HEARING
IN THE MATTER OF
RULE 108
"PATIENT-CENTERED MEDICAL HOME STANDARDS"

BEFORE THE HONORABLE LENITA BLASINGAME
CHIEF DEPUTY COMMISSIONER AND HEARING OFFICER
ARKANSAS INSURANCE DEPARTMENT

HEARING PROCEEDINGS

OCTOBER 29, 2014

10:00 a.m.

REPORTED BY:
MICHELLE R. SATTERFIELD, CCR #570
1955 LITTLE RIVER DRIVE
CONWAY, ARKANSAS 72034
SATTERFIELD@CONWAYCORP.NET
(501)336-7414

A P P E A R A N C E S

BOOTH RAND
Managing Attorney
Arkansas Insurance Department Legal Division
1200 West Third Street
Little Rock, Arkansas 72201-1904

ZANE A. CHRISMAN
Associate Counsel
Arkansas Insurance Department Legal Division
1200 West Third Street
Little Rock, Arkansas 72201-1904

JOSEPH W. THOMPSON, MD, MPH
Arkansas Surgeon General

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(ALL EXHIBITS BOUND SEPARATELY & ATTACHED HERETO.)

HEARING OFFICER: All right. Today is October 29, 2014 and we're here in the matter of Proposed Rule 108, "Patient-Centered Medical Home Standards."

My name is Lenita Blasingame. I'm the Chief Deputy Commissioner for the Insurance Department and Commissioner Bradford has appointed me to be the Hearing Officer today.

Present at the counsel table is Ms. Zane Chrisman, Mr. Booth Rand and Dr. Joe Thompson.

Mr. Rand, you may proceed.

MR. RAND: Thank you, Ms. Hearing Officer.

Today we have set for an administrative hearing Proposed Rule 108, which is Patient-Centered Medical Home Standards. I'm going to a call it P-C-M-H so I don't have to keep saying that phrase.

I want to go ahead and admit into the administrative record a number of items that we have to submit to the legislature to qualify the rule to be promulgated first, and then what I propose to do, Ms. Hearing Officer, is then come back and explain what the proposed rule does and a little bit of a history with this rule because we've had to file it before and we had re-notice it, and then if you have any questions related to what the program is doing, how it's supposed to function, Dr. Thompson is here to address program

parameters and purposes of PCMH.

The first exhibit, Ms. Hearing Officer, is the Designation of the hearing Officer, which appoints you to hear this matter today at 10 a.m. by Commissioner Jay Bradford. That is Exhibit No. 1.

Exhibit No. 2 is the Arkansas Insurance Department's Notice of Public Hearing. Under statutory law under the APA Rule we're required to provide notice of public hearings related to rules. This was our notice setting today's hearing for 10:00 October 29th, 2014 for both Rules 108 and 106. We're taking up 108 here first because it went through the system over at the legislature faster and it had some more urgency.

Exhibit No. 3 is the proposed rule itself. Obviously we submit the actual proposed rule that we drafted as part of the record.

Exhibit 4 and items 4A through E are our communications to the Arkansas Democrat Gazette, which provides the Notice, which runs in the newspaper for three days to explain to the public when we're going to have a hearing on Rule 108.

Exhibit 4A is the confirmation from the Arkansas Democrat Gazette that the public notice for -- advising the public of the date of the hearing ran for three dates beginning on, I believe, September the 17th

for three days. I'll go through each of those if you want.

HEARING OFFICER: No, that's fine.

MR. RAND: Exhibit 4 shows the billing and notices and the nature and description of the notice that ran in the newspaper for those who were curious and want to see the notice that ran in the paper. It's in 4C.

Exhibit 5, Ms. Hearing Officer, as you know we send out e-mails of our rules that we're proposing to the members of the industry who have sent us notice that they want to be sent copies of rules that we proposed.

Exhibit 5 is evidence that we have generated from our records at the Legal Division by Ms. LoRraine Rowland of our staff showing that she distributed, by e-mail Blast System to the industry a copy of Rule 108.

Exhibit 6, Ms. Hearing Officer, as you know you're aware that when we file a rule the Arkansas Legislative Council requires us to file a number of items, including a cover letter, questionnaire, financial impact, a summary of the rule, economic impact. That's in Exhibit 6.

I mean, if you have questions over items or answers to questionnaires and questions in any of those I'll be glad to answer those, but those were submitted on

September the 15th, 2014 to the Legislative Council, to Ms. Davis and her staff.

Exhibit 7 is a copy of a letter which evidenced the enclosure of the proposed rule we sent to the Governor's office. As you know we advise other departments and agencies in the Governor's staff when we're doing rules. This is evidence that we have sent Mr. Miller, who is our contact at the Governor's Office, a copy of the rule.

Exhibit 8 is a copy of the letter that we sent the AG's Offices, which enclosed a copy of the rule advising the AG's Office of what we were doing with Rule 108.

Exhibit 9 is a copy of the rule and cover letter that we sent to the Arkansas Secretary State's Office showing -- giving them a copy of the actual proposed rule.

Exhibit 10, we are required by statute, also, to provide a copy of the proposed rule to the Arkansas Economic Development Commission, so that AEDC can review the impact, if any, on small businesses of the proposal rules.

Exhibit 11, Ms. Hearing Officer, are public comments that we have received about Proposed Rule 108. They are voluminous. There's probably 30 to 35 different

e-mails and letters that we received, comments from the public that we received from nurses and physicians and medical provider organizations about their opinions about the rule. That is in Exhibit 11.

I want to make sure, also, that we included back into this transcript of this administrative record, comments that we received from the medical organizations before 9/15. We did have a hearing on this issue on this on August the 5th. I wanted to make sure when this transcript of this hearing goes over to the legislature and the Legislative Council, that they can see all the comments that were made about the rule before we filed this second filing, so that they'll have a good idea of what -- of every one's opinion about it, because not everybody responded again after we refiled the second ruling.

I also included the transcript of the August 5th, 2014 hearing, which included the testimony and statements made on the record by a variety of persons in support of or in opposition of the rule as it was then, to give, again, a full and complete description of public comments made before we had to refile and after.

So at this time I move to admit those items into the administrative record.

HEARING OFFICER: Mr. Rand, are you

prepared to summarize the comments that we got?

MR. RAND: I will. I will say that we have reviewed each and every one of those e-mails. I can read all of those verbatim.

HEARING OFFICER: I think a summary will be adequate.

MR. RAND: And I apologize if I inadequately or inarticulately describe the comments from organizations that have submitted them, but the way I understand the general dynamics of the comments --

HEARING OFFICER: Let's admit these Exhibits 1 through 13 into the record.

(Exhibits 1-13 were admitted into the record and attached hereto.)

MR. RAND: There are three or four lines of comments made by a variety of medical providers and by the health insurers. Let me take the medical providers. Nurse practitioners, advanced nurse practitioners want a neutral definition of who the provider can be in the PCMH team model. The originally-filed rule that we had was a neutrally-defined, provider-led definition.

The physicians -- family physicians, the Arkansas Medical Society, and the Arkansas Family Practitioners Organization -- I'm sorry, I cannot recall. A-A-F-P, and other medical organizations, however, want

the PCMH team provider model leader to be a primary care physician or a physician. The arguments by the Medical Society and by physicians is their level of training and their ability to admit persons into hospitals and a variety of other scope parameters which are broader than advanced nurse practitioners, gives them a much more principal and significant role in the leadership of the PCMH team model, more so than the APN.

I'm not picking sides. This is just what the comments have been. The physicians certainly want nurse practitioners to be involved in the team, but in terms of leadership, they feel it's much better for the physician to actually be the team leader.

In addition to that, the current State Medicare Manual or PCMH, which is what Medicaid and the issuers are participating in currently require a primary care physician leadership role does not permit neutral or advanced nurse practitioners to operate as the lead team leader in PCMH.

So AMS and other medical organizations want us to be consistent with what is currently underway right now with the PCMH model, which is a primary care physician role or leadership role. The advanced nurse practitioners and nurses point out, quite accurately, that the progressive nature of these models and parameters is to

look towards an APN possibility with leadership in PCMH team models.

The NCQA model permits advanced nurse practitioners to be the leader in PCMH teams. There are some other accrediting organizations that recognize that as well. So the progressive interpretation is to permit a neutral definition. So there are -- I would say out of the 35, 40 comments that we've received after 9/15, most of them are this issue about whether a primary care physician should be the leader of the team, PCMH, or whether it should be neutral and it should allow carriers to designate advanced nurse practitioners.

So the doctors -- and, again, I don't mean -- there's much more articulated, better wording than what I'm saying, but the typical letter from the physician, is that they have a higher level of training and they have an ability to do things in terms of prescriptions and admission that gives them a much more pivotal role that needs to be a leadership role as opposed to a neutral definition.

The other line of comments that came back from the first hearing that we had on this, I think there was several objections or concerns that have been raised to the Department. One, is do we want PCMH to apply to only HCIP enrollees under the HCIP Act. Dr. Thompson and

I have taken the interpretation that if the issue is participating in the marketplace, they have agreed to apply PCMH to both in-market place enrollees -- I mean, all marketplace enrollees, not just HCIP enrollees.

Blue Cross Blue Shield, QCA point out that if you read the HCIP Act strictly, it says that PCMH must be supported for HCIP enrollees. We don't interpret it that way. Some of the other concerns -- I believe this is raised by the Bureau of Legislative Research. There is in this, Ms. Hearing Officer, a $5 support fee that the issuers have to provide providers who are agreeing to participate in PCMH for each enrollee per month and the question was raised with the Department -- of course, you're aware under the Arkansas Procedure Act that we've changed the Act, at least several sessions ago, that when agencies impose fees, they have to have a specific law that specifically and expressly authorizes that fee.

And if you look at HCIP or the Healthcare Independence Act, it does provide the Arkansas Insurance Department, and I believe ADHS with rule-making authority in general. It does not reference the support fee. And I think my response back to the bureau and legislature is that although the statute does not expressly permit this fee, this is not a typical fee that the Department is going out collecting from insurance agents or producers or

from insurance companies that go into general revenue. This is a fee that's optional that the carriers are having to pay providers, so it's not like we're going out collecting -- the Insurance Department increased agent fees or certificate of authority annual fees and we're absorbing that or collecting that out from the general revenue.

So I don't interpret the APA to apply for this particular fee. It is a voluntary fee for providers. Providers aren't required to do PCMH. This proposed rule makes it voluntary. For those who do, the support payment fee has to be made to providers based upon attributing enrollees. But the providers' participation is strictly voluntary. It's not just a fee that we typically go out and impose on the industry. We don't collect it and it's not sent to us.

So those have been some of the general comments that we have in the record, both before and after today's hearing. Again, I can read all of those, but I think the Commissioner and you have gone through some of these as well.

HEARING OFFICER: I've read them all.

Dr. Thompson, do you have any comments at this point?

DR. THOMPSON: I think Mr. Rand has

represented it well.

MR. RAND: Let me, Ms. Hearing Officer, explain some of the rule that we've done, if that's okay.

HEARING OFFICER: Surely.

MR. RAND: The 9/15/2014 proposed Rule 108 no longer is a neutral provider defined PCMH rule. It now requires the healthcare insurance company that's adopting PCMH to follow the state Medicaid PCMH Manual, therefore, because the state Medicaid PCMH Manual requires a primary care physician to be the leader of the PCMH, this rule will follow the state Medicaid Manual to make -- to require that the PCMH team leader is a primary care physician.

Now, that is the change that we have made to the previously followed rule. Other changes that we've had are not significantly that different from what we had before. The only significant change that we've made is the issue of a provider. We do believe, though, that -- and Dr. Thompson can speak to this -- we have some proposed edits to the recently followed rule to make it more clearer that we are relegating it to primary care physician leadership.

There are references throughout the rule, Ms. Hearing Officer, to "provider." And even though we tied the rule leadership to the state Medicaid Manual,

which is primary care physician, several physicians said it's still not clear. You've got the word medical provider throughout some of these sections and it doesn't say primary care physician.

No. 2, you've got a definition of primary care physician, but you don't ever use it in the rule. So I think our position on it was that if we require the insurance companies to follow the state Medicaid Manual on PCMH, we really didn't need to state the obvious, that it's primary care physician restriction, but we do propose to go back through where there is a reference to provider, to put in primary care physician. And we certainly do not, and are not intending in any way to suggest that nurses are not going to be involved in the team of care in this program.

That is one edit that we would like to make, is to go through, even from this proposed rule, and make it clear that when we use provider, we're talking about primary care physician. And Dr. Thompson can speak to -- we're also making a proposed amendment to Section 5B related to attribution.

Joe, if you'll talk about what we want to add there.

DR. THOMPSON: Sure. Two comments. First, before the additional attribution, it is not intended that

advanced practice nurses or physician assistants cannot be providers or the lead provider in primary care as a primary care relationship. It's that the team is led by a primary care physician. That's the Medicaid model, that's the Payment Improvement Model, and I think those are the changes that Mr. Rand is alluding to.

Separately, because it is a voluntary physician-led effort, we need a mechanism to actually attribute patients -- sorry, attribute enrollees to their primary care setting. We have been working with the three carriers and have agreement among the participating carriers for an attribution method that would standardize the approach across the carriers to make sure that the application of the rule is equally applied across the carriers and it would require -- it's under Subsection B, under Section 5, that states that health carriers will prospectively attribute qualified health plan enrollees to primary care practices either based on the enrollee's choice, which currently is not in place, or according to the plurality of visits.

Then there's an agreement among the carriers that that would happen on a quarterly basis to enable movement of enrollees between primary care providers to be appropriately allocated to their selected source of primary care.

So that's a new addition to the rule. I think it is -- it's been agreed to by the three carriers. It has the support of the clinical associations, and I think it standardizes the application in an area that there was some lack of specificity that this strengthens the applicability to the carriers through the process.

MR. RAND: And, Ms. Hearing Officer, we have the suggested edit to that section that Dr. Thompson raises in Exhibit 14 to Section 5B. It is underlined and we do anticipate deliberating with both you and the Commissioner to go through all these comments and edits so that you both can review it to see if those are needed amendments.

Dr. Thompson is right. We do not feel the amendment to Section 5B related to attribution is controversial or is significant or would require re-notification. It is an agreed to, non-controversial issue related to how enrollees are attributed.

So, again, just to go back through the basics of this rule, and we have not yet given a general description of it, but, Ms. Hearing Officer, as you know the legislature wants to advance the initiative of PCMH to save and reduce healthcare plan costs and to re -- to reignite or ignite provider payments to be based on medical outcomes that are achieved by providers, instead

of fee for service. And what this rule is essentially doing, is requiring carriers to offer the option of PCMH to providers. It's not mandating every provider and every network of the carriers have to do PCMH. Providers can voluntarily do PCMH if they want to. If they do, the carrier is agreeing to provide the support fees to help providers have the resources to do PCMH.

One of the reasons for this support fee is that -- and Dr. Thompson is much more articulate than me. There are resource requirements that are -- that could be -- require some expenses, medical records requirements, being open 24/7. There's a list of PCMH requirements that providers have to abide by to meet PCMH, and I think the fee is to help providers to develop the capacity to achieve these goals.

And the whole point of this isn't to -- just to do a fee for a fee. It's to help us reduce health plan costs, it's to help health insurance companies have better outcomes, and it's to improve patient care. And so this is a good thing we want to promote and I think it's kind of gotten lost in this issue over nurses versus physicians.

I mean, we certainly did not want to just get into that. The whole point of this is to try to improve healthcare for patients and to track outcome and

metrics, so that we know what we're doing is right and working in the exchange and marketplace.

HEARING OFFICER: Anything else, Dr. Thompson?

DR. THOMPSON: I would -- for the purpose of background, so the Arkansas Payment Improvement Initiative is a multi-payer effort to transform the Arkansas healthcare system. Participants include not only the carriers that would be affected by this rule, but also other carriers not participating in the marketplace, as well as public and private self-insured employers.

So this is a four-year process of which the Payment Improvement Initiative is showing positive impacts on improving the quality of care, the efficiency of care and containing the cost of care.

HEARING OFFICER: Okay. Anything further, Mr. Rand, before we hear from interested parties?

MR. RAND: No, Ms. Hearing Officer.

HEARING OFFICER: When I call your name, would you mind moving to the end of this table down here where this mic is and introduce yourself, any group that you're affiliated with, and if your name is like Blasingame, would you spell it, please?

All right. Jim Couch?

MR. COUCH: I'm only going to comment on

106.

HEARING OFFICER: All right. Victor, did you have comments?

MR. RAY: I'm with Mr. Couch.

HEARING OFFICER: Rule 106.

All right. Mr. Sewall?

MR. SEWALL: I think, Ms. Hearing Officer, you have the wrong list, or we all signed up for the wrong list.

HEARING OFFICER: This is 106. I do have the wrong sheet.

Mary Garnica, would you like to comment on 108?

MS. GARNICA: Yes, ma'am.

HEARING OFFICER: Okay. Would you please come forward?

MS. GARNICA: Sure.

HEARING OFFICER: Introduce yourself, spell your last name.

MS. GARNICA: I'm Dr. Mary Garnica. I am representing the Arkansas Nurses Association as their Health Policy Chair. My last name is spelled G-A-R-N-I-C-A.

HEARING OFFICER: Thank you. You may proceed.

MS. GARNICA: Okay. I am reading from the Arkansas Nurses Association's letter dated today, October 29th, 2014 to the Honorable Jay Bradford of the Arkansas Insurance Department regarding Rule 108 on Patient-Centered Medical Home Standards.

"Dear Commissioner Bradford: The Arkansas Nurses Association (ARNA) wishes to comment on the proposed Rule 108, "Patient-Centered Medical Home (PCMH) Standards." Specifically we're commenting in opposition to the changes made to the proposed rules issued on September 15, 2014. We believe that the original proposed rule issued May 13, 2014 more closely follows the General Assembly's intent to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers, A.C.A. 20-77-2402.

In effect the new rule eliminates the ability of advanced practice registered nurses (APRNs) to lead PCMHs and deliver much needed healthcare in an efficient and cost-sensitive manner.

This language is inconsistent with the provider neutral language in the Arkansas Healthcare Independent Act, A.C.A. 20-17-2106(d)(1), and the Department of Health and Human Services Section 1115, Demonstration Waiver. As you know, the PCMH is a national

concept of coordinated primary care and is already being carried out in Arkansas via the Comprehensive Primary Care Initiative (CPCI) funded by the Centers for Medicare & Medicare Services. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and a team leader in PCMH would expand the workforce, helping to alleviate access issues across the state.

Recognizing APRNs as team leaders in the PCMH follows model federal guidelines, national trends, recommendations from CMS, the National Centers for Quality Assurance, and the Institute of Medicine.

We believe the Arkansas Insurance Department should follow the intent of the General Assembly and directions of DHS and CMS by allowing APRNs to serve as PCMH team leaders for the Patient-Centered Medical Home.

Respectfully, Mary Garnica, DNP, FNP-BC, Chair, Health Policy Committee, Arkansas Nurses Association; Rhonda Finnie, DNP, APRN, AGACNP-BC, FNFA, President, Arkansas Nurses Association."

HEARING OFFICER: Thank you.

MS. GARNICA: You are welcome.

HEARING OFFICER: Mr. Laffoon?

MR. LAFFOON: I'm speaking on Rule 106.

HEARING OFFICER: Is there anyone else who

would like to comment on 108?

MS. BYRD: I've combined all my comments on 106 and 108 into one letter.

HEARING OFFICER: Okay. And your name is?

MS. BYRD: Darlene Byrd.

HEARING OFFICER: Okay. Did you sign in on a speaker sheet somewhere?

MS. BYRD: Yes.

HEARING OFFICER: Well, the other one appears to be blank, so we'll just -- when we get through with 108, anyone that wants to speak on 106, we'll give you an opportunity.

MS. BYRD: Okay.

HEARING OFFICER: Mr. Rand, do you have any closing remarks?

MR. RAND: I do not. And I have had the request, Ms. Hearing Officer, that we keep the record open for comments for another day.

HEARING OFFICER: Like 24 hours?

MR. RAND: Like until 5:00 tomorrow. How about that?

HEARING OFFICER: All right.

MR. RAND: If that's okay?

HEARING OFFICER: I have no objection to that.

MR. RAND: And I have no further comments.

HEARING OFFICER: Does anyone else have something?

If not, this hearing is adjourned. We'll take about a ten-minute recess and start with 106.

(WHEREUPON, at 10:34 a.m., the above hearing concluded.)

C E R T I F I C A T E

STATE OF ARKANSAS }
}
COUNTY OF FAULKNER}

RE: PROPOSED RULE 108-"PATIENT-CENTERED MEDICAL HOME STANDARDS

I, Michelle R. Satterfield, CCR, a Notary Public in and for Faulkner County, Arkansas, do hereby certify that the transcript of the foregoing public hearing accurately reflects the testimony given; and that the foregoing was transcribed by me, or under my supervision, on my Eclipse computerized transcription system from my machine shorthand notes taken at the time and place set out on the caption hereto.

I FURTHER CERTIFY that I am neither counsel for, related to, nor employed by any of the parties to the action in which this proceeding was taken; and, further that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially interested, or otherwise, in the outcome of this action.

GIVEN UNDER MY HAND AND SEAL OF OFFICE on this the 5th day of November 2014.

Michelle R. Satterfield, CCR
LS Certificate No. 570
Notary Public in and for
Faulkner County, Arkansas
Notary License #12369856

My commission expires: February 9, 2019.

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EXHIBIT LIST

DATE: **October 29, 2014**

SUBJECT: **PROPOSED RULE 108: "PATIENT-CENTERED MEDICAL HOME STANDARDS"**

HEARING OFFICER: **LENITA BLASINGAME, CHIEF DEPUTY COMMISSIONER & HEARING OFFICER**

EXHIBIT # DESCRIPTION

1 Designation of Hearing Officer

2 Arkansas Insurance Department 9-15-2014 Notice of Public Hearing concerning Proposed Rule 108 "Patient-Centered Medical Home Standards"

3 Proposed Rule 108 "Patient-Centered Medical Home Standards" Filed 9-15-2014.

4 Proof of Publication of Hearing on Proposed Rule 108 in the Arkansas Democrat-Gazette as required by Arkansas Administrative Procedures Act, Ark. Code Ann. §§ 25-15-201, *et seq.*

a) Email to Arkansas Democrat Gazette 9-15-2014
b) 9-15-2014 Cover Letter to ADG
c) Copy of ADG Notice
d) Copy of ADG Billing and Notice
e) Copy of ADG receipt

5 September 15, 2014 Evidence of Blast Mail concerning Proposed Rule 108 "Patient-Centered Medical Home Standards"

6 9-15-2014 ALC Cover Letter, Questionnaire and Financial Impact Statement for Proposed Rule 108 "Patient-Centered Medical Home Standards," Summary, and Economic Impact Statement.

a) Questionnaire
b) Financial Impact
c) Summary
d) Economic Impact

7 Copy of September 15, 2014 correspondence to James Miller, Regulatory Liaison, Office of the Governor, providing Notice of Public Hearing and Proposed Rule 108

8 Copy of September 15, 2014 correspondence to Brandon Robinson, Assistant Attorney General, Office of the Attorney General, providing Notice of Public Hearing and Proposed Rule 108

9 Copy of September 15, 2014 correspondence to Arkansas Secretary of State, providing copies of the Notice of Hearing and Proposed Rule 108

10 Copy of September 15, 2014 correspondence to Pat Brown, Arkansas Economic Development Commission, providing Notice of Hearing and a copy of Proposed Rule 108

11 Public Comments after 9-15-2014

12 Public Comments before 9-15-14

13 Transcript August 5, 2014 Hearing

MEMORANDUM

TO: Lenita Blasingame, Chief Deputy Commissioner

FROM: Jay Bradford, Insurance Commissioner

SUBJECT: Designation of Hearing Officer

DATE: October 28, 2014

Pursuant to Ark. Code Ann. §23-61-103(e)(1), I am delegating to you the duty of Hearing Officer in the matter of "Rule 108 Patient-Centered Medical Home Standards", on October 29, 2014 at 10:00 a.m., or any postponement thereof.

10-28-14

EXHIBIT

1

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

DATE: SEPTEMBER 15, 2014

TO: ALL ACCIDENT AND HEALTH INSURERS, HEALTH MAINTENANCE ORGANIZATIONS AND HOSPITAL AND MEDICAL SERVICE CORPORATIONS & OTHER INTERESTED PARTIES

FROM: ARKANSAS INSURANCE DEPARTMENT

SUBJECT: RULE 108: "PATIENT-CENTERED MEDICAL HOME STANDARDS"

NOTICE OF PUBLIC HEARING

Please find attached or available by electronic publication by the Arkansas Insurance Department ("Department") Proposed Rule 108, "PATIENT-CENTERED MEDICAL HOME STANDARDS." The Arkansas Insurance Commissioner ("Commissioner") is re-filing for public comment and public hearing, a proposed regulation governing patient-centered medical home programs for health care insurers issuing policies in the health insurance marketplace under Act 1498 of 2013 of the Arkansas Eighty-Ninth General Assembly, known as the "Health Care Independence Act of 2013."

Pursuant to Ark. Code Ann. §§20-77-2105(g)(1), 20-77-2106(e), 23-61-108(a)(1), 23-61-108(b)(1), and other applicable laws or rules, NOTICE is hereby given that a PUBLIC HEARING will be held on October 29, 2014, at 10:00 A.M., in the First Floor Hearing Room, Arkansas Insurance Department ("Department"), 1200 West Third Street, Little Rock, Arkansas.

The purpose of the Public Hearing will be to determine whether the Commissioner should adopt Proposed Rule 108, "PATIENT-CENTERED MEDICAL HOME STANDARDS."

All interested persons are encouraged to make comments, statements or opinions to the address below or attend the Public Hearing and present, orally or in writing, statements, arguments or opinions on the proposed Rule. All licensees and other interested persons are responsible for notifying all their personnel, agents, and employees about this Public Hearing.

Persons wishing to testify should notify the Legal Division as soon as possible, and are requested to submit intended statements in writing in advance.

Direct your inquiries to the Legal Division at (501) 371-2820 or insurance.legal@arkansas.gov.

A copy of Proposed Rule 108 can be obtained or viewed on the Legal Division's Internet Web Site at http://insurance.arkansas.gov/prop-rules.htm

Sincerely,

Booth Rand
Managing Attorney
Arkansas Insurance Department
(501) 371-2820

EXHIBIT
2

PROPOSED RULE 108
PATIENT-CENTERED MEDICAL HOME STANDARDS

Table of Contents

Section 1. **Authority**
Section 2. **Purpose**
Section 3. **Applicability & Scope**
Section 4. **Definitions**
Section 5. **Requirements**
Section 6. **Enforcement**
Section 7. **Effective Date**

Section 1. Authority

This Rule is issued pursuant to Section One of Act 1498 of 2013 of the Arkansas Eighty-Ninth General Assembly, also known as the "Health Care Independence Act of 2013" (hereafter, the "Health Care Independence Program," or "HCIP"), now codified in Ark. Code Ann. §§ 20-77-2401 et seq. Pursuant to Ark. Code Ann. § 20-77-2405(g)(1) and Ark. Code Ann. § 20-77-2406(e), the Arkansas Insurance Department ("AID") and Arkansas Department of Human Services ("ADHS") are authorized to issue Rules to implement provisions under HCIP. In addition, this Rule is issued pursuant to Ark. Code Ann. § 23-61-108(b)(1) which states that the Arkansas Insurance Commissioner ("Commissioner") has authority to promulgate rules and regulations necessary for the effective regulation of the business of insurance.

Section 2. Purpose

The purpose of this Rule is to provide standards for patient-centered medical home ("PCMH") programs for Health Carriers in the Health Insurance Marketplace which issue Qualified Health Plans ("QHPs") on or after January 1, 2015.

Section 3. Applicability & Scope

This Rule applies to all Health Carriers issuing QHPs in the Health Insurance Marketplace on or after January 1, 2015. Under Ark. Code Ann. § 20-77-2406(d), Health Carriers participating in the Health Insurance Marketplace are required to participate in in Arkansas Payment Improvement Initiatives ("APII") including: (1) Assignment of primary care clinician; (2) Support for patient-centered medical home; and (3) Access of clinical performance

data for providers. The HCIP requires Health Carriers to participate in the APII as multi-payer participants. This Rule requires Health Carriers to participate in PCMH standards as one active or available option in Qualified Health Plan networks on or after January 1, 2015. Additionally, these standards set a floor for participation and do not preclude Health Carriers from developing and implementing standards that exceed the requirements set forth in this Rule.

Section 4. Definitions

The following definitions shall apply in this Rule, unless otherwise defined by HCIP:

(1) "ADHS" means the Arkansas Department of Human Services;

(2) "AID" means the Arkansas Insurance Department;

(3) "APII" means the Arkansas Payment Improvement Initiatives, as referenced in Ark. Code Ann. § 20-77-2406(d), which is a multi-payer program that connects medical payment to medical providers to achieve high quality care at an appropriate cost;

(4) "Arkansas PCMH Model" means the PCMH provisions in Section 200 of the Arkansas Medicaid Provider Manual;

(5) "DMS" means the Arkansas Department of Medicaid Services under ADHS;

(6) "HCIP" means the Program established under Act 1498 of 2013 by the Arkansas State Legislature known as the "Health Care Independence Act of 2013";

(7) "Health Carrier" means a private entity certified by AID and offering plans through the Health Insurance Marketplace;

(8) "Healthcare coverage" shall mean healthcare benefits as defined under Ark. Code Ann. § 20-77-2404(4);

(9) "Health Insurance Marketplace" means the marketplace as defined by Ark. Code Ann. § 20-77-2404(5);

(10) "Qualified Health Plan" means an AID certified individual health insurance plan offered by a Health Carrier through the Health Insurance Marketplace;

(11) "QHP Enrollee" means a person insured under a Qualified Health Plan;

(12) "Patient Centered Medical Home" ("PCMH") means a "Patient Centered Medical Home" as defined under Section 200 of the Arkansas PCMH Model.

(13) "Primary Care Physician" means a "Primary Care Physician" as defined under Section 171 of the Arkansas PCMH Model.

Section 5. Requirements

For QHPs issued on or after January 1, 2015, Health Carriers shall adopt the following requirements and provide the opportunity for providers eligible to participate in the Arkansas PCMH model to participate in a PCMH program according to these standards:

(a) A Health Carrier shall follow the requirements of the Arkansas PCMH Model or may develop its own PCMH standards based upon an accepted national PCMH model, as approved by the Commissioner, to the extent that such provisions are consistent with and not in conflict with this Rule or the Arkansas PCMH Model.

(b) Health Carriers will prospectively attribute QHP enrollees to primary care practices either based on enrollee choice or according to the plurality of professional visits for primary care evaluation and management paid by the Health Carrier over the prior year. Health Carriers may develop their own method for attributing enrollees for whom coverage was discontinuous during the prior year;

(c) Notwithstanding the PCMH Model chosen by the Health Carrier in Section Five (5) (a) of this Rule, Health Carriers will offer practice support to primary care provider practices that have been identified by Medicaid as participating in the Arkansas PCMH model through the APII. Health Carriers may identify additional PCMH participants with at least three hundred (300) enrollees for inclusion in the Arkansas PCMH Model. Practice support will be provided in the form of care coordination payments equivalent to or greater than an average of five dollars ($5.00) per enrollee per month. Health Carriers may use a risk adjustment method of their choosing for determining the actual payment, so long as the average payment per enrollee is no less than five dollars ($5.00) per month;

(d) Health Carriers may terminate payment of practice support for provider failure to meet milestones or deadlines for practice transformation activities and benchmarks or targets for clinical quality. In order to minimize provider administrative burden and encourage meaningful data reporting, quality metrics collected and reported by Health Carriers must incorporate Arkansas PCMH model requirements;

(e) Health Carriers shall provide performance reports for PCMH practice transformation and quality on a quarterly basis. A standardized report form shall be made available to Health Carriers from the Arkansas Health Care Payment Improvement Initiative Web Site (www.paymentinitiative.org) and reporting should include total cost of patient care and care categories (not shown in referenced report);

(f) Health Carriers shall share statistics with AID or its designee(s) (output of analyzed claims data used to create above reports) for streamlined provider use at an aggregate multi-payer level;

(g) On or after January 1, 2016, Health Carriers should expect to participate in development of mechanisms to share savings with PCMH practices for achieving a per issuer enrollee cost of care that is below its benchmark cost.

(h) Health Carriers shall educate QHP enrollees about the Health Carrier's PCMH program and indicate which practices are participating in the program.

Section 6. Enforcement

AID shall review a Health Carrier's compliance with the provisions of this Rule in its role of recommending approval or non-approval for certification of qualified health plans sold in the Health Insurance Marketplace.

Section 7. Effective Date

The effective date of this Rule shall be January 1, 2015.

_____

JAY BRADFORD
INSURANCE COMMISSIONER

_____

DATE

LoRraine Rowland

From: Legal Ads <legalads@arkansasonline.com>
Sent: Monday, September 15, 2014 10:35 AM
To: LoRraine Rowland
Subject: Re: Proposed Rule 108 "Patient-Centered Medical Home Standards

Received and processed to begin on the 17th for 3 days.
Thanks
Pam

From: LoRraine Rowland
Sent: Monday, September 15, 2014 10:06 AM
To: 'Legal Ads (legalads@arkansasonline.com)'
Cc: LoRraine Rowland ; Booth Rand
Subject: Proposed Rule 108 "Patient-Centered Medical Home Standards

Please find attached the Department's Legal Ad for Proposed Rule 108. Please provide me with the dates this Rule will run.

Thank you,

LoRraine Rowland
Administrative Analyst/Legal Division
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201
501-371-2831 (office)
501-371-2639 (fax)
lorraine.rowland@arkansas.gov

"I have seeds in the ground and I am in a great place"

EXHIBIT
4A

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

September 15, 2014

Arkansas Democrat-Gazette
P O Box 2221
Little Rock, AR 72203
Attn: Ms. Pam Dicus, Legal Ad Department
Facsimile: 501-378-3591

RE: Legal Notices: Public Hearing on Proposed Rule # 108

Dear Ms. Dicus:

The Insurance Commissioner is proposing to adopt Rule 108, "Patient-Centered Medical Home Standards." In order to publish it per the Arkansas Administrative Procedure Act, as amended, and per the Arkansas Insurance Code, we need to publish a **FULL RUN** legal ad or notice on the Commissioner's Public Hearing for the Rule set on October 29, 2014 at 10:00 a.m.

In compliance with Ark. Code Ann. § 25-15-204 and § 16-3-102, please find enclosed a legal ad for Notice of Public Hearing which should be published for three (3) consecutive days beginning on June 30, 2014.

Please send the billing invoices to Mrs. Pam Looney, Assistant Commissioner, Accounting Division, Arkansas Insurance Department, 1200 West Third, Little Rock, Arkansas 72201-1904, accompanied by a printed copy of the Legal Ad and proof of publication. Thank you in advance for your cooperation.

Sincerely,

Booth Rand
Managing Attorney/Legal Division
booth.rand@arkansas.gov

LRR

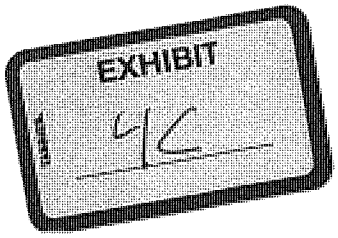
Attachment – Legal Ad for Proposed Rule 108 Adoption

cc: LoRraine Rowland, Administrative Analyst

EXHIBIT
48

NOTICE OF PUBLIC HEARING

The Arkansas Insurance Department will host a Public Hearing on October 29, 2014 beginning at 10:00 a.m. in the First Floor Hearing Room, Arkansas Insurance Department, 1200 West Third Street (Third and Cross Streets), Little Rock, Arkansas, to consider adoption of proposed Rule 108, "Patient-Centered Medical Home Standards." The Insurance Commissioner is re-filing for public hearing and comments a previously filed proposed Rule on Patient-Centered Medical Home Standards, due to proposed changes following a public hearing on August 4, 2014. Copies of proposed Rule 108 may be obtained by writing or calling the Arkansas Insurance Department, or may be accessed at http://insurance.arkansas.gov/prop-rules.htm or www.accessarkansas.org/insurance for links there. All interested persons are encouraged to make comments, statements or opinions to at the address above or attend the Public Hearing and present, orally or in writing, statements, arguments or opinions on the proposed Rule. For more information, please contact Ms. LoRraine Rowland, Legal Division, Arkansas Insurance Department at 501-371-2820.



Arkansas Democrat Gazette

STATEMENT OF LEGAL ADVERTISING

ARK INSURANCE DEPARTMENT
1200 W THIRD
LITTLE ROCK AR 72201

ATTN: Pam Looney
DATE : 09/19/14 INVOICE #: 2938261
ACCT #: L801001 P.O. #:

REMIT TO:
ARKANSAS DEMOCRAT-GAZETTE, INC.
P.O. BOX 2221
LITTLE ROCK, AR 72203

BILLING QUESTIONS CALL 378-3812

STATE OF ARKANSAS,)
COUNTY OF PULASKI,) ss.

I, Annette Holcombe do solemnly swear that I am the Legal Billing Clerk of the Arkansas Democrat - Gazette, a daily newspaper printed and published in said County, State of Arkansas; that I was so related to this publication at and during the publication of the annexed legal advertisement in the matter of:

HEARING

pending in the Court, in said County, and at the dates of the several publications of said advertisement stated below, and that during said periods and at said dates, said newspaper was printed and had a bona fide circulation in said County; that said newspaper had been regularly printed and published in said County, and had a bona fide circulation therein for the period of one month before the date of the first publication of said advertisement; and that said advertisement was published in the regular daily issues of said newspaper as stated below.

DATE	DAY	LINAGE	RATE	DATE	DAY	LINAGE	RATE
09/17	Wed	50	1.25				
09/18	Thu	50	1.25				
09/19	Fri	50	1.25				

TOTAL COST ---------- 187.50
Billing Ad #: 72807442

Annette M Holcombe

Subscribed and sworn to me this 19 day of Sept 20 14

Bennie J Fuller
Notary Public

OFFICIAL SEAL - # 12381354
BENNIE J. FULLER
NOTARY PUBLIC - ARKANSAS
PULASKI COUNTY
MY COMMISSION EXPIRES: 3-21-2021

NOTICE OF PUBLIC HEARING

The Arkansas Insurance Department will host a Public Hearing on October 29, 2014 beginning at 10:00 a.m. in the First Floor Hearing Room, Arkansas Insurance Department, 1200 West Third Street (Third and Cross Streets), Little Rock, Arkansas, to consider adoption of proposed Rule 108, "Patient-Centered Medical Home Standards." The Insurance Commissioner is re-filing for public hearing and comments a previously filed proposed Rule on Patient-Centered Medical Home Standards, due to proposed changes following a public hearing on August 4, 2014. Copies of proposed Rule 108 may be obtained by writing or calling the Arkansas Insurance Department, or may be accessed at http://insurance.arkansas.gov/prop-rules.htm or www.accessarkansas.org/insurance for links there. All interested persons are encouraged to make comments, statements or opinions to at the address above or attend the Public Hearing and present, orally or in writing, statements, arguments or opinions on the proposed Rule. For more information, please contact Ms. LoRraine Rowland, Legal Division, Arkansas Insurance Department at 501-371-2820.
72807442f

RECEIVED
SEP 22 2014
ACCOUNTING
ARKANSAS INSURANCE DEPARTMENT

EXHIBIT
40

Arkansas Democrat Gazette

STATEMENT OF LEGAL ADVERTISING

ARK INSURANCE DEPARTMENT
1200 W THIRD
LITTLE ROCK AR 72201

ATTN: Pam Looney
DATE : 09/19/14 INVOICE #: 2938261
ACCT #: L801001 P.O. #:

REMIT TO:
ARKANSAS DEMOCRAT-GAZETTE, INC.
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BILLING QUESTIONS CALL 378-3812

STATE OF ARKANSAS, }
COUNTY OF PULASKI, } ss.

