears on quarterly reports and have it corrected for the next reporting period.

RE: The shared savings model is unfair. Change the pool size to 1,200 instead of 5,000 to make Shared Savings possible for small practices.

RE: State-wide default pool. Within the State-wide Default Pool create pool groups with comparable benchmark costs for internal medicine, family medicine, and pediatrics.

RE: Section 214.000. Remove DMS retains the right to disallow the beneficiary removal form caseloads from PCMH manual.

RE: Practice Support Activity "L." Proposed verbiage: "Join SHARE or have the ability to obtain inpatient discharge information from hospitals."

RESPONSE:
Quality Metric 3,4, 5

Thank you for your comment concerning quality metrics for the 2016 Medicaid PCMH program. Arkansas Medicaid is aware of the workforce challenges in our rural state. Past assessments of Medicaid panels, however, indicated shortage areas for pediatrics only in the Sebastian County region of state. The PCMH program encourages use of health professionals to care for the preventive and chronic care needs of their Medicaid panels. Nurse practitioners and physician assistants are critical

components of many busy, effective medical homes. Metric one specifically targets high priority patients with medical or social conditions that put them at risk for medical complications or increased resource consumption related to their health and functional status. Medical homes should organize their workflow to ensure that most of these high priority patients are seen and assessed by physicians twice a year as appropriate for their clinical status.

Review and Approve Provider Manual Changes and Updates. (SAG)

The PCMH program will consider this for 2016, but replacing the Strategic Advisory Group would not be a solution. The SAG meetings keeps the providers informed of changes within the program monthly and allows the PCMH's to provide much needed feedback to assist the PCMH program in moving forward ending this meeting could hinder the providers in pursuing the what is required to function within the PCMH Program. DMS will keep minutes of the SAG meetings and present them for review at each subsequent SAG meetings. DMS will also post SAG meeting minutes at the APII website.

Appeal and Review Process Verification of an appeals process and review oversight

Current Reconsideration and Appeals process are as followed:

How and When to Request Reconsideration
The Division of Medical Services must receive written request for reconsideration within (30) calendar days of any adverse decision/action from the Division of Medical Services PCMH unit. Send your request to the Director, Division of Medical Services P.O. Box 1437, Slot S401, Little Rock, Arkansas, 72203

How and When to Request an Administrative Appeal (per Section 160.000 of the Arkansas Medicaid Manual)

The Arkansas Department of Health must receive a written appeals request within (30) calendar days of an adverse decision/action, or within (10) calendar days of receiving a reconsideration decision. Requests must be in writing and include:

1. A copy of the letter or notice of adverse decision/action

2. Additional documentation that supports medical necessity

Administrative reconsideration does not postpone any adverse action that may be imposed pending appeal. Send your request to Arkansas Department of Health: Attn: Medicaid Provider Appeals Office, 4815 West Markham Street, Slot 31, Little Rock, AR 72205.

In response to this comment the following language was added.

Providers who have concerns about information included in their reports should send an email to **PCMH@AFMC.org**. 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@HPE.com**.

APPEALS

If you disagree with the 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.

Request Reconsideration

The Division of Medical Services must receive written request for reconsideration within (30) calendar days of the Date of the adverse action, notice. Send your request to the Director, Division of Medical Services P.O. Box 1437, Slot S401, Little Rock, AR 72203.

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.

Share Savings Model Unfair

Thank you for your comment concerning the 5000 beneficiary requirement for the 2016 Medicaid PCMH program. At this time, Arkansas Medicaid is in the process of seeking approval from CMS to decrease this requirement for the 2017 PCMH Program year. At this time, we are unable to successfully implement this requirement for the 2016 PCMH program year, as the earliest possible approval date from CMS would be May 2016,

well after the January 1, 2016 proposed start date. DMS will collaborate with SAG to explore this option for 2017.

Quality Metrics 9, 12, 13, 14, 15

Currently these metrics are calculated as follows:
QM 9 URI measure: 94/115 performance currently above the target (data source EHR)
QM 12 Xanax measure: 89/111 performance currently above the target (data source EHR)
QM 13 BP monitoring (meaningful use specification, & data source is EHR)
QM 14 HbA1C poor control (meaningful use specification & data source is EHR)
QM 15 BMI (meaningful use specification & data source is EHR)

In response to the comment received, DMS will set quality metrics targets no higher than the average performance of shared savings entities for those metrics that have data available from the previous full calendar year (ex CY2014)

Statewide Default Pool

The proposed 2016 manual has been changed to reflect that Quality Metrics compliance in the default pool will continue to be assessed on the individual PCMH level.