I, Annette Holcombe do solemnly swear that I am the Legal Billing Clerk of the Arkansas Democrat - Gazette, a daily newspaper printed and published in said County, State of Arkansas; that I was so related to this publication at and during the publication of the annexed legal advertisement in the matter of:

HEARING

pending in the Court, in said County, and at the dates of the several publications of said advertisement stated below, and that during said periods and at said dates, said newspaper was printed and had a bona fide circulation in said County; that said newspaper had been regularly printed and published in said County, and had a bona fide circulation therein for the period of one month before the date of the first publication of said advertisement; and that said advertisement was published in the regular daily issues of said newspaper as stated below.

DATE	DAY	LINAGE	RATE	DATE	DAY	LINAGE	RATE
09/17	Wed	50	1.25				
09/18	Thu	50	1.25				
09/19	Fri	50	1.25				

TOTAL COST ---------- 187.50
Billing Ad #: 72807442

Subscribed and sworn to me this _____ day of _____, 20 _____

Notary Public

AD COPY

PLEASE REMIT THIS COPY WITH PAYMENT

IN ACCORDANCE WITH FEDERAL RESERVE GUIDELINES, CHECKS YOU SEND US FOR PAYMENT MAY BE PROCESSED ELECTRONICALLY. THIS MEANS CHECKS CLEAR FASTER AND BANK STATEMENTS ARE VALID PROOF OF PAYMENT.

EXHIBIT
4E

LoRraine Rowland

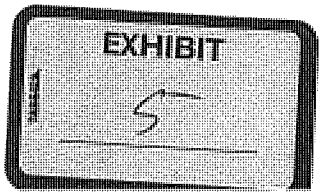
From: LoRraine Rowland
Sent: Monday, September 15, 2014 1:47 PM
To: LoRraine Rowland
Subject: E-Mail Scheduled

The following e-mail was successfully scheduled.

Subject: Proposed Rule 108 "Patient-Centered Medical Home Standards"

Message: Please click on the link below to view the Department's Proposed Rule 108 "Patient-Centered Medical Home Standards"
http://insurance.arkansas.gov/prop-rules.htm
Should you have questions regarding this Rule please contact the Legal Division at 501-371-2820 or via email @ insurance.Legal@arkansas.gov Sincerely,

Attachment: None



Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

September 15, 2014

HAND DELIVERY

Ms. Donna Davis
Arkansas Legislative Council
Arkansas Bureau of Legislative Research
State Capitol, Suite 315
Little Rock, Arkansas 72201

RE: Proposed Rule 108: "Patient-Centered Medical Home Standards"

Dear Ms. Davis:

Enclosed for your review and for filing with the Subcommittee of the Arkansas Legislative Council, is proposed Rule 108, "Patient-Centered Medical Home Standards."

The Arkansas Insurance Department ("Department") is re-filing for public hearing and comments a previously filed proposed Rule on Patient-Centered Medical Home Standards, due to proposed changes following a public hearing on August 4, 2014. We believe the changes the Commissioner wanted to make to the originally filed proposed Rule, following the administrative hearing, necessitate a new public hearing and comment period.

The proposed Rule establishes requirements related to patient-centered medical home programs for health care insurers issuing policies in the health insurance marketplace under the "Health Care Independence Act of 2013."

The Department has scheduled another public hearing for October 29, 2014, at 10:00 A.M., at the Arkansas Insurance Department, to consider adopting this proposed Rule.

I have enclosed a triplicate set of the proposed Rule, our Notice of Public Hearing, the standard Questionnaire, Financial Impact Statement as well as a summary of the proposed Rule.

Sincerely,

Booth Rand
Managing Attorney/Legal Division
booth.rand@arkansas.gov

cc: LoRraine Rowland, Administrative Analyst
cc: Jessica Sutton and Issac Linam, Bureau of Legislative Services

EXHIBIT
6

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

DEPARTMENT/AGENCY Arkansas Insurance Department
DIVISION Legal Division
DIVISION DIRECTOR Bill Lacy
CONTACT PERSON Booth Rand
ADDRESS 1200 West Third Street, Little Rock, Arkansas 72201
PHONE NO. 501-371-2820 **FAX NO.** 501-371-2639 **E-MAIL** booth.rand@arkansas.gov
NAME OF PRESENTER AT COMMITTEE MEETING (Booth Rand & Dr. Joe Thompson)
PRESENTER E-MAIL booth.rand@arkansas.gov

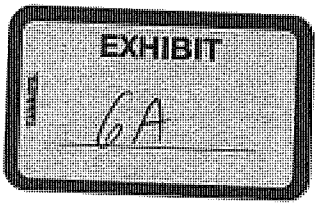
INSTRUCTIONS

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
Room 315, State Capitol
Little Rock, AR 72201

****

1. What is the short title of this rule?



Rule 108, "Patient-Centered Medical Home Standards"

2. What is the subject of the proposed rule?

The Arkansas Insurance Department ("Department") is re-filing for public hearing and comments a previously filed proposed Rule on Patient-Centered Medical Home Standards, due to proposed changes following a public hearing on August 4, 2014. We believe the changes the Commissioner wanted to make to the originally filed proposed Rule, following the administrative hearing, necessitate a new public hearing and comment period.

The proposed Rule establishes requirements for health insurers implementing patient-centered medical home programs (PCMH) under Act 1498 of 2013 of the Arkansas Eighty-Ninth General Assembly, also known as the "Health Care Independence Act of 2013" (hereafter, the "Health Care Independence Program," or "HCIP"), now codified in Ark. Code Ann. §§ 20-77-2101 et seq. HCIP requires all health insurers participating in the marketplace or exchange to "support" PCMH and to participate in the Arkansas Payment Improvement Initiatives (APII). The proposed Rule provides standards for insurers to use to offer PCMH to their medical providers (in primary care practices) desiring to participate in PCMH for qualified health plans (QHPs) issued on or after January 1, 2015.

A similarly proposed and numbered Rule was originally filed this summer with an August 4, 2011 hearing date. The Department held a public hearing on August 4, 2011 and decided to make changes in response to comments and concerns to the originally filed Rule. The currently proposed Rule has been changed to

defer the requirements of PCMH to the requirements in the Arkansas State Medicaid PCMH manual, and states that, although the health insurer may develop its own PCMH requirements following an approved national model, the health insurer must not adopt requirements in conflict with the State Medicaid PCMH Manual. The purpose of these recent changes is to avoid conflicts with the State Medicaid PCMH requirements. Under the proposed Rule, health insurers will provide the opportunity for providers to participate in a PCMH program conforming to the State Medicaid PCMH manual requirements, or to participate in an approved PCMH model approved by the Insurance Commissioner not in conflict with the Medicaid parameters.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes_____No __X__

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes_____ No__X__

   If yes, what is the effective date of the emergency rule? _____N/A_____

   When does the emergency rule expire? _____N/A_____

   Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? N/A Yes_____ No_____

5. Is this a new rule? Yes___X___ No_____ If yes, please provide a brief summary explaining the regulation.

Please find an attached Summary including a power point from ACHI (Arkansas Center for Health Improvement) explaining the background and objectives for this proposed Rule.

Does this repeal an existing rule? Yes_____ No__X__ 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__X__If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes.

6. Cite the state law that grants the authority for this proposed rule? If codified, please give Arkansas Code citation.

   Ark. Code Ann. § 20-77-2405(g)(1) and Ark. Code Ann. § 20-77-2406(e)

7. What is the purpose of this proposed rule? Why is it necessary?

   The purpose of the proposed Rule is to provide standards for health insurers to use to offer PCMH and payment enhancements to their medical providers (in primary care practices) desiring to participate in PCMH for qualified health plans (QHPs) issued on or after January 1, 2015. Under the proposed Rule, health insurers will provide the opportunity for providers to participate in a PCMH program conforming to the State Medicaid PCMH manual requirements, or to participate in an approved PCMH model approved by the Insurance Commissioner not in conflict with the Medicaid parameters. See attached Summary explaining the proposed PCMH Rule.

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). http://insurance.arkansas.gov/prop-rules.htm

9. Will a public hearing be held on this proposed rule? Yes__X__ No_____
If yes, please complete the following:
Date: October 29, 2014
Time: 10:00 a.m.
Place: Arkansas Insurance Department, First Floor Hearing Room

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

October 29, 2014 unless the Commissioner desires to keep the record open for more comments following the hearing. If we have significant medical provider or insurer disputes or concerns, we will keep the record open for as long as possible to consider everyone's comments or concerns.

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

As currently drafted on January 1, 2015.

12. Do you expect this rule to be controversial? Yes__X___ No ___ If yes, please explain.

Yes, see summary for more detail. The nursing community wants to be allowed to be designated as a lead provider in PCMH programs and wants a neutral definition of primary care provider in the Rule, to allow for nurse practitioners. The physician and especially family physicians in this State, including their organizations, e.g., Arkansas Medical Society, want the lead primary care provider to be a physician so as we have consistency with the Medicaid PCMH requirements. The originally filed Rule had a neutral provider definition, however after receipt of comments and concerns that a neutral definition conflicts with the State PCMH Model in Medicaid, we have agreed in this latest proposed Rule to change the Rule to comply with Arkansas Medicaid PCMH requirements. The State Medicaid PCMH model definition of PCMH restricts the lead provider in PCMH to be a "primary care physician."

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.

We expect the nurses and physicians to once again make public comments. We however do not know right now which specific groups or organizations will again comment for or against the Rule. We will be glad to update this information including providing Legislative Research with a transcript and copy of all comments made to the proposed Rule when we receive those comments.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT____Arkansas Insurance Department_____
DIVISION_____Legal Division_____
PERSON COMPLETING THIS STATEMENT_____Booth Rand_____
TELEPHONE NO.__371-2820__FAX NO.__371-2820__EMAIL: booth.rand@arkansas.gov

To comply with Act 1104 of 1995, please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE _____Rule 108, "Patient-Centered Medical Home Standards"

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes _____ No _____ Unknown. We have not calculated financial impact to health benefit plans subject to the proposed Rule in terms of premium rate or cost impact.

2. Does this proposed, amended, or repealed rule affect small businesses?
   Yes _____ No ___X_____

   If yes, please attach a copy of the economic impact statement required to be filed with the Arkansas Economic Development Commission under Arkansas Code § 25-15-301 et seq.

   The Economic Impact Statement is included in our filings.

3. If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.

We have not calculated any premium or plan rate impact this proposed Rule would or would not have, at this time. One of the goals of PCMH is reduction and control of medical costs which drive up the cost of health insurance.

4. If the purpose of this rule is to implement a federal rule or regulation, please give the incremental cost for implementing the rule. Please indicate if the cost provided is the cost of the program.

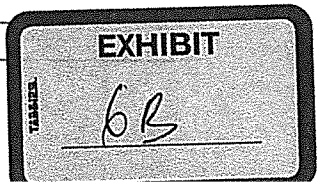
   We do not anticipate any costs to the Department or State in our implementation of this Rule.

Current Fiscal Year

General Revenue_____
Federal Funds_____

Next Fiscal Year

General Revenue_____
Federal Funds_____



Cash Funds_____
Special Revenue_____
Other (Identify)_____

Total_____

Cash Funds_____
Special Revenue_____
Other (Identify)_____

Total_____

5. What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule? Identify the party subject to the proposed rule and explain how they are affected.

N/A

Current Fiscal Year

$____N/A_____

Next Fiscal Year

$_____N?A_____

6. What is the total estimated cost by fiscal year to the agency to implement this rule? Is this the cost of the program or grant? Please explain.

N/A

Current Fiscal Year

$_____

Next Fiscal Year

$_____

_____
_____
_____

SUMMARY
PROPOSED RULE 108

"PATIENT-CENTERED MEDICAL HOME STANDARDS"

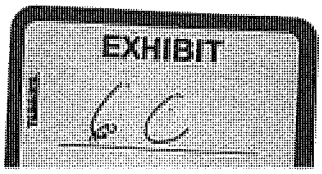
The proposed Rule establishes patient-centered medical home standards ("PCMH") for health insurers issuing policies in the marketplace or Exchange on or after January 1, 2015. Under Act 1498 of 2013, known as the Health Care Independence Act of 2013 ("HCIP"), health insurers participating in the marketplace are required to participate in the Arkansas Payment Improvement Initiative and are required to "support" PCMH.

PCMH is essentially a team-based treatment approach for patients who are insured in the marketplace and who typically may have chronic medical issues. The program is established at the primary care practice level, with a patient being assigned a team of medical providers who have the goal of tracking and reporting treatment for the purpose of achieving the most qualitatively and cost effective outcome. The program is designed to reduce medical costs and to improve medical care. Importantly, it also is designed to improve primary care provider reimbursement by providing payment incentives for providers following its requirements. It is also designed to improve and streamline primary care provider practices and enhance the patient's experience with medical providers due to the focused team approach placed on the patient.

We previously filed a similarly named and numbered Rule this summer and held a public hearing on August 4, 2014. The originally drafted and filed Rule used a neutral definition of primary care provider which did not require the "lead" medical provider to be a physician, this therefore permitted medical providers other than physicians to lead PCMH teams, e.g., nurses or nurse practitioners. This broader or neutral definition however conflicted with the State Medicaid PCMH manual which only permitted primary care physicians to lead PCMH.

In Section 200 of the PCMH Medicaid manual: Patient-Centered Medical Home (PCMH) is expressly defined to be "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."

In this current, latest amendment, to avoid conflicts with Medicaid and the only State model we have on PCMH which are already being followed by the insurers in pilot programs, the Department is simply taking the position that the PCMH programs of health insurers need to follow the State Medicaid PCMH requirements, and this may include the provider type which is required to lead the PCMH. Health insurers are however able to develop their own PCMH programs based on an approved other national model, as long as its requirements do not conflict with the State Medicaid PCMH manual.



As provided in the proposed Rule, PCMH is only required to be offered to providers by the health insurers on or after January 1, 2015, for plans issued in the marketplace on or after that date, as one active or available option, for providers desiring to participate in the program including payment incentives or shared savings.

ECONOMIC IMPACT STATEMENT OF PROPOSED RULES OR REGULATIONS

EO 05-04: Regulatory Flexibility

Department: *Arkansas Insurance Department*
Division: *Legal*
Contact Person: *Booth Rand*
Date: *9/15/2014*
Contact Phone: *501-371-2820*
Contact Email: *booth.rand@arkansas.gov*

Title or Subject:

Proposed Rule 108 "Patient-Centered Medical Home Standards"

Benefits of the Proposed Rule or Regulation

1. Explain the need for the proposed change(s). Did any complaints motivate you to pursue regulatory action? If so, please explain the nature of such complaints.

   The proposed rule is a re-filing of an earlier proposed rule pertaining to the same subject matter, following a public hearing held on August 5, 2014. The newly amended Rule now defers and follows the State Medicaid PCMH Manual.

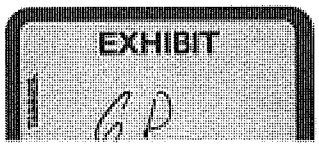
   Given that the needed changes to the originally proposed Rule, after the public hearing, were more than stylistic or cosmetic, we are re-noticing for public hearing an amended proposed Rule dealing with patient-centered medical home standards. Neither the new changes nor was the originally proposed rule derived from consumer complaints. The proposed Rule is needed to provide standards to health care insurers issuing policies in the "health insurance marketplace" which are participating in patient-centered medical home programs under Act 1498 of 2013 known as the Health Care Independence Program."

2. What are the top three benefits of the proposed rule or regulation?

   A patient-centered medical home program ("PCMH") is essentially a team-based approach to coordination of a patient's care, formed, established and accountable at the primary care practice level of the patient. The three best benefits of this program are:

   1. The program is designed to lower medical costs, improve health outcomes and track medical costs and utilization to lower overall insurance costs. The newly amended Rule now defers or follows the State Medicaid PCMH manual.
   2. The program is designed to also improve the patient's overall experience of medical care and improve his or her overall health due to the team-based focus for the patient. The program is designed to chart and track metrics to achieve a cost effective, qualitative positive health outcome.
   3. As part of the payment care improvement initiative, PCMH is designed to provide primary care practices with enhanced payments and to thereby reinvigorate PCP's revenue and take-home pay, and improve practice processes and workflows.

3. What, in your estimation, would be the consequence of taking no action, thereby maintaining the status quo?



Possible uncertainty as to the official regulatory standards health care issuers in the marketplace have to abide by for its providers to participate in PCMH. There is a need for clarification in the market for health insurers offering PCMH programs to its providers that they should follow and not conflict with the State Medicaid PCMH model requirements as a basis for developing their PCMH programs.

4. Describe market-based alternatives or voluntary standards that were considered in place of the proposed regulation and state the reason(s) for not selecting those alternatives.
Although we are aware that health care insurers may have already internally developed or implemented similar medical home or medical team coordination concepts to improve patient care and lower costs in the market, the proposed regulation is needed to set out our state-specific requirements if issuers and their providers want the State's payment improvement initiatives and shared savings. The Department believes the proposed Rule provides flexibility to issuers to use or develop their own PCHM or medical home standards or requirements, assuming the standards do not conflict with the State Medicaid PCMH model.

Impact of Proposed Rule or Regulation

5. Estimate the cost to state government of *collecting information, completing paperwork, filing, recordkeeping, auditing and inspecting* associated with this new rule or regulation.
None.

6. What types of small businesses will be required to comply with the proposed rule or regulation? Please estimate the number of small businesses affected.
None. The proposed Rule is applied to health care insurers in the health insurance marketplace and not applied to "small business owners."

7. Does the proposed regulation create barriers to entry? If so, please describe those barriers and why those barriers are necessary.
None.

8. Explain the additional requirements with which small business owners will have to comply and estimate the costs associated with compliance.
None.

9. State whether the proposed regulation contains different requirements for different sized entities, and explain why this is, or is not, necessary.
None.

10. Describe your understanding of the ability of small business owners to implement changes required by the proposed regulation.
The propose Rule does not require "small business owners" to implement provisions in the proposed Rule.

11. How does this rule or regulation compare to similar rules and regulations in other states or the federal government?
The proposed Rule is not derived from any organization model rule or law or other state law, however, we are aware that other States have implemented or are currently in the process of implementing similar PCMH or "medical home" programs.

12. Provide a summary of the input your agency has received from small business or small business advocates about the proposed rule or regulation.

The Department has not received input from small business per se about this proposed Regulation although has received substantial input from a variety of medical providers and insurers for and against the originally proposed Rule. Please see the Legislative Questionnaire about these comments.

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

September 15, 2014

VIA STATE MESSENGER

Mr. James Miller
Regulatory Liaison
Office of the Governor
State Capitol Building
Little Rock, AR 72201

RE: Arkansas Insurance Department Rule 108: "Patient-Centered Medical Home Standards"

Dear Mr. Miller:

Enclosed for your review is the Arkansas Insurance Department's proposed Rule 108, "Patient-Centered Medical Home Standards."

The Insurance Commissioner is re-filing for public hearing and comments a previously filed proposed Rule on Patient-Centered Medical Home Standards, due to proposed changes following a public hearing on August 4, 2014. The Arkansas Insurance Department ("Department") is proposing a Rule to establish requirements related to patient-centered medical home programs for health care insurers issuing policies in the health insurance marketplace under Act 1498 of 2013 of the Arkansas Eighty-Ninth General Assembly, known as the "Health Care Independence Act of 2013."

The Department has scheduled a public hearing for October 29, 2014, at 10:00 A.M., at the Arkansas Insurance Department, to consider adopting this proposed Rule.

Please do not hesitate to contact me at 371-2820 if you have any questions.

Sincerely,

Booth Rand
Managing Attorney/Legal Division
booth.rand@arkansas.gov

cc: LoRraine Rowland, Administrative Analyst

EXHIBIT
7

1200 West Third Street, Little Rock, AR 72201-1904 · (501) 371-2600 · (501) 371-2618 fax · www.insurance.arkansas.gov
Information (800) 282-9134 · Consumer Services (800) 852-5494 · Seniors (800) 224-6330 · Criminal Inv. (866) 660-0888

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

September 15, 2014

Mr. Brandon Robinson, ESQ.
Office of the Attorney General
323 Center Street, Suite 200
Little Rock, AR 72201

RE: Arkansas Insurance Department Rule 108: "Patient-Centered Medical Home Standards"

Dear Mr. Robinson:

Enclosed for your review is the Arkansas Insurance Department's proposed Rule 108, "Patient-Centered Medical Home Standards."

The Insurance Commissioner is re-filing for public hearing and comments a previously filed proposed Rule on Patient-Centered Medical Home Standards, due to proposed changes following a public hearing on August 4, 2014. The Arkansas Insurance Department ("Department") is proposing a Rule to establish requirements related to patient-centered medical home programs for health care insurers issuing policies in the health insurance marketplace under Act 1498 of 2013 of the Arkansas Eighty-Ninth General Assembly, known as the "Health Care Independence Act of 2013."

Please do not hesitate to contact me at 371-2820 if you have any questions.

Sincerely,

Booth Rand
Managing Attorney/Legal Division
booth.rand@arkansas.gov

cc: LoRraine Rowland, Administrative Analyst

EXHIBIT
8

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

September 15, 2014

Arkansas Secretary of State
State Capitol Building
Little Rock, AR 72201
Attn. Arkansas Register

Re: Rule 108, "Patient-Centered Medical Home Standards"

Dear Secretary:

Arkansas Act 1478 of 2003 adds to requirements for adoption and re-adoption of public agency rules and regulations. In that regard, the new Act:

(a) Requires notice of proposed Rule 108, as well as the Public Rule Hearing at the Arkansas Insurance Department, to be published by the Arkansas Secretary Of State on the Internet for thirty (30) days pursuant to Ark. Code Ann. § 25-15-218 of the Arkansas Administrative Procedure Act, as amended; and

(b) Requires DOI filing of its adopted and proposed rules and notices with the Arkansas Secretary Of State in an electronic format acceptable to the Secretary.

In that regard, the Department has scheduled a public hearing as to proposed adoption of Rule 108. Enclosed are the DOI Notices of Public Hearing and a copy of the proposed rule.

Please arrange to publish the information in a format acceptable to the Secretary for at least 30 days in advance. Can you send us confirmation that we can use in the transcript as a public hearing exhibit?

An electronic filing will be made within the statutorily required 7 days. Thanks for your help.

Sincerely,

LoRraine Rowland

LoRraine Rowland
Administrative Analyst/Legal Division
Lorraine.rowland@arkansas.gov
371-2820

Enclosures

EXHIBIT
4

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

September 15, 2014

Ms. Pat Brown
Economic Development Commission
One Capitol Mall
Little Rock, AR 72202

RE: Rule 108, "Patient-Centered Medical Home Standards"

Dear Ms. Brown:

Enclosed for your review is the Arkansas Insurance Department's proposed Rule 108, "Patient-Centered Medical Home Standards."

The Insurance Commissioner is re-filing for public hearing and comments a previously filed proposed Rule on Patient-Centered Medical Home Standards, due to proposed changes following a public hearing on August 4, 2014. The Arkansas Insurance Department ("Department") is proposing a Rule to establish requirements related to patient-centered medical home programs for health care insurers issuing policies in the health insurance marketplace under Act 1498 of 2013 of the Arkansas Eighty-Ninth General Assembly, known as the "Health Care Independence Act of 2013."

The Department has scheduled a public hearing for October 29, 2014, at 10:00 A.M., at the Arkansas Insurance Department, to consider adopting this proposed Rule.

Please do not hesitate to contact me at 371-2820 if you have any questions.

Sincerely yours,

LoRraine Rowland

LoRraine Rowland
Administrative Analyst/Legal Division
Lorraine.rowland@arkansas.gov
501-371-2831

Enclosures

ACR/

EXHIBIT
10

UnitedHealthcare
EMPLOYER & INDIVIDUAL
10 Cadillac Drive Suite 200
Brentwood, TN 37027
615 372 3614 fax 615 372 3640

October 28, 2014

Booth Rand, Senior Counsel
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

RE: Proposed Rule 108

Dear Mr. Rand,

Please consider this letter a record of written comments to Proposed Rule 108, Patient-Centered Medical Home Standards, on behalf of UnitedHealthcare ("UHC"). Thank you for the opportunity provided to carriers to submit comments prior to the hearing.

As you have set out in the proposed rules, Ark. Code Ann. § 20-77-2406(d), requires carriers who offer coverage to the expanded Medicaid population through the individual exchange Marketplace ("the Marketplace") to participate in certain Health Care Payment Improvement Initiatives including supporting patient-centered medical homes. The statute does not codify specific examples of what should be considered the required carrier support. The Department seeks to accomplish this statutory requirement by requiring Qualified Health Plans ("QHP"s) to meet the standards established in this proposed rule.

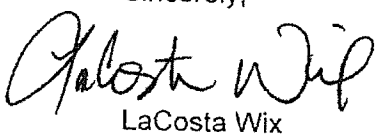
As a general comment, given that the Centers for Medicare and Medicaid Services' ("CMS") Comprehensive Primary Care Initiative ("CPCI") has not yet yielded meaningful results for 2013 and 2014, it seems premature to require carriers to adopt those practices at a state level. UHC recommends that the DOI give time for the lessons of the CPCI to become known before incorporating those models into the Marketplace. Delaying the implementation of these models until more is understood could prevent carriers from having to make costly and administratively burdensome changes in the future.

More specifically, UHC would like to make the following recommendations of changes to the Departments proposal:

- That the Department consider a provision that would allow the $5 PMPM care management fee be lessened over time as savings begin to be seen by the providers, as provider shared savings payments, and carriers alike.
- That it be specified that high risk case management be defined as a milestone for clinical quality, and that failure to meet that milestone be a reason a carrier may terminate practice support for that provider.
- That multi-payer aggregation be excluded as a provision of the program until more is learned about its value proposition.

If you have any questions about the comments above, or would like more detail on any of the recommendations, please feel free to contact me directly. Again, we appreciate the opportunity to comment. We hope this process can be collaborative in order to achieve the most beneficial outcome for Arkansas.

Sincerely,



LaCosta Wix
Director of Regulatory Affairs, MidSouth

FAX

To: Booth Rand

Fax Number: 501-371-2639

From: Dr. Byrd, APN

Number of pages (including cover sheet) 3

Comments: If you have any questions regarding my public comment feel free to contact me at 501-337-6652 (cell) or at dbyrd@apn-healthcare.com

APN HealthCare
B. Darlene Byrd, DNP, APRN, FAANP
14 Tahoe P.O. 1523
Cabot, Arkansas 72023
501-605-8110
dbyrd@apn-healthcare.com

October 29, 2014

Jay Bradford , Commissioner
Arkansas Insurance Department
12 West Third Street
Little Rock, AR 72201

Dear Mr. Bradford,

I'm Dr. Darlene Byrd, APRN. I appreciate the opportunity to express my concerns regarding Arkansas Insurance Department (AID) proposed rule 106 and 108. I understand that proposed rule 106 will set the definition and evaluation for insurance carriers to show they have an adequate provider network. A network, as stated in section 5 of rule 106 , "...that is sufficient in numbers and types of providers to assure that all health care services to covered persons will be accessible without unreasonable delay". Currently the state's major insurance carriers recognize APRNs as primary care providers. That being the case, we should be included, as we are, in the definition of adequate network and be counted as the primary care providers that we are. I would also point out that Arkansas Medicaid regulations recognize that APRNs provide primary care services.

Proposed rule 106 is in direct conflict with rule 108. First, there are conflicting definitions for patient centered medical homes (PCMH) between the rules. Second, in rule 106 the defination of "health care provider", "provider" and "primary care professional" are all neutual in their language while rule 108 the defination laguage is specific to physicians. Third, in Rule 106 APRNs are counted as primary care providers for the carrier to ensure an adequate provider network. However rule 108 ties the hands of APRNs and does not recognize APRNs as primary care providers or leaders of PCMH. Therefore on paper a carrier may have an adequate network but in reality they do not since rule 108 will limit access to APRNs and prohibit APRNs from fully practicing their profession as licensed by the state of Arkansas. It has the potential to injure and restrict the professional practice of APRNs. It further violates ACA 23-99-202 by violating the patient's right to choose their healthcare providers. It will disenfranchise patients from the benefits a patient centered medical home may provide when they choose to see an APRN exclusively or when the APRN is the only provider in their community. Therefore a carrier will not have an adequate network because access will be limited creating the potential for unreasonable delays to health care.

I have not been able to identify any specific federal/CMS rule that would prohibit APRNs from being leaders of a medical home. In fact all of the major PCMH certifying agencies recognize APRNs as leaders of the medical home. I do not believe the legislature intended to require the free market of insurance carriers to look and operate like Arkansas Medicaid as rule 108 prescribes.

Therefore I would encourage the commissioner to clear this conflict by returning to the original proposed rule 108, issued May 13, 2014, which follows the General Assembly's intent to maximize the available health care service and to promote healthcare efficiencies that will deliver value to the Arkansas taxpayers. The Insurance Department should produce rules that are consistent with the legislation and the legislator's declared intent. This would let the insurance carriers continue to use APRNs in their primary care provider counts to establish network adequacy and to determine who will be leaders of the patient centered medical home for their beneficiaries.

Thank you for this opportunity to share my concerns.

Sincerely,

Darlene Byrd APRN

Dr. Darlene Byrd, APRN
Family Nurse Practitioner

Email: Cynthia.Crone@Arkansas.Gov

From: Darlene Byrd [mailto:dbyrd@apn-healthcare.com]
Sent: Wednesday, September 17, 2014 9:30 AM
To: Cynthia Crone
Subject: Re: Public Comment Dates for 106 and 108

Thanks

Dr. Darlene Byrd, APN
APN HealthCare
Sent from my iPhone

On Sep 17, 2014, at 8:19 AM, Cynthia Crone <Cynthia.Crone@arkansas.gov> wrote:

> Fyi.
> Thanks, Cindy
>
> Cynthia C. Crone, APRN
> Deputy Commissioner
> Arkansas Insurance Department
> Arkansas Health Connector Division
> 1200 West Third Street
> Little Rock, AR 72201
>
> Phone: 501-683-3634
> Fax: 501-371-2629
> Email: Cynthia.Crone@Arkansas.Gov

From: Zane Chrisman
Sent: Wednesday, September 17, 2014 7:21 AM
To: Cynthia Crone
Subject: RE: Public Comment Dates for 106 and 108

It will be from now until the hearing. She can also come to the hearing to make comments then as well.

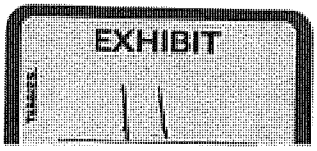
From: Cynthia Crone
Sent: Tuesday, September 16, 2014 10:26 PM
To: Zane Chrisman
Subject: Fwd: Public Comment Dates for 106 and 108

Do you know the answer to this? Cindy

Sent from my iPhone

Begin forwarded message:

> **From:** Darlene Byrd <dbyrd@apn-healthcare.com>
> **Date:** September 16, 2014 at 2:25:20 PM CDT
> **To:** Cynthia Crone <Cynthia.Crone@arkansas.gov>
> **Subject: Public Comment Dates for 106 and 108**
>
> Cindy



Just saw the rule change. The notice for public hearing does not indicated to dates for the public comment period. Can you send me thse dates?

Thanks

Darlene Byrd, DNP, APN, FAANP
APN HealthCare
14 Tahoe
Cabot, AR 72023
501-605-8110
dbyrd@apn-healthcare.com

Booth Rand

From: David Wroten <dwroten@arkmed.org>
Sent: Tuesday, September 23, 2014 10:01 AM
To: Booth Rand; Scott Smith; David Ivers
Cc: Sara Farris; Robert Wright; Mike Mitchell
Subject: RE: Proposed Rule 108

Dear Booth,
Please see the email below from Scott Smith. We are assuming the defined term should have been "primary care provider" which is defined as a primary care physician.

David Wroten

Executive Vice President

Arkansas Medical Society

501-224-8967 (office)

501-224-6489 (fax)

501-425-7735 (cell)

From: Scott Smith
Sent: Tuesday, September 23, 2014 8:49 AM
To: David Ivers; David Wroten
Cc: Sara Farris; Robert Wright; Mike Mitchell
Subject: RE: Proposed Rule 106

I have a question about the new proposed rule 108. In the definition section, there's a definition of "primary care physician" which is defined as a..."primary care physician." What? Think they meant to say "primary care provider" would be defined as a "primary care physician?"

I'm confused. Could someone call or e-mail Booth on that as well? I'm about to head to the Capitol.

Thanks.

Scott

Booth Rand

From: Cynthia Crone
Sent: Friday, September 26, 2014 12:11 PM
To: Booth Rand
Subject: FW: Public Comment Dates for 106 and 108

Cynthia C. Crone, APRN
Deputy Commissioner
Arkansas Insurance Department
Arkansas Health Connector Division
1200 West Third Street
Little Rock, AR 72201

Phone: 501-683-3634
Fax: 501-371-2629
Email: Cynthia.Crone@Arkansas.Gov

From: Cynthia Crone
Sent: Tuesday, September 23, 2014 10:25 AM
To: 'Darlene Byrd'
Subject: RE: Public Comment Dates for 106 and 108

Hello Darlene,
You requested CMS reference to Primary Care Physician . See below.
Thanks, Cindy

--- CMS Medical Home
according to the below ... definition refers to a physician
http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/demonstrations/fact_sheet.pdf
3-year demonstration providing reimbursement in the form of a care management fee to physician practices for the services of a "personal physician." The legislation directs CMS to use the relative values scale update committee (RUC) process to establish the care management fee codes for care management fees.
http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/demonstrations/demo_qa.pdf
The enabling legislation requires that Medical Home Providers must be MDs and DOs who are board certified. This does not preclude midlevel practitioners from participating under the auspices of a Medical Home Provider.

Cynthia C. Crone, APRN
Deputy Commissioner
Arkansas Insurance Department
Arkansas Health Connector Division
1200 West Third Street
Little Rock, AR 72201

Phone: 501-683-3634
Fax: 501-371-2629

Booth Rand

From: Cynthia Crone
Sent: Tuesday, September 30, 2014 1:41 PM
To: Booth Rand
Subject: RE: Proposed Rule 108

At your place? Cindy

Cynthia C. Crone, APRN
Deputy Commissioner
Arkansas Insurance Department
Arkansas Health Connector Division
1200 West Third Street
Little Rock, AR 72201

Phone: 501-683-3634
Fax: 501-371-2629
Email: Cynthia.Crone@Arkansas.Gov

From: Booth Rand
Sent: Friday, September 26, 2014 1:37 PM
To: 'S. Graham Catlett'
Cc: Cynthia Crone; Zane Chrisman
Subject: RE: Proposed Rule 108

See if Cindy is here, and or Zane. That's okay with me. I can meet with you without them, but I'd like Cindy involved in this.

From: S. Graham Catlett [mailto:gcatlett@catlaw.com]
Sent: Friday, September 26, 2014 12:57 PM
To: Booth Rand
Cc: Cynthia Crone
Subject: RE: Proposed Rule 108

Thank you.
How about Tuesday at 9am or 2pm?

Graham

----- Original Message -----
From: Booth Rand <booth.rand@arkansas.gov>
To: "'S. Graham Catlett'" <gcatlett@catlaw.com>
Sent: 9/26/2014 11:59AM
Subject: RE: Proposed Rule 108

Just come visit with me next week, but we might need Cindy and or Zane in this, I?m here all week, just set out a time, and schedule a time so we can get everyone together on this and talk about this.

From: S. Graham Catlett [mailto:gcatlett@catlaw.com]
Sent: Friday, September 26, 2014 11:33 AM
To: Booth Rand
Subject: RE: Proposed Rule 108

Booth

I am still having trouble understanding why the Insurance Dept is subordinate to the Medicaid Manual on determining who can be a Lead Provider.

Can we meet for a few minutes so I can understand your legal reasoning or do you have notes you can send me?

If you want to meet, I am available anytime in the next 2 weeks except Wed-Fri of next week.

Thanks,

Graham

----- Original Message -----

From: Booth Rand <booth.rand@arkansas.gov>

To: "'S. Graham Catlett'" <gcatlett@catlaw.com>

Sent: 9/08/2014 2:10PM

Subject: RE: Proposed Rule 108

Be glad to visit with you but would prefer to do so after we notice these changes back out.

Booth Rand

From:	Lonnie Robinson <lonrob89@suddenlink.net>
Sent:	Wednesday, October 08, 2014 9:45 PM
To:	Booth Rand
Cc:	dwroten@arkmed.org; 'Scott Smith'; 'arafp'; 'Knight, Daniel A'; jdrewdawson@yahoo.com; tommywwagner@yahoo.com; 'Julea Garner'; 'Dennis Yelvington'; rhayes1951@aol.com
Subject:	Proposed Rule 108
Importance:	High

REGIONAL FAMILY MEDICINE
630 BURNETT DRIVE MOUNTAIN HOME, AR 72653
PH: 870-425-6971 Fx: 870-508-8900

J. Gregory Elders, M.D. George S. Lawrence, M.D. Ronald F. Bruton, M.D. Lonnie S. Robinson, M.D.
Michael S. Hagaman, M.D. Lori M. Cheney, M.D. Ross E. Halsted, M.D. Andrea N. Bounds, M.D.
Christiana Marie Thompson C.N.P. Mary Burr C.N.P. Corinne Hiser C.N.P.

August 28, 2014

The Honorable Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201

RE: Proposed Rule 108, Patient Centered Medical Home Standards

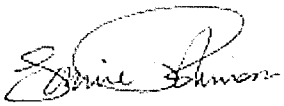
Dear Commissioner Bradford,

I am again writing to voice my support of physician-led Patient Centered Medical Home. I am in full agreement with the recent change in language of the rule, which specifically mandates physician leadership.

"Team-based" care is the cornerstone of a PCMH, but the primary role of leadership should remain the responsibility of a primary care physician. Physicians have the most extensive, broadest education with the highest level of training. Although crucial to these teams, limited-scope practitioners are not fully equipped to lead a team which must be able to provide care in a complex environment that requires consideration of numerous factors and circumstances.

Having a primary care physician leading a PCMH provides the highest quality of care possible, and is already a successful model being used in Arkansas. Medicaid standards for PCMHs recognize that physicians should be leading the team. The Arkansas Health Care Payment Improvement Initiative has set a clear statewide standard with physicians as the lead and is already working well. This standard should be followed to provide consistency, improve coordination and increase efficiency.

Sincerely,



Lonnie Robinson, MD, FAAFP

Past President, Arkansas Chapter AAFP
Alternate Delegate to the AAFP Congress of Delegates, Arkansas Chapter
Commissioner, AAFP Commission on Continuing Professional Development
Director of PCMH Transformation, Regional Family Medicine
Mountain Home, Arkansas

Booth Rand

From: FRANKLIN, SARAH <SFRANKLIN@uams.edu>
Sent: Thursday, October 09, 2014 2:30 PM
To: Booth Rand
Subject: Proposed Rule 108
Attachments: Medical Student Form Letter Proposed Rule 108.docx

I wanted to voice my support for the Proposed Rule 108.

Thank you,
Sarah

Sarah Franklin
College of Medicine
University of Arkansas Medical Science
MD Candidate, Class of 2016

Booth Rand

From: Teri Jeffers <terijeffers@gmail.com>
Sent: Tuesday, October 14, 2014 11:16 AM
To: Booth Rand
Subject: Proposed Rule 108

To The Honorable Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

RE: Arkansas Insurance Department Proposed Rule 108

Dear Mr. Commissioner,

I write to support Proposed Rule 108. Specifically, I support language that a primary care physician be the leader of the Patient Centered Medical Home. Physicians have the highest level training, and although other health care providers are integral to the team approach, their scope of practice is limited. Recognizing physicians as team leaders will provide the highest quality care for Arkansans.

I appreciate your time and consideration.

Sincerely,

Teri Jeffers, MD
Four Seasons Allergy and Asthma Clinic, PA
11614A Huron Lane
Little Rock, AR 72211
(501) 221-1956
fax (501) 219-2327

Ouachita Valley Family Clinic

A BAPTIST HEALTH AFFILIATE

353 Cash Road, 71701
PO Box 757, 71711
Camden, AR
870 836-8101
870 837-2329 (Fax)

Family Practice
Lawrence F. Braden, M.D.
Mark R. Crump, M.D.
William D. Dedman, M.D.
Amy S. DeLuca, M.D.
Erin Braden Goss, M.D.
Judson N. Hout, M.D.
Mimo Rose Lemdja, M.D.
Johnathan W. Lewis, M.D.
David H. Mosley, M.D.

Internal Medicine
William A. Daniel, M.D.
Joseph A. DeLuca, M.D.

Hospitalist
Eric Henriksen, M.D.
Rollin A. Wycoff, M.D.

General Surgery
Frederick H. Perkins, D.O.
Sam H. Arnold, D.O.

Pam Jennings, A.P.N.
Kim L. McCord, P.A.-C.

Members, Arkansas Health Group

October 14, 2014

The Honorable Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: Proposed Rule 108 – Patient Centered Medical Home

Dear Commissioner Bradford:

I support Rule 108 as proposed. Team based care should be lead by a physician because physicians have the most extensive education with the highest level of training.

The Arkansas Health Care Payment Improvement Initiative has set a clear statewide standard with physician leadership and it is working well. While mid level providers are important to the success of the team based approach, a physician should lead the team.

Sincerely,

David H. Mosley

David Mosley, M.D.

Ouachita Valley Family Clinic
A BAPTIST HEALTH AFFILIATE

353 Cash Road, 71701
PO Box 757, 71711
Camden, AR
870 836-8101
870 837-2329 (Fax)

October 14, 2014

The Honorable Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: Proposed Rule 108 – Patient Centered Medical Home

Dear Commissioner Bradford:

I support proposed Rule 108. Having a primary care physician lead the PCMH team provides the highest quality care and is already a model being successfully used in Arkansas. While mid level providers are important to the success of the care team, the team should be lead by a physician who is qualified to manage the requirements and challenges of this undertaking.

Sincerely,

Bill Dedman, M.D.

Ouachita Valley Family Clinic

A Baptist Health Affiliate

353 Cash Road, 71701
PO Box 757, 71711
Camden, AR
870 836-8101
870 837-2329 (Fax)

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Pam Jennings, A.P.N.
Kim L. McCord, P.A.-C.

Members, Arkansas Health Group

October 14, 2014

The Honorable Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: Proposed Rule 108

Dear Commissioner Bradford:

I support proposed Rule 108 addressing Patient Centered Medical Home Standards. While mid level providers are crucial to the team based care provided by a PCMH, the team should be lead by a physician who is qualified to manage the requirements and challenges of a PCMH.

Sincerely,

Erin Goss, M.D.

Ouachita Valley Family Clinic

A BAPTIST HEALTH AFFILIATE

353 Cash Road, 71701
PO Box 757, 71711
Camden, AR
870 836-8101
870 837-2329 (Fax)

October 14, 2014

The Honorable Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: Proposed Rule 108 – Patient Centered Medical Home

Dear Commissioner Bradford:

I support this rule and the language stating that a primary care physician should lead the PCMH team. While other providers are excellent at what they do and are an integral part of the care team, only physicians are qualified to manage the full range of challenges and requirements of the PCMH.

Sincerely,

Johnathan Lewis, M.D.

Ouachita Valley Family Clinic

A BAPTIST HEALTH AFFILIATE

353 Cash Road, 71701
PO Box 757, 71711
Camden, AR
870 836-8101
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Sam H. Arnold, D.O.

Pam Jennings, A.P.N.
Kim L. McCord, P.A.-C.

Members, Arkansas Health Group

October 14, 2014

The Honorable Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: Proposed Rule 108 – Patient Centered Medical Home

Dear Commissioner Bradford:

I support proposed Rule 108 and specifically support the language regarding primary care physician leadership. Although crucial to the success of the PCMH team, limited scope practitioners are not equipped to lead the team which must be able to provide care in various circumstances.

Sincerely,

Amy DeLuca, M.D.

Ouachita Valley Family Clinic

A BAPTIST HEALTH AFFILIATE

353 Cash Road, 71701
PO Box 757, 71711
Camden, AR
870 836-8101
870 837-2329 (Fax)

October 14, 2014

The Honorable Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: Proposed Rule 108 – Patient Centered Medical Home

Dear Commissioner Bradford:

I support proposed Rule 108. Having a primary care physician leading the PCMH provides the highest quality possible and is a model successfully being used in Arkansas. While other providers are important to the team concept employed in a PCMH, they do have limited scope of practice and the team is better served with physician leadership.

Sincerely,

Larry Braden, M.D.

October 18, 2014
The Honorable Jay Bradford
Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Dear Commissioner Bradford,

We, the members of the Independence County Medical Society are writing in support of the current, unambiguous language of Proposed Rule 108. As a society of specialists and primary care physicians, we recognize the linchpin of a patient centered medical home is "Team-Based" care. Primary care physician have the most extensive as well as the highest level of training, in relation to the goals of the patient centered medical home. Those of us who are specialists recognize our role in "Team-Based" care. Those of us who are primary care physicians, recognize our role as the leaders of these teams. Our goals are aligned, to protect and serve the citizens of the great state of Arkansas. Thank you for your lifetime of service to the same.

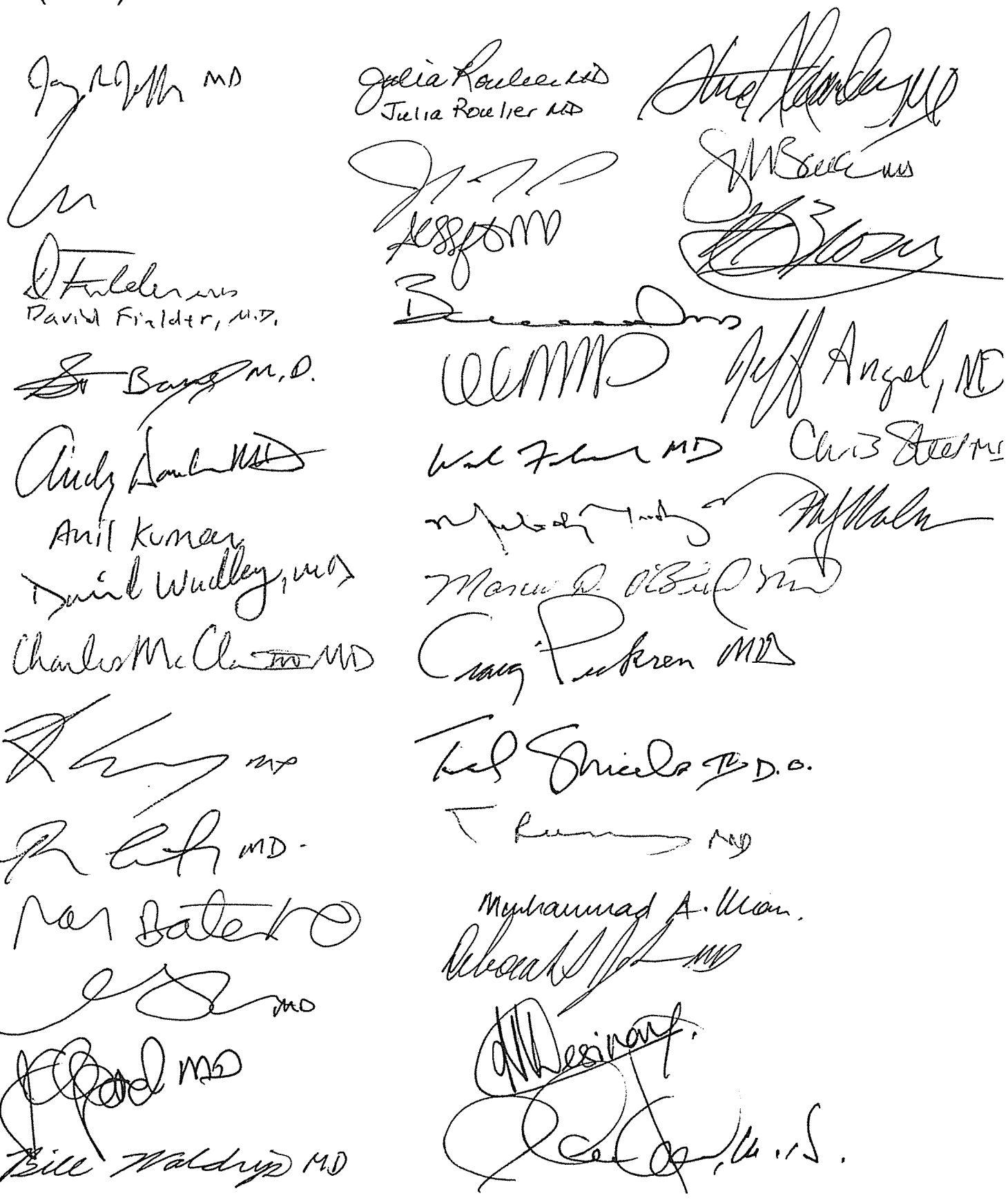
Sincerely yours,

Ron McCann MD

Independence County Medical Society

200 AGNUS DEI LANE DESHA, ARKANSAS 72527

Independence County Medical Society Physicians Supporting the language stating that a primary care physician should lead a Patient Centered Medical Home (PCMH)



The Arkansas Nurses Association (ARNA) wishes to comment on proposed Rule 108: "Patient Centered Medical Home ("PCMH") Standards."

Specifically we are commenting in opposition to the changes made to the proposed rule issued on September 15, 2014. We believe that the original proposed rule, issued May 13, 2014, more closely follows the General Assembly's intent to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. A.C.A. § 20-77-2402. In effect, the new rule eliminates the ability of advanced practice registered nurses ("APRNs") to lead PCMHs and deliver much needed healthcare in an efficient and cost sensitive manner.

This language is inconsistent with the provider neutral language in the Arkansas Health Care Independence Act A.C.A. § 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. As you know the, PCMH is a national concept of coordinated primary care and is already being carried out in Arkansas via the Comprehensive Primary Care Initiative ("CPCI"), funded by Centers for Medicare & Medicaid Services ("CMS"). In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in PCMHs, would expand the workforce, helping to alleviate access issues across the state.

Recognizing APRNs as team leaders in the PCMH follows model federal guidelines, national trends, recommendations from CMS, the National Centers for Quality Assurance and the Institute of Medicine. We believe the Arkansas Insurance Department should follow the intent of the General Assembly and directions of DHS and CMS by allowing APRNs to serve as PCMH team leaders.

I am an advanced practice registered nurse ("APRNs") licensed to practice in Arkansas and I am writing to oppose the current Insurances Department proposed Rule 108: "Patient Centered Medical Home ("PCMH") Standards."

As a healthcare provider, my foremost concern is for the wellbeing of my patients. My continued access to the largest possible pool of patients is in everyone's best interests. I know our legislators agree that we should strive to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The only way to achieve those goals is to allow advance practice nurses full access to patients so they can care for them to the extent of the nurses' scope of practice.

The changes made to the proposed rule issued on September 15, 2014 eliminates the ability of APRNs to lead PCMHs and deliver much needed healthcare in an efficient and cost sensitive manner. The original proposed rule, issued May 13, 2014, more closely follows the General Assembly's intent to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The Insurance Department should produce a rule that is consistent with the legislator's declared intent and allow APRNs to lead PCMHs.

Sincerely,

Kristi Jones APRN, MNS, FNP-BC

October 14, 2014

Arkansas Insurance Department
Attention: Booth Rand
1200 W. Third Street
Little Rock, AR 72201-2618

Dear Mr. Rand:

I am an advanced practice registered nurse ("APRN") licensed to practice in Arkansas and I am writing to oppose the current Insurance Department proposed Rule 108: "Patient Centered Medical Home ("PCMH") Standards."

As a healthcare provider, my foremost concern is for the wellbeing of my patients. My continued access to the largest possible pool of patients is in everyone's best interests. I know our legislators agree that we should strive to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The only way to achieve those goals is to allow advance practice nurses full access to patients so they can care for them to the extent of the nurses' scope of practice.

The changes made to the proposed rule issued on September 15, 2014 eliminates the ability of APRNs to lead PCMHs and deliver much needed healthcare in an efficient and cost sensitive manner. The original proposed rule, issued May 13, 2014, more closely follows the General Assembly's intent to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The Insurance Department should produce a rule that is consistent with the legislator's declared intent and allow APRNs to lead PCMHs.

Sincerely,

Mary Garnica, DNP, APRN, FNP-BC
Maumelle, Arkansas

The Arkansas Nurses Association (ARNA) wishes to comment on proposed Rule 108: "Patient Centered Medical Home ("PCMH") Standards."

Specifically we are commenting in opposition to the changes made to the proposed rule issued on September 15, 2014. We believe that the original proposed rule, issued May 13, 2014, more closely follows the General Assembly's intent to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. A.C.A. § 20-77-2402. In effect, the new rule eliminates the ability of advanced practice registered nurses ("APRNs") to lead PCMHs and deliver much needed healthcare in an efficient and cost sensitive manner.

This language is inconsistent with the provider neutral language in the Arkansas Health Care Independence Act A.C.A. § 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. As you know the, PCMH is a national concept of coordinated primary care and is already being carried out in Arkansas via the Comprehensive Primary Care Initiative ("CPCI"), funded by Centers for Medicare & Medicaid Services ("CMS"). In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in PCMHs, would expand the workforce, helping to alleviate access issues across the state.

Recognizing APRNs as team leaders in the PCMH follows model federal guidelines, national trends, recommendations from CMS, the National Centers for Quality Assurance and the Institute of Medicine. We believe the Arkansas Insurance Department should follow the intent of the General Assembly and directions of DHS and CMS by allowing APRNs to serve as PCMH team leaders.

I am an advanced practice registered nurse ("APRNs") licensed to practice in Arkansas and I am writing to oppose the current Insurance Department proposed Rule 108: "Patient Centered Medical Home ("PCMH") Standards."

As a healthcare provider, my foremost concern is for the wellbeing of my patients. My continued access to the largest possible pool of patients is in everyone's best interests. I know our legislators agree that we should strive to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The only way to achieve those goals is to allow advance practice nurses full access to patients so they can care for them to the extent of the nurses' scope of practice.

The changes made to the proposed rule issued on September 15, 2014 eliminates the ability of APRNs to lead PCMHs and deliver much needed healthcare in an efficient and cost sensitive manner. The original proposed rule, issued May 13, 2014, more closely follows the General Assembly's intent to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The Insurance Department should produce a rule that is consistent with the legislator's declared intent and allow APRNs to lead PCMHs.

Sincerely,

Melissa Bedford, APRN, MNSc, FNP-BC

2014

RECEIVED
OCT 21 2014
LEGAL
ARKANSAS INSURANCE DEPT

Rule 108 – A voice to support APRNs as PCMH "Team" leader role.

RETAIN PROVIDER NEUTRAL LANGUAGE

KATHERINE DARLING, DNP, PMHNP-C, FNP-C, APRN

An Opinion *against* the Changes to Rule 108 which would eliminate APRNs as "Team Leaders" of Patient Centered Medical Homes.

The Insurance Department proposed, in May, 2014, "provider neutral" language for Rule 108, the "Patient Centered Medical Home (PCMH) Standard. This original language would permit APRNs to lead PCMHs and would assure more options for essential healthcare delivery. This proposal from the Arkansas Insurance Department aligns with the General Assembly's intent to maximize limited resources and assure access to patient centered healthcare delivery. Additionally, the proposal for "provider neutral language" would promote the opportunity for Arkansas taxpayers to get more "bang for their buck".

The changes to the original proposal on September 15, 2014 would eliminate the ability for APRNs to lead PCMHs. While physician led PCMH appears to make sense, the reality is that the purpose for the PCMH is to coordinate and assure comprehensive care. It is a "model" for more efficient and cost effective healthcare delivery, where the "leader" and the "team" assure access to the available resources in the provision of comprehensive care. This model involves patients and their families in healthcare decision making, treatment, and will assure system integration and the measurement of critical outcomes. These are high level management and integrative services, not the actual delivery of care by the "leader" of the PCMH. The actual "care" delivered requires the expertise of varied healthcare professionals. The PCMH involves high level "case management" of individuals and "populations" of people within the context of the family and community. The bottom line for success of the PCMH is to prevent disease, promote health, and manage chronic conditions in a timely and cost effective manner, thereby reducing the need for inpatient and other costly services. When these healthcare outcomes are achieved, the burden of rising healthcare costs will be reduced. APRNs are experts in the coordination of care, promotion of health, and providing patient centered care. The APRNs background in providing this level of service on a smaller scale, their education, and their experience is suitable for "leading the team".

The following quote from the Agency for Healthcare Research and Quality (AHRQ) defines the medical or healthcare home as:

Defining the PCMH

> The medical home model holds promise as a way to improve health care in America by transforming how primary care is organized and delivered. Building on the work of a large and growing community, the Agency for Healthcare Research and Quality (AHRQ) defines a medical home not simply as a place but as a model of the organization of primary care that delivers the core functions of primary health care.
>
> The medical home encompasses five functions and attributes:
>
> 1. Comprehensive care
> 2. Coordinated care
> 3. Accessible services
> 4. Patient Centered Care
> 5. Quality and safety
> 6. Accessible services
>
> Retrieved 10/20/14 from: http://pcmh.ahrq.gov/page/defining-pcmh

The Arkansas Nurses Association (ARNA) wishes to comment on proposed Rule 108: "Patient Centered Medical Home ("PCMH") Standards."

Specifically we are commenting in opposition to the changes made to the proposed rule issued on September 15, 2014. We believe that the original proposed rule, issued May 13, 2014, more closely follows the General Assembly's intent to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. A.C.A. § 20-77-2402. In effect, the new rule eliminates the ability of advanced practice registered nurses ("APRNs") to lead PCMHs and deliver much needed healthcare in an efficient and cost sensitive manner.

This language is inconsistent with the provider neutral language in the Arkansas Health Care Independence Act A.C.A. § 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. As you know the, PCMH is a national concept of coordinated primary care and is already being carried out in Arkansas via the Comprehensive Primary Care Initiative ("CPCI"), funded by Centers for Medicare & Medicaid Services ("CMS"). In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in PCMHs, would expand the workforce, helping to alleviate access issues across the state.

Recognizing APRNs as team leaders in the PCMH follows model federal guidelines, national trends, recommendations from CMS, the National Centers for Quality Assurance and the Institute of Medicine. We believe the Arkansas Insurance Department should follow the intent of the General Assembly and directions of DHS and CMS by allowing APRNs to serve as PCMH team leaders.

I am an advanced practice registered nurse ("APRNs") licensed to practice in Arkansas and I am writing to oppose the current Insurance Department proposed Rule 108: "Patient Centered Medical Home ("PCMH") Standards."

As a healthcare provider, my foremost concern is for the wellbeing of my patients. My continued access to the largest possible pool of patients is in everyone's best interests. I know our legislators agree that we should strive to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The only way to achieve those goals is to allow advance practice nurses full access to patients so they can care for them to the extent of the nurses' scope of practice.

The changes made to the proposed rule issued on September 15, 2014 eliminates the ability of APRNs to lead PCMHs and deliver much needed healthcare in an efficient and cost sensitive manner. The original proposed rule, issued May 13, 2014, more closely follows the General Assembly's intent to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The Insurance Department should produce a rule that is consistent with the legislator's declared intent and allow APRNs to lead PCMHs.

From,

Lori Posey APRN

The Winston Clinic
508 Little Creek Cutoff
Sheridan AR 72150

Post-it® Fax Note 7671	Date 10.14.14	# of pages ▶ 1
To Booth Rand	From Judy	
Co./Dept.	Co.	
Phone #	Phone # 870.269.3838	
Fax # 501.371.2618	Fax # 870.269.6838	

JAMES E. ZINI, D.O.
PO BOX 1160
1816 EAST MAIN STREET
MOUNTAIN VIEW, AR 72560
October 14, 2014

RECEIVED
OCT 15 2014
LEGAL
ARKANSAS INSURANCE DEPT

The Honorable Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

RE: Arkansas Insurance Department Proposed Rule 108
Patient-Centered Medical Home Standards

Dear Commissioner Bradford:

I support Rule 108 as proposed with the language confirming that a Patient Centered Medical Home would be lead by a primary care physician.

Team-based care is the most effective way to serve patients but only physicians – D.O.s and M.D.s – have the highest level of training to effectively and efficiently manage the vast range of requirements (and challenges) that are brought forth by a Patient-Centered Medical Home. With each team member contributing their specific and specialized care, the physician-leader can insure that the PCMH can give to Arkansans a much needed global service.

Sincerely,

James Zini DO.

James E. Zini, D.O., F.A.C.O.F.P.

ARCARE

PO BOX 172
1310 N CENTER ST
LONOKE, AR. 72086
PH# 501-676-0181
Fax#870-569-3541

To: Arkansas Insurance	From: Lisa Dillon
Fax: 501-371-2018	Pages: 2
Phone:	Date: 10-15-14
Re:	cc:

Comments:

facsimile

I am an advanced practice registered nurse ("APRNs") licensed to practice in Arkansas and I am writing to oppose the current Insurance Department proposed Rule 108: "Patient Centered Medical Home ("PCMH") Standards."

As a healthcare provider, my foremost concern is for the wellbeing of my patients. My continued access to the largest possible pool of patients is in everyone's best interests. I know our legislators agree that we should strive to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The only way to achieve those goals is to allow advance practice nurses full access to patients so they can care for them to the extent of the nurses' scope of practice.

The changes made to the proposed rule issued on September 15, 2014 eliminates the ability of APRNs to lead PCMHs and deliver much needed healthcare in an efficient and cost sensitive manner. The original proposed rule, issued May 13, 2014, more closely follows the General Assembly's intent to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The Insurance Department should produce a rule that is consistent with the legislator's declared intent and allow APRNs to lead PCMHs.

Lydia Dillon APRN
501-278-1434
ldillon077@yahoo.com

ARCARE

PO BOX 172
1310 N CENTER ST
LONOKE,AR. 72086
PH# 501-676-0181
Fax#870-569-3541

To: Arkansas Insurance	From: Lisa Dillon
Fax: 501-371-2018	Pages: 2
Phone:	Date: 10-15-14
Re:	cc:

Comments:

facsimile

I am an advanced practice registered nurse ("APRNs") licensed to practice in Arkansas and I am writing to oppose the current Insurance Department proposed Rule 108: "Patient Centered Medical Home ("PCMH") Standards."

As a healthcare provider, my foremost concern is for the wellbeing of my patients. My continued access to the largest possible pool of patients is in everyone's best interests. I know our legislators agree that we should strive to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The only way to achieve those goals is to allow advance practice nurses full access to patients so they can care for them to the extent of the nurses' scope of practice.

The changes made to the proposed rule issued on September 15, 2014 eliminates the ability of APRNs to lead PCMHs and deliver much needed healthcare in an efficient and cost sensitive manner. The original proposed rule, issued May 13, 2014, more closely follows the General Assembly's intent to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The Insurance Department should produce a rule that is consistent with the legislator's declared intent and allow APRNs to lead PCMHs.

Lisa Dillon APRN
501-278-1434
ldillon077@yahoo.com

ARcare

615 North Main
Brinkley, AR 72021
Phone: 870-734-1150
Fax: 870-734-1179

FAX

Fax Transmittal Form

To: Commissioner Bradford
Fax: 501-371-2618
Phone:
Re: Rule 108
Date: 10-15-14

From: Courtney Marcott APRN
Fax:
Phone:
Pages: 2
CC:

Urgent
~~For Review~~
Please Comment
Please Reply

Message:

October 15, 2014

Dear Commissioner Bradford,

I am an advanced practice registered nurse ("APRNs") licensed to practice in Arkansas and I am writing to oppose the current Insurance Department proposed Rule 108: " Patient Centered Medical Home ("PCMH") Standards."

As a healthcare provider, my foremost concern is for the wellbeing of my patients. My continued access to the largest possible pool of patients is in everyone's best interests. I know our legislators agree that we should strive to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The only way to achieve those goals is to allow advance practice nurses full access to patients so they can care for them to the extent of the nurses' scope of practice.

The changes made to the proposed rule issued on September 15, 2014 eliminates the ability of APRNs to lead PCMHs and deliver much needed healthcare in an efficient and cost sensitive manner. The original proposed rule, issued May 13, 2014, more closely follows the General Assembly's intent to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The Insurance Department should produce a rule that is consistent with the legislator's declared intent and allow APRNs to lead PCMHs.

Sincerely,

Courtney Manatt, APRN

Courtney Manatt, APRN
Berryville, AR
PH (615-351-1939)

ARcare
406 Rodgers Dr.
Searcy, AR 72143
Phone 501-279-7979 Fax 501-305-3535
Clinic NPI 1861642985

FACSIMILE TRANSMITTAL SHEET

Booth Rand — TO
Linda McIntosh, APRN — FROM

501-371-2618 — FAX NUMBER
2 — TOTAL # OF PAGES (including cover)

501-305-3535 — PHONE NUMBER
RE: (patient's name)

☐ URGENT ☐ FOR REVIEW ☐ PLEASE REPLY ☐ SEND REPORT/RECORDS

NOTES/COMMENTS

cell 870-256-5265

Thank You
Linda McIntosh APRN

October 15, 2014

Arkansas Insurance Department
Attn: Booth Rand
1200 West Third Street
Little Rock, AR 72201-1904
OFF: 501-371-2820
FAX: 501-371-2618

Dear Mr. Rand:

I am an advanced practice registered nurse (APRN) licensed to practice in Arkansas and I am writing to oppose the current Insurance Department proposed Rule 108: "Patient Centered Medical Home (PCMH) Standards." I practice in rural Arkansas as a family nurse practitioner.

As a healthcare provider, my foremost concern is for the well being of my patients. My continued access to the largest possible pool of patients is in everyone's best interests. I know our legislators agree that we should strive to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The only way to achieve those goals is to allow advance practice nurses full access to patients so they can care for them to the extent of the nurses' scope of practice.

The changes made to the proposed rule issued on September 15, 2014 eliminates the ability of APRNs to lead PCMHs and deliver much needed healthcare in an efficient and cost sensitive manner. The original proposed rule, issued May 13, 2014, more closely follows the General Assembly's intent to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The Insurance Department should produce a rule that is consistent with the legislator's declared intent and allow APRNs to lead PCMHs.

Please keep the provider neutral language that will allow the APRNs trained and licensed in primary care to continue to care for their patients. If you have any questions or concerns; please call me or email me. 870-256-5265 cell or mcintoshsl@centurylink.net.

Sincerely,

L McIntosh, APRN

Linda McIntosh, APRN

644 Cain Road

Griffithville, AR 72060

870-256-5265 cell

Valley Health Services

Garry Stewart, M.D.

1545 Hogan Lane, Conway, AR. 72034 *Mail-P.O. Box 11349*
Ph: 501-513-1225 *Fx: 501-513-1228*

Fax Cover Sheet

Confidentiality Notice:
The information transmitted is intended only for the person or entity to which it is addressed and may contain confidential material. If you receive this material/information in error, please contact the sender and delete or destroy the material/information.

TO: Booth Rad **FROM:** Gary Stewart

FAX: 501 371-2618 **PAGES:**

Comments:

Garry Stewart, M.D.

P.O. Box 11349 • 1545 Hogan Lane • Conway, AR 72034 • Phone: 501-513-1225 • Fax: 501-513-1228

The Honorable Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

October 15, 2014

Dear Commissioner Bradford:

Thank you for your service to the citizens of Arkansas as Chairman of the Insurance Commission.

I am writing to encourage you to support Rule 108. As a primary care physician I lead my healthcare team through the kaleidoscope of regulatory and evidence based changes in the medical arena on a daily basis. This maze is of such great complexity that I fear limited scope practitioners fall short as desirable leaders for a Patient Centered Medical Home (PCMH). I have followed the concept of the patient Centered Medical Home from its inception. This concept is a natural extension of what a primary care physician does on a daily basis regardless. From the beginning, the primary care physician has been recognized by Organized Medicine and CMS as the obvious choice to lead the PCMH.

As it currently stands, there are too many hurdles to overcome to allow for limited scope of practice practitioners to accept this responsibility. Please take a moment and check the Novitis website (Arkansas's Medicare Administrative Contractor) for the number of advanced practice nurses that have taken the responsibility to enroll with Novitis as providers so that their services may be billed appropriately. You will find that number to be less than 16%. If these healthcare providers are not responsible enough to accomplish the most basic task necessary to provide care, enrollment, how will they rise to the magnanimous challenge of managing a 5000 patient medical panel.

Respectfully,

Garry Stewart MD
Diplomate American Board of Family Medicine

BIL

October 12, 14

Arkansas Insurance Department

ATTN: Booth Rand

1200 West Third Street

Little Rock, AR 72201-1904

To Whom It May Concern:

I am an advanced practice registered nurse ("APRNs") licensed to practice in Arkansas and I am writing to oppose the current Insurance Department proposed Rule 108: "Patient Centered Medical Home ("PCMH") Standards."

As a healthcare provider, my foremost concern is for the wellbeing of my patients. My continued access to the largest possible pool of patients is in everyone's best interests. I know our legislators agree that we should strive to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The only way to achieve those goals is to allow advance practice nurses full access to patients so they can care for them to the extent of the nurses' scope of practice.

The changes made to the proposed rule issued on September 15, 2014 eliminates the ability of APRNs to lead PCMHs and deliver much needed healthcare in an efficient and cost sensitive manner. The original proposed rule, issued May 13, 2014, more closely follows the General Assembly's intent to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The Insurance Department should produce a rule that is consistent with the legislator's declared intent and allow APRNs to lead PCMHs.

Sincerely,

Kimberly N. Carney DNP APRN 10/12/14

Dr. Kimberly Carney, DNP, APRN, FNP-BC, CDE

BR

WEST MEMPHIS
EYE
CENTER, P.A.

303 West Polk
West Memphis, AR 72301
(870) 732-2100
1-800-462-8859
FAX (870) 732-3027

G.E. Bryant, Jr. M.D.
OPHTHALMOLOGY
DIPLOMATE
AMERICAN BOARD OF OPHTHALMOLOGY

The Honorable Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: Arkansas Insurance Department Proposed Rule 108 (Patient-Centered Medical Home Standards)

I Support proposed Rule 108. Having a primary care physician leading a PCMH provides the highest quality of care possible and is already a successful model being used in Arkansas. Medicaid standards for PCMHS recognize that physicians should be leading the team. The Arkansas Health Care Payment Improvement Initiative has set a clear statewide standard with physicians as the lead and is already working well. This standard should be followed to provide consistency, improve coordination and increase efficiency.

G. Edward Bryant, Jr. M.D.

EyeMD OPHTHALMOLOGY

Laser, Surgery
& Medicine of

REGIONAL FAMILY MEDICINE
630 BURNETT DRIVE MOUNTAIN HOME, AR 72653
PH: 870-425-6971 Fx: 870-508-8900
J. Gregory Elders, M.D. George S. Lawrence, M.D. Ronald F. Bruton, M.D. Lonnie S. Robinson, M.D.
Michael S. Hagaman, M.D. Lori M. Cheney, M.D. Ross E. Halsted, M.D. Andrea N. Bounds, M.D.
Christiana Marie Thompson C.N.P. Mary Burr C.N.P. Corinne Hiser C.N.P.

The Honorable Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201

RE: Proposed Rule 108, Patient Centered Medical Home Standards

August 28, 2014

Dear Commissioner Bradford,

I am writing to add my voice to support of **physician**-led Patient Centered Medical Home. I am in full agreement with the recent change in language of the rule, which specifically mandates physician leadership.

As an active employer and trainer of Advanced Nurse Practitioners, I fully understand the strengths and weaknesses of these important team members. Only physicians have the depth and breadth of education to fulfill the role of team leaders in the Medical Home model.

Having a primary care physician leading a PCMH provides the highest quality of care possible, and is already a successful model being used in Arkansas. Medicaid standards for PCMHs recognize that physicians should be leading the team. The Arkansas Health Care Payment Improvement Initiative has set a clear statewide standard with physicians as the lead and is already working well. This standard should be followed to provide consistency, improve coordination and increase efficiency.

Sincerely,

John Gregory Elders MD
President/CEO, Regional Family Medicine
Mountain Home AR

COMPASS HEALTHCARE, LLC
COMPASS CONCIERGE HEALTHCARE, LLC

URGENT CARE | CONCIERGE FAMILY PRACTICE | OCCUPATIONAL HEALTH | AESTHETICS

2606 Pine Street
Arkadelphia, AR 71923
870-210-5243 Office
870-210-5287 Fax
Cassie Gonzales, APRN, CN
Alisha Ashley, APRN, CNP
R. Scott, Exum, MD
Sangeeth Samuel, MD

Date: 10/17/14

TO: Arkansas Insurance Dept

ATTN: Booth Rand

Fax Number: 501 371 2618

Phone Number: 870-210-5243

From: Alisha Ashley

Number of Pages (including cover): 2

Message:

FROM THE DESK OF

ALISHA ASHLEY, APRN

October 17, 2014

Alisha Ashley, MSN, APRN, CNP
Compass Healthcare, LLC
2606 Pine St
Arkadelphia, AR 71923

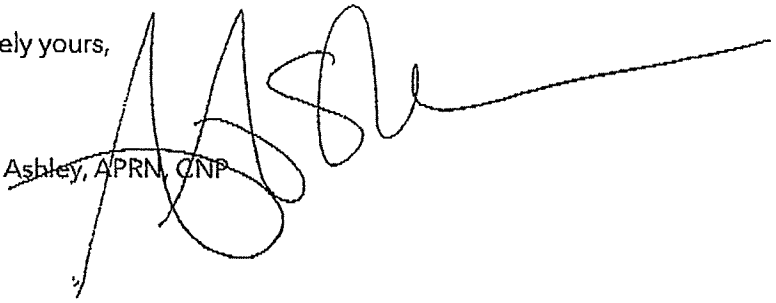
To whom it may concern,

I am an advanced practice registered nurse ("APRNs") licensed to practice in Arkansas and I am writing to oppose the current Insurance Department proposed Rule 108: "Patient Centered Medical Home ("PCMH") Standards."

As a healthcare provider, my foremost concern is for the wellbeing of my patients. My continued access to the largest possible pool of patients is in everyone's best interests. I know our legislators agree that we should strive to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The only way to achieve those goals is to allow advance practice nurses full access to patients so they can care for them to the extent of the nurses' scope of practice. This is especially important in rural Arkansas.

The changes made to the proposed rule issued on September 15, 2014 eliminates the ability of APRNs to lead PCMHs and deliver much needed healthcare in an efficient and cost sensitive manner. The original proposed rule, issued May 13, 2014, more closely follows the General Assembly's intent to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The Insurance Department should produce a rule that is consistent with the legislator's declared intent and allow APRNs to lead PCMHs.

Sincerely yours,



Alisha Ashley, APRN, CNP

2606 PINE ST ARKADELPHIA, AR 71923 870-210-5243

10/16/2014

Arkansas Insurance Department
Attn: Booth Rand
1200 West Third Street
Little Rock, AR 72201-1904
501-371-2820

Dear Mr. Rand:

I am an advanced practice registered nurse (APRN) licensed to practice in Arkansas and I am writing in strong opposition to the current Insurance Department proposed Rule 108: "Patient Centered Medical Home (PCMH) Standards."

As a healthcare provider, my foremost concern is for the well-being of my patients who in my practice are children, the future of our country. My continued access to the largest possible pool of patients is in everyone's best interests. I know our legislators agree that we should strive to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the taxpayers. The only way to achieve those goals is to allow APRNs full access to patients so they can care for them to the extent of the nurses' scope of practice.

The changes made to the proposed rule issued on September 15, 2014 eliminates the ability of APRNs to lead PCMHs and deliver much needed healthcare in an efficient and cost sensitive manner. The original proposed rule, issued May 13, 2014, more closely follows the General Assembly's intent to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the taxpayers. The Insurance Department should produce a rule that is consistent with the legislator's declared intent and allow APRNs to lead PCMHs.

Thank you for considering this very important matter.

Sincerely,

Sharon Stevenson, DNP, APRN, PPCNP-BC

cc: Senator Jane English
Representative Jim Nickels

ARKANSAS MEDICAL SOCIETY
P.O. Box 55088 • Little Rock, AR • 72215-5088
Telephone (501) 224-8967 • WATS 1-800-542-1058 • FAX (501) 224-6489 • E-MAIL ams@arkmed.org • WEB PAGE www.arkmed.org

October 27, 2014

The Honorable Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

Re: Proposed Rule 108

Commissioner Bradford:

On behalf of the 4,500 physician-members of the Arkansas Medical Society, we would like to thank you for the consideration given to the request in our earlier letter regarding Proposed Rule 108. We now support the rule, and more specifically, support the language stating that a primary care physician should lead a Patient Centered Medical Home (PCMH).

All other provider types, while excellent at what they do, have limited scopes of practice. Only physicians are qualified to manage the full range of requirements and challenges posed by a PCMH.

Having a primary care physician leading a PCMH provides the highest quality of care possible and is already a successful model being used in Arkansas. Medicaid standards for PCMHs recognize that physicians should be leading the team.

Additionally, the Arkansas Health Care Payment Improvement Initiative has set a clear statewide standard with physicians as the lead and is already working well. This standard should be followed to provide consistency, improve coordination and increase efficiency.

Thank you for your time and consideration.

Sincerely,

H. Scott Smith, JD
Director of Governmental Affairs
Arkansas Medical Society

We?ve spent tons and tons of time deeply studying this issue and conflicts and the laws, manual and rule you cite down there.