This is something that AR PCMH Program will consider for 2017 but unfortunately we will not be able to implement this change in 2016. Panel size for eligibility for shared savings is a complex issue. Very small panels place a practice at risk for skewed costs because of one or two high-cost patients. Small panels also do not pass the scrutiny of actuaries to assure stability of performance and therefore proper rewarding of shared savings for actual effective clinical performance as opposed to random statistical noise. Our program was designed to be inclusive for smaller practices by allowing enrollment and upfront per member per month payments as long as the practice had 300 Medicaid patients and could meet performance expectations such as live voice coverage at night and on weekends. We liberalized the shared savings pooling requirements in the second year to allow for larger groups of clinics to work together on a medical home initiative. In many ways this larger pooling opportunity represented a "light" version of an ACO program. Some clinics entered into pooling arrangements but did not share data in 2014 and had difficulties in achieving a group success. Our program does not intend to micromanage how practices develop its staffing or implementation of

their medical homes – but we are interested in creating a broad framework that will result in more patient centered, effective care for Arkansas patients. We agree that clinics that voluntarily band together to work on their metrics and economic performance have a greater likelihood of success in achieving shared savings We continue to believe that the potential for shared savings will result in local and regional innovation and partnerships that will improve health care delivery in Arkansas.

Quality Metric

(a)PCMH is looking at using EHR metrics in future years as a means of collecting data, however many provider's EHR systems they are currently using are not as current enough, and to require this now we feel could cause undue expense on the provider. (Please see response #10) This will be continued to be looked at.

(b) This is an over-all Medicaid policy and outside the PCMH program and would be need to be further discussed from a Medicaid policy and legal.

(c) We are continuing to have discussions for regarding ways to obtain real-time data that will be beneficial to providers for practice transformation. We will continue to research these possibilities for the upcoming PCMH performance year.

DMS will adjust metric numerators and denominators when provided documentation of services that were not reflected in claims data and when relevant patients are no longer appropriately attributed to a specific PCMH panel.

Statewide Default Pool

This is something that AR PCMH Program could consider for 2017 but unfortunately we will not be able to implement this change in 2016. (Please see #6)

Section 214.000 PCP Caseloads

This provision was put into the PCMH manual because CMS expected CMS to have a provision which would prevent panel manipulation. The PCMH program has not exercised this right because we have not observed any problems which would cause us to invoke this provision. The suggested language was included in the PCMH manual.

Join Share Practice Support Activity L:

The suggested new language was added in the PCMH manual "Join Share or participate in a network that delivers hospital discharge information to your practice within 48hrs.

The proposed effective date is pending legislative approval.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Arkansas Code Annotated § 20-76-201 (12) gives the Department the general authority to "make rules and regulations and take actions as are necessary or desirable to carry out the provisions of this chapter and that are not inconsistent therewith."

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

DEPARTMENT/AGENCY Department of Human Services
DIVISION Division of Medical Services
DIVISION DIRECTOR Dawn Stehle
CONTACT PERSON Lech Matuszewski
ADDRESS PO Box 1437, Slot S295, Little Rock, AR 72203
PHONE NO. 501-320-6220 **FAX NO.** 501-404-4619 **E-MAIL** lech.matuszewski@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? Patient-Centered Medical Home 1-15 and Section V-8-15

2. What is the subject of the proposed rule? Moving total cost of care calculation criteria and enrollment criteria to the APII website and other date and definition clarifications.

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. _____

   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. _____

   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 Statute 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary? The purpose of the proposed rule is to change and move enrollment criteria and total cost of care calculation criteria to the APII website, and to remove a reporting requirement for a participating 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).
https://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.)
    November 14, 2015

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
    January 1, 2016

12. Do you expect this rule to be controversial? Yes ☐ No ☒
    If yes, please explain. _____

13. 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.

There should be no provider comment against this rule.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Lech Matuszewski

TELEPHONE NO. 320-6220 **FAX NO.** 404-4619 **EMAIL:** lech.matuszewski@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 1-15 and Section V-8-15

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

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**
$ $0	$ $0

There is no budget impact as the proposed changes have no impact on the cost of the program.

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 of PCMH 1-15 and Section V-8-15

To clarify that specific total cost of care calculations criteria and changes in enrollment criteria, will be posted separately on the APII website. Clarifications in dates, deadlines, definitions, attestation failure and validation failure, and prescriptive remediation timelines for both are also included in the provider manual update.