The specific problem is with the PCMH section (Section 171 and Section 200) in the State Medicaid PCMH manual which clearly restricts the ?lead provider? in PCMH to ?primary care PHYSICIAN,? and not with HCIP or with Federal Medicaid Rules or to the modern trend nationally by accrediting organizations to have a neutral provider-led definition. We are talking about who can be the LEAD provider in a PCMH model, and not whether nurses can be involved in the primary care team.

From: S. Graham Catlett [mailto:gcatlett@catlaw.com]
Sent: Monday, September 08, 2014 1:38 PM
To: Booth Rand
Subject: Proposed Rule 108

Booth

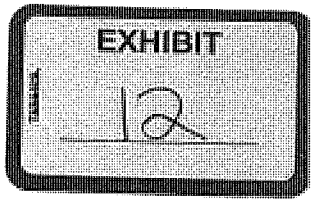
Our Firm represents the Arkansas Nurses Association and fully supported Rule 108 as proposed.

I understand that you may think it violates some rule of Medicaid; we do not. In fact the Arkansas statute is provider neutral and the federal medicaid rules are also provider neutral.

If we can visit with you before the Rule is rewritten, we would be glad to show you why we do not believe there is any legal issue with it.

Best,

Graham



S. Graham Catlett
Attorney at Law
+1.501.801.8088 ext 319 (direct)
+1.501.421.0045 (fax)
gcatlett@catlaw.com

CATLETT
LAW FIRM, PLC
323 Center St., Suite 1800
The Tower Building
Little Rock, AR 72201
www.catlaw.com

Chance Armour

From: Katherine Darling <katherinedarlingllc@gmail.com>
Sent: Friday, July 11, 2014 4:37 PM
To: Booth Rand
Subject: Provider neutral language
Attachments: Booth Rand letter.docx

Dear Mr. Rand,

Please find my letter expressing my thoughts in favor of provider neutral language. I appreciate your support and forward thinking. As we all work together to build a healthier Arkansas, we will accomplish great things!

Thank you for your support. If I can be of any assistance to you, please don't hesitate to contact me.

Kind Regards,

Katherine Darling

--
Dr. Katherine Darling, DNP, PMHNP/FNP-BC, APRN
Katherine Darling, PLLC
637 Cougar Lane
Mountain Home, AR 72653
870 421-5875 (C)
870 425-4849 (H)
katherinedarlingllc@gmail.com

Practice Kindness - You won't regret it!

Katherine Darling, DNP, PMHNP-C, FNP-C, APRN
637 Cougar Lane
Mountain Home, AR 72653
870 421-5875

July 10, 2014

Mr. Booth Rand
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904
Booth.rand@arkansas.gov

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years, seriously jeopardizing access to care in all communities. This is another important reason to have provider neutral language in this rule.

Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Katherine Darling, DNP, APRN

Janis Bishop DNP, FNP-BC, CRNP

Chance Armour

From: NIX, SAMUEL <SNIX@uams.edu>
Sent: Sunday, August 24, 2014 9:59 AM
To: Booth Rand
Subject: RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

August 24, 2014
Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. It is also important to note:

- Most NPs (89%) are prepared in a primary care focus; e.g. adult, family, older adults, pediatric, or women's health (AANP, 2013). Regardless of population focus, primary care NPs are educationally prepared, nationally certified and licensed to provide primary care across many settings including but not limited to:
  - Care at first contact
  - Ongoing management of acute and chronic conditions
  - Health promotion
  - Care coordination

- Four decades of research on NP practice consistently support the high quality and cost-effectiveness of APN care. There is extensive and consistent evidence that NPs provide care of equal or better quality at a lower cost than comparable services provided by others.

I practice in Southwest Arkansas in the primary care setting. Removing provider neutral language will leave a large section of the population in Arkansas without a provider. There is already a shortage of primary care providers in Arkansas and the removal of provider neutral language would increase this shortage thus decreasing access to care. This is not a professional battle, but a battle for access to care for a large portion of Arkansans.

Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Samuel Nix

Chance Armour

From: Janis Bartlett
Sent: Thursday, July 31, 2014 1:30 PM
To: Booth Rand
Cc: Wilson, Craig (JCWilson@uams.edu); Ray Scott
Subject: Proposed Rule 108

Importance: High

I have reviewed the AID Proposed Rule 108 and visited with Craig Wilson from ACHI about the PCMH requirements. Because the Arkansas PCMH Model is not defined, do you think there could be any confusion around what that model is or what those requirements are? Do you think the model needs to be defined? If you have an opportunity to discuss this by phone in the next day or so, I would appreciate having the opportunity to do so. Thank you.

Jan Bartlett, J.D.
Policy Director

SHARE State Health Alliance for Records Exchange OHIT

Office: 501.410.1990 **Fax:** 501.978.3940

Web: SHAREarkansas.com / OHIT.arkansas.gov **Twitter:** @SHAREarkansas / @AR_OHIT

Arkansas Office of Health Information Technology, 1501 North University Avenue, Suite 420, Little Rock, AR 72207

Chance Armour

From: Mary Garnica <marynp9@gmail.com>
Sent: Friday, July 11, 2014 3:26 PM
To: Booth Rand
Subject: Proposed rule 108

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. This is another important reason to have provider neutral language in this rule.

Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Mary Garnica, DNP, APRN, FNP-BC

Maumelle, AR

Chance Armour

From: Kimberly Joy L. Carney <kjbcnp@yahoo.com>
Sent: Thursday, July 10, 2014 9:11 PM
To: Booth Rand
Subject: Proposed rule 108

July 10, 2014

Mr. Booth Rand
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904
Booth.rand@arkansas.gov

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. This is another important reason to have provider neutral language in this rule.

Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Dr. Kimberly Carney
DNP, APRN, FNP-BC, CDE
kjbcnp@yahoo.com

Chance Armour

From: Rebekah Mize <rmizeapn@gmail.com>
Sent: Sunday, August 24, 2014 10:46 PM
To: Sandy Myrick; Booth Rand
Subject: ACA 20-17-2016(d)(1) ARKANSAS HEALTH CARE INDEPENDENCE ACT

August 23, 2014

Jay Bradford
Arkansas Insurance Commissioner
1220 West Third Street
Little Rock, AR 72201-1904

RE: ARKANSAS HEALTH CARE INDEPENDENCE ACT/ACA 20-17-2016(d)(1)

I am writing asking your support in favor of Rule 108 (provider neutral language). The language is consistent withe the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2016(d)(1)) and the Department o f Health and Human Services Section 1115 Demonstration Waiver. In Arkansas having the opportunity for APRNs to be recognized as a primary care providesr and team leaders in patient centered medical homes would create the potential for new access points for primary care across the state. According the the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,00 primary care physicians withing the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. Please note: Most NPs are prepared in a primary care focus, such as adult, family, geriatrics, pediatric or women's health (AANP, 2013). Regardless of their population focus, primary care NPs are educationally prepared, nationally certified and licensed to provide primary care across the life span and in many settings including, but not limited to: Care at first contact; ongoing management of acute and chronic conditions; health promotion; and care coordination and case management.

As a Family Practice Nurse Practitioner, I can assure you we are not trying to take the place of MDs or DOs in the community. NPs work in collaboration with other members of the healthcare team to try and provide the best possible outcomes for the patients we care for. NPs are very sure of their capabilities and limitations in patient care. Besides being beneficial to the healthcare shortage we face now and in the future and for helping with issues our State faces for current health disparities, gaining primary care status would also improve current patient continuum of care. As the Insurance Commissioner I am sure you are familiar with the benefits of this and the potential benefits of APRNs gaining primary care can bring to the people of our state.

Thank you for supporting Rule 108. I know you will do what is best for the residents of The Natural State.

Most Sincerely,
Rebekah Mize, APRN, FNP-C
47-774-9992

cc: Booth Rand

Chance Armour

From: Megan Wylie <ispfree@gmail.com>
Sent: Monday, August 25, 2014 7:56 AM
To: Sandy Myrick
Cc: Booth Rand
Subject: ACA 20-17-2016(d)(1) ARKANSAS HEALTH CARE INDEPENDENCE ACT

August 25, 2014

Jay Bradford
Arkansas Insurance Commissioner
1220 West Third Street
Little Rock, AR 72201-1904

RE: ARKANSAS HEALTH CARE INDEPENDENCE ACT/ACA 20-17-2016(d)(1)

I am writing to ask your support in favor of Rule 108 (provider neutral language). The language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2016(d)(1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as primary care providers and team leaders in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. Please note: Most NPs are prepared in a primary care focus, such as adult, family, geriatrics, pediatric or women's health (AANP, 2013). Regardless of their population focus, primary care NPs are educationally prepared, nationally certified and licensed to provide primary care across the life span and in many settings including, but not limited to: Care at first contact; ongoing management of acute and chronic conditions; health promotion; and care coordination and case management.

NPs work in collaboration with other members of the healthcare team to try to provide the best possible outcomes for the patients they care for. NPs are very sure of their capabilities and aware of their limitations in patient care. Besides being beneficial to the healthcare shortage we face now and in the future and for helping with issues our State faces for current health disparities, gaining primary care status would also improve current patient continuum of care. As the Insurance Commissioner I am sure you are familiar with the benefits of this and the potential benefits of APRNs gaining primary care can bring to the people of our state.

Thank you for your time and for supporting Rule 108. I know you will do what is best for the residents of The Natural State.

Sincerely,

Megan Wylie
#2 St. Jude Circle
Clarksville, AR 72830
479-754-0619

cc: Booth Rand
Booth.rand@arkansas.gov

Chance Armour

From: Scott Smith <ssmith@arkmed.org>
Sent: Wednesday, July 30, 2014 4:29 PM
To: Booth Rand
Cc: David Wroten; David Ivers; Mike Mitchell
Subject: Arkansas Medical Society Letter on Proposed Rule 108
Attachments: 2014 Rule 108 Comment Letter to Arkansas Insurance Department (scan) July 30.pdf

Booth,

It was good to visit with you. We sincerely appreciate your work on this issue. Here's our scanned letter.

Take care,

Scott

H. Scott Smith, JD
Director of Governmental Affairs
Arkansas Medical Society

Chance Armour

From: Pei Purdom <pei.purdom@gmail.com>
Sent: Monday, August 25, 2014 9:21 AM
To: Booth Rand
Subject: Support Neutral Language in Rule 108
Attachments: PCMH AID comment letter PPurdom.docx

Dear Mr. Rand,

It is to our attention that AR Insurance Dept. has used neutral language "primary care provider" in the proposal of rule 108. This is a huge progress in the landscape of healthcare in AR.

In response to the opposition from the medical society, I as a member of nursing community, a to-be doctorate-prepared Family Nurse Practitioner would like to express my support for this change in legislative language.

Please see the attached letter,

I appreciate your time and attention to this matter, and I sincerely request the Insurance Dept would do what is the best for AR residents!

RN, BSN, UTHSC DNP/FNP 2015 candidate
ARNA Health Policy Committee Member
ARNA/ANA & AANP Member
Maumelle, AR 72113

Date 08/25/2014

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. It is also important to note:

- Most NPs (89%) are prepared in a primary care focus; e.g. adult, family, older adults, pediatric, or women's health (AANP, 2013). Regardless of population focus, primary care NPs are educationally prepared, nationally certified and licensed to provide primary care across many settings including but not limited to:
    - Care at first contact
    - Ongoing management of acute and chronic conditions
    - Health promotion
    - Care coordination

- Four decades of research on NP practice consistently support the high quality and cost-effectiveness of APN care. There is extensive and consistent evidence that NPs provide care of equal or better quality at a lower cost than comparable services provided by others.

Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Pei Purdom, RN, BSN, FNP/DNP Student at UTHSC

Cc: Booth Rand Booth.rand@arkansas.gov

FAX

Date:	08/11/2014
Pages including cover sheet:	2

To:	+15013712639
Phone	
Fax Number	*+15013712639*

From:	Lofton Family Clinic
	Lofton Family Clinic
	203 W. De Queen Ave
	De Queen
	AR 71832
Phone	*(870) 642-4000*
Fax Number	*(870) 277-4293*

NOTE:

Lofton Family Clinic

AMP FITNESS
870-584-4267

The Wellness Center

LOFTON FAMILY CLINIC
870-642-4000

August 11, 2014

Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201

RE: Proposed Rule 108

Dear Commissioner Bradford,

Representing over 1100 Family Practice Physicians in the State of Arkansas, the Arkansas Chapter, American Academy of Family Physicians offers the following commentary:

Regarding Section 3, Item (1) Assignment of Primary Care Clinician
Regarding Section 4, Item (12) Primary Care " Provider"

The Patient Centered Medical Home (PCMH) concept was created by a team of Physicians, to better care for the more chronically-ill, complex patients. The Physician is educated in all scopes of patient care. The PCMH concept models have been developed by the American Academy of Family Physicians. Physicians created the concept of program and thus should be the Leaders. Advance Practice Nurses are truly limited in their scope of practice dealing with the more complex, chronically-ill patients. The PCMH program is a "Team" approach of care, but should be lead by a board certified physician due to the policy of our national organization, the AAFP.

Today, 9 out of 10 Americans choose a Physician to lead their medical team. Americans clearly prefer that their health care be physician led when asked to choose between physicians and nurse practitioners. This was a survey that was conducted by the IPOS on health care and health care providers. We as Physicians of the PCMH program believe that the use of the generic terms of "clinicians" and "Providers" will open the door for non-physician led PCMH programs, and in our opinion, such entities would create an environment that is sub-optimal for patient care. Thus, high quality, lost cost, patient-centered-care should be lead by Physicians.

Thank you for your consideration of our concerns

Sincerely,

Jason Lofton, MD
Delegate to the AAFP Congress

Chance Armour

From: Betty Diehl <nanabdiehl@yahoo.com>
Sent: Sunday, August 31, 2014 5:16 PM
To: Booth Rand
Subject: Comment letter regarding Patient Care Medical Home
Attachments: 2014 Aug PCMH AID comment letter.doc

Please see attached letter.

Betty Diehl
2710 Archer Lane
Conway, AR 72034

Chance Armour

From: Leonie DeClerk <leoniedeclerk@yahoo.com>
Sent: Saturday, August 23, 2014 5:22 PM
To: Booth Rand
Subject: Comment on Proposed Rule 108 regarding patient centered medical home
Attachments: PCMH AID comment letter Leonie DeClerk.docx

Mr. Rand,

My letter is attached. Please forward to Mr. Bradford.

Leonie DeClerk, DNP, APRN, FNP-BC

5121 Madison Ave,
Jacksonville, AR 72076

August 23, 2014

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. It is also important to note:

- Most NPs (89%) are prepared in a primary care focus; e.g. adult, family, older adults, pediatric, or women's health (AANP, 2013). Regardless of population focus, primary care NPs are educationally prepared, nationally certified and licensed to provide primary care across many settings including but not limited to: care at first contact, ongoing management ot acute and chronic conditions, health promotion, and care coordination.

- Four decades of research on NP practice consistently support the high quality and cost-effectiveness of APN care. There is extensive and consistent evidence that NPs provide care of equal or better quality at a lower cost than comparable services provided by others.

I worked as a primary care provider in a clinic in Little Rock with patients who were primarily uninsured for 10 years; for a significant part of that time I was the sole provider in the clinic. Currently I teach in the family nurse practitioner specialty track at UAMS. In my current role, I have the opportunity to visit my students in clinical sites throughout the state. In most sites, whether there is an on-site physician or not, the APRNs serve as primary care providers for their patients. In many sites, especially those in rural Arkansas, the APRN is the only provider in the clinic. APRNs have been providing primary care, managing acute and chronic conditions, providing preventive health care and health education, and coordinating care with appropriate referrals and contact with specialists for the residents of Arkansas since 1995. Please maintain the provider neutral language in proposed Rule 108 so that we can continue to provide the excellent primary care that we are educated, certified and licensed to give, and be recognized for doing so.

Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Leonie DeClerk, DNP, APRN, FNP-BC

Cc: Booth Rand Booth.rand@arkansas.gov

Chance Armour

From: Terry Scott
Sent: Tuesday, August 12, 2014 8:31 AM
To: Booth Rand
Subject: FW: Fax from fax@loftonclinic.com re: proposed rule 108

Electronically Received
August 12 2014
Legal Division
Arkansas Insurance Department

Terry Scott

Corporate Affairs, Legal Division
ARKANSAS INSURANCE DEPARTMENT
1200 West Third Street
Little Rock, AR 72201-1904
(501) 371-2820

From:
Sent: Monday, August 11, 2014 5:52 PM
To: LoRraine Rowland; Terry Scott
Subject: Fax from fax@loftonclinic.com

Chance Armour

From: LoRraine Rowland
Sent: Friday, August 01, 2014 2:55 PM
To: Booth Rand
Cc: LoRraine Rowland
Subject: FW: PCMH - request to clarify language regarding medical home
Attachments: pcmh primary care provider letter to bradford.doc

Here is another comment.

LoRraine Rowland
Administrative Analyst/Legal Division
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201
501-371-2831 (office)
501-371-2639 (fax)
lorraine.rowland@arkansas.gov

"I have seeds in the ground and I am in a great place"

-----Original Message-----
From: Aimee Berry [mailto:berryaimee@sbcglobal.net]
Sent: Friday, August 01, 2014 2:32 PM
To: LoRraine Rowland
Subject: PCMH - request to clarify language regarding medical home

Aimee Olinghouse (formerly Berry)
Executive Director
Arkansas Chapter
American Academy of Pediatrics
#1 Children's Way, Slot 900
Little Rock, Arkansas 72202
aimee.olinghouse@yahoo.com
501.831.3057
www.arkansasaap.org

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Arkansas Chapter
#1 Children's Way, Slot 900
Little Rock, AR 72202-3510
Phone: 501/364-4410
Fax: 501/364-1561
E-mail: berryaimee@sbcglobal.net

Arkansas Chapter Executive Committee

President
Orrin Davis, MD, FAAP
3380 N. Futrall
Fayetteville, Arkansas 72703
Phone: 479-443-3471
E-mail: orrin.davis@mana.md

Vice President
Dennis Kuo, MD, FAAP
#1 Children's Way, Slot 900
Little Rock, Arkansas 72202
Phone: 501-364-1100
E-mail: dzkuo@uams.edu

Secretary
Chad Rodgers MD, FAAP
500 South University, Ste. Ste 302
Little Rock, Arkansas 72205
Phone: 501-664-4044
E-mail: drchadinlr.@comcast.net

Treasurer
Chris Schluterman, MD, FAAP
7303 Rogers Ave
Fort Smith, Arkansas 72903
Phone: 479-478-7200
E-mail: cschluterman@hotmail.com

Immediate Past President
David Matthews, MD, FAAP
800 S. Church Street
Jonesboro, AR 72401-4176
Phone: 870-935-6012
Fax: 870-934-3152
E-mail: dmatthews@tccjbr.com

Chapter Executive Director
Aimee S. Olinghouse
#1 Children's Way, Slot 900
Little Rock, AR 72202-3510
Phone: 501/364-4410
Fax: 501/364-1561
Cell: 501/831-3057
E-mail: berryaimee@sbcglobal.net

August 1, 2014

The Honorable Jay Bradford
Insurance Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

Dear Commissioner Bradford:

The Arkansas Chapter, American Academy of Pediatrics is asking you to amend the proposed Rule 108 which provides standards for Patient-Centered Medical Homes (PCMH) because of vague language in regard to whether non-physician clinicians would be eligible to lead comprehensive healthcare teams providing care under the PCMH model. We strongly agree with the "Joint Principles of the Patient-Centered Medical Home" (Joint Principles) published by the Patient Centered Primary Care Collaborative and developed by the several national medical organizations with a focus on providing primary care, including the AAP. While the Joint Principles recognize the value of interprofessional healthcare teams, it is clear states that the physician should be the leader of that team. Allowing non-physicians to lead teams of healthcare providers providing comprehensive care through the PCMH model has significant risks that could negatively impact the quality of care provided to patients. The physician-led medical model ensures that professionals with complete medical education and training are adequately involved in patient care.

While we support the intent of this proposal to establish rules for the operation of PCMH in the state, and appropriate payment for care provided under this model, the current definition of "Primary Care Provider" in Proposed Rule 108 section (4)(12) needs to be clear. This ambiguity leaves it up to the carrier to decide the definition of primary care provider for the purposes of the PCMH which could lead to non-physician clinicians inappropriately leading comprehensive patient care, which is beyond their education and training. This could also create incongruity in state regulation of medical practice whereby the scope of practice for nurse practitioners and other healthcare professionals may greatly expand without appropriate oversight and supervision. The definition of "Primary care provider" under the proposed rule should instead be amended to specifically define this healthcare professional as a physician.

Making this change would be inline with The Joint Principles which clearly state that the physician should lead the care provided under the PCMH model. In fact, the first two principles are: "Personal Physician," recognizing the need for each patient to have an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care, and "Physician Directed Medical Practice," supporting the concept of a physician led team of healthcare professionals at the practice level who collectively take responsibility for the ongoing care of patients.

Additionally, section (5)(a) of Proposed Rule 108 specifies that the Health Carrier must reasonably follow the standards or guidelines for a national or state standardized PCMH model as approved by the Commissioner. The national standard, as established by the Joint Principles, clearly maintains that physicians must be in the role of "Primary Care

Provider" and leader of the comprehensive care team. This mirrors the PCMH standards

American Academy of Pediatrics
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in Arkansas as defined in the Arkansas Medicaid Provider Manual which states that PCMH is: "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." In fact, in section 171.630 of the manual it states that "Licensed nurse practitioners or licensed physician assistants employed by a Medicaid-enrolled RHC provider may not function as PCP substitutes."

We are specifically requesting that Section 4, Paragraph 12 be amended (in approximate wording) to the following:"Primary Care Provider" means a participating health care provider practicing within their licensed scope of practice physician licensed by the Arkansas State Medical Board and designated by the Health Carrier to supervise, coordinate or provide initial care or continuing care to a covered person, who may be required by the Health Carrier to initiate a referral for a specialty care and maintain supervision of health care services rendered to the covered person.

Potentially allowing non-physician clinicians to serve as a "Primary Care Provider" within the PCMH model would run counter to existing state policy and national PCMH principles, and may deteriorate the quality of care provided to Arkansas patients through this model. We urge you to protect the safety of Arkansas' patients and the integrity of the PCMH model by defining "Primary Care Provider" as a physician. Should you need any additional information, please feel free to contact me at your convenience. Thank you in advance for your attention to this matter.

Sincerely,

Aimee Olinghouse

Aimee Olinghouse
Executive Director
Arkansas Chapter, American Academy of Pediatrics
1 Children's Way, Slot 900
Little Rock, Arkansas 72202
501.831.3057
berryaimee@sbcglobal.net

ARKANSAS ACADEMY OF
FAMILY PHYSICIANS

500 Pleasant Valley Drive
Building D, Suite 102
Little Rock, Arkansas 72227

July 31, 2014

Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201

RE: Proposed Rule 108

Dear Commissioner Bradford,

Representing over 1100 Family Practice Physicians in the State of Arkansas, the Arkansas Chapter, American Academy of Family Physicians offers the following commentary:

Regarding Section 3, Item (1) Assignment of Primary Care Clinician
Regarding Section 4, Item (12) Primary Care "Provider"

The Patient Centered Medical Home (PCMH) concept was created by our colleagues in Pediatrics for application to complex, chronically-ill patients. The AAFP has a long,proud history of developing a more comprehensive model of the PCMH concept , appropriate for broader application in primary care. It is the policy of our national organization, the American Academy of Family Physicians, one which we wholly endorse as a state chapter, that the Patient Centered Medical Home (PCMH) should be a team consisting of many different and valued members of the healthcare sytem, but that it should remain Physician Led. Please see the AAFP position paper on use of generic term, "provider" or "clinician". http://www.aafp.org/about/policies/all/Provider-term-position.html.

We believe that the use of the generic terms "clinician" and "Provider" will open the door for non-physician led PCMH, and in our opinion, such entities would create an environment that is sub-optimal for patient care. Each member of the PCMH team brings their own value to the team based approach, but the intensity and breadth of training for physicians uniquely qualifies them to lead the effort to provide high quality, low cost, patient centered care. It is our opinion that patients deserve the competency and comprehensive care that is provided by a physician-led team operating within the context of a PCMH. More detailed information about the AAFP's policy on physician leadership of the PCMH can be found at the following links (http://www.aafp.org/dam/AAFP/documents/about_us/initiatives/AAFP-PCMHWhitePaper.pdf And http://blogs.aafp.org/cfr/leadervoices/entry/nps_no_substitute_for_physician).

Thank you for your consideration of our concerns.

Sincerely,

Lonnie Robinson, M.D.
Delegate to the AAFP Congress

Phone: (501) 223-2272

Fax: (501-223-2280

Email:
arafp@sbcglobal.net

August 2, 2014

The Honorable Jay Bradford, Commissioner

Arkansas Insurance Department

1200 West Third Street

Little Rock, AR 72201

Re: Proposed Rule 108

Commissioner Bradford:

On behalf of the over 500 physician members of the Arkansas Chapter of the American College of Physicians (the nation's largest specialty physician organization) I wish to comment on proposed Rule 108.

The American College of Physicians is a strong proponent of PCMH's and of team-based care and has done much to promote their use. The proposed Rule is; however, open to interpretation such that a non-physician could be classified as a PCP.

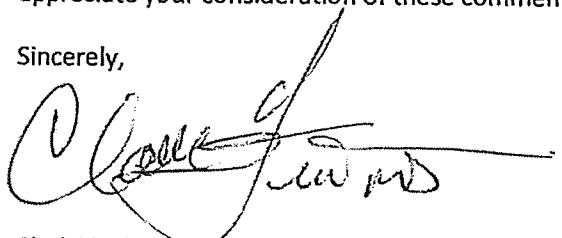
We have great respect for limited scope practitioners, including APN's, NP's and PA's. But it is our feeling that the best person to lead the teams is a physician PCP. The physician has the best training to function in this role and, we believe, is the most qualified to do so. Every team needs a captain and that person needs to be the one with the most training and experience so that patients ultimately receive the most benefit from these new avenues with which to deliver quality care.

I have read the letter from Scott Smith at the Arkansas Medical Society and agree with it in every particular. I have also consulted my governing council and have received strong support from them to express this opinion regarding physician leadership in the PCMH.

We agree with the Medical Society that PCP's should be physicians who are licensed in the specialties of family practice, general practice, internal medicine, pediatrics and adolescent medicine or obstetrics and gynecology.

We look forward to working with all team members to develop a better system for delivery of care and appreciate your consideration of these comments.

Sincerely,



Clark Fincher, MD, FACP

Governor, Arkansas Chapter, American College of Physicians

SECTION II PATIENT CENTERED MEDICAL HOME (PCMH) CONTENTS

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- 251.000 CPC Initiative Practice Participation

200.000 DEFINITIONS

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 shared savings incentive payments.
Benchmark cost	The projected cost of care for a specific shared savings entity against which savings are measured. Benchmark costs are expressed as an average amount per beneficiary.
Benchmark trend	The fixed percentage growth applied to PCMH practices' historical baseline fixed costs of care to project

	benchmark cost.
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.
Cost thresholds	Cost thresholds are the per beneficiary cost of care values (high and medium) against which a shared savings entity's per beneficiary cost is measured.
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.
Historical baseline cost of care	A multi-year weighted average of a shared savings entity's per beneficiary cost of care.
Medical neighborhood barriers	Obstacles to the delivery of coordinated care that exist in areas of the health system external to PCMH.
Minimum savings rate	A fixed percentage set by DMS. In order to receive shared savings incentive payments for performance improvement described in Section 237.000, part A, a shared savings entity must achieve a per beneficiary cost of care that is below its benchmark cost by at least the minimum savings rate.
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.
Per beneficiary cost of care	The risk- and time-adjusted average of attributed beneficiaries' total Medicaid fee-for-service claims (based on the published reimbursement methodology) during the performance period, net of exclusions.
Per beneficiary cost of care floor	The lowest per beneficiary cost of care for which practices within a shared savings entity can receive shared savings incentive payments.
Per beneficiary savings	The difference between a shared savings entity's benchmark cost and its per beneficiary cost of care in a given performance period.

Performance period	The period of time over which performance is aggregated and assessed.
Pool	A. The beneficiaries who are attributed to one or more participating practice(s) for the purpose of forming a shared savings entity; or B. The action of aggregating beneficiaries for the purposes of shared savings incentive payment calculations (i.e., the action of forming a shared savings entity).
Practice support	Support provided by Medicaid in the form of care coordination payments to a participating practice and practice transformation support provided by a DMS contracted vendor.
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 this 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.
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.
Risk adjustment	An adjustment to the cost of beneficiary care to account for patient risk.
Same-day appointment request	A beneficiary request to be seen by a clinician within 24 hours.
Shared savings entity	A participating practice or participating practices that, contingent on performance, may receive shared savings incentive payments.
Shared savings incentive payment cap	The maximum shared savings incentive payment that DMS will pay to practices in a shared savings entity, expressed as a percentage of that entity's benchmark cost for the performance period.
Shared savings incentive payments	Annual payments made to reward cost-efficient and quality care.
Shared savings percentage	The percentage of a shared savings entity's total savings that is paid to practice(s) in a shared savings entity as a shared savings incentive payment for performance improvement.
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

1-1-14

To be eligible to enroll in the PCMH Program initially:

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. The practice must have at least 300 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

1-1-14

Enrollment in the PCMH program is voluntary and practices must re-enroll annually. To enroll, practices must access the provider portal and submit a complete and accurate Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement (DMS-844) available at **www.paymentinitiative.org**. Once enrolled, a participating practice remains in the PCMH program until:

A. The practice withdraws;

B. The practice or provider 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. This update must be submitted in writing within 30 days.

To withdraw from the PCMH program, the participating practice must deliver to DMS a signed and accurate Arkansas Patient-Centered Medical Home Withdrawal Form (DMS-846), available at **www.paymentinitiative.org**.

213.000 Enrollment Schedule

1-1-14

Initial enrollment periods are October 1, 2013 through December 15, 2013 and January 1, 2014 through May 15, 2014.

Beginning with the 2015 calendar year, enrollment is open for approximately 3 months in Q3 and Q4 of the preceding year.

DMS will return any enrollment documents received other than during an enrollment period.

214.000 Caseload Management

1-1-14

A participating practice must manage its caseload of attributed beneficiaries, including removal of a beneficiary from its panel, according to the rules described in Section 171.200 of this manual. Additionally, a participating practice must submit, in writing at the end of every calendar quarter, an explanation of each beneficiary removal during such quarter. DMS retains the right

to disallow these beneficiary removals. If a participating practice removes a beneficiary from its PCMH panel, then that beneficiary is also removed from its ConnectCare panel.

220.000 PRACTICE SUPPORT

221.000 Practice Support Scope 1-1-14

Practice support includes both care coordination payments made to a participating practice and practice transformation support provided by a DMS contracted vendor.

Receipt and use of the care coordination payments is not conditioned on the practice 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 will contract with a practice transformation vendor on behalf of participating practices that require additional support to catalyze practice transformation and retain and use such vendor. Practices must maintain documentation of the months they have contracted with a practice transformation vendor. Practice transformation vendors must report to DMS the level and type of service delivered to each practice. Payments to a practice transformation vendor on behalf of a participating practice may continue for up to 24 months.

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

DMS will also support practices through improved access to information through the reports described in Section 245.000.

222.000 Practice Support Eligibility 1-1-14

In addition to the enrollment eligibility requirements listed in Section 211.000, in order for practices to receive practice support, DMS measures participating practice performance against activities tracked for practice support identified in Section 241.000 and the metrics tracked for practice support identified in 242.000. Participating practices must meet the requirements of these sections to receive practice support.

Each participating practice that has pooled its attributed beneficiaries with other participating practices in a shared savings entity:

A. Has its performance individually compared to activities tracked for practice support and metrics tracked for practice support.

B. Will, if qualified, receive practice support even if other practices in a shared savings entity do not qualify for practice support.

223.000 Care Coordination Payment Amount 1-1-14

The care coordination payment is risk adjusted (e.g., ranging from $1 to $30 per attributed beneficiary per month) based on factors including demographics (age, sex), diagnoses and utilization.

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

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

In order to begin receiving care coordination payments for the quarter starting January 1, 2014, a practice must submit a complete PCMH Practice Participation Agreement on or before December 15, 2013. In order to begin receiving care coordination payments for the quarter starting July 1, 2014, a practice must submit the PCMH Practice Participation Agreement on or before May 15, 2014. For all subsequent years, in order to participate in the PCMH program, a practice must submit the PCMH Practice Participation Agreement before the end of the enrollment period of the preceding year.

230.000 SHARED SAVINGS INCENTIVE PAYMENTS

231.000 Shared Savings Incentive Payments Scope 1-1-14

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

232.000 Shared Savings Incentive Payments Eligibility 1-1-14

To receive shared savings incentive payments, a shared savings entity must have a minimum of 5,000 attributed beneficiaries once the below exclusions have been applied. A shared savings entity may meet this requirement as a single practice or by pooling attributed beneficiaries across more than one practice as described in Section 233.000.

A. For purposes of calculating shared savings incentive payments only, the following beneficiaries shall not be counted toward the 5,000 attributed beneficiary requirement.

1. Beneficiaries that have been attributed to that entity's practice(s) for less than half of the performance period.
2. Beneficiaries that a practice prospectively designates for exclusion from per beneficiary cost of care (also known as physician-selected exclusions) on or before the 90th day of the performance period. Once a beneficiary is designated for exclusion, a practice may not update selection for the duration of the performance period. The total number of physician-selected exclusions will be directly proportional to the practice'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 or provider experience with select beneficiary populations. DMS will publish such addition, removal or modification on **www.paymentinitiative.org**.

B. Shared savings incentive payments are conditioned upon a shared savings entity:

1. Enrolling during the enrollment period prior to the beginning of the performance period;
2. Meeting requirements for metrics tracked for shared savings incentive payments in section 244.000 based on the aggregate performance for beneficiaries attributed to the shared savings entity for the majority of the performance period; and
3. Maintaining eligibility for practice support as described in Section 251.000.

Eligibility requirements for shared savings for Comprehensive Primary Care (CPC) practices are described in Section 251.000.

233.000 Pools of Attributed Beneficiaries 1-1-14

Participating practices will meet the minimum pool size of 5,000 attributed beneficiaries as described in 232.000 by forming a shared savings entity in one of three ways:

A. Meet minimum pool size independently;

B. Pool attributed beneficiaries with other participating practices as described in 234.000. In this method, practices voluntarily agree to have their performance measured together by aggregating performance (both per beneficiary cost of care and quality metrics tracked for shared savings incentive payments) across the practices; or

C. Participate in a default pool if the practice does not meet the requirements for A or B of this section. Practices with beneficiaries in a default pool will have per beneficiary cost of care performance measured across the combined pool of all attributed beneficiaries in the default pool. There is no default pool in the first performance period beginning January 1, 2014.

234.000 Requirements for Joining and Leaving Pools 1-1-14

Practices may pool for purposes described in 233.000, part B, before the end of the enrollment period that precedes the start of the performance period. To pool, practices must submit to DMS a signed Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement with a completed and accurate Arkansas Medicaid Patient-Centered Medical Home Pooling Request Form, available at **www.paymentinitiative.org**, executed by all practices participating in the pool.

In the first performance period beginning January 1, 2014, a maximum of two practices may agree to voluntarily pool their attributed beneficiaries.

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

When a practice has pooled, its performance is measured in the associated shared savings entity throughout the duration of the performance period unless it withdraws from the PCMH program during the performance period. When a practice that has pooled withdraws from the PCMH program, the other practice or practices in the shared savings entity will have performance measured as if the withdrawn practice had never participated in the pool.

235.000 Per Beneficiary Cost of Care Calculation 1-1-14

Each year the per beneficiary cost of care performance is aggregated and assessed across a shared savings entity. Per beneficiary cost of care is calculated as the risk- and time-adjusted average of such entity's attributed beneficiaries' total fee-for-service claims (based on the published reimbursement methodology) during the annual performance period, with adjustments and exclusions as defined below.

One hundred percent of the dollar value of care coordination payments is included in the per beneficiary cost of care calculation, except for the performance period which begins January 1, 2014, for which fifty percent of the dollar value of care coordination payments is included.

As described in Section 232.000, beneficiaries not counted toward the minimum number of attributed beneficiaries for shared savings incentive payments will be excluded from the calculation of per beneficiary cost of care.

A. The following costs are excluded from the calculation of per beneficiary cost of care:

1. All costs in excess of $100,000 for any individual beneficiary.
2. Behavioral health costs for beneficiaries with the most complex behavioral health needs.
3. Select costs associated with developmental disabilities (DD) services, identified on the basis of DD provider types.

4. Select direct costs associated with Long-Term Support and Services (LTSS).
5. Select costs associated with nursing home fees, transportation fees, dental and vision.
6. Select neonatal costs.
7. Other costs as determined by DMS.

Detailed information on specific exclusions are at **www.paymentinitiative.org**.

A. The following adjustments are made to costs for calculation of per beneficiary cost of care:

1. Inpatient hospital claims will be adjusted to reflect a standard per diem.
2. Pharmacy costs will be adjusted to reflect rebates.
3. The per beneficiary cost of care for a shared savings entity is adjusted by the amount of supplemental payment incentives, both positive and negative, made under Episodes of Care for the beneficiaries attributed to practice(s) as described in Section 232.000.
4. Technical adjustments may be made by DHS and will be posted at **www.paymentinitiative.org**

If the shared savings entity's per beneficiary cost of care falls below the current performance period total cost of care floor, then the shared savings entity's per beneficiary cost of care will be set at the total cost of care floor, for purposes of calculating shared savings incentive payments. The 2014 cost of care floor is set at $1,400 and will increase by 1.5% each subsequent year.

236.000 Baseline and Benchmark Cost Calculations 1-1-14

For the performance period that begins in January 2014, DMS will calculate a historical baseline per beneficiary cost of care for each shared savings entity. This shared savings entity-specific historical baseline will be calculated as a multi-year blended average of each shared savings entity's per beneficiary cost of care.

DMS will calculate benchmark costs for each shared savings entity by applying a 2.6% benchmark trend to the entity's historical baseline per beneficiary cost of care. DMS may reevaluate the value of this benchmark trend if the annual, system-average per beneficiary cost of care growth rate differs significantly from a benchmark, to be specified by DMS. DMS will publish any modification to the benchmark trend at **www.paymentinitiative.org**.

237.000 Shared Savings Incentive Payments Amounts 1-1-14

A shared savings entity is eligible to receive a shared savings incentive payment that is the greater of: (A) a shared savings incentive payment for performance improvement; or (B) a shared savings incentive payment for absolute performance.

A. Shared savings incentive payments for performance improvement are calculated as follows:

1. During each performance period, each shared savings entity's per beneficiary savings is calculated as: [benchmark cost for that performance period] – [per beneficiary cost of care for that performance period].
2. If the shared savings entity's per beneficiary cost of care falls below that entity's benchmark cost for that performance period by at least the minimum savings rate, only then may the shared savings entity be eligible for a shared savings incentive payment for performance improvement.
3. The per beneficiary shared savings incentive payment for performance improvement for which the shared savings entity may be eligible is calculated as follows: [per beneficiary savings for that performance period] * [shared savings entity's shared savings percentage for that performance period].

4. To establish shared savings percentages for a given performance period, DMS will compare the entity's previous year per beneficiary cost of care to the previous year's medium and high cost thresholds. For the performance period beginning January 2014, DMS will compare the entity's historical baseline cost to the base year thresholds to establish such entity's shared savings percentage.
5. If, in the previous performance period, a shared savings entity's per beneficiary cost of care was:
    a. Below the medium cost threshold, then the shared savings entity may receive 50% of per beneficiary savings created in the current performance period (i.e., the entity's shared savings percentage will be 50%);
    b. Between the medium and high cost thresholds, then the shared savings entity may receive 30% of per beneficiary savings created in the current performance period (i.e., the entity's shared savings percentage will be 30%);
    c. Above the high cost threshold, then the shared savings entity will not share in risk. Instead, the shared savings entity may receive 10% of per beneficiary savings created in the current performance period (i.e., the entity's shared savings percentage will be 10%).

B. Shared savings incentive payments for absolute performance are calculated as follows:

    If the shared savings entity's per beneficiary cost of care falls below the current performance period medium cost threshold, then the shared savings entity may be eligible for a shared savings incentive payment for absolute performance. The per beneficiary shared savings incentive payment for absolute performance for which the entity may be eligible is calculated as follows: ([medium cost threshold for that performance period] – [per beneficiary cost of care for that performance period]) * [50%].

The medium and high cost thresholds for 2014 are:

A. Medium cost threshold: $2,032

B. High cost threshold: $2,718

These thresholds reflect an annual increase of 1.5% from the base year thresholds (base year medium cost threshold: $1,972; base year high cost threshold: $2,638) and will increase by 1.5% each subsequent year.

The minimum savings rate is 2%. DMS may adjust this rate based on new research, empirical evidence or experience from initial provider experience with shared savings incentive payments. DMS will publish any such modification of the minimum savings rate at **www.paymentinitiative.org**.

If the per beneficiary shared savings incentive payment for which the shared savings entity is eligible exceeds the shared savings incentive payment cap, expressed as 10% of the shared savings entity's benchmark cost for that performance period, the shared savings entity will be eligible for a per beneficiary shared savings incentive payment equal to 10% of its benchmark cost for that performance period.

If the shared savings entity's per beneficiary cost of care falls above the current performance period high cost threshold, then the shared savings entity is not eligible for a shared savings incentive payment for that performance period.

A shared savings entity's total shared savings incentive payment will be calculated as the per beneficiary shared savings incentive payment for which it is eligible multiplied by the number of attributed beneficiaries as described in Section 232.000, adjusted based on the amount of time beneficiaries were attributed to such entity's practice(s) and the risk profile of the attributed beneficiaries.

If participating practices have pooled their attributed beneficiaries together, then shared savings incentive payments will be allocated to those practices in proportion to the number of attributed beneficiaries that each practice contributed to such pool.

A shared savings entity will not receive shared savings incentive payments unless it meets all the conditions described in Section 232.000.

DMS pays shared savings incentive payments on an annual basis for the most recently completed performance period and may withhold a portion of shared savings incentive payments to allow for final payment adjustment after a year of claims data is available.

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 practice.

240.000 METRICS AND ACCOUNTABILITY FOR PAYMENT INCENTIVES

241.000 Activities Tracked for Practice Support 1-1-14

Using the provider portal, participating practices must complete and document the activities as described in the table below by the deadline indicated in the table. The reference point for the deadlines is the first day of the first calendar year in which the participating practice is enrolled in the PCMH program.

Activity	Deadline
A. Identify top 10% of high-priority beneficiaries using: 1. DMS patient panel data that ranks beneficiaries by risk at beginning of performance period and/or 2. The practice's patient-centered assessment to determine which beneficiaries on this list are high-priority. Submit this list to DMS via the provider portal.	3 months and again 3 months after the start of each subsequent performance period (If such list is not submitted by this deadline, DMS will identify a default list of high-priority beneficiaries for the practice, based on risk scores).
B. Assess operations of practice and opportunities to improve and submit the assessment to DMS via the provider portal.	6 months and again at 24 months
C. Develop and record strategies to implement care coordination and practice transformation. Submit the strategies to DMS via the provider portal.	6 months
D. Identify and reduce medical neighborhood barriers to coordinated care at the practice level. Describe barriers and approaches to overcome local challenges for coordinated care. Submit these descriptions of barriers and approaches to DMS via the provider portal.	6 months
E. Make available 24/7 access to care. Provide telephone access to a live voice (e.g., an employee of the primary care physician or an answering service) or to an answering machine that immediately pages an on-call medical professional 24 hours per day, 7 days per week. The on-call professional must: 1. Provide information and instructions for treating	6 months

Activity	Deadline
emergency and non-emergency conditions, 2. Make appropriate referrals for non-emergency services and 3. Provide information regarding accessing other services and handling medical problems during hours the PCP's office is closed. Response to non-emergency after-hours calls must occur within 30 minutes. A call must be treated as an emergency if made under circumstances where a prudent layperson with an average knowledge of health care would reasonably believe that treatment is immediately necessary to prevent death or serious health impairment. 1. PCPs must make the after-hours telephone number known by, at a minimum, providing the 24-hour emergency number to all beneficiaries; posting the 24-hour emergency number on all public entries to each site; and including the 24-hour emergency phone number on answering machine greetings. 2. When employing an answering machine with recorded instructions for after-hours callers, PCPs should regularly check to ensure that the machine functions correctly and that the instructions are up to date. Practices must document completion of this activity by written report to DMS via the provider portal.	
F. Track same-day appointment requests by: 1. Using a tool to measure and monitor same-day appointment requests on a daily basis and 2. Recording fulfillment of same-day appointment requests. Practices must document compliance by written report to DMS via the provider portal.	6 months
G. Establish processes that result in contact with beneficiaries who have not received preventive care. Practices must document compliance by written report to DMS via the provider portal.	
H. Complete a short survey related to beneficiaries' ability to receive timely care, appointments and information from specialists, including Behavioral Health (BH) specialists.	12 months
I. Invest in health care technology or tools that support practice transformation. Practices must document health care technology investments by written report to DMS via the provider portal.	12 months
J. Join SHARE and be able to access inpatient discharge and transfer information. Practices must document compliance	12 months

Activity	Deadline
by written report to DMS via the provider portal.	
K. Incorporate e-prescribing into practice workflows. Practices must document compliance by written report to DMS via the provider portal.	18 months
L. Use Electronic Health Record (EHR) for care coordination. The EHR adopted must be one that is certified by Office of the National Coordinator for Health Information Technology and is used to store care plans. Practices are to document completion of this activity via the provider portal.	24 months

DMS may add, remove, or adjust these metrics or deadlines, including additions beyond 24 months, based on new research, empirical evidence or experience from initial metrics. DMS will publish such extension, addition, removal or adjustment at **www.paymentinitiative.org**.

242.000 Metrics Tracked for Practice Support 1-1-14

DMS assesses practices on the following metrics tracked for practice support starting on the first day of the first calendar year in which the participating practice is enrolled in the PCMH program and continuing through the full calendar year. To receive practice support, participating practices must meet a majority of targets listed below.

Metric	Target for Calendar Year Beginning January 1, 2014
A. Percentage of high-priority beneficiaries (identified in Section 241.000) whose care plan as contained in the medical record includes: 1. Documentation of a beneficiary's chief complaint and problems; 2. Plan of care integrating contributions from health care team (including behavioral health professionals) and from the beneficiary; 3. Instructions for follow-up and 4. Assessment of progress to date. The care plan must be updated at least twice a year.	At least 70%
B. Percentage of a practice's high priority beneficiaries seen by their attributed PCP at least twice in the past 12 months	At least 67%
C. Percentage of beneficiaries who had an acute inpatient hospital stay and were seen by health care provider within 10 days of discharge	At least 33%
D. Percentage of emergency visits categorized as non-emergent by the NYU ED algorithm	Less than or equal to 50%

DMS will publish targets for subsequent years, calibrated based on experience from targets initially set, at **www.paymentinitiative.org**. Such targets will escalate over time.

DMS may add, remove, or adjust these metrics based on new research, empirical evidence or experience from initial metrics.

243.000 Accountability for Practice Support 1-1-14

If a practice does not meet deadlines and targets for A) activities tracked for practice support and B) metrics tracked for practice support as described in Sections 241.000 and 242.000, then the practice must remediate its performance to avoid suspension or termination of practice support. Practices must submit an improvement plan within 1 month of the date that a report provides notice that the practice failed to perform on the activities or metrics indicated above.

A. With respect to activities tracked for practice support, practices must remediate performance before the end of the first full calendar quarter after the date the practice receives notice via the provider report that target(s) have not been met, except for activity A in Section 241.000 where no such remediation time will be provided.

B. With respect to metrics tracked for practice support, practices must remediate performance before the end of the second full calendar quarter after the date the practice receives notice via the provider report that target(s) have not been met. For purposes of remediation, performance is measured on the most recent four calendar quarters.

If a practice fails to meet the deadlines or targets for activities and metrics tracked for practice support within this remediation time, then DMS will terminate practice support. DMS may resume practice support when the practice meets the deadlines or targets for activities and metrics tracked for practice support in effect for that quarter.

DMS retains the right to confirm practices' performance against deadlines and targets for activities and metrics tracked for practice support.

244.000 Quality Metrics Tracked for Shared Savings Incentive Payments 1-1-14

DMS assesses the following quality metrics tracked for shared savings incentive payments according to the targets below. The quality metrics are assessed at the level of shared savings entity, except for the default pool. The quality metrics are assessed only if the entity or practice has at least 25 attributed beneficiaries in the category described for the majority of the performance period. To receive a shared savings incentive payment, the shared savings entity or practice must meet at least two-thirds of the quality metrics on which the entity or practice is assessed.

Quality Metric	Target for Calendar year Beginning January 1, 2014
A. Percentage of beneficiaries 31 days to15 months of age who complete at least four wellness visits	At least 67%
B. Percentage of beneficiaries 3-6 years of age who complete at least one wellness visit	At least 67%
C. Percentage of beneficiaries 12-21 years of age who complete at least one wellness visit	At least 40%
D. Percentage of diabetes beneficiaries who complete annual HbA1C testing	At least 75%
E. Percentage of beneficiaries prescribed appropriate asthma medications	At least 70%
F. Percentage of CHF beneficiaries on beta blockers	At least 40%

Quality Metric	Target for Calendar year Beginning January 1, 2014
G. Percentage of women > 50 years who have had breast cancer screening in past 24 months	A least 50%
H. Percentage of beneficiaries on thyroid drugs who had a TSH test in past 24 months	At least 80%
I. Percentage of beneficiaries 6-12 years of age with an ambulatory prescription dispensed for ADHD medication that was prescribed by their attributed PCP, and who had one follow-up visit with that PCP during the 30-day Initiation Phase.	At least 25%

DMS will publish targets for subsequent performance periods, calibrated based on experience from targets initially set, at **www.paymentinitiative.org**.

DMS may add, remove or adjust these quality metrics based on new research, empirical evidence or experience from initial quality metrics.

245.000 Provider Reports 1-1-14

DMS provides participating practices provider reports containing information about their practice performance on activities tracked for practice support, metrics tracked for practice support, quality metrics tracked for shared saving incentive payments and their per beneficiary cost of care via the provider portal.

250.000 COMPREHENSIVE PRIMARY CARE (CPC) INITIATIVE PRACTICE PARTICIPATION IN THE PCMH PROGRAM

251.000 CPC Initiative Practice Participation 1-1-14

Practices and physicians participating in the CPC initiative are not eligible to receive PCMH program practice support.

Practices participating in the CPC initiative may receive PCMH program shared savings incentive payments if they:

A. Enroll in the PCMH program;

B. Meet the requirements for shared savings incentive payments, except that a practice participating in CPC need not maintain eligibility for practice support described in Section 222.000; and

C. Achieve all CPC milestones and measures on time.

Chance Armour

From: LoRraine Rowland
Sent: Thursday, July 31, 2014 11:37 AM
To: Booth Rand
Cc: LoRraine Rowland
Subject: FW: PDF Document 140731095453_0001.pdf Proposed Rule 108
Attachments: 140731095453_0001.pdf

FYI:

LoRraine Rowland
Administrative Analyst/Legal Division
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201
501-371-2831 (office)
501-371-2639 (fax)
lorraine.rowland@arkansas.gov

"I have seeds in the ground and I am in a great place"

From: arafp [mailto:arafp@sbcglobal.net]
Sent: Thursday, July 31, 2014 10:34 AM
To: LoRraine Rowland
Subject: PDF Document 140731095453_0001.pdf Proposed Rule 108

Please find attached the Arkansas Academy of Family Physicians comments on Proposed Rule 108 which will also be mailed today. Thank you. Carla Coleman, Executive Vice President

Chance Armour

From: Coin, Savannah Lee <scoin@uthsc.edu>
Sent: Friday, September 05, 2014 2:26 PM
To: Booth Rand
Subject: Insurance Commission Letter for PCMH
Attachments: insurance commission letter for PCMH 2014.doc

Savannah Coin, BSN UTHSC Student DNP/ACFNP
Paragould, AR
Graduation Date: May 2015

Date: 9/5/14

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."
I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. It is also important to note:

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    - Ongoing management of acute and chronic conditions
    - Health promotion
    - Care coordination

- Four decades of research on NP practice consistently support the high quality and cost-effectiveness of APN care. There is extensive and consistent evidence that NPs provide care of equal or better quality at a lower cost than comparable services provided by others.

Thank you for the opportunity to comment on proposed rule 108.
Sincerely,

Savannah Coin

Cc: Booth Rand Booth.rand@arkansas.gov

Chance Armour

From: Amanda L. Henard <alhenard@wcmc.org>
Sent: Monday, August 04, 2014 10:23 AM
To: Booth Rand
Subject: Letter from Dr. Clark Fincher
Attachments: image2014-08-04-093444.pdf

Please see the attached letter from Dr. Fincher.

Thanks,

Amanda

Amanda Henard, MBA
Searcy Medical Center
An Outpatient Department of WCMC
2900 Hawkins Drive
Searcy, AR 72143
Ph: (501) 278-8363 Fax: (501) 278-2883
alhenard@wcmc.org

Chance Armour

From: drs250r@cox.net
Sent: Monday, August 25, 2014 8:07 PM
To: Booth Rand
Subject: PCMH AID
Attachments: PCMH AID comment letter individualAug2014.docx

Attached is my letter regarding PCMH AID.
Thanks for your time.

8/25/14

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. It is also important to note:

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Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Kathleen Smith APRN, Cardiovascular Surgical Clinical Clinic Fayetteville Arkansas

Cc: Booth Rand Booth.rand@arkansas.gov

Chance Armour

From: Linda or Steve McIntosh <mcintoshsl@centurylink.net>
Sent: Saturday, August 23, 2014 8:52 AM
To: Booth Rand
Subject: PCMH Comment Letter
Attachments: PCMH AID comment letter individualAug2014.docx

Mr Rand:

I have mailed a signed copy of this letter to Jay Bradford State Insurance Commissioner.

Thank You for your consideration.

Sincerely,

Linda McIntosh, APRN, FNP
ARcare
406 Rodgers Dr.
Searcy, AR 72143
870-256-5265
mcintoshsl@centurylink.net

August 23, 2014

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am a APRN, Family Nurse Practitioner in rural Arkansas. I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. It is also important to note:

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- Four decades of research on NP practice consistently support the high quality and cost-effectiveness of APN care. There is extensive and consistent evidence that NPs provide care of equal or better quality at a lower cost than comparable services provided by others.

Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Linda McIntosh, APRN, FNP

Cc: Booth Rand Booth.rand@arkansas.gov

Chance Armour

From: Patsy Cornelius <Patsy.Cornelius@uafs.edu>
Sent: Monday, August 25, 2014 10:57 AM
To: Booth Rand
Subject: PCMH proposed rule 108
Attachments: PBC_PCMH AID comment letter individualAug2014.docx

Thank you for continuing to include provider neutral language in the Patient Centered Medical Home proposed rule 108. I have attached a letter, which more fully delineates reasons for keeping provider neutral language in the proposed rule 108 for PCMH.

Patsy B. Cornelius, PhD, RN
Faculty Senate Chair
Assistant Professor, BSN Program
UAFS, College of Health Sciences
479-788-7831 – work
479-424-6831 - fax

August 25, 2014

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years, which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas, as a result of the Healthcare Independence Act, provides another important reason to have provider neutral language in this rule. It is also important to note:

- Most NPs (89%) are prepared in a primary care focus; e.g. adult, family, older adults, pediatric, or women's health (AANP, 2013). Regardless of population focus, primary care NPs are educationally prepared, nationally certified and licensed to provide primary care across many settings including but not limited to:
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    - Ongoing management of acute and chronic conditions
    - Health promotion
    - Care coordination

- Four decades of research on NP practice consistently supports the high quality and cost-effectiveness of APN care. There is extensive and consistent evidence that NPs provide care of equal or better quality at a lower cost than comparable services provided by others.

Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Patsy B. Cornelius

Cc: Booth Rand Booth.rand@arkansas.gov

Chance Armour

From: Janis Bartlett
Sent: Friday, August 01, 2014 10:49 AM
To: Booth Rand
Cc: Wilson, Craig (JCWilson@uams.edu)
Subject: PCMH Requirements from Medicaid
Attachments: PCMH Manual 2014.pdf

You probably have this – but in case you don't, attached are the Medicaid requirements.

Jan Bartlett, J.D.
Policy Director

SHARE State Health Alliance for Records Exchange OHIT

Office: 501.410.1990 **Fax:** 501.978.3940

Web: SHAREarkansas.com / OHIT.arkansas.gov **Twitter:** @SHAREarkansas / @AR_OHIT

Arkansas Office of Health Information Technology, 1501 North University Avenue, Suite 420, Little Rock, AR 72207

Chance Armour

From: Elliott, Jeanne <JNElliott@stvincenthealth.com>
Sent: Tuesday, August 26, 2014 11:37 AM
To: Booth Rand
Subject: Primary care provider under proposed Rule 108
Attachments: August 26.doc

Please see attached document. Thanks, Jeanne Elliott APRN

August 26, 2014

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. It is also important to note:

- Most NPs (89%) are prepared in a primary care focus; e.g. adult, family, older adults, pediatric, psychiatric and/or women's health (AANP, 2013). Regardless of population focus, primary care NPs are educationally prepared, nationally certified and licensed to provide primary care across many settings including but not limited to:
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    - Ongoing management of acute and chronic conditions
    - Health promotion
    - Care coordination

- Four decades of research on NP practice consistently support the high quality and cost-effectiveness of APN care. There is extensive and consistent evidence that NPs provide care of equal or better quality at a lower cost than comparable services provided by others.

Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Jeanne N Elliott APRN, FNP-C, ACNP-C

Phone : 510 – 241 - 0558

Chance Armour

From: Alisa Ruffner <alisa_danielle@att.net>
Sent: Friday, September 05, 2014 2:27 PM
To: Booth Rand
Subject: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

September 5, 2014

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

Dear Mr Bradford,

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule.
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Most NPs (89%) are prepared in a primary care focus; e.g. adult, family, older adults, pediatric, or women's health (AANP, 2013). Regardless of population focus, primary care NPs are educationally prepared, nationally certified and licensed to provide primary care across many settings including but not limited to:
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Ongoing management of acute and chronic conditions Health promotion Care coordination

Four decades of research on NP practice consistently support the high quality and cost-effectiveness of APN care. There is extensive and consistent evidence that NPs provide care of equal or better quality at a lower cost than comparable services provided by others.
Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Alisa Ruffner, RN, BSN

Cc: Booth Rand Booth.rand@arkansas.gov

Chance Armour

From: STRICKLER, AMBER <ASTRICKLER@uams.edu>
Sent: Sunday, August 24, 2014 2:11 PM
To: Booth Rand
Subject: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards"
Attachments: Proposed Rule 108.docx

Please see attached letter.

Thank you in advance for your attention to this matter,
Sincerely,

Amber Strickler, RN, MNSc-FNP Student

Date 8/24/2013

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. It is also important to note:

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- Four decades of research on NP practice consistently support the high quality and cost-effectiveness of APN care. There is extensive and consistent evidence that NPs provide care of equal or better quality at a lower cost than comparable services provided by others.

Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Amber Strickler, RN, MNSc-FNP Student

Cc: Booth Rand Booth.rand@arkansas.gov

Chance Armour

From: Omar Atiq <otatiq@gmail.com>
Sent: Wednesday, August 27, 2014 3:26 PM
To: Booth Rand
Subject: Proposed Rule 108

Dear Sir,

Team based care is the basis of PCMH. It is imperative that we have a physician, the most educated and the most extensively trained team member, lead the team to obtain best outcomes for our patients. I would never be a patient in a PCMH led by anyone else.

Thank you.
Omar Atiq, MD
Pine Bluff

Chance Armour

From: Lusk, Wanda <WLLusk@stvincenthealth.com>
Sent: Tuesday, August 26, 2014 12:21 PM
To: Booth Rand
Subject: Proposed Rule 108

August 26, 2014

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. It is also important to note:

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- Four decades of research on NP practice consistently support the high quality and cost-effectiveness of APN care. There is extensive and consistent evidence that NPs provide care of equal or better quality at a lower cost than comparable services provided by others.

Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Wanda Lusk MNSc ACNP-BC
4 East Neurospine Unit
CHI St. Vincent Infirmary
P: 501-552-2469 C: 501-680-4759
WLCrumpton@stvincenthealth.com

prohibited. If you received this email in error, immediately reply to the sender and delete the message completely from your computer system.

Chance Armour

From: Angela Foster <afoster@conwayregional.org>
Sent: Tuesday, August 26, 2014 10:54 AM
To: Booth Rand
Subject: proposed rule 108
Attachments: PCMH letter.docx

Pease see the attached letter

26 August 2014

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. It is also important to note:

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- Four decades of research on NP practice consistently support the high quality and cost-effectiveness of APN care. There is extensive and consistent evidence that NPs provide care of equal or better quality at a lower cost than comparable services provided by others.

Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Angela Foster, APRN

Cc: Booth Rand Booth.rand@arkansas.gov

Chance Armour

From: Ramonda Housh <ramonda.housh@blackrivertech.edu>
Sent: Monday, August 25, 2014 10:26 AM
To: Booth Rand
Subject: Proposed Rule 108
Attachments: PCMH AID comment letter individualAug2014.docx

Thank you for your time and attention to this letter.

Sincerely,

Ramonda Housh, MNSc, APRN

August 25, 2014

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. It is also important to note:

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- Four decades of research on NP practice consistently support the high quality and cost-effectiveness of APN care. There is extensive and consistent evidence that NPs provide care of equal or better quality at a lower cost than comparable services provided by others.

As a Pediatric Nurse Practitioner who provides care to children in northeast Arkansas, I am grateful that parents would have the option of choosing me as their child's Primary Care Provider.

Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Ramonda Housh

Ramonda Housh, MNSc, APRN, C-PNP

Cc: Booth Rand Booth.rand@arkansas.gov

Chance Armour

From: Colleen Atchley <Colleen.Atchley@wacgc.org>
Sent: Saturday, August 16, 2014 7:52 PM
To: Booth Rand
Subject: Proposed rule 108

8/16/2014

Dear Commissioner Bradford:

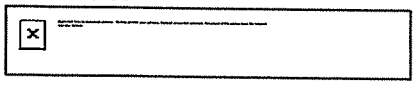
My name is Colleen Atchley. I am an advanced practice registered nurse currently working at a community mental health center in Fort Smith, Arkansas. I would like to personally thank you for using provider neutral language in PCMH proposed rule 108. Our agency's only full time medical staff consists of nurse practitioners who work alongside a competent team of licensed social workers, licensed practical nurses, licensed profession counselors, licensed psychological examiners, psychologists, physicians, a speech therapist and countless other non-licensed professionals. I greatly appreciate the use of provider neutral language as restrictive language negatively impacts our patients in so many ways. In Arkansas, having the opportunity for APRNs to be recognized as a primary care leader and team leader in patient centered homes would create the potential for new access points for primary care across the state. I would be happy to share personal experiences from my practice about how I believe restrictive language and other barriers to care increase costs and lead to patient frustration, confusion and, at times, unbearable waits. I welcome you to contact me or visit our clinic anytime.

In our agency the medical staff supervisor is an advanced practice nurse with many years in community mental health service. I have friends and colleagues that own and operate their own businesses as nurse practitioners in Arkansas. The use of appropriate provider neutral language allows these clinicians to better serve the residents of their communities in capacities they are well qualified to serve in. I get frustrated when scope of practice, education, qualifications and training come into question in politically charged debates because this rarely happens at the community level where we rely on each other for support while acting independently as licensed clinicians.

As a member and leader of a community-based interdisciplinary team, I am well-versed in providing much-needed service to patients unlikely to be served in other settings. We have long stood with our patients while they faced complex medical and psychosocial circumstances and worked tirelessly to ensure care was being managed appropriately. I have to admit despite the flood of new patients it has been a little easier to do with the enactment of the Affordable Care Act. I guess what I am saying is a lot of what is asked only now of "leaders of medical homes" we have strived for as long as I have been a nurse. I feel confident nurse practitioners will continue doing this day after day even if we don't have a particular title or recognition but I would gladly embrace the change.

Respectfully,

Visit Us!



Chance Armour

From: tracy baltz <tracybaltz@mac.com>
Sent: Wednesday, August 13, 2014 4:27 PM
To: Booth Rand
Subject: Proposed rule 108

Dear Mr Rand/ Commissioner Bradford;

Concerning the PCMH, it is my understanding that the leader is not defined as a physician (MD or DO). While advanced practice nurses are needed to expand access to medical care, they do not have the breadth of knowledge to lead a PCMH.

I personally have experienced APN's over testing/over treating - increasing costs.

I encourage the Arkansas Insurance Department to define the leader of a PCMH as a physician (MD or DO).

Tracy Baltz MD

Sent from my iPhone

Chance Armour

From: Sanderson, Herb <HSanderson@aarp.org>
Sent: Monday, August 04, 2014 4:49 PM
To: LoRraine Rowland; Booth Rand
Subject: Proposed Rule 108
Attachments: Letter AR Proposed Rule 108 Comments PDF.pdf

Please find attached AARP Arkansas' comments on Proposed Rule 108.

Herb Sanderson
AARP Arkansas
Associate State Director for Advocacy
1701 Centerview Drive, Suite 205
Little Rock, AR 72211

E-mail: Hsanderson@aarp.org
Phone: 501-217-1639
www.aarp.org/ar
AARP Arkansas is on Facebook! Become a FAN!
AARP Arkansas is on twitter! FOLLOW us!

Chance Armour

From: Janis Bartlett
Sent: Friday, August 01, 2014 10:06 AM
To: Booth Rand
Cc: Wilson, Craig (JCWilson@uams.edu); Ray Scott
Subject: Proposed Rule 108

Importance: High

Thank you for the response. I appreciate your concerns. The NCQA materials I have define a practice "as a clinician or clinicians practicing together at a single geographic location, includes nurse-led practices in states where state licensing designates NPs as independent practitioners."

My understanding of the proposed rule language in Section 5(d) which states, "In order to minimize provider administrative burden and encourage meaningful data reporting, quality metrics collected and reported by Health Carriers must incorporate Arkansas PCMH model requirements" is that regardless of the model selected, the baseline is the Arkansas PCMH model which would require a connection to SHARE. Is that your understanding as well?

Jan Bartlett, J.D.
Policy Director

SHARE State Health Alliance for Records Exchange OHIT

Office: 501.410.1990 **Fax:** 501.978.3940

Web: SHAREarkansas.com / OHIT.arkansas.gov **Twitter:** @SHAREarkansas / @AR_OHIT

Arkansas Office of Health Information Technology, 1501 North University Avenue, Suite 420, Little Rock, AR 72207

From: Booth Rand
Sent: Thursday, July 31, 2014 2:23 PM
To: Janis Bartlett
Cc: Wilson, Craig (JCWilson@uams.edu); Ray Scott
Subject: RE: Proposed Rule 108

I did not write this exact language I believe but I think everyone agrees or should agree It needs to be clarified or language restricted to refer to an actual model or some official published requirements. This is exactly what Blue Cross called to make note of.

I agree with these points, and I think this is written so open-ended for a reason which is, I think, we are trying to stay out of what appears to be a dispute between the APNs and the Family physicians as to who or what type of provider can be

the point for medical home management. Given the written submissions, apparently the APNs like this open definition, the family doctors do not, including AMS.

My guess is if you correct that to say a specific state PCMH model and let's say it's the ADHS model, its my understanding only physicians can be the PCP or primary care provider in Medicaid medical home, according to what others have told me, but I have not looked through the Medicaid medical home requirements. If we say a national PCMH model, it may be pretty modern and prospective looking and not require a licensed physician requirement at the gatekeeper point. I have not looked at any national PCMH criteria, either from NCQA or CMS or whoever is promulgating those standards.

So, the problem here is we do need to clarify this, but how do we do this without saying something in here which might act to operate to restrict a type, and OUR definitions, the way I read them is for the insurer to designate this.

I'm going to try to come up with a solution to this, if possible, but this is up to the Commissioner and Cindy and I do what they want.

From: Janis Bartlett
Sent: Thursday, July 31, 2014 1:30 PM
To: Booth Rand
Cc: Wilson, Craig (JCWilson@uams.edu); Ray Scott
Subject: Proposed Rule 108
Importance: High

I have reviewed the AID Proposed Rule 108 and visited with Craig Wilson from ACHI about the PCMH requirements. Because the Arkansas PCMH Model is not defined, do you think there could be any confusion around what that model is or what those requirements are? Do you think the model needs to be defined? If you have an opportunity to discuss this by phone in the next day or so, I would appreciate having the opportunity to do so. Thank you.

Jan Bartlett, J.D.
Policy Director

SHARE State Health Alliance for Records Exchange OHIT

Office: 501.410.1990 **Fax:** 501.978.3940

Web: SHAREarkansas.com / OHIT.arkansas.gov **Twitter:** @SHAREarkansas / @AR_OHIT

Arkansas Office of Health Information Technology, 1501 North University Avenue, Suite 420, Little Rock, AR 72207

Chance Armour

From: Bishop, Janis <Janis.Bishop@Mercy.Net>
Sent: Tuesday, August 26, 2014 2:12 PM
To: Booth Rand
Subject: Provider neutral language

Date August 26, 2014

Jay Bradford, Insurance Commissioner

Arkansas Insurance Department

1220 West Third Street

Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. It is also important to note:

- Most NPs (89%) are prepared in a primary care focus; e.g. adult, family, older adults, pediatric, or women's health (AANP, 2013). Regardless of population focus, primary care NPs are educationally prepared, nationally certified and licensed to provide primary care across many settings including but not limited to:
    - Care at first contact
    - Ongoing management of acute and chronic conditions
    - Health promotion
    - Care coordination

- Four decades of research on NP practice consistently support the high quality and cost-effectiveness of APN care. There is extensive and consistent evidence that NPs provide care of equal or better quality at a lower cost than comparable services provided by others.

Thank you for the opportunity to comment on proposed rule 108.

AARP Real Possibilities in
Arkansas

1701 Centerview Drive, #205 | Little Rock, AR 72211
1-866-554-5379 | Fax: 501-227-7710 | TTY: 1-877-434-7598
aarp.org/ar | araarp@aarp.org | twitter: @ARAARP
facebook.com/AARPArkansas

August 4, 2014

Jay Bradford
Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

RE: Proposed Rule 108 regarding Patient-Centered Medical Home Standards

Dear Commissioner Bradford:

AARP is a membership organization of people 50 and older with 325,000+ members in Arkansas and is pleased to have the opportunity to provide our comments on Proposed Rule 108 regarding Patient-Centered Medical Home Standards. We are committed to championing access to affordable, high quality health care for all generations, providing the tools needed to save for retirement, and serving as a reliable information source on issues critical to Americans age 50+.

AARP believes that the proposed rule's inclusive definition of primary care provider is necessary to help assure consumer access to and choice of high quality health care professionals within this model of care. The proposal provides the following definition:

> "Primary care provider" means a participating health care provider practicing within their licensed scope of practice and designated by the Health Carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the Health Carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

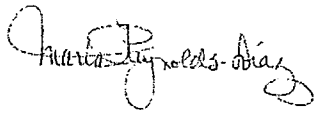
Such an inclusive definition is vital given the shortage of primary care professionals in our state. AARP supports the Institute of Medicine's definition of primary care – "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."

AARP believes that all health professionals who are licensed to provide primary care services, including physicians, advance practice registered nurses, physician assistants and others, should be available to consumers participating in patient centered medical homes and should be allowed to lead such practices. Patient-Centered Medical Homes should be designed to give consumers greater access to care and should assure that consumers are at the center of decision-making, including in their choice of health professionals.

We are pleased with the proposed rule's emphasis on improved care coordination, the "complete health needs" of the patient population, and care that is "customized for their patients' care needs with a focus on prevention and management of chronic disease through monitoring patient progress and coordination of care."

AARP Arkansas is deeply appreciative of the primary care and chronic care management provided by all clinicians. We need to be certain, however, that our members and all health care consumers can access a primary care provider when and where they need one. This rule would help ensure such access to care.

Sincerely,



Maria Reynolds-Diaz
State Director
AARP Arkansas

cc: Booth Rand

Chance Armour

From: Terry Scott
Sent: Wednesday, August 27, 2014 8:41 AM
To: Zane Chrisman; Cynthia Crone
Cc: Booth Rand
Subject: RE: Fax from NEABC Fax Server

Thank you.

Terry Scott

Corporate Affairs, Legal Division
ARKANSAS INSURANCE DEPARTMENT
1200 West Third Street
Little Rock, AR 72201-1904
(501) 371-2820

From: Zane Chrisman
Sent: Wednesday, August 27, 2014 7:59 AM
To: Terry Scott; Cynthia Crone
Subject: RE: Fax from NEABC Fax Server

Should be Booth's. They are providing a comment for the PCMH Rule.

From: Terry Scott
Sent: Tuesday, August 26, 2014 4:03 PM
To: Cynthia Crone; Zane Chrisman
Subject: FW: Fax from NEABC Fax Server

Does this belong to your division? (at first, I sent it to Booth)

Electronically Received
August 26 2014
Legal Division
Arkansas Insurance Department

Terry Scott

Corporate Affairs, Legal Division
ARKANSAS INSURANCE DEPARTMENT
1200 West Third Street
Little Rock, AR 72201-1904
(501) 371-2820

From: Terry Scott
Sent: Tuesday, August 26, 2014 3:57 PM
To: Booth Rand
Subject: FW: Fax from NEABC Fax Server

Booth: is this yours?

Electronically Received
August 26 2014
Legal Division
Arkansas Insurance Department

Terry Scott

Corporate Affairs, Legal Division
ARKANSAS INSURANCE DEPARTMENT
1200 West Third Street
Little Rock, AR 72201-1904
(501) 371-2820

From:
Sent: Tuesday, August 26, 2014 4:41 PM
To: LoRraine Rowland; Terry Scott
Subject: Fax from NEABC Fax Server

<< File: document2014-08-26-154045.pdf >>

Chance Armour

From: LoRraine Rowland
Sent: Friday, August 01, 2014 2:51 PM
To: Booth Rand
Subject: RE: PCMH Rule Exhibits
Attachments: Exhibit List.doc

What about this one?

LoRraine Rowland
Administrative Analyst/Legal Division
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201
501-371-2831 (office)
501-371-2639 (fax)
lorraine.rowland@arkansas.gov

"I have seeds in the ground and I am in a great place"

From: Booth Rand
Sent: Friday, August 01, 2014 1:12 PM
To: LoRraine Rowland
Subject: PCMH Rule Exhibits

I want it kind of like this.

Designation of Hearing Officer
NOPH
Copy of Filed Rule or the Rule itself.
All the Newspaper transmittals and newspaper running information.
Legislative Council Filing cover letter/
Qustionarire
Financial Impact Statement/and all other ALC materials (if any)
Gov's office letter
AG office letter
Sec State
State Library
AEDC (Economic Development)
Summary of Rule

Stop there,

And for the last exhibit, I just call it one number: "Exhibit # [what ever next number is] Public Comments

And I just tuck and add all of those into that one exhibit,and I'll have those all on Monday.

EXHIBIT LIST

DATE: August 5, 2014

SUBJECT: Proposed Rule 108
"Patient-Centered Medical Home Standards"

HEARING OFFICER: William R. Lacy,
Deputy Commissioner

Exhibit No.	Description
1.	Designation of Hearing Officer
2.	Arkansas Insurance Department's June 26, 2014 NOTICE OF PUBLIC HEARING concerning Proposed Rule 108 "Patient-Centered Medical Home Standards"
3.	Proposed Rule 108"Patient-Centered Medical Home Standards"
4.	Proof of Publication of Hearing on Proposed Amended Rule 108 in the Arkansas Democrat-Gazette as required by the Arkansas Administrative Procedures Act, Ark. Code Ann. §§ 25-15-201, *et seq.*
5.	Copy of June 26, 2014 correspondence regarding submission of Proposed Rule 108 to the Arkansas Bureau of Legislative Research
6.	Questionnaire and Financial Impact Statement for Proposed Rule 108
7.	Copy of June 26, 2014 correspondence to James Miller, Regulatory Liaison, Office of the Governor, providing Notice of Public Hearing and Proposed Rule 108
8.	Copy of June 26, 2014 correspondence to Brandon Robinson, Assistant Attorney General, Office of the Attorney General, providing Notice of Public Hearing and Proposed Rule 108
9.	Copy of June 26, 2014 correspondence to the Arkansas Secretary of State, providing copies of the Notice of Public Hearing and Proposed Rule 108, including June 27, 2014 email to Secretary of State
10.	Copy of June 26, 2014 correspondence to Mary Brewer, Arkansas State Library, providing Notice of Hearing, Proposed Rule 108 and Financial Impact Statement

11. Copy of June 26, 2014 correspondence to Pat Brown, Arkansas Economic Development Commission, providing Notice of Hearing and a copy of Proposed Rule 108

12. Summary of Proposed Rule 108

13. Arkansas Insurance Department's May 13, 2014 correspondence regarding presentment of Proposed Rule 108 to the Arkansas Bureau of Legislative Council

14. Comments Regarding Proposed Rule 108

Chance Armour

From: Cynthia Crone
Sent: Friday, August 01, 2014 6:48 AM
To: Booth Rand; Jay Bradford; Zane Chrisman; Dan Honey
Cc: Tangelia Marshall
Subject: RE: PDF Document 140731095453_0001.pdf Proposed Rule 108

Agree. Will be tough to schedule. Tangelia can help. Remember I will be in Chicago at time of hearing. Thanks, Cindy

Cynthia C. Crone, APRN
Deputy Commissioner
Arkansas Insurance Department
Arkansas Health Connector Division
1200 West Third Street
Little Rock, AR 72201

Phone: 501-683-3634
Fax: 501-371-2629
Email: Cynthia.Crone@Arkansas.Gov

From: Booth Rand
Sent: Thursday, July 31, 2014 12:04 PM
To: Cynthia Crone; Jay Bradford; Zane Chrisman; Dan Honey
Subject: FW: PDF Document 140731095453_0001.pdf Proposed Rule 108

We need to meet about this issue before the hearing.

It appears the docs are going to attack this rule now.

From: LoRraine Rowland
Sent: Thursday, July 31, 2014 11:37 AM
To: Booth Rand
Cc: LoRraine Rowland
Subject: FW: PDF Document 140731095453_0001.pdf Proposed Rule 108

FYI:

LoRraine Rowland
Administrative Analyst/Legal Division
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201
501-371-2831 (office)
501-371-2639 (fax)
lorraine.rowland@arkansas.gov

"I have seeds in the ground and I am in a great place"

From: arafp [mailto:arafp@sbcglobal.net]
Sent: Thursday, July 31, 2014 10:34 AM
To: LoRraine Rowland
Subject: PDF Document 140731095453_0001.pdf Proposed Rule 108

Please find attached the Arkansas Academy of Family Physicians comments on Proposed Rule 108 which will also be mailed today. Thank you. Carla Coleman, Executive Vice President

Chance Armour

From: Cynthia Crone
Sent: Friday, August 01, 2014 9:40 AM
To: Booth Rand
Cc: Bill Lacy
Subject: RE: PDF Document 140731095453_0001.pdf Proposed Rule 108

Thanks. That would help, I think.
Cindy

Cynthia C. Crone, APRN
Deputy Commissioner
Arkansas Insurance Department
Arkansas Health Connector Division
1200 West Third Street
Little Rock, AR 72201

Phone: 501-683-3634
Fax: 501-371-2629
Email: Cynthia.Crone@Arkansas.Gov

From: Booth Rand
Sent: Friday, August 01, 2014 8:51 AM
To: Cynthia Crone
Cc: Bill Lacy
Subject: RE: PDF Document 140731095453_0001.pdf Proposed Rule 108

Bill is the Hearing Officer. We can keep the record open beyond the hearing date to receive additional comments and suggested language.

Its up to him and Jay, but given that the effective date of the rule is 1-1-2015, we have plenty of time, as far as I know, and I would think we can leave it open to continue to work out this issue beyond Tuesday.

From: Cynthia Crone
Sent: Friday, August 01, 2014 6:50 AM
To: Booth Rand
Subject: RE: PDF Document 140731095453_0001.pdf Proposed Rule 108

You know Commissioner is now gone and I won't be here Tuesday either. Shall we wait for all comments at Hearing? How does this work—timing wise?
Cindy.

Cynthia C. Crone, APRN
Deputy Commissioner
Arkansas Insurance Department
Arkansas Health Connector Division
1200 West Third Street
Little Rock, AR 72201

Phone: 501-683-3634
Fax: 501-371-2629

Email: Cynthia.Crone@Arkansas.Gov

From: Booth Rand
Sent: Thursday, July 31, 2014 11:40 AM
To: Cynthia Crone; Zane Chrisman; Jay Bradford
Subject: FW: PDF Document 140731095453_0001.pdf Proposed Rule 108

We need to meet about this.

From: LoRraine Rowland
Sent: Thursday, July 31, 2014 11:37 AM
To: Booth Rand
Cc: LoRraine Rowland
Subject: FW: PDF Document 140731095453_0001.pdf Proposed Rule 108

FYI:

LoRraine Rowland
Administrative Analyst/Legal Division
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201
501-371-2831 (office)
501-371-2639 (fax)
lorraine.rowland@arkansas.gov

"I have seeds in the ground and I am in a great place"

From: arafp [mailto:arafp@sbcglobal.net]
Sent: Thursday, July 31, 2014 10:34 AM
To: LoRraine Rowland
Subject: PDF Document 140731095453_0001.pdf Proposed Rule 108

Please find attached the Arkansas Academy of Family Physicians comments on Proposed Rule 108 which will also be mailed today. Thank you. Carla Coleman, Executive Vice President

Chance Armour

From: Total Access Solutions <piccsolutions@gmail.com>
Sent: Sunday, August 24, 2014 10:00 AM
To: Booth Rand
Subject: RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

August 24, 2014

Jay Bradford, Insurance Commissioner

Arkansas Insurance Department

1220 West Third Street

Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. It is also important to note:

- Most NPs (89%) are prepared in a primary care focus; e.g. adult, family, older adults, pediatric, or women's health (AANP, 2013). Regardless of population focus, primary care NPs are educationally prepared, nationally certified and licensed to provide primary care across many settings including but not limited to:
    - Care at first contact
    - Ongoing management of acute and chronic conditions
    - Health promotion
    - Care coordination

- Four decades of research on NP practice consistently support the high quality and cost-effectiveness of APN care. There is extensive and consistent evidence that NPs provide care of equal or better quality at a lower cost than comparable services provided by others.

I practice in Southwest Arkansas in the primary care setting. Removing provider neutral language will leave a large section of the population in Arkansas without a provider. There is already a shortage of primary care providers in Arkansas and the removal of

provider neutral language would increase this shortage thus decreasing access to care. This is not a professional battle, but a battle for access to care for a large portion of Arkansans.

Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Sam Nix RN, BSN, CFRN
Total Access Solutions PLLC
1 Jan Place
Texarkana, Arkansas
71854
903-276-7635
piccsolutions@gmail.com

Chance Armour

From: Cheryl Perry <cxp027@email.uark.edu>
Sent: Friday, July 11, 2014 2:01 PM
To: Booth Rand
Subject: RE: Proposed Rule 108: "Patient Centered Medical Home Standards"

Dear Mr. Rand,

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH Proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. This is another important reason to have provider neutral language in this rule.

Thank you so much for the opportunity to comment on Proposed Rule 108.

Sincerely,

Cheryl Perry, BSN, RN

Doctor of Nursing Practice Graduate Student

University of Arkansas - Fayetteville

Home Address: 1327 Kelly Road, Alma, AR 72921

Cell: 479-651-6187

email: cxp027@email.uark.edu

Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Chance Armour

From: johnson9299@aol.com
Sent: Wednesday, September 03, 2014 10:13 AM
To: Booth Rand
Subject: Rule 108
Attachments: letter to commissioner.docx

Date: 9-2-2014

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. It is my belief that the recognition of APRNs as primary care providers in patient centered medical homes would help to alleviate the gaps in healthcare and thus provide healthcare services to those that otherwise may not receive it. It is also important to note:

- Most NPs (89%) are prepared in a primary care focus; e.g. adult, family, older adults, pediatric, or women's health (AANP, 2013). Regardless of population focus, primary care NPs are educationally prepared, nationally certified and licensed to provide primary care across many settings including but not limited to:
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Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Gayla Johnson

Chance Armour

From: Tammy McCoy <Tammy.McCoy@uafs.edu>
Sent: Tuesday, September 02, 2014 9:22 AM
To: Booth Rand
Subject: Proposed Rule 108: PCMH Standards

2 September 2014

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

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Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Tammy McCoy, MSN, RN
Instructor, School of Nursing
College of Health Sciences, Office 251

University of Arkansas – Fort Smith
5210 Grand Avenue
Forth Smith, Arkansas, 72913
Tammy.McCoy@uafs.edu
479-788-7848
479-788-6848 (fax)
"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."
— Maya Angelou

Chance Armour

From: bridgett reid <reidbridgett@yahoo.com>
Sent: Wednesday, September 03, 2014 1:58 PM
To: Booth Rand
Subject: Proposed rule 108

September 3, 2014

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. It is also important to note:

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Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Bridgett Brantley, RN, BSN, APRN Student

Cc: Booth Rand Booth.rand@arkansas.gov

September 2, 2014

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. It is also important to note:

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Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Rebecca Cowie, MSN, APRN, RN, ACNS-BC, CCRN

Cc: Booth Rand Booth.rand@arkansas.gov

September 2, 2014

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

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Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Rebecca Cowie, MSN, APRN, RN, ACNS-BC, CCRN

Cc: Booth Rand Booth.rand@arkansas.gov

Chance Armour

From: Elizabeth Jarvis <mimijarvis@yahoo.com>
Sent: Tuesday, September 02, 2014 4:35 AM
To: Booth Rand
Subject: Proposed Rule 108

Date September 2nd, 2014

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. It is also important to note:

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Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Elizabeth Jarvis

Cc: Booth Rand Booth.rand@arkansas.gov

Chance Armour

From: Rhonda K. Finnie <rkfinnie@practice-plus.com>
Sent: Friday, September 05, 2014 2:29 PM
To: Booth Rand
Subject: Proposed Rule 108

September 5, 2014
Jay Bradford, Insurance Commissioner
Rand Booth, Associate Counsel, Arkansas Insurance Department
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

Dear Mr. Bradford

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver.

I am an acute care nurse practitioner and receive referrals from Advanced Practice Registered Nurses, Physicians and Physician Assistants. When I confirm their primary care provider, several of my patients are cared for routinely by an APRN who may or may not be in the same location as the collaborative physician. The historic lack of recognition for the APRN as a primary care provider and leader of that patient's medical home has led to disruption in the continuity of care for the patient. I have had complex patients whose records were sent to another location and when I have seen them in follow up from the hospital, I found that the APRN who was their provider in the community had received no information regarding the hospitalization or injury. Provider neutral language would allow the practitioner who does the work to be recognized for that work. It is critical, particularly in transitional care.

Again, I am very pleased that the wording in the proposed rule recognizes the contribution of practitioners who are educated, licensed and boarded to provide primary care services in our state. I believe that this is a critical step in removing barriers to practice for non-physician providers and improving access to quality health care for patients and families.

Sincerely,

Rhonda Finnie, DNP, APRN, AGACNP-BC, RNFA
Neurosurgery Arkansas
9601 Baptist Health Drive Suite 310
Little Rock, AR 72205

Cc: Booth Rand Booth.rand@arkansas.gov

IMPORTANT DISCLAIMER NOTICE

The information, both of the message and any attachments, contained in this message is intended only for the use of the individual or entity to which it is addressed. This message may contain information that is privileged, confidential and exempt from disclosure under applicable law.

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Chance Armour

From: S. Graham Catlett <gcatlett@catlaw.com>
Sent: Monday, September 08, 2014 2:46 PM
To: Booth Rand
Subject: RE: Proposed Rule 108

Follow Up Flag: Follow up
Flag Status: Flagged

Booth

We are convinced that it is simply an attempt to protect some people's income even if it adversely affects access to healthcare.

The Ark model for PCMH initially allowed both physicians and APRNS to be the lead provider as is the national model; but someone was persuaded to change it.

I suspect that the State Medicaid rule you cite is violative of the federal law as well as recent FTC Rulings on anti-competitive behavor regarding similar issues in other States.

I understand it is controversial with the physicians. But we believe it is legal and certainly in the best interests of access to healthcare in Arkansas.

We will be glad to meet at your convenience whenever you think best. But we do not believe any change in your Proposed Rule is necessary.

Best,
Graham

S. Graham Catlett
Attorney at Law
+1.501.801.8088 ext 319 (direct)
+1.501.421.0045 (fax)
gcatlett@catlaw.com

323 Center St., Suite 1800
The Tower Building
Little Rock, AR 72201
www.catlaw.com

----- Original Message -----
From: Booth Rand <booth.rand@arkansas.gov>
To: "'S. Graham Catlett'" <gcatlett@catlaw.com>
Sent: 9/08/2014 2:10PM
Subject: RE: Proposed Rule 108

Be glad to visit with you but would prefer to do so after we notice these changes back out.

We?ve spent tons and tons of time deeply studying this issue and conflicts and the laws, manual and rule you cite down there.

The specific problem is with the PCMH section (Section 171 and Section 200) in the State Medicaid PCMH manual which clearly restricts the ?lead provider? in PCMH to ?primary care PHYSICIAN,? and not with HCIP or with Federal Medicaid

Rules or to the modern trend nationally by accrediting organizations to have a neutral provider-led definition. We are talking about who can be the LEAD provider in a PCMH model, and not whether nurses can be involved in the primary care team.

From: S. Graham Catlett [mailto:gcatlett@catlaw.com]
Sent: Monday, September 08, 2014 1:38 PM
To: Booth Rand
Subject: Proposed Rule 108

Booth

Our Firm represents the Arkansas Nurses Association and fully supported Rule 108 as proposed.

I understand that you may think it violates some rule of Medicaid; we do not. In fact the Arkansas statute is provider neutral and the federal medicaid rules are also provider neutral.

If we can visit with you before the Rule is rewritten, we would be glad to show you why we do not believe there is any legal issue with it.

Best,

Graham

S. Graham Catlett
Attorney at Law
+1.501.801.8088 ext 319 (direct)
+1.501.421.0045 (fax)
gcatlett@catlaw.com

323 Center St., Suite 1800
The Tower Building
Little Rock, AR 72201
www.catlaw.com

Chance Armour

From: Brigance, Peggy <PBrigance@uams.edu>
Sent: Tuesday, September 02, 2014 10:27 AM
To: Booth Rand
Subject: Re Proposed rule 108 and APRNs

September 2, 2014

Jay Bradford, Insurance Commissioner
Arkansas Insurance Department
1220 West Third Street
Little Rock, AR 72201-1904

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. The growing insured population in Arkansas as a result of the Healthcare Independence Act provides another important reason to have provider neutral language in this rule. It is also important to note:

- Most NPs (89%) are prepared in a primary care focus; e.g. adult, family, older adults, pediatric, or women's health (AANP, 2013). Regardless of population focus, primary care NPs are educationally prepared, nationally certified and licensed to provide primary care across many settings including but not limited to:
    - Care at first contact
    - Ongoing management of acute and chronic conditions
    - Health promotion
    - Care coordination

- Four decades of research on NP practice consistently support the high quality and cost-effectiveness of APN care. There is extensive and consistent evidence that NPs provide care of equal or better quality at a lower cost than comparable services provided by others.

As a Family Practice NP at UAMS-West in Fort Smith, I provide primary care to many patients in our patient centered medical home. I encourage you to support the provider neutral language in the Proposed rule 108, so that myself and other NPs can continue to be leaders and primary care providers.

Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Peggy Brigance, APN, FNP-C
Director of Nursing Education
UAMS AHEC West
UAMS Family Medical Center Fort Smith
UAMS CON Faculty
479-424-3163

Pbrigance@uams.edu

Cc: Booth Rand Booth.rand@arkansas.gov

October 25, 2014

Arkansas Insurance Department
Attention: Booth Rand
1200 W. Third Street
Little Rock, AR 72201-2618

Dear Mr. Rand:

I am Registered Nurse licensed to practice in Arkansas and I am writing to oppose the current Insurance Department proposed Rule 108: "Patient Centered Medical Home ("PCMH") Standards."

As a healthcare provider, my foremost concern is for the wellbeing of patients. It is in everyone's best interests to allow for an APRN to have continued access to the largest possible pool of patients. I know our legislators agree that we should strive to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The only way to achieve those goals is to allow advance practice nurses full access to patients so they can care for them to the extent of the nurses' scope of practice.

The changes made to the proposed rule issued on September 15, 2014 eliminates the ability of APRNs to lead PCMHs and deliver much needed healthcare in an efficient and cost sensitive manner. The original proposed rule, issued May 13, 2014, more closely follows the General Assembly's intent to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The Insurance Department should produce a rule that is consistent with the legislator's declared intent and allow APRNs to lead PCMHs.

Sincerely,

Sharon Parrett R.N.

Sharon Parrett R.N.

Hot Springs, AR

Cc: Representative John Vines

Arkansas Insurance Department
Attn: Booth Rand
1200 West Third Street
Little Rock, AR 72201-1904
501-371-2820

FAX: 501-371-2618

I am an advanced practice registered nurse ("APRNs") licensed to practice in Arkansas and I am writing to oppose the current Insurance Department proposed Rule 108: "Patient Centered Medical Home ("PCMH") Standards."

As a healthcare provider, my foremost concern is for the wellbeing of my patients. My continued access to the largest possible pool of patients is in everyone's best interests. I know our legislators agree that we should strive to maximize the available healthcare service options and to promote healthcare efficiencies that will deliver value to the tax payers. The only way to achieve those goals is to allow advance practice nurses full access to patients so they can care for them to the extent of the nurses' scope of practice.

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Sincerely,

J Early APRN

Jacquolyn Early ARRN

Lee County Cooperative Clinic

5121 Madison Ave
Jacksonville, AR 72076

October 25, 2014

Arkansas Insurance Department
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1200 West Third Street
Little Rock, AR 72201-1904

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Sincerely,

Leonie DeClerk, DNP, APRN, FNP-BC

LDeClerk, DNP, APRN, FNP-BC

CC: Jane English, Senator District 34

Bentonville, AR 72712
(479) 986-6090

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Facility: Arkansas Insurance Department Unit/Department:

Attention: Booth Land Phone:

SENDER INFORMATION:

Sending Fax Number: 479-986-6250

Facility: CCBH Unit/Department:

From: Christine Bryant Phone: 479-986-6090

COMMENTS:

Regarding:

☐ Continuing Medical Care
☐ Billing
☐ Legal
☐ Other

October 25, 2014

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Respectfully,

Christine Bryant, MSN, CNP, FNP-C

October 25, 2014

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Little Rock, AR 72201-2618

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Leonie DeClerk, DNP, APRN, FNP-BC

L. DeClerk, DNP, APRN, FNP-BC

CC: Jane English, Senator District 34

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Attention: Booth Land Phone:

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From: Christine Bryant Phone: 479-986-6090

COMMENTS:

Regarding:

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☐ Billing
☐ Legal
☐ Other

October 25, 2014

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Respectfully,

Christine Bryant, MSN, CNP, FNP-C

HEARING

IN THE MATTER OF

RULE 108

"PATIENT-CENTERED MEDICAL HOME STANDARDS"

HEARING PROCEEDINGS

AUGUST 5, 2014

AT 10:00 A.M.

HONORABLE WILLIAM R. LACY, DEPUTY COMMISSIONER

AND HEARING OFFICER

TIFFANIE N. HARRISON, CCR
P.O. BOX 883
LITTLE ROCK, ARKANSAS 72203
(501) 960-2219
harrisonreporting@outlook.com

APPEARANCES

Booth Rand
Managing Attorney
Arkansas Insurance Department
1200 West Third St.
Little Rock, AR 72201

Frank Sewall
Arkansas BlueCross BlueShield

Alicia Berkemeyer
Arkansas BlueCross BlueShield

Mike Stock
QualChoice

Mark Johnson
QualChoice

Craig Wilson
Arkansas Center for Health Improvement

Joe Thompson
Arkansas Center for Health Improvement

Andy Davis
Arkansas Democrat Gazette

Kelly McArthur
Arkansas Health and Wellness

Suzanne McCarthy
Arkansas Center for Health Improvement

Isaac Linam
Bureau of Legislative Research

Annabelle Tuck
Arkansas Health Insurance Marketplace

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CAPTION

PROCEEDINGS in the above-styled and numbered cause on the 5th day of August, 2014, before Tiffanie N. Harrison, Arkansas Supreme Court Certified Court Reporter #757, at 10:00 a.m., in the Hearing Room of the Arkansas Insurance Department, 1200 West Third Street, Little Rock, Arkansas, pursuant to the agreement hereinafter set forth.

* * * * * * * * * * *

PROCEEDINGS

August 5, 2014

HEARING OFFICER: My name is William R. Lacy, I have been appointed by the commissioner to reside over proposed Rule 108 hearing. I will be receiving comments, both written and oral. Mr. Rand is here on behalf of the Department. Would you like begin?

MR. RAND: I will, Mr. Officer; if that's ok.

HEARING OFFICER: Sure.

MR. RAND: We're here today to consider the promulgation of proposed Rule 108, which deals with patient-centered medical home standards. By way of background, Mr. Hearing Officer, the department has already presented under the Healthcare Independence Program Act, Act 1438 of 2013 -- 1498. The department is required to provided notice to the Legislative Council 30 days prior to rule-making. And to explain the proposed rules before we actually initiate rule-making. We did this about two months ago at the legislature and so, they had no objection to the beginning of rule-making. So, we started rule-making on PCMH on the rule. And I will just go through the -- if it's ok with the hearing officer, just go through the requirements they filed and rule notices; if that's ok.

HEARING OFFICER: That will be fine.

MR. RAND: Mr. Hearing Officer, you have already been presented or handed you a copy of the notebook. Exhibit number 1 is the Designation of Hearing Officer. Commissioner has designated you as the hearing officer for purposes of this rule today. That is Exhibit number 1, signed by Jay Bradford, August 1, 2014.

Exhibit 2, Mr. Hearing Officer, is a June 26, 2014, Notice of Public Hearing. As you know, that is our written notice that has to be distributed to the public and it is providing notice to the public as to when the hearing date is for consideration of the rule, to receive comments, written comments and oral comments. It establishes the date, time and place of the hearing. That is exhibit number two. We do blast out or email these notices of public hearings to interested parties who have signed up to be informed of our public hearings. They are also uploaded and provided notice from our website for pending hearings.

Exhibit 2A, Mr. Hearing Officer, is a copy of the AID mail out of the NOPH of proposed rule 108 that was emailed to persons who had agreed to or wanted to receive notices of our public hearings.

Exhibit 3 is a copy of the proposed rule that we filed with the Legislative Research on June 26, 2014.

Exhibit four is a copy, as you know, under the APA

we are required to run an advertisement, advertising the date of the hearing, 30 days in advance of the hearing for three days in the Arkansas APA. Exhibit 4 is a copy of the billing statement and reflection from the Arkansas Democrat Gazette that we ran an ad for three days on June 30th, July 1st and July 2nd providing notice of today's hearing in consideration of the -- providing time, date, place of the hearing for today's discussion of the proposed rule. The ad copy that ran is on the corner or side of Exhibit number four.

Exhibit 5 is the cover letter that we submitted to the Legislative Research -- Arkansas Legislative Council, Ms. Donna Davis. With that cover letter and Exhibit 5 are several exhibits that we intend to provide Legislative Council. One of which is Exhibit 6, which is a copy of our questionnaire. Legislative Council and I believe, statutorily, were required to fill out these questionnaires. Basically -- not reading all the questions and answers -- basically asked the purposes of the rule. Whether -- what's the financial impact, Whether it's emergency rule, whether its controversial. I'm not going to go through all the answers, but the -- we did file one of those with our cover letter that's Exhibit 6.

Exhibit 6 also includes an economic statement, that

discusses the economic impact from the purposed rule and discusses the benefits of the proposed rule and costs; if we know them.

Exhibit 7 is -- Mr. Hearing Officer, as you know, we have to provide notice to other governmental bodies, one of which is the Governor's office. Mr. James Miller was given a copy of the rule, proposed rule. On June 26th we mailed that to him of 2014, discussing or providing a copy of the rule.

Exhibit 8, we are also required to notify Attorney General's office, when we begin rule-making. We gave Mr. Brandon Robinson, who is our liaison at the AG's office for the Insurance Department, he was given a copy of our rule June 30th.

Exhibit 9 is -- we are required to provide the copy of the rule to the Arkansas Secretary of State, which we did on June 26th. Exhibit 9, I think, the back part of Exhibit 9, Lorraine -- Ms. Rowland, who is our legal administrative assistant, provided electronic notices to the Secretary of State.

Exhibit 10, we are also required to provide and file copies of the proposed rule with the Arkansas State Library. Exhibit 10 is a copy of the cover letter that was sent to the library.

Finally, Exhibit 11, we are also required, I

believe by statute, to provide the Economic Development Commission with notice and a copy of our proposed rule so that they can provide comments if they want to. Exhibit 11 is a June 26, 2014 letter to Ms. Pat Brown at AEDC.

Exhibit 12, the Legislative Council likes me to provide a summary of the proposed rule and try to make it as brief as I can. And in it, I am explaining what the rule does and what the purpose of the rule is and how it is to function. Part of the summary, Mr. Hearing Officer, that we gave to the Legislative Council included a power point presentation or model that the Surgeon General and ACHI, Arkansas Center of Health Improvement, is provided with ADHS and developed -- it's provides a basic understanding of how the Arkansas Provider Medicaid Manual and ACHI and others envision and want PCMH, or Patient-centered Medical Home, requirements to be applied to work and in tandem with the Arkansas Payment Improvement Initiatives and shared savings. And so, I wanted to give Legislative Council, in addition to my summary, a copy of the power point, which I think is a pretty good description of the goals of PCMH. Dr. Joe Thompson is here to discuss those, if you have some questions.

Exhibit 13 is a copy of the earlier requirement

that we had presented the rule to the Legislative Council 30 days before the department began its rule-making, which I talked about initially in my remarks. And that is all. And so, at this time we move to admit those items into administrative record, before I discuss the comments and have those entered into evidence.

HEARING OFFICER: Okay. So, the fist 13 exhibits without objection will be admitted and made part of the record of this hearing?

MR. RAND: Yes. Okay. Mr. Hearing Officer, we have got many exhibits where there are public comments that I have attached to the notebook and want to make part of the record. I am not going to read everybody's letter. I will just identify the letter and understand that I might make a general remark and it may not be entirely thorough for your comments, but I just want to identify those. And we have those in the record for the hearing officer to review, as well as the Commissioner. The Commissioner will review these. I'll just go through these, Mr. Hearing Officer, at this time.

HEARING OFFICER: Okay.

MR. RAND: Exhibit number one, which I will call PC Exhibit number one for public comment is an August 4, 2014 letter from Mr. Frank Sewell, who is Regulatory

Counsel for Arkansas Blue Cross and Blue Shield. Mr. Sewell has got several concerns and issues with respect to some of the wording with the rule. All of which the department is aware of and we can discuss these issues. But, that is PC, public comment number 1. And Mr. Sewell, or someone from Blue Cross and Blue Shield, may be here to provide oral comments about these concerns.

Public Comment number two is a letter from Dr. Clark Fincher with the Arkansas Chapter of the American College of Physicians, who has an objection to the broad definition of primary care professional in the proposed rule. Many of the physician providers, who are providing comments today, in writing or -- are concerned about the broad definition not being restricted to physician-led PCMH. That is public comment number two.

Public comment number three is a comment coming from the American Academy of Pediatrics, singed by Aimee Ollinghouse, Executive Director of Arkansas Chapter of American Academy of Pediatrics. I'm not going to read all the rule, but again, the point from this organization is that the PCMH, the PCP, primary care provider, primary care professional -- the definition in the proposed rule should be restricted to physician-led practices and should not be broad and opened ended to permit anyone to be a primary care professional. It

should be physician restricted. She sets out the reasons why that is necessary.

Public comment number four is a comment from Dr. Kimberly Carney, who is supportive of the neutral language of the primary care professional definition in the proposed rule, where it is not restricted to physicians.

Public comment number five, is a comment from the Arkansas Medical Society by Scott Smith, who again -- this is a comment or concern about the broad scope of the definition of primary care professional. I believe Scott and David Wroten and the Arkansas Medial Society are concerned that, although they appreciate the role of nurses and advanced nurse practitioners in the role of management of patient care, providing care, they are concerned that an open ended definition of primary care professionals not desired by the legislature and it's not consistent with the Arkansas Provider Medicaid Manual, which is restricting PCMH and it's Medicaid Manual to physician-led PCMH. And so, they have objections to the definition of primary care proposed and provided alternative language restricting, and specific to, the physicians that are licensed by the board, the Arkansas Medical Board.

Public comment number 6 is a letter from the

Arkansas Academy of Family Physicians. Again, this is another criticism or objection to the rule not being restricted to physician-led PCMH. It is a letter from Dr. Lonnie Robinson, M.D.

Public comment number 7 is a comment, written comment from Ms. Cheryl Perry, a nurse from Fayetteville. She is providing -- written to the department, pleased with the neutral definition of primary care professional and believes it's progressive and modern forward thinking and it needs to be preserved in the proposed rule.

Public comment number 8 is another -- it's an email or letter from a nurse from Mountain Home, who is in support of the provider neutral language in the primary care professional -- in the professional primary care provider definition that we have in the proposed rule.

I'm going to add, this is public comment number 9, which came in late yesterday afternoon, Mr. Hearing Officer. It is a written comment from the Arkansas AARP. AARP is in support of the proposed rule's neutral primary care provider definition. It is signed by Maria Reynolds Diaz and she advocates keeping a more neutral definition due to the need for having nurses and others off-set the low volume of primary -- family physicians that we have in Arkansas. So, those are the public

comments that I received today, Mr. Hearing Officer. I will move at this time to admit those into evidence.

HEARING OFFICER: Okay. The written public comments are going to be received and made part of the record, including that last one. That would be -- when will these be made available to the public?

MR. RAND: I can get them out, I guess, a couple days. Two days. Two or three days.

HEARING OFFICER: You can?

MR. RAND: Yes, sir.

HEARING OFFICER: Put on the website?

MR. RAND: Yes. I want to also add into the administrative record, Mr. Hearing Officer, a copy of the Arkansas Provider of Medicaid Manual on PCMH, which I would like to make as Exhibit 14 - no 15, Exhibit 15. So, if the Commissioner can see the PCMH Medicaid Provider Manual. Then I want to also make a copy and add to the administrative record the Arkansas Act 1498, which is the HCIP, Health Care Independence Program Act. I would like to make that Exhibit 16.

HEARING OFFICER: That's 20-77-2101 et seq?

MR. RAND: Correct.

HEARING OFFICER: Okay.

MR. RAND: And for everyone's identification, it's my understanding that the Act, although is referencing

20-77-2101 et seq. It is now being recodified, so if you are looking in your Arkansas Code Annotated for this law, it's going to be in the 2400 sub chapters. But, the act itself, refers to the 2100. So, we will edit the rule accordingly to change the cites to the more recently codified statutory sections that we refer to in the rule to the 2400's.

HEARING OFFICER: Exhibits 15 and 16 will be admitted.

MR. RAND: Yes, Mr. Hearing Officer, at this time.

HEARING OFFICER: Do you have anything else?

MR. RAND: I do. Before we go into public comments, just a sort of, brief description of some of the issues in the rule, which you may have -- sort of gleaned from the comments that I made. Mr. Hearing Officer, the proposed rule, as it is written, has several issues and concerns that have been raised. One of the most primary concerns is, as it's written currently, the definition that is proposed, if the Hearing Officer will look at a copy of the proposed rule, under section 412, the primary disputes or dispute in this rule, other than possible concerns over the fees, and need for the fees and those things, is that under the -- the only known state standards that had been published for patient medical - patient-centered medical home, Mr. Hearing

Officer, have been published by the Arkansas ADHS, under the Medicaid Provider Manual.

If we look at the PCMH provisions in the Arkansas Provider Medicaid Manual, there is a clear restriction that the PCMH teams have to be led by physicians. It is spread throughout the whole Medicaid manual. There is no discretion or permission for a nurse-led or physician assistant-led PCMH team. Ms. Crone, I believe wants to -- is desired to have a more progressive and modern definition of who can lead PCMH programs. There is another national model by NCQA, National Committee of Quality Assurance, who recently, I believe in their model, permit nurse or physician assistant led PCMH, assuming certain conditions are complied with. Ms. Crone desires a modern, progressive, open, definition that's not restricted to physicians. It conflicts with the Arkansas Medicaid Provider Manual, which does restrict the PCMH program to physicians.

Currently, Arkansas Medicaid is employing PCMH in Medicaid, for traditional Medicaid beneficiaries in pilot programs that are being participated in by Arkansas Blue and Cross Blue Shield, QCA, Delta Dental, I believe EVD, and in those programs, the -- these carriers are following the Arkansas Medicaid Provider Manual, which is a physician restricted led PCMH model.

I believe our position, or the department's position, is to encourage the open definition of a primary care provider's to report more with modern, progressive, developments in permitted nurse-led or physician assistant-led or nurse-led PCMH teams. And we would like to emphasize the department doesn't want to get involved in the dispute between the two groups. The providers, the physician providers and nurses, over who gets to lead the actual PCMH team or not.

We do recognize the Medicaid Model does not allow for nurses. We, however, in our definition would like to emphasize that we wanted to allow the carrier to make this decision of designation. It is not -- we are not mandating that nurses be a PCMH-led entity. We are allowing the carrier to make the decision to let a nurse or someone else do that, or not. It is strictly up to the carrier the way we have written the definition of primary care provider.

The other issues are about the inexactitude or lack of clarity in the proposed rule as to what model we're talking about. The Arkansas provided Medicaid requirements are actually a rule. They are not really called a model. So, we will propose to edit the proposed rule as it is, to define the Arkansas model to be the Provider Medicaid Manual model in PCMH. And when

we do an edit of the rule. And we also are proposed to define primary care provider to make it clear that the designation of provider type, although the definition is open, would be a designation determination by the health carrier.

So, we're going to make some changes to this to reflect and provide more exactitude as to what we're talking about when we refer to the state model or national model. National model, as I understand it, is the NCQA, PCMH model, which I believe they most recently developed or sent out in March of 2014. So, we're going to clarify these models. Some of the objections to the rule have been that the rules language, which permits compared to follow a state or national model as approved by the commissioner, is not clear enough for the carriers to decide what particularly we're talking about. So, we are going to go back into this rule and edit the rule to make it clear what models we're talking about. So, that's some suggestions that we're going to do.

The other part of this rule relates to the practice support fee. Carriers will have to pay for providers who want to participate in a PCMH program. Again, this is a voluntary program. The carriers will have to pay five dollars per enrollment, per month. There is a fee

amount. Dr. Joe Thompson and Craig from ACHI is here to explain how that fee was arrived at, and why it's needed. And it is my understanding to help off-set costs the providers are having to incur to try to develop these programs, which has an overall goal of reducing costs and improving patient care. So, Joe is here to talk about that if you have any questions. So, Mr. Hearing Officer, that's all I had to say.

We do intend to make edits to these, to clarify and fix some of the lack of exactitude as to the models. And to make it more clear, at least in the definition of primary care provider, that it is the designation and determination of the provider type that's going to be done by the carrier, not by the department.

HEARING OFFICER: Okay. Thank you Mr. Rand.

MR. THOMPSON: Mr. Hearing Officer, if I can just add one thing.

HEARING OFFICER: One second. So, are we now ready for public comments?

MR. RAND: Yes.

HEARING OFFICER: And I guess, Joe Thompson, is first.

MR. RAND: Yes.

HEARING OFFICER: Go ahead. Please identify yourself.

MR. THOMPSON: Sure. Joe Thompson, Director of the Center for Health Improvement and Surgeon General for the State. I just want to clarify on the Medicaid Patient-centered Medical Home Model, advanced practice nurses can fully participate, but not autonomously participate. They can have a panel of patients. They can serve as the primary care clinician, but the team itself has to have a physician lead to be able to qualify as a participating entity.

I think the issue in the comment letters are specifically about the autonomy of the leader of that team. Whether it requires a physician leader or whether it does not require a physician leader. I think the other thing that is important is, for now four years in a multi payer efforts, we have had the Arkansas Payment Improvement Initiative moving forward. It has had participation of QualChoice, Blue Cross, Public and -- the public school employees, the state employees. We also have private self insurers, Walmart and others, participating with the legislative passage of the Healthcare Independence Act. Because of concerns about cost containment, legislature did write in to the Act the requirement of carriers participating in the market place through the private option to participate in the payment improvement effort that effectively transitioned

it from a carrier voluntary participation to a condition of market place participation. And moving forward we have, with the carriers, a major federal grant or state innovation grant that is supporting the continued transformation.

The rule is intended to set a floor of what the carriers are obligated to support. The voluntarily participating primary care providers carries can obviously exceed that floor, should they want to. The final comment is the per member, per month, payments are to the providers so that they are reaching out and assisting individuals that may or may not frequent their clinic. So, it is not tied to a utilization based visit. It is actually tied to a population based responsibility that those providers are newly taking on and, therefore, the per member, per month, payments are the support for that.

I mentioned the variation per member, per month, in our model. Medicare is paying on average twenty dollars per member, per month. That varies from eight to forty based upon risk of the individual. Medicaid, combining it's pre-existing per member, per month, is paying seven dollars and the commercial target at five dollars, was based upon the participating level of our progress, to date, in the patient-centered medical home development.

HEARING OFFICER: Thank you. Are there any other interested parties seeking to comment?

MR. SEWELL: Yes.

HEARING OFFIER: Okay. Mr. Sewell. And I assume, Mr. Sewell, this will supplement your written response, and not replace it in full?

MR. SEWELL: I will be brief, Mr. Hearing Officer.

HEARING OFFICER: Okay.

MR. SEWELL: My name is Frank Sewell. I am Senior Counsel for Regulatory Affairs at Arkansas Blue Cross and Blue Shield. Today, I have with me to answer your questions, if you have any, Alicia Berkemeyer is our Vice President for Primary Care Physician or Provider Initiatives.

I want to emphasize, first of all, and I think the comments of Dr. Thompson and Mr. Rand, both mentioned this, that Arkansas Blue Cross and Blue Shield is an enthusiastic supporter of patient-centered medical home. We have been -- we started piloting this program with our various practices that serve our members in 2010. We have participated in the program that Dr. Thompson mentioned and we have developed patient-centered medical home practices throughout the state.

Having said that, I have some concerns about the rule, the way it is written and I appreciate Mr. Rand's

comments about clarifying some of the provisions in the rule. I think that may resolve, at least in part, some of the comments that we gave to you. We're concerned about being able to maintain flexibility as a carrier in continuing to develop patient-centered medical home.

We have some concerns about the rule, because, first of all, we believe it's over-broad. I think Dr. Thompson correctly stated what the Arkansas Healthcare Independence Act provides. It provides that carriers who participate in the market place to provide coverage through the private option are required to provide patient-centered medical home. That means the rule, the way I read it, is that any carriers who participate in the market place are required to provide patient-centered medical home as part of their certification. I don't think, and I point these facts out in detail in my letter -- I don't think that -- certainly the Arkansas Independence Act doesn't say that, and I don't think that the federal law, the Affordable Care Act of 2010 or any regulations issued thus far say that. They do encourage carriers to participate in various quality initiatives; patient-centered medical home being one of them. But it doesn't anywhere specify that in order to get certification through the exchange, the carrier must participate in patient-centered medical home.

Secondly, and I mentioned specifically our concerns and Mr. Rand has already stated one of them. I don't think that the standards for compliance with this rule, as far as what carriers have to do, are clear. There are a lot of general statements about the operation of patient-centered medical homes, the affiliation of members to patient-centered medical home, but I think there should be more flexibility there. For example, part of the rule says that he used the previous year's claims experience to assign individuals to a PCP if those individuals do not choose a PCP. Why limit it to one year? I mean, are there any other methods of making that affiliation that have not been thought of yet?

Finally, I think since it's our view that the patient-centered medical home requirement, that's imposed by the Arkansas Independence Act, relates directly to the Arkansas Independence -- Healthcare Independence Program, commonly known as the private option, which is sponsored by DHS and the Medicaid program; that the patient-centered medical home model that should be used is the Arkansas Medicaid developed patient-centered medical home model. And that model has a lot of the specifics in it already that this rule sort of alludes to, but doesn't make any specific standard. And I think that the Insurance Department should

regulate insurance companies and the financial and marketing of insurance, and we should leave the operation of patient-centered medical home, especially with respect to the private option, to the Department of Human Services.

And finally, I have to plead that this regulation, in some areas, may be premature. Patient-centered medical home is a relatively new concept here in Arkansas. We've been wanting to do -- you know, as a state citizen and as a former regulator, I do not think that the Commissioner or anyone else wants to scratch patient-centered medical home by over regulating the concept, now. And, you know, we provided a copy of a draft rule to the department to consider in whatever edits it makes. And I am sure Mr. Rand will look at that and if he has any questions he'll call me and he'll adopt those provisions and recommend them to the Hearing Officer, that he thinks are appropriate and the Commissioner thinks appropriate. But, we're offering this as a enthusiastic supporter of patient-centered medical home.

HEARING OFFICER: Thank you Mr. Sewell. Is there anyone else that would like to make any oral statement or comment? Mr. Rand, would you like to respond?

MR. RAND: I would -- if Dr. Thompson would like to

respond to Frank's comments about that. I'll let Joe -- let me say, initially, the issue about whether PCMH is restricted in its application only to program eligible individuals, which are your below 138, but not eligible for Medicare, private option people, derives from some language in one of the sub sections that says that the programs are for program eligible individuals.

We respectfully take the interpretation that if you are participating in health insurance market place and you are participating in providing plans to these program eligible individuals, you are required to support PCMH, even if you've got others in the exchange who are not HCIP, or not private option. So, also -- and Joe can talk about this, the program works much better by including everybody in the health insurance market place and the PCMH support model. He can address that. So, we will try to clarify and make suggestion edits so that people will understand what models we're referring to and so on. But, in terms of some of his comments, I better let Dr. Thompson respond to them.

HEARING OFFICER: Dr. Thompson, you can respond if you wish.

MR. THOMPSON: So, I'd like to pick up the issue of separation of insurance rules from Medicaid rules and the integration of those efforts in the Arkansas Health

Insurance market place. We had received a waiver and from the Center for Medicaid and Children Services and support from the Federal CCIIO Agency to actually do the new and innovative private option strategy. This is a new Medicaid strategy that previously has not been implemented anywhere in the United States. It effectively authorizes the Division of Human Services to pay premium support to insurance carriers on the market place and buy private health insurance.

That insurance offering is governed by and overseen by the Department of Insurance, not the Department of Human Services. It is a separation of Medicaid authority to buy private health insurance coverage. It still has to abide through the Department of Human Services by Medicaid law, but it is, in its application, locally governed by the Department of Insurance and the Commissioner. Thus the requirement for this rule to be applied to the carriers operating on the market place, the Division of Medical Services, the Division of Human Services, does not have any authority to apply a rule to carriers on the health insurance marketplace. It has seeded that authority to the Insurance Department.

In doing so, there are two important agreements that are in place. One is a memorandum of agreement between the Department of Human Services and the

Department of Insurance. A second set of agreements are in place between each of the participating carriers and both the Department of Insurance and the Department of Human Services, that outline this transfer of responsibility from human services to the Insurance Department.

So, I think, again, just adding, hopefully, some clarification. This is not Medicaid managing a Medicaid managed-care contract on the carriers. This is Medicaid using premium assistant to buy private health insurance on a private marketplace, overseen by the Department of Insurance. And that's the reason that you have this rule coming through the Department of Insurance regulatory process and referring to a rule that Medicaid has established in a simplimentation of the mulit-payer efforts and the payment improvement effort. So, I think that's the clarifying piece on that construct and it may be that those documents would be of value. I don't know.

HEARING OFFICER: Okay. Are there any more oral statements? And those that have been made are received and are to be made part of the record. Do we need to hold the record open for any reason?

MR. RAND: Let me make a suggestion, giving the number of concerns or objections that we keep the record

open for 30 days. If the department may require edits to -- changes to the rule to make it more clear as to definition of the model to be used and to more better clarify some of the concerns of the Arkansas Blue Cross is making and others. And then I would think if there is enough edits, this is sort of a judgment call, we would re-notice the rule next month and have everybody come back after looking at an amended rule and have these discussions or objections again.

I think that if I make all the changes or edits that are going to be made, that we change the nature of the rule significantly enough that I could not leave this hearing room, go to Legislative Council, without someone possibly raising the fact that we significantly changed the rule without notice. So, we've got some time here, the rules effective is January 1, 2015. I would propose to keep the record open for 30 days for edits. And if the department would republish a new amended rule and then set it for another hearing and have people come back and make comments.

HEARING OFFICER: Okay. The record will remain open for 30 days. Let's see today is the fifth, so that would be August the 4th? No, it's September 4th, we're in August.

MR. RAND: And with a goal there of a hearing in

late or mid to late October.

HEARING OFFICER: We'll see what dates September the 4th is on. That's a Thursday, so why don't we hold open until Friday, September the 5th. Okay. In the meantime, Mr. Rand will take the comments under advisement, will discuss with the commissioner and you will do the edits we know that need to be made. We'll discuss the additional concerns and make what we can make there. And then it is likely that we'll need to notice it back out.

MR. RAND: It is, but it's not guaranteed, so. The Commissioner may like the way it's worded.

HEARING OFFICER: So, if everybody likes the way it's worded by the 5th, then that will be it. Otherwise, you will be getting a notice on probably the 8th or the 9th. Okay, if there is nothing else, then this hearing is complete.

(WHEREUPON, the proceedings were concluded in this matter at 10:42 a.m.)

CERTIFICATE

STATE OF ARKANSAS)
)ss
COUNTY OF PULASKI)

I, Tiffanie N. Harrison, CCR, Certified Stenomask Reporter before whom the foregoing testimony was taken, do hereby certify that the witness was duly sworn by me; that the testimony of said witness was taken by me and was thereafter reduced to typewritten form under my supervision; that the deposition is a true and correct record of the testimony given by said witness; that I am neither counsel for, related to, nor employed by the parties to the action in which this deposition was taken, and further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially interested in the outcome of this action.

I FURTHER CERTIFY, that I have no contract with the parties within this action that affects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original deposition transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties to the action.

WITNESS MY HAND AND SEAL this 5th day of September, 2014.

ARKANSAS SUPREME COURT
TIFFANIE HARRISON
No. 757
CERTIFIED COURT REPORTER

Tiffanie Harrison

TIFFANIE N. HARRISON
Arkansas State Supreme Court
Certified Court Reporter #757

TIFFANIE N. HARRISON
PULASKI COUNTY
NOTARY PUBLIC - ARKANSAS
My Commission Expires January 21, 2023
Commission No. 12391770

EXHIBIT LIST

DATE: August 5, 2014

SUBJECT: Proposed Rule 108
"Patient-Centered Medical Home Standards"

HEARING OFFICER: William R. Lacy,
Deputy Commissioner

Exhibit No.	Description
1.	Designation of Hearing Officer
2.	Arkansas Insurance Department's June 26, 2014 NOTICE OF PUBLIC HEARING concerning Proposed Rule 108 "Patient-Centered Medical Home Standards"
3.	Proposed Rule 108"Patient-Centered Medical Home Standards"
4.	Proof of Publication of Hearing on Proposed Amended Rule 108 in the Arkansas Democrat-Gazette as required by the Arkansas Administrative Procedures Act, Ark. Code Ann. §§ 25-15-201, *et seq.*
5.	Copy of June 26, 2014 correspondence regarding submission of Proposed Rule 108 to the Arkansas Bureau of Legislative Research
6.	Questionnaire and Financial Impact Statement for Proposed Rule 108
7.	Copy of June 26, 2014 correspondence to James Miller, Regulatory Liaison, Office of the Governor, providing Notice of Public Hearing and Proposed Rule 108
8.	Copy of June 26, 2014 correspondence to Brandon Robinson, Assistant Attorney General, Office of the Attorney General, providing Notice of Public Hearing and Proposed Rule 108
9.	Copy of June 26, 2014 correspondence to the Arkansas Secretary of State, providing copies of the Notice of Public Hearing and Proposed Rule 108, including June 27, 2014 email to Secretary of State
10.	Copy of June 26, 2014 correspondence to Mary Brewer, Arkansas State Library, providing Notice of Hearing, Proposed Rule 108 and Financial Impact Statement

11. Copy of June 26, 2014 correspondence to Pat Brown, Arkansas Economic Development Commission, providing Notice of Hearing and a copy of Proposed Rule 108

12. Summary of Proposed Rule 108

13. Arkansas Insurance Department's May 13, 2014 correspondence regarding presentment of Proposed Rule 108 to the Arkansas Bureau of Legislative Council

14. Comments Regarding Proposed Rule 108

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

DESIGNATION OF HEARING OFFICER

DATE: August 1, 2014

SUBJECT: PROPOSED RULE 108

HEARING OFFICER: WILLIAM LACY
GENERAL COUNSEL AND DEPUTY COMMISSIONER

Pursuant to Ark. Code Ann. § 23-61-103(e)(1), I hereby delegate William Lacy, General Counsel and Deputy Commissioner, to serve as the Hearing Officer in the above-referenced matter. Pursuant to this Designation, Mr. Lacy will have at his disposal all of the powers and duties vested in the office of the Commissioner of Insurance for the State of Arkansas.

Jay Bradford

JAY BRADFORD
INSURANCE COMMISSIONER
STATE OF ARKANSAS

August 1, 2014
Date

EXHIBIT
1

1200 West Third Street, Little Rock, AR 72201-1904 · (501) 371-2600 · (501) 371-2618 fax · www.insurance.arkansas.gov
Information (800) 282-9134 · Consumer Services (800) 852-5494 · Seniors (800) 224-6330 · Criminal Inv. (866) 660-0888

data for providers. The HCIP requires Health Carriers to participate in the APII as multi-payer participants and to attribute QHP beneficiaries to primary care providers, provide practice support for PCMH implementation, and enable provider access to clinical performance data. APII participation required by this Rule does not preclude Health Carriers from developing separate and distinct care delivery models and offering to providers financial or other support to promote practice transformation and care coordination and incentives on quality and cost of care through shared savings, so long as the standards for such delivery models and support reasonably follow the standards outlined in the APII. This Rule requires Health Carriers to participate in PCMH standards as one active or available option for primary care providers in Qualified Health Plan networks on or after January 1, 2015. Additionally, these standards set a floor for participation and do not preclude Health Carriers from developing and implementing standards that exceed the requirements set forth in this Rule.

Section 4. Definitions

The following definitions shall apply in this Rule, unless otherwise defined by HCIP:

(1) "ADHS" means the Arkansas Department of Human Services;

(2) "AID" means the Arkansas Insurance Department;

(3) "APII" means the Arkansas Payment Improvement Initiatives, as referenced in Ark. Code Ann. § 20-77-2106(d), which is a multi-payer program that connects medical payment to medical providers to achieve high quality care at an appropriate cost for QHP Enrollees;

(4) "DMS" means the Arkansas Department of Medicaid Services under ADHS;

(5) "HCIP" means the Program established under Act 1498 of 2013 by the Arkansas State Legislature known as the "Health Care Independence Act of 2013";

(6) "Health Carrier" means a private entity certified by AID and offering plans through the Health Insurance Marketplace;

(7) "Healthcare coverage" shall mean healthcare benefits as defined under Ark. Code Ann. § 20-77-2104(4);

(8) "Health Insurance Marketplace" means the marketplace as defined by Ark. Code Ann. § 20-77-2104(5);

(9) "Qualified Health Plan" means an AID certified individual health insurance plan offered by a Health Carrier through the Health Insurance Marketplace;

(10) "QHP Enrollee" means a person insured under a Qualified Health Plan;

(11) "Patient Centered Medical Home" ("PCMH") means a local point of access to care that proactively looks after patients' health on a "24-7" basis. A PCMH bears responsibility for coordinating care to address the complete health needs of a patient population and supports patients to connect with other providers to form a health services team, customized for their patients' care needs with a focus on prevention and management of chronic disease through monitoring patient progress and coordination of care;

(12) "Primary care provider" means a participating health care provider practicing within their licensed scope of practice and designated by the Health Carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the Health Carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

Section 5. Requirements

For QHPs issued on or after January 1, 2015, Health Carriers shall adopt the following requirements and provide the opportunity for primary care providers to participate in an approved PCMH model according to these standards:

(a) The Health Carrier must reasonably follow the standards or guidelines of a national or State standardized PCMH model as approved by the Commissioner;

(b) Health Carriers will prospectively attribute QHP enrollees to primary care practices either based on enrollee choice or according to the plurality of professional visits for primary care evaluation and management paid by the Health Carrier over the prior year. Health Carriers may develop their own method for attributing enrollees for whom coverage was discontinuous during the prior year;

(c) Health Carriers will offer practice support to primary care .provider practices that have been identified by Medicaid as participating in the Arkansas PCMH model through the APII. Health Carriers may identify additional PCMH participants with at least three hundred (300) enrollees for inclusion in the Arkansas PCMH Model. Practice support will be provided in the form of care coordination payments equivalent to or greater than an average of five dollars ($5.00) per .enrollee per month. Health Carriers may use a risk adjustment method of their choosing for determining the actual payment, so long as the average payment per enrollee is no less than five dollars ($5.00) per month;

(d) Health Carriers may terminate payment of practice support for provider failure to meet milestones or deadlines for practice transformation activities and benchmarks or targets for clinical quality. In order to minimize provider administrative burden and encourage meaningful data reporting, quality metrics collected and reported by Health Carriers must incorporate Arkansas PCMH model requirements;

(e) Health Carriers shall provide performance reports for PCMH practice transformation and quality on a quarterly basis. A standardized report form shall be made available to Health Carriers from the Arkansas Health Care Payment Improvement Initiative Web Site (www.paymentinitiative.org) and reporting

should include total cost of patient care and care categories (not shown in referenced report);

(f) Health Carriers shall share statistics with AID or its designee(s) (output of analyzed claims data used to create above reports) for streamlined provider use at an aggregate multi-payer level;

(g) On or after January 1, 2016, Health Carriers should expect to participate in development of mechanisms to share savings with PCMH practices for achieving a per issuer enrollee cost of care that is below its benchmark cost.

(h) Health Carriers shall educate QHP enrollees about the Health Carrier's PCMH program and indicate which practices are participating in the program.

Section 6. Enforcement

AID shall review a Health Carrier's compliance with the provisions of this Rule in its role of recommending approval or non-approval for certification of qualified health plans sold in the Health Insurance Marketplace.

Section 7. Effective Date

The effective date of this Rule shall be January 1, 2015.

_____

JAY BRADFORD
INSURANCE COMMISSIONER

_____

DATE

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

DATE: JUNE 26, 2014

TO: ALL ACCIDENT AND HEALTH INSURERS, HEALTH MAINTENANCE ORGANIZATIONS AND HOSPITAL AND MEDICAL SERVICE CORPORATIONS & OTHER INTERESTED PARTIES

FROM: ARKANSAS INSURANCE DEPARTMENT

SUBJECT: RULE 108: "PATIENT-CENTERED MEDICAL HOME STANDARDS"

NOTICE OF PUBLIC HEARING

Please find attached or available by electronic publication by the Arkansas Insurance Department ("Department") Proposed Rule 108, "PATIENT-CENTERED MEDICAL HOME STANDARDS." The Arkansas Insurance Commissioner ("Commissioner") is proposing to issue a regulation governing patient-centered medical home programs for health care insurers issuing policies in the health insurance marketplace under Act 1498 of 2013 of the Arkansas Eighty-Ninth General Assembly, known as the "Health Care Independence Act of 2013."

Pursuant to Ark. Code Ann. §§20-77-2105(g)(1), 20-77-2106(e), 23-61-108(a)(1), 23-61-108(b)(1), and other applicable laws or rules, NOTICE is hereby given that a PUBLIC HEARING will be held on August 5, 2014, at 10:00 A.M., in the First Floor Hearing Room, Arkansas Insurance Department ("Department"), 1200 West Third Street, Little Rock, Arkansas.

The purpose of the Public Hearing will be to determine whether the Commissioner should adopt Proposed Rule 108, "PATIENT-CENTERED MEDICAL HOME STANDARDS."

All interested persons are encouraged to make comments, statements or opinions to the address below or attend the Public Hearing and present, orally or in writing, statements, arguments or opinions on the proposed Rule. All licensees and other interested persons are responsible for notifying all their personnel, agents, and employees about this Public Hearing.

Persons wishing to testify should notify the Legal Division as soon as possible, and are requested to submit intended statements in writing in advance.

Direct your inquiries to the Legal Division at (501) 371-2820 or insurance.legal@arkansas.gov.

A copy of Proposed Rule 108 can be obtained or viewed on the Legal Division's Internet Web Site at http://insurance.arkansas.gov/Legal%20Dataservices/divpage.htm.

Sincerely,

Booth Rand
Managing Attorney
Arkansas Insurance Department

EXHIBIT
2

LoRraine Rowland

From: AIDMAILOUT
Sent: Tuesday, July 01, 2014 5:01 PM
To: AIDMAILOUT
Cc: LoRraine Rowland
Subject: Notice of Hearing and Proposed Rule 108 "Patient-Centered Medical Home Standards"

Please click on the link below to view the Department's Notice of Hearing and Proposed Rule 108 "Patient-Centered Medical Home Standards"

http://insurance.arkansas.gov/prop-rules.htm

Should you have questions regarding this proposed rule please contact Booth Rand @501-371-2820 or booth.rand@arkansas.gov

Sincerely,

To remove your e-mail address from our mailing list, please click here to sign in. Then select "Remove E-Mail Address".

EXHIBIT
2a

PROPOSED RULE 108
PATIENT-CENTERED MEDICAL HOME STANDARDS

Table of Contents

Section 1. Authority
Section 2. Purpose
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Section 1. Authority

This Rule is issued pursuant to Section One of Act 1498 of 2013 of the Arkansas Eighty-Ninth General Assembly, also known as the "Health Care Independence Act of 2013" (hereafter, the "Health Care Independence Program," or "HCIP"), now codified in Ark. Code Ann. §§ 20-77-2101 et seq. Pursuant to Ark. Code Ann. § 20-77-2105(g)(1) and Ark. Code Ann. § 20-77-2106(e), the Arkansas Insurance Department ("AID") and Arkansas Department of Human Services ("ADHS") are authorized to issue Rules to implement provisions under HCIP. In addition, this Rule is issued pursuant to Ark. Code Ann. § 23-61-108(b)(1) which states that the Arkansas Insurance Commissioner ("Commissioner") has authority to promulgate rules and regulations necessary for the effective regulation of the business of insurance.

Section 2. Purpose

The purpose of this Rule is to provide standards for patient-centered medical home ("PCMH") programs for Health Carriers in the Health Insurance Marketplace which issue Qualified Health Plans ("QHPs") on or after January 1, 2015.

Section 3. Applicability & Scope

This Rule applies to all Health Carriers issuing QHPs in the Health Insurance Marketplace on or after January 1, 2015. Under Ark. Code Ann. § 20-77-2106(d), Health Carriers participating in the Health Insurance Marketplace are required to participate in in Arkansas Payment Improvement Initiatives ("APII") including: (1) Assignment of primary care clinician; (2) Support for patient-centered medical home; and (3) Access of clinical performance

data for providers. The HCIP requires Health Carriers to participate in the APII as multi-payer participants and to attribute QHP beneficiaries to primary care providers, provide practice support for PCMH implementation, and enable provider access to clinical performance data. APII participation required by this Rule does not preclude Health Carriers from developing separate and distinct care delivery models and offering to providers financial or other support to promote practice transformation and care coordination and incentives on quality and cost of care through shared savings, so long as the standards for such delivery models and support reasonably follow the standards outlined in the APII. This Rule requires Health Carriers to participate in PCMH standards as one active or available option for primary care providers in Qualified Health Plan networks on or after January 1, 2015. Additionally, these standards set a floor for participation and do not preclude Health Carriers from developing and implementing standards that exceed the requirements set forth in this Rule.

Section 4. Definitions

The following definitions shall apply in this Rule, unless otherwise defined by HCIP:

(1) "ADHS" means the Arkansas Department of Human Services;

(2) "AID" means the Arkansas Insurance Department;

(3) "APII" means the Arkansas Payment Improvement Initiatives, as referenced in Ark. Code Ann. § 20-77-2106(d), which is a multi-payer program that connects medical payment to medical providers to achieve high quality care at an appropriate cost for QHP Enrollees;

(4) "DMS" means the Arkansas Department of Medicaid Services under ADHS;

(5) "HCIP" means the Program established under Act 1498 of 2013 by the Arkansas State Legislature known as the "Health Care Independence Act of 2013";

(6) "Health Carrier" means a private entity certified by AID and offering plans through the Health Insurance Marketplace;

(7) "Healthcare coverage" shall mean healthcare benefits as defined under Ark. Code Ann. § 20-77-2104(4);

(8) "Health Insurance Marketplace" means the marketplace as defined by Ark. Code Ann. § 20-77-2104(5);

(9) "Qualified Health Plan" means an AID certified individual health insurance plan offered by a Health Carrier through the Health Insurance Marketplace;

(10) "QHP Enrollee" means a person insured under a Qualified Health Plan;

(11) "Patient Centered Medical Home" ("PCMH") means a local point of access to care that proactively looks after patients' health on a "24-7" basis. A PCMH bears responsibility for coordinating care to address the complete health needs of a patient population and supports patients to connect with other providers to form a health services team, customized for their patients' care needs with a focus on prevention and management of chronic disease through monitoring patient progress and coordination of care;

(12) "Primary care provider" means a participating health care provider practicing within their licensed scope of practice and designated by the Health Carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the Health Carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

Section 5. Requirements

For QHPs issued on or after January 1, 2015, Health Carriers shall adopt the following requirements and provide the opportunity for primary care providers to participate in an approved PCMH model according to these standards:

(a) The Health Carrier must reasonably follow the standards or guidelines of a national or State standardized PCMH model as approved by the Commissioner;

(b) Health Carriers will prospectively attribute QHP enrollees to primary care practices either based on enrollee choice or according to the plurality of professional visits for primary care evaluation and management paid by the Health Carrier over the prior year. Health Carriers may develop their own method for attributing enrollees for whom coverage was discontinuous during the prior year;

(c) Health Carriers will offer practice support to primary care provider practices that have been identified by Medicaid as participating in the Arkansas PCMH model through the APII. Health Carriers may identify additional PCMH participants with at least three hundred (300) enrollees for inclusion in the Arkansas PCMH Model. Practice support will be provided in the form of care coordination payments equivalent to or greater than an average of five dollars ($5.00) per enrollee per month. Health Carriers may use a risk adjustment method of their choosing for determining the actual payment, so long as the average payment per enrollee is no less than five dollars ($5.00) per month;

(d) Health Carriers may terminate payment of practice support for provider failure to meet milestones or deadlines for practice transformation activities and benchmarks or targets for clinical quality. In order to minimize provider administrative burden and encourage meaningful data reporting, quality metrics collected and reported by Health Carriers must incorporate Arkansas PCMH model requirements;

(e) Health Carriers shall provide performance reports for PCMH practice transformation and quality on a quarterly basis. A standardized report form shall be made available to Health Carriers from the Arkansas Health Care Payment Improvement Initiative Web Site (www.paymentinitiative.org) and reporting

should include total cost of patient care and care categories (not shown in referenced report);

(f) Health Carriers shall share statistics with AID or its designee(s) (output of analyzed claims data used to create above reports) for streamlined provider use at an aggregate multi-payer level;

(g) On or after January 1, 2016, Health Carriers should expect to participate in development of mechanisms to share savings with PCMH practices for achieving a per issuer enrollee cost of care that is below its benchmark cost.

(h) Health Carriers shall educate QHP enrollees about the Health Carrier's PCMH program and indicate which practices are participating in the program.

Section 6. Enforcement

AID shall review a Health Carrier's compliance with the provisions of this Rule in its role of recommending approval or non-approval for certification of qualified health plans sold in the Health Insurance Marketplace.

Section 7. Effective Date

The effective date of this Rule shall be January 1, 2015.

_____

JAY BRADFORD
INSURANCE COMMISSIONER

_____

DATE

Arkansas Democrat Gazette

STATEMENT OF LEGAL ADVERTISING

ARK INSURANCE DEPARTMENT
1200 W THIRD
LITTLE ROCK AR 72201

ATTN: Pam Looney

DATE : 07/02/14 INVOICE #: 2923815
ACCT #: L801001 P.O. #:

REMIT TO:
ARKANSAS DEMOCRAT-GAZETTE, INC.
P.O. BOX 2221
LITTLE ROCK, AR 72203

BILLING QUESTIONS CALL 378-3812

STATE OF ARKANSAS, }
COUNTY OF PULASKI, } ss.

I, Annette Holcombe do solemnly swear that I am the Legal Billing Clerk of the Arkansas Democrat - Gazette, a daily newspaper printed and published in said County, State of Arkansas; that I was so related to this publication at and during the publication of the annexed legal advertisement in the matter of:

HEARING

pending in the Court, in said County, and at the dates of the several publications of said advertisement stated below, and that during said periods and at said dates, said newspaper was printed and had a bona fide circulation in said County; that said newspaper had been regularly printed and published in said County, and had a bona fide circulation therein for the period of one month before the date of the first publication of said advertisement; and that said advertisement was published in the regular daily issues of said newspaper as stated below.

DATE	DAY	LINAGE	RATE	DATE	DAY	LINAGE	RATE
06/30	Mon	41	1.25				
07/01	Tue	41	1.25				
07/02	Wed	41	1.25				

TOTAL COST ---------- 153.75
Billing Ad #: 72679609

Annette M Holcombe

Subscribed and sworn to me this 2 day of July, 20 14

Bennie J. Fuller
Notary Public

OFFICIAL SEAL - # 12361344
BENNIE J. FULLER
NOTARY PUBLIC - ARKANSAS
PULASKI COUNTY
MY COMMISSION EXPIRES: 5-21-2021

AD COPY

NOTICE OF PUBLIC HEARING
The Arkansas Insurance Department will host a Public Hearing on August 5, 2014 beginning at 10:00 a.m. in the First Floor Hearing Room, Arkansas Insurance Department, 1200 West Third Street (Third and Cross Streets), Little Rock, Arkansas, to consider adoption of proposed Rule 108, "Patient-Centered Medical Home Standards." Copies of proposed Rule 108 may be obtained by writing or calling the Arkansas Insurance Department, or by visiting our Internet site at http://www.state.ar.us/insurance/legal/legal_p1.html. Or www.accessarkansas.org/insurance for links there. All interested persons are encouraged to make comments, statements or opinions to at the address above or attend the Public Hearing and present, orally or in writing, statements, arguments or opinions on the proposed Rule. For more information, please contact Ms. LoRraine Rowland, Legal Division, Arkansas Insurance Department at 501-371-2820.
72679609

RECEIVED
JUL 03 2014
ACCOUNTING
ARKANSAS INSURANCE DEPARTMENT

EXHIBIT
4

LoRraine Rowland

From: Legal Ads <legalads@arkansasonline.com>
Sent: Friday, June 27, 2014 10:29 AM
To: LoRraine Rowland
Subject: Re: Proposed Rule 108

The 30th, 1st & 2nd.
Thanks
Pam

From: LoRraine Rowland
Sent: Friday, June 27, 2014 10:03 AM
To: 'Legal Ads'
Cc: LoRraine Rowland
Subject: RE: Proposed Rule 108

Thank you Pam, please provide the dates this Notice will run.

LoRraine Rowland
Administrative Analyst/Legal Division
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201
501-371-2831 (office)
501-371-2639 (fax)
lorraine.rowland@arkansas.gov

"I have seeds in the ground and I am in a great place"

From: Legal Ads [mailto:legalads@arkansasonline.com]
Sent: Thursday, June 26, 2014 1:53 PM
To: LoRraine Rowland
Subject: Re: Proposed Rule 108

Received and processed as requested
thanks
pam

From: LoRraine Rowland
Sent: Thursday, June 26, 2014 1:48 PM
To: 'Legal Ads (legalads@arkansasonline.com)'
Cc: LoRraine Rowland ; Booth Rand
Subject: Proposed Rule 108

Please run the attached Notice of hearing on the next available three business days for our Legal Division. Please confirm via email.

Thank you,

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

June 26, 2014

HAND DELIVERY

RECEIVED

JUN 26 2014

BUREAU OF
LEGISLATIVE RESEARCH

Ms. Donna Davis
Arkansas Legislative Council
Arkansas Bureau of Legislative Research
State Capitol, Suite 315
Little Rock, Arkansas 72201

RE: Proposed Rule 108: "Patient-Centered Medical Home Standards"

Dear Ms. Davis:

Enclosed for your review and for filing with the Subcommittee of the Arkansas Legislative Council, is proposed Rule 108, "Patient-Centered Medical Home Standards."

Donna, just for your records, this is the proposed Rule the Department had to previously "present" to Legislative Council on the June 11, 2014 agenda before we could begin actual rule-making due a requirement in Act 1498 of 2013. Act 1498 of 2013, a/k/a, the Health Care Independence Act of 2013 ("HCIP") requires AID to present proposed rules to Legislative Council which implement provisions in that Act thirty (30) days before we begin normal rule-making.

During the June 11, 2014 meeting of the Administrative Rules Subcommittee, the Subcommittee took the position, pursuant to a policy adopted by the Subcommittee that day, that this proposed Rule was "presented" when first filed by AID with Legislative Council. Our records indicate this date to be May 13, 2014 when we filed our initial letter and proposed Rule with you. Given that under Act 1498 of 2013 thirty (30) days has now passed from the date the proposed Rule was deemed "presented" to Legislative Council on May 13, 2014, we are now permitted to begin the formal or standard APA rule-making process with this proposed Rule.

The Arkansas Insurance Department ("Department") is proposing a Rule to establish requirements related to patient-centered medical home programs for health care insurers issuing policies in the health insurance marketplace under HCIP.

EXHIBIT
6

The Department has scheduled a public hearing for August 5, 2014, at 10:00 A.M., at the Arkansas Insurance Department, to consider adopting this proposed Rule.

I have enclosed a triplicate set of the proposed Rule, our Notice of Public Hearing, the standard Questionnaire, Financial Impact Statement as well as a summary of the proposed Rule.

Sincerely,

Booth Rand
Managing Attorney/Legal Division
booth.rand@arkansas.gov
501-371-2820

cc: LoRraine Rowland, Administrative Analyst
Jessica Sutton at Bureau of Legislative Services

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

DEPARTMENT/AGENCY Arkansas Insurance Department
DIVISION Legal Division
DIVISION DIRECTOR Bill Lacy
CONTACT PERSON Booth Rand
ADDRESS 1200 West Third Street, Little Rock, Arkansas 72201
PHONE NO. 501-371-2820 **FAX NO.** 501-371-2639 **E-MAIL** booth.rand@arkansas.gov
NAME OF PRESENTER AT COMMITTEE MEETING (Booth Rand & Dr. Joe Thompson)
PRESENTER E-MAIL booth.rand@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
Room 315, State Capitol
Little Rock, AR 72201

****

1. What is the short title of this rule?

Rule 108, "Patient-Centered Medical Home Standards"

2. What is the subject of the proposed rule?

The proposed Rule establishes requirements for health insurers implementing patient-centered medical home programs (PCMH) under Act 1498 of 2013 of the Arkansas Eighty-Ninth General Assembly, also known as the "Health Care Independence Act of 2013" (hereafter, the "Health Care Independence Program," or "HCIP"), now codified in Ark. Code Ann. §§ 20-77-2101 et seq. HCIP requires all health insurers participating in the marketplace or exchange to "support" PCMH and to participate in the Arkansas Payment Improvement Initiatives (APII). The proposed Rule provides standards for insurers to use to offer PCMH to their medical providers (in primary care practices) desiring to participate in PCMH for qualified health plans (QHPs) issued on or after January 1, 2015. Under the proposed Rule, health insurers will adopt the Rule's proposed requirements and provide the opportunity for primary care providers to participate in an approved PCMH model approved by the Arkansas Insurance Department ("Department").

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes_____ No __X__

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes_____ No__X__

If yes, what is the effective date of the emergency rule? _____N/A_____

When does the emergency rule expire? _____N/A_____

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? N/A Yes_____ No_____

5. Is this a new rule? Yes___X___ No_____ If yes, please provide a brief summary explaining the regulation.

Please find an attached Summary including a power point from ACHI (Arkansas Center for Health Improvement) explaining the background and objectives for this proposed Rule.

Does this repeal an existing rule? Yes_____ No__X__ 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__X__If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes.

6. Cite the state law that grants the authority for this proposed rule? If codified, please give Arkansas Code citation.

Ark. Code Ann. § 20-77-2105(g)(1) and Ark. Code Ann. § 20-77-2106(e)

7. What is the purpose of this proposed rule? Why is it necessary?

The purpose of the proposed Rule is to provide standards for health insurers to use to offer PCMH and payment enhancements to their medical providers (in primary care practices) desiring to participate in PCMH for qualified health plans (QHPs) issued on or after January 1, 2015. Under the proposed Rule, health insurers will adopt the Rule's proposed requirements and provide the opportunity for primary care providers to participate in an approved PCMH model approved by the Arkansas Insurance Department ("Department"). See attached Summary and Power point explaining PCMH.

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).
http://insurance.arkansas.gov/Legal%20Dataservices/divpage.htm

9. Will a public hearing be held on this proposed rule? Yes__X__ No_____
If yes, please complete the following:
Date: August 5, 2014
Time: 10:00 a.m.
Place: Arkansas Insurance Department, First Floor Hearing Room

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

August 5, 2014 unless the Commissioner desires to keep the record open for more comments following the hearing. If we have significant medical provider or insurer disputes or concerns, we will keep the record open for as long as possible to consider everyone's comments or concerns.

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

As currently drafted on January 1, 2015.

12. Do you expect this rule to be controversial? Yes__X___ No ___ If yes, please explain.

We anticipate or believe some insurers may have concerns over the $5.00 per member per month, care coordination fee proposed in the Rule. We intend to listen to "all sides" or points on this during the comment and hearing process. For other issues which raise controversies, we will advise the Bureau of Legislative Research with the concerns and how the Department answered or responded to such concerns or controversies.

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.

We do not know right now which specific groups or organizations will comment for or against the Rule. We will be glad to update this information including providing Legislative Research with a transcript and copy of all comments made to the proposed Rule when we receive those comments.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT____Arkansas Insurance Department_____
DIVISION_____Legal Division_____
PERSON COMPLETING THIS STATEMENT_____Booth Rand_____
TELEPHONE NO.__371-2820__FAX NO.__371-2820__EMAIL: booth.rand@arkansas.gov

To comply with Act 1104 of 1995, please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE _____Rule 108, "Patient-Centered Medical Home Standards"

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes _____ No _____ Unknown. We have not calculated financial impact to health benefit plans subject to the proposed Rule in terms of premium rate or cost impact.

2. Does this proposed, amended, or repealed rule affect small businesses?
   Yes _____ No ___X_____

   If yes, please attach a copy of the economic impact statement required to be filed with the Arkansas Economic Development Commission under Arkansas Code § 25-15-301 et seq.

   The Economic Impact Statement is included in our filings.

3. If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.

   We have not calculated any premium or plan rate impact this proposed Rule would or would not

have, at this time. One of the goals of PCMH is reduction and control of medical costs which drive up the cost of health insurance.

4. If the purpose of this rule is to implement a federal rule or regulation, please give the incremental cost for implementing the rule. Please indicate if the cost provided is the cost of the program.

We do not anticipate any costs to the Department or State in our implementation of this 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 party subject to the proposed, amended, or repealed rule? Identify the party subject to the proposed rule and explain how they are affected.

N/A

Current Fiscal Year	**Next Fiscal Year**
$____N/A_____	$_____N?A_____

6. What is the total estimated cost by fiscal year to the agency to implement this rule? Is this the cost of the program or grant? Please explain.

N/A

Current Fiscal Year	**Next Fiscal Year**
$_____	$_____

_____

_____

_____

ECONOMIC IMPACT STATEMENT
OF PROPOSED RULES OR REGULATIONS
EO 05-04: Regulatory Flexibility

Department: *Arkansas Insurance Department*
Division: *Legal*
Contact Person: *Booth Rand*
Date: *06/25/2014*
Contact Phone: *501-371-2820*
Contact Email: *booth.rand@arkansas.gov*

Title or Subject:

Proposed Rule 108 "Patient-Centered Medical Home Standards"

Benefits of the Proposed Rule or Regulation

1. Explain the need for the proposed change(s). Did any complaints motivate you to pursue regulatory action? If so, please explain the nature of such complaints.

   The proposed rule is not derived from complaints but needed to provide standards to health care insurers issuing policies in the "health insurance marketplace" which are participating in patient-centered medical home programs under Act 1498 of 2013 known as the Health Care Independence Program."

2. What are the top three benefits of the proposed rule or regulation?

   A patient-centered medical home program ("PCMH") is essentially a team-based approach to coordination of a patient's care, formed, established and accountable at the primary care practice level of the patient. The three best benefits of this program are:

   1. The program is designed to lower medical costs, improve health outcomes and track medical costs and utilization to lower overall insurance costs.
   2. The program is designed to also improve the patient's overall experience of medical care and improve his or her overall health due to the team-based focus for the patient. The program is designed to chart and track metrics to achieve a cost effective, qualitative positive health outcome.
   3. As part of the payment care improvement initiative, PCMH is designed to provide primary care practices with enhanced payments and to thereby reinvigorate PCP's revenue and take-home pay, and improve practice processes and workflows.

3. What, in your estimation, would be the consequence of taking no action, thereby maintaining the status quo?
   Possible uncertainty as to the official regulatory standards health care issuers in the marketplace have to abide by for its providers to participate in PCMH.

4. Describe market-based alternatives or voluntary standards that were considered in place of the proposed regulation and state the reason(s) for not selecting those alternatives.

Although we are aware that health care insurers may have already internally developed or implemented similar medical home or medical team coordination concepts to improve patient care and lower costs in the market, the proposed regulation is needed to set out our state-specific requirements if issuers and their providers want the State's payment improvement initiatives and shared savings. The Department believes the proposed Rule provides flexibility to issuers to use or develop their own PCHM or medical home standards, assuming the standards follow an approved model as described in this proposed Rule.

Impact of Proposed Rule or Regulation

5. Estimate the cost to state government of *collecting information, completing paperwork, filing, recordkeeping, auditing and inspecting* associated with this new rule or regulation.
None.

6. What types of small businesses will be required to comply with the proposed rule or regulation? Please estimate the number of small businesses affected.
None. The proposed Rule is applied to health care insurers in the health insurance marketplace and not applied to "small business owners."

7. Does the proposed regulation create barriers to entry? If so, please describe those barriers and why those barriers are necessary.
None.

8. Explain the additional requirements with which small business owners will have to comply and estimate the costs associated with compliance.
None.

9. State whether the proposed regulation contains different requirements for different sized entities, and explain why this is, or is not, necessary.
None.

10. Describe your understanding of the ability of small business owners to implement changes required by the proposed regulation.

    The propose Rule does not require "small business owners" to implement provisions in the proposed Rule.

11. How does this rule or regulation compare to similar rules and regulations in other states or the federal government?
    The proposed Rule is not derived from any organization model rule or law or other state law, however, we are aware that other States have implemented or are currently in the process of implementing similar PCMH or "medical home" programs.

12. Provide a summary of the input your agency has received from small business or small business advocates about the proposed rule or regulation.

    None so far as of the date of filing. We will be glad to submit this summary and comments as soon as, or if we receive them.

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

June 26, 2014

VIA STATE MESSENGER

Mr. James Miller
Regulatory Liaison
Office of the Governor
State Capitol Building
Little Rock, AR 72201

RE: Arkansas Insurance Department Rule 108: "Patient-Centered Medical Home Standards"

Dear Mr. Miller:

Enclosed for your review is the Arkansas Insurance Department's proposed Rule 108, "Patient-Centered Medical Home Standards."

The Arkansas Insurance Department ("Department") is proposing a Rule to establish requirements related to patient-centered medical home programs for health care insurers issuing policies in the health insurance marketplace under Act 1498 of 2013 of the Arkansas Eighty-Ninth General Assembly, known as the "Health Care Independence Act of 2013."

The Department has scheduled a public hearing for August 5, 2014, at 10:00 A.M., at the Arkansas Insurance Department, to consider adopting this proposed Rule.

Please do not hesitate to contact me at 371-2820 if you have any questions.

Sincerely,

Booth Rand
Managing Attorney/Legal Division
booth.rand@arkansas.gov

cc: LoRraine Rowland, Administrative Analyst

EXHIBIT

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

June 26, 2014

JUN 30 2014

VIA STATE MESSENGER ATTORNEY GENERAL OF ARKANSAS

Mr. Brandon Robinson, ESQ.
Office of the Attorney General
323 Center Street, Suite 200
Little Rock, AR 72201

RE: Arkansas Insurance Department Rule 108: "Patient-Centered Medical Home Standards"

Dear Mr. Robinson:

Enclosed for your review is the Arkansas Insurance Department's proposed Rule 108, "Patient-Centered Medical Home Standards."

The Arkansas Insurance Department ("Department") is proposing a Rule to establish requirements related to patient-centered medical home programs for health care insurers issuing policies in the health insurance marketplace under Act 1498 of 2013 of the Arkansas Eighty-Ninth General Assembly, known as the "Health Care Independence Act of 2013."

The Department has scheduled a public hearing for August 5, 2014, at 10:00 A.M., at the Arkansas Insurance Department, to consider adopting this proposed Rule.

Please do not hesitate to contact me at 371-2820 if you have any questions.

Sincerely,

Booth Rand
Managing Attorney/Legal Division
booth.rand@arkansas.gov

cc: LoRraine Rowland, Administrative Analyst

RECEIVED
JUL 08 2014
LEGAL
ARKANSAS INSURANCE DEPT

EXHIBIT

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

June 26, 2014

Arkansas Secretary of State
State Capitol Building
Little Rock, AR 72201
Attn. Arkansas Register

Re: Rule 108, "Patient-Centered Medical Home Standards"

Dear Secretary:

Arkansas Act 1478 of 2003 adds to requirements for adoption and re-adoption of public agency rules and regulations. In that regard, the new Act:

(a) Requires notice of proposed Rule 108, as well as the Public Rule Hearing at the Arkansas Insurance Department, to be published by the Arkansas Secretary Of State on the Internet for thirty (30) days pursuant to Ark. Code Ann. § 25-15-218 of the Arkansas Administrative Procedure Act, as amended; and

(b) Requires DOI filing of its adopted and proposed rules and notices with the Arkansas Secretary Of State in an electronic format acceptable to the Secretary.

In that regard, the Department has scheduled a public hearing as to proposed adoption of Rule 108. Enclosed are the DOI Notices of Public Hearing and a copy of the proposed rule.

Please arrange to publish the information in a format acceptable to the Secretary for at least 30 days in advance. Can you send us confirmation that we can use in the transcript as a public hearing exhibit?

An electronic filing will be made within the statutorily required 7 days. Thanks for your help.

Sincerely,

LoRraine Rowland

LoRraine Rowland
Administrative Analyst/Legal Division
Lorraine.rowland@arkansas.gov
371-2820

Enclosures

FILED
SECRETARY OF STATE
STATE OF ARKANSAS
BY
14 JUN 26 PM 3:43
REGISTER DIV.

EXHIBIT
9

LoRraine Rowland

From: LoRraine Rowland
Sent: Friday, June 27, 2014 10:03 AM
To: register@sos.arkansas.gov
Cc: LoRraine Rowland; Booth Rand
Subject: Rule 108
Attachments: PROPOSED RULE 108.docx

Please find attached Proposed Rule 108. Should you need additional information please contact me.

Sincerely,

LoRraine Rowland
Administrative Analyst/Legal Division
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201
501-371-2831 (office)
501-371-2639 (fax)
lorraine.rowland@arkansas.gov

"I have seeds in the ground and I am in a great place"

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

June 26, 2014

VIA HAND DELIVERY

Mary Brewer
Arkansas State Library
One Capitol Mall
Little Rock, AR 72201

RE: Arkansas Insurance Department Rule 108, "Patient-Centered Medical Home Standards"

Dear Ms. Brewer:

Please find enclosed fifteen (15) copies of proposed Rule 108, "Patient-Centered Medical Home Standards," fifteen (15) copies of the Financial Impact Statement, and four (4) copies of the Notice of Public Hearing.

Sincerely,

Booth Rand
Managing Attorney/Legal Division
Booth.rand@arkansas.gov
501-371-2820

Enclosures

cc: LoRraine Rowland, Administrative Analyst

EXHIBIT
10

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

VIA MESSENGER MAIL

June 26, 2014

Ms. Pat Brown
Economic Development Commission
One Capitol Mall
Little Rock, AR 72202

RE: Rule 108, "Patient-Centered Medical Home Standards"

Dear Ms. Brown:

Enclosed for your review is the Arkansas Insurance Department's proposed Rule 108, "Patient-Centered Medical Home Standards."

The Arkansas Insurance Department ("Department") is proposing a Rule to establish requirements related to patient-centered medical home programs for health care insurers issuing policies in the health insurance marketplace under Act 1498 of 2013 of the Arkansas Eighty-Ninth General Assembly, known as the "Health Care Independence Act of 2013."

The Department has scheduled a public hearing for August 5, 2014, at 10:00 A.M., at the Arkansas Insurance Department, to consider adopting this proposed Rule.

Please do not hesitate to contact me at 371-2820 if you have any questions.

Sincerely yours,

LoRraine Rowland

LoRraine Rowland
Administrative Analyst/Legal Division
Lorraine.rowland@arkansas.gov
501-371-2831

Enclosures

EXHIBIT
11

SUMMARY
PROPOSED RULE 108

"PATIENT-CENTERED MEDICAL HOME STANDARDS"

The proposed Rule establishes patient-centered medical home standards ("PCMH") for health insurers issuing policies in the marketplace or Exchange on or after January 1, 2015. Under Act 1498 of 2013, known as the Health Care Independence Act of 2013 ("HCIP"), health insurers participating in the marketplace are required to participate in the Arkansas Payment Improvement Initiative and are required to "support" PCMH.

PCMH is essentially a team-based treatment approach for patients who are insured in the marketplace and who typically may have chronic medical issues. The program is established at the primary care practice level, with a patient being assigned a team of medical providers who have the goal of tracking and reporting treatment for the purpose of achieving the most qualitatively and cost effective outcome. The program is designed to reduce medical costs and to improve medical care. Importantly, it also is designed to improve primary care provider reimbursement by providing payment incentives for providers following its requirements. It is also designed to improve and streamline primary care provider practices and enhance the patient's experience with medical providers due to the focused team approach placed on the patient.

As provided in the proposed Rule, PCMH is only required to be offered to providers by the health insurers on or after January 1, 2014, for plans issued in the marketplace on or after that date, as one active or available option, for providers desiring to participate in the program including payment incentives or shared savings.

We are attaching to this Summary a copy of a power point description which describes the PCMH model and objectives of the program, as prepared by the Arkansas Center for Health Improvement ("ACHI").

ATTACH TO SUMMARY FOR RULE 109

Health Care Payment Improvement Initiative

Building a healthier future for all Arkansans

Arkansas Payment Improvement Initiative (APII):

Patient-centered Medical Homes (PCMH)

:ember 20, 2013

Nationally, Patient Centered Medical Homes aim to reinvigorate primary care and achieve the triple aim

Current state

Jim (citizen)

- Does not have a single provider who the system has assigned to be accountable for his care
- Has difficulty navigating a complex system

Dr. Smith (PCP)

- Receives lower income than specialist peers
- Has difficulty finding a younger physician to work in practice
- Considering using EMR, but not using it currently
- Gets little information from hospitals and ER's about his patients

Future state through PCMH

Triple Aim:

Improve the health of the population

Enhance the patient experience of care

Reduce or control the cost of care

Reinvigorate primary care:

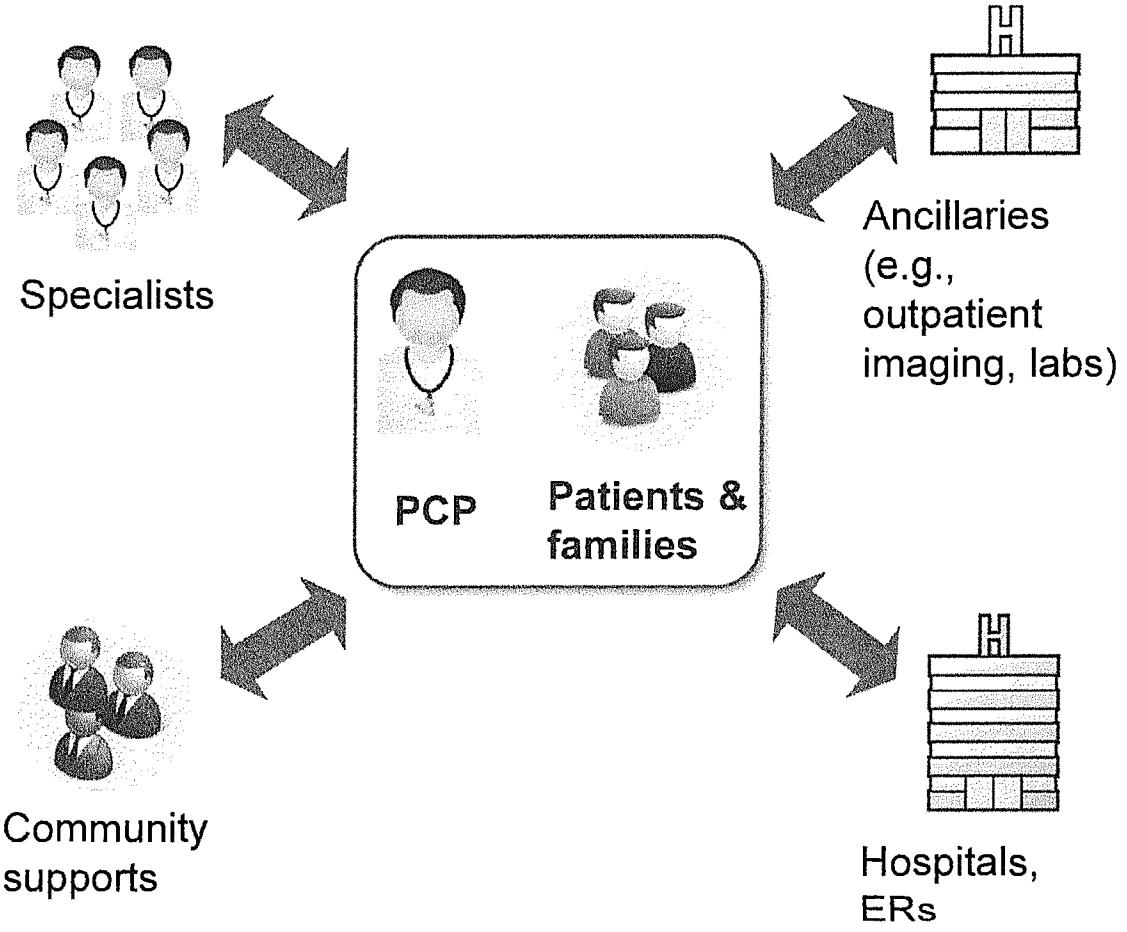
Increase in PCP's revenue and take-home pay

Improved practice processes and workflows

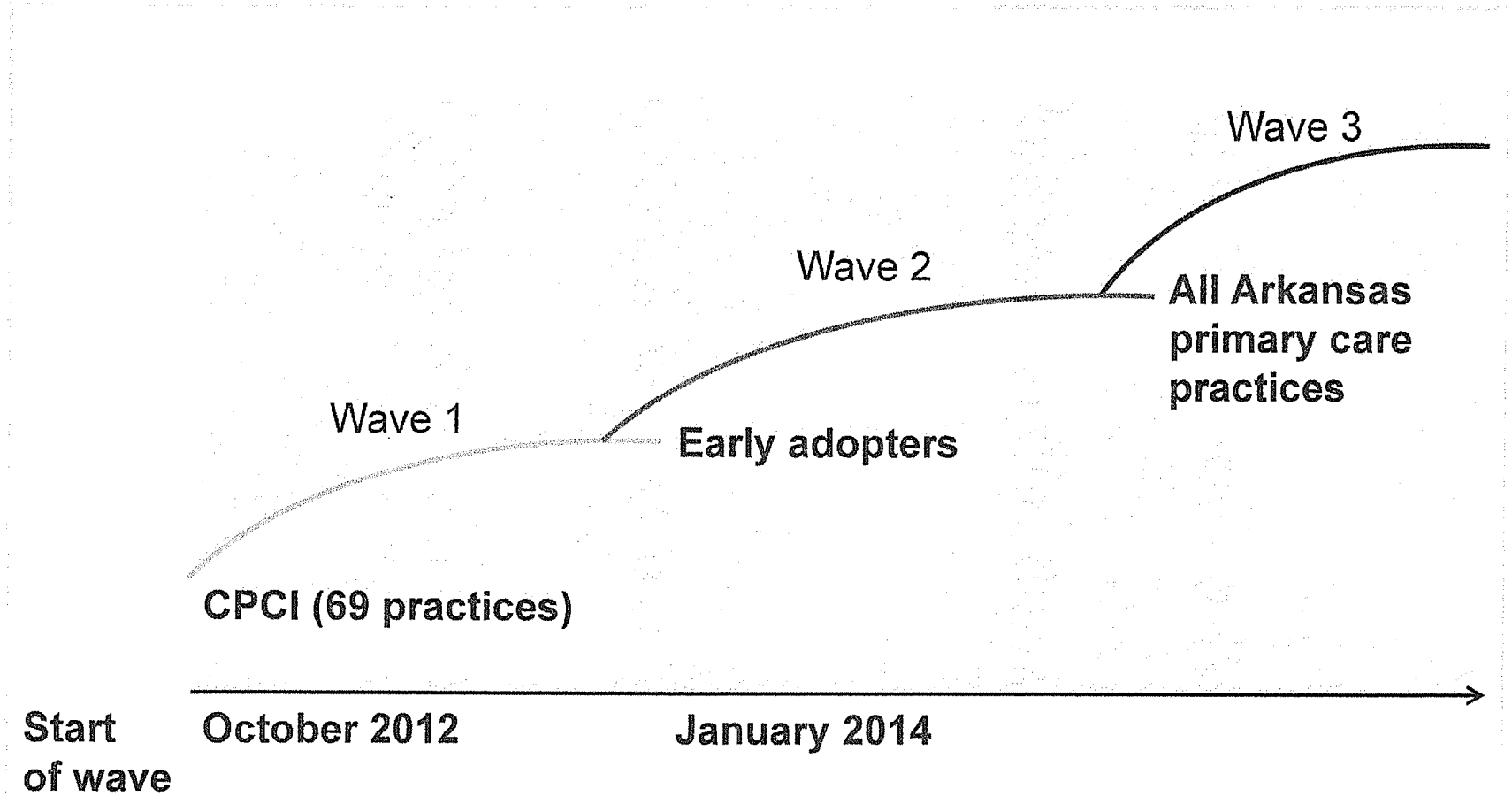
Why primary care and PCMH?

- **Changes in the healthcare system are ongoing and inevitable** (e.g. pay for value, acquisition, consolidation)
- **PCMH enables primary care providers to succeed** in this environment by empowering them to play a **central role** in managing quality and cost of care across the health system
- **Recognizing that changing practice patterns** is challenging, **the Arkansas Model aims to deliver support to help practices** – rural and urban, small, and large – meet this challenge

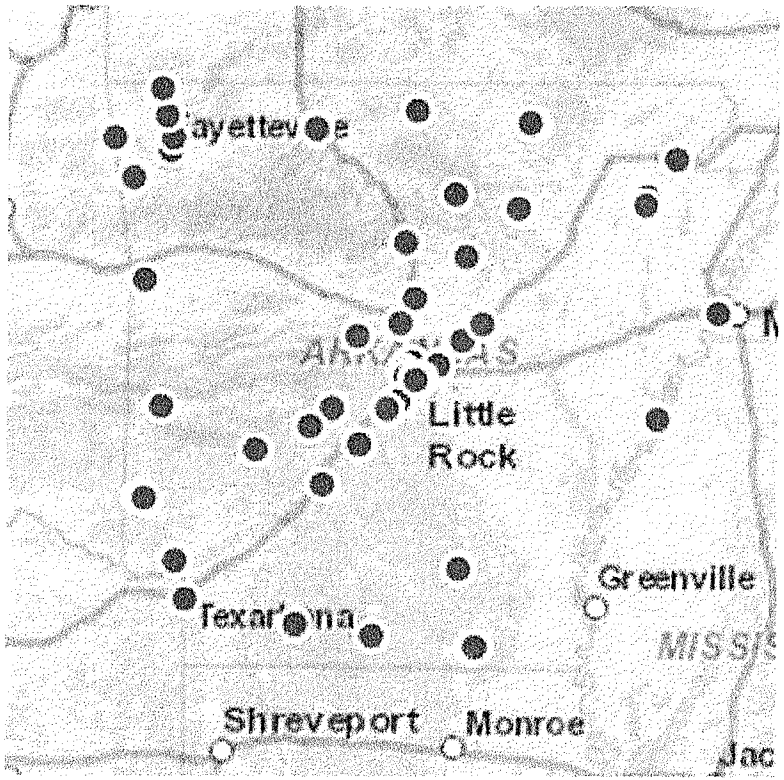
ILLUSTRATIVE



Arkansas PCMH launches in 3 waves



Medical Home: Comprehensive Primary Care Initiative



- **69 primary care practices**
  - Receiving FFS + enhanced payments
  - Improving patient experience: care coordination, access, communication
  - Practices responsible for ALL patients
  - Quality, cost, and transformation milestones will be evaluated
- **PMPM began October '12**
  - Medicare $8–40; risk-adjusted
  - Medicaid +$3 kids; +$7 adults
  - Private $ variable
- **Must meet targets**
  - Quality, performance, transformation
- **Shared savings model yrs 2–4**

http://innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html

Providers signal commitment to transform by enrolling in PCMH

Participation Requirements

Enroll in PCMH

To enroll in PCMH initially, a practice must

- Participate in the ConnectCare **Primary Care Case Management** Program
- Maintain at least **300 attributed beneficiaries**

Shared savings incentives

Shared savings payments made to entities with a **minimum of 5,000 Medicaid beneficiaries attributed for at least 6 months** of the performance period. May be formed in one of three ways:

- **Standalone practice** meets the minimum independently
- **Voluntary pool** (up to 2 practices per entity in 2014; greater than 2 per entity starting in 2015)
- **Default pool, e.g. statewide** (launched in 2015)

Starting in 2015, practices must be part of a shared savings entity to participate in PCMH

Framework for transformation

● Completion of activity and timing of reporting

Activity	Commit	Start	Evolve	Continue	
Month	0-3	6	12	16-18	24
Identify office lead(s) for both care coordination and practice transformation	●				
Assess operations of practice and opportunities to improve (internal to PCMH)		●			
Develop strategy to implement care coordination and practice transformation improvements		●			
Identify top 7-15% of high-priority patients (including BH clients)	●				
Identify and address medical neighborhood barriers to coordinated care (including BH professionals and facilities)		●			
Provide 24/7 access to care		●			
Document approach to expanding access to same-day appointments		●			
Complete a short survey related to patients' ability to receive timely care, appointments, and information from specialists (including BH specialists)			●		
Document approach to contacting patients who have not received preventive care			●		
Document investment in healthcare technology or tools that support practice transformation			●		
Join SHARE to get inpatient discharge information from hospitals			●		
Incorporate e-prescribing into practice workflows				●	
Integrate EHR into practice workflows					●

Metrics tracked for practice support payments

- **Metrics evaluated as a portfolio**
- **Practices must meet targets for majority of metrics for practice support**

Metric	Target		
	12 months	24 months	36 months and beyond
Percentage high-priority patients with care plan in medical record (incorporating information from specialists, including behavioral health)	70%	90%	Increasing
Percentage of high priority patients seen by PCP at least twice in the past 12 months	67%	75%	Increasing
Percentage of patients with acute inpatient hospital stay seen by physician within 10 days of discharge	33%	Increasing	Increasing
Percentage non-emergent emergency visits (NYU algorithm)	<50%	Decreasing	Decreasing

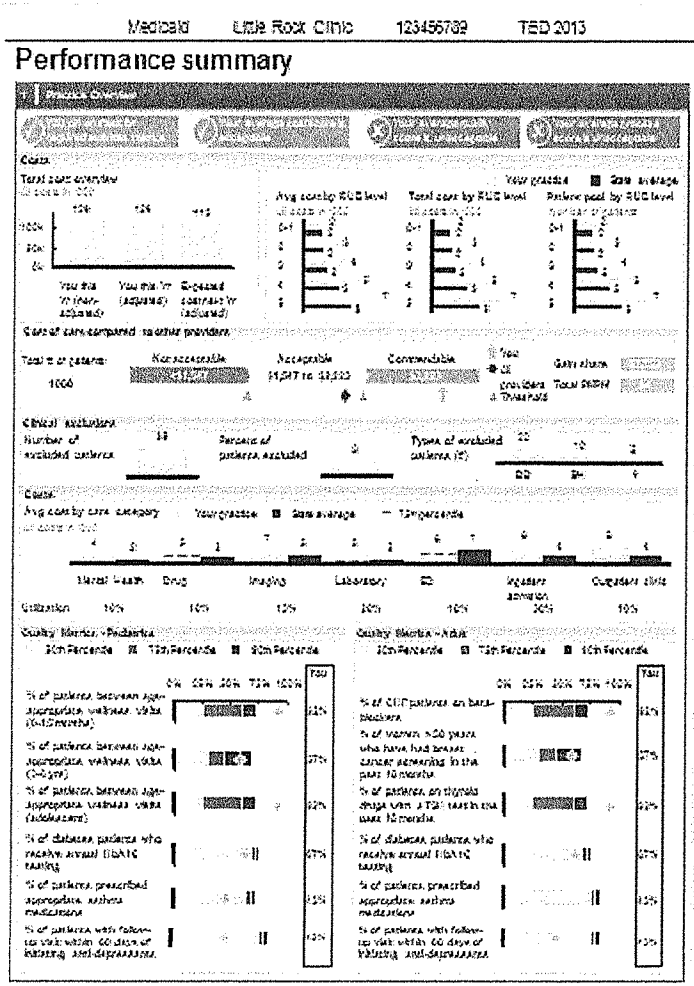
Quality metrics tracked for shared savings

Metric	Target
Pediatric patients who receive age-appropriate wellness visits • 0-12 months • 3, 4, 5, 6, years • 12-20 years	 67% 67% 40%
Diabetes patients who receive annual HbA1C testing	75%
Patients prescribed appropriate asthma medications	70%
CHF patients on beta blockers	40%
Women > 50 years with breast cancer screening in past 24 months	50%
Patients on thyroid drugs with TSH test in past 18 months	80%
Patients prescribed ADHD medications by PCP who receive appropriate follow-up care	25%

Additional Context

1. Assess quality metrics annually
2. Each metric is evaluated only if n is greater than or equal to 25
3. Must meet greater than or equal to 2/3 of quality targets to be eligible for shared savings
4. Quality metrics are likely to evolve over time

Transparency into performance



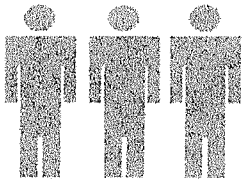
Provider quarterly reports

Report content and format will evolve over time information may include:

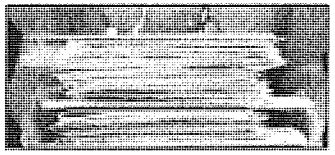
- **Program performance**, e.g.,
  - Activities and metrics tied to practice support payments
  - Quality metrics tied to shared savings incentives payments
- **Cost / utilization data**, e.g.,
  - Total beneficiary cost of care
  - Breakdown of cost by category of spend (e.g. imaging, inpatient, drug) and by priority diseases (e.g. COPD, CHF, mental health)
  - Utilization indicators (e.g. readmission rate)
  - Costs in the medical neighborhood (e.g. efficiency of nearby specialists and facilities)

With PCMH, existing fee-for-service reimbursement remains the same…

Patients and providers deliver care as today



Patients seek care and select providers as they do today



Providers submit claims as they do today

Payers reimburse for all services as they do today

ACHI

… But PCPs can also receive shared savings payments

For a shared savings entity (PCMH or group of voluntarily affiliated PCMHs)

A

Providers must **perform on quality metrics**

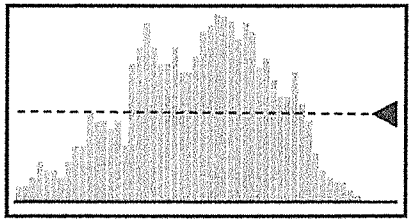
- Must meet ¾ of targets for quality metrics

And providers must

- Remain in good standing for practice support payments

B

Payers calculate **average yearly cost per member** for each shared savings entity



Average costs are compared to

- Pre-set "medium" and "high" cost levels
- Benchmark costs, based on historical costs projected forward

C

Results

PCMH can **earn shared savings payment in one of two ways** (receive greater of the two):

- **Beating its own benchmark cost**
- **Beating a system-wide medium cost threshold**

If the PCMH is not eligible for either payment, then the provider sees no change in reimbursement.

www.paymentinitiative.org

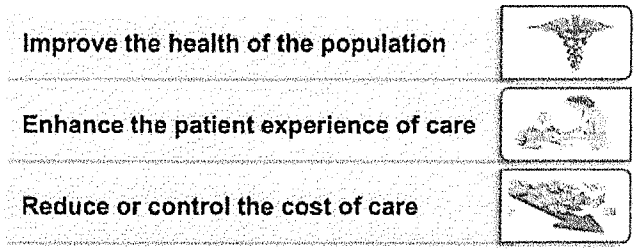
Health Care Payment Improvement Initiative

Building a Healthier Future for all Arkansans

Medical Homes
- Practice Support
- Shared Savings
- Eligibility Requirements
- Enrollment
- FAQs
- Key Webinars
- Useful Links

Medical Homes

The goal of PCMH is to achieve the Triple Aim



Today, visits to primary care doctors often focus on acute illnesses with much less attention to managing chronic conditions. PCMH can change that. PCMH will actively promote prevention services, such as vaccines, and will empower patients with the education they need to stay healthy.

For more information, please watch this quick video.

PCMH Overview Webinar

Contact information:
Phone: 1-866-322-4696 or 1-501-301-8311
Email: ARKPCMH@hp.com

Health Care Independence Act and Patient-Centered Medical Homes

- ACA 20-77-2106(d) outlines participation in the AR Payment Improvement Initiative
  - Assignment of primary care clinician
  - Support for PCMH
  - Access of clinical performance data for providers

Potential requirements for QHP participation in PCMH

Strawman requirements for first year of a QHP's involvement

Participation

- Educate all members re: PCMH and facilitate PCP selection
- Make PCMH offering available to
  - All practices participating in Medicaid's PCMH and
  - Practices not enrolled in Medicaid PCMH but that have minimum of X attributed QHP members (e.g.,300)

Payment Model

- Provide PCMHs value based payments equivalent to a minimum average PMPM for care coordination and practice transformation that are tied to performance on Medicaid's practice support activities/ metrics. e.g.,
  - PMPMs for "attributed" beneficiaries
  - New FFS codes/payments for care coordination activities
  - Bonus payments for effective performance
- For providers that elect a total cost of care based payment incentive in the first year of participation, QHPs may offer an actuarially equivalent incentive in place of the value based payments, e.g., shared savings, capitation

Reporting

- In light of expected QHP reporting burden we suggest a step-wise process, which in the first year consists of providing
  - Provider performance report in pre-specified standardized format
  - Sharing statistics (output of analyzed claims data used to create above reports) for potential multi-payer use

Important Dates and Next Steps

- Expected date for AID to issue plan guidance for 2015—January 31, 2014
- Plan certification recommendation deadline for 2015—April 30, 2014
- Issuers to provide comments on whether Medicaid PCMH rule is a good starting point

SECTION II PATIENT-CENTERED MEDICAL HOME (PCMH)

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200.000 DEFINITIONS

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 program (PCCM). 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 shared savings incentive payments.
Benchmark cost	The projected cost of care for a specific shared savings entity against which savings are measured. Benchmark costs are expressed as an average amount per beneficiary.
Benchmark trend	The fixed percentage growth applied to PCMH practices' historical baseline costs of care to project benchmark cost.
Care coordination	The ongoing work of engaging beneficiaries and organizing their care needs across providers and care settings.
Care coordination	Quarterly payments made to participating practices to support care coordination services. Payment amount is calculated per attributed

payment	beneficiary, per month.
Cost thresholds	Cost thresholds are the per beneficiary cost of care values (high and medium) against which a shared savings entity's per beneficiary cost is measured
Default pool	A pool of beneficiaries who are attributed to participating practices that do not meet the requirements of 233.000 A or B.
Historical baseline cost of care	A multi-year weighted average of a shared savings entity's per beneficiary cost of care.
Medical neighborhood barriers	Obstacles to the delivery of coordinated care that exist in areas of the health system external to PCMH.
Minimum savings rate	A fixed percentage set by DMS. In order to receive shared savings incentive payments for performance improvement described in 237.000A, a shared savings entity must achieve a per beneficiary cost of care that is below its benchmark cost by at least the minimum savings rate.
Participating practice	A physician practice, which may include: 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 or 04); C. A Rural Health Clinic (Provider Type 29) as defined by the Rural Health Clinic Provider Manual Section 201.000; or D. An Area Health Education Center (Provider Type 69), that is enrolled in the PCMH program.
Patient centered medical home (PCMH)	A team-based care delivery model led by PCPs who comprehensively manage patients' health needs with an emphasis on health care value.
Per beneficiary cost of care	The risk- and time-adjusted average of attributed beneficiaries' total Medicaid fee-for-service claims (based on the published reimbursement methodology) during the performance period, net of exclusions.
Per beneficiary cost of care floor	The lowest per beneficiary cost of care for which practices within a shared savings entity can receive shared savings incentive payments.
Per beneficiary savings	The difference between a shared savings entity's benchmark cost and its per beneficiary cost of care in a given performance period.
Performance period	The period of time over which performance is aggregated and assessed.
Pool	A. The beneficiaries who are attributed to one or more participating practice(s) for the purpose of forming a shared savings entity; or B. The action of aggregating beneficiaries for the purposes of shared savings calculations (i.e., the action of forming a shared savings entity).
Practice support	Support provided by Medicaid in the form of care coordination payments to a participating practice and practice transformation support provided by a DMS contracted vendor.
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 171.100 of this manual.

Provider portal	The website that participating practices use for purposes of enrollment, reporting to DMS and receiving information from DMS.
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.
Risk adjustment	An adjustment to the cost of beneficiary care to account for patient risk.
Same-day appointment request	A patient request to be seen by a clinician within 24 hours.
SHARE	SHARE is the State Health Alliance for Records Exchange, the Arkansas Health Information Exchange. For more information go to http://ohit.arkansas.gov.
Shared savings incentive payment cap	The maximum shared savings incentive payment that DMS will pay to practices in a shared savings entity, expressed as a percentage of that entity's benchmark cost for the performance period.
Shared savings entity	A participating practice or participating practices that, contingent on performance, may receive shared savings.
Shared savings incentive payments	Annual payments made to reward cost efficient and quality care.
Shared savings percentage	The percentage of a shared savings entity's total savings that is paid to practice(s) in a shared savings entity as a shared savings incentive payment for performance improvement.

210.000 ENROLLMENT AND CASELOAD MANAGEMENT

211.000 Enrollment Eligibility 1-1-2014

To be eligible to enroll in the PCMH Program initially:

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

B. The practice must include PCPs enrolled in the ConnectCare Primary Care Case Management program.

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

D. The practice must have at least 300 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 on www.paymentinitiative.org any such modification.

212.000 Practice Enrollment 1-1-2014

Enrollment in the PCMH program is voluntary and practices must re-enroll annually. To enroll practices must access the provider portal and submit a complete and accurate Practice Participation Agreement available at (www.paymentinitiative.org). Once enrolled, a participating practice remains in the PCMH program until:

A. The practice withdraws;

B. The practice or provider 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 DHS of changes to the list of physicians who are part of your practice in writing within 30 days.

To withdraw from the PCMH program the participating practice must deliver a signed and accurate PCMH withdrawal form, available at (www.paymentinitiative.org), to DMS.

213.000 Enrollment Schedule 1-1-2014

A. Initial enrollment periods are October 1, 2013 through December 15, 2013 and January 1, 2014 through May 15, 2014.

B. Beginning with the 2015 calendar year, enrollment is open for approximately 3 months in Q3 and Q4 of the preceding year.

C. DMS will return any enrollment documents received other than during an enrollment period.

214.000 Caseload Management 1-1-2014

A participating practice must manage its caseload of attributed beneficiaries, including removal of a beneficiary from its panel, according to the rules described in Section 171.200 of this manual. Additionally, a participating practice must submit, in writing at the end of every calendar quarter, an explanation of each beneficiary removal during such quarter. DMS retains the right to disallow these patient removals. If a participating practice removes a beneficiary from its PCMH panel, that patient is also removed from its ConnectCare panel.

220.000 PRACTICE SUPPORT

221.000 Practice Support Scope 1-1-2014

Practice support includes both care coordination payments made to a participating practice and practice transformation support provided by a DMS contracted vendor.

Receipt and use of the care coordination payments is not conditioned on the practice 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 patients with different risk profiles.

DMS will contract with a practice transformation vendor on behalf of participating practices that require additional support to catalyze practice transformation and retain and use such vendor. Practices must maintain documentation of the months they have contracted with a practice transformation vendor. Practice transformation vendors must report to DMS the level and type of service delivered to each practice. Payments to a practice transformation vendor on behalf of a participating practice may continue for up to 24 months.

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

DMS will also support practices through improved access to information through the reports described in Section 245.000.

222.000 Practice Support Eligibility 1-1-2014

In addition to the enrollment eligibility requirements listed in Section 211.000, in order for practices to receive practice support, DMS measures participating practice performance against activities tracked for practice support identified in Section 241.000 and the metrics tracked for practice support identified in 242.000. Participating practices must meet the requirements of these sections to receive practice support.

Each participating practice that has pooled its attributed beneficiaries with other participating practices in a shared savings entity:

A. Has its performance individually compared to activities tracked for practice support and metrics tracked for practice support.

B. Will, if qualified, receive practice support even if other practices in a shared savings entity do not qualify for practice support.

223.000 Care Coordination Payment Amount 1-1-2014

The care coordination payment is risk adjusted (e.g., range from $1 to $30 per attributed beneficiary per month) based on factors including demographics (age, sex), diagnoses, and utilization.

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

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

In order to begin receiving care coordination payments for the quarter starting January 1, 2014, a practice must submit a complete PCMH enrollment application on or before December 15, 2013. In order to begin receiving care coordination payments for the quarter starting July 1, 2014, a practice must submit the PCMH enrollment application on or before May 15, 2014. For all subsequent years, in order to participate in the PCMH program, a practice must submit the PCMH enrollment application before the end of the enrollment period of the preceding year.

230.000 SHARED SAVINGS INCENTIVE PAYMENTS

231.000 Shared Savings Incentive Payments Scope 1-1-2014

Shared savings incentive payments are payments made to a shared savings entity for delivery of economic, efficient and quality care that meets the requirements of Section 232.000.

232.000 Shared Savings Incentive Payments Eligibility 1-1-2014

To receive shared savings incentive payments, a shared savings entity must have a minimum of 5,000 attributed beneficiaries once the below exclusions have been applied. A shared savings entity may meet this requirement as a single practice or by pooling attributed beneficiaries across more than one practice as described in Section 233.000.

For purposes of calculating shared savings incentive payments only, the following beneficiaries shall not be counted toward the 5,000 attributed beneficiary requirement:

A. Beneficiaries that have been attributed to that entity's practice(s) for less than the majority of the performance period.

B. Beneficiaries that a practice prospectively designates for exclusion from per beneficiary cost of care (also known as physician-selected exclusions) on or before the 90th day of the performance period. Once a beneficiary is designated for exclusion, a practice may not update selection for the duration of the performance period. The total number of physician-selected exclusions will be directly proportional to the practice's total number of attributed beneficiaries (e.g., up to 1 exclusion for every 1,000 attributed beneficiaries).

C. 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 or provider experience with select patient populations. DMS will publish such addition, removal or modification on www.paymentinitiative.org.

Shared savings incentive payments are conditioned upon a shared savings entity:

A. Enrolling during the enrollment period prior to the beginning of the performance period.

B. Meeting requirements for metrics tracked for shared savings in section 244.000 based on the aggregate performance for beneficiaries attributed to the shared savings entity for the majority of the performance period; and

C. Maintaining eligibility for practice support as described in 222.000.

Eligibility requirements for shared savings for CPC practices are described in Section 251.000.

233.000 Pools of Attributed Beneficiaries 1-1-2014

Participating practices will meet the minimum pool size of 5,000 attributed beneficiaries as described in 232.000 by forming a shared savings entity in one of three ways:

A. Meet minimum pool size independently;

B. Pool attributed beneficiaries with other participating practices as described in 234.000. In this method, practices voluntarily agree to have their performance measured together by aggregating performance (both per beneficiary cost of care and quality metrics tracked for shared savings incentive payments) across the practices; or

C. Participate in a default pool if the practice does not meet the requirements for A or B of this section. Practices with beneficiaries in a default pool will have per beneficiary cost of care performance measured across the combined pool of all attributed beneficiaries in the default pool. There is no default pool in the first performance period beginning January 1, 2014.

234.000 Requirements for Joining and Leaving Pools 1-1-2014

Practices may pool for purposes of 233.000B before the end of the enrollment period that precedes the start of the performance period. To pool, practices must submit to DMS a signed practice participation agreement with a completed and accurate pooling request form, available at www.paymentinitiative.org, executed by all practices participating in the pool.

In the first performance period beginning January 1, 2014, a maximum of two practices may agree to voluntarily pool their attributed beneficiaries.

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

When a practice has pooled, its performance is measured in the associated shared savings entity throughout the duration of the performance period, unless it withdraws from the PCMH program during the performance period. When a practice that has pooled withdraws from the

PCMH program, the other practice or practices in the shared savings entity will have performance measured as if the withdrawn practice had never participated in the pool.

235.000 Per Beneficiary Cost of Care Calculation 1-1-2014

Each year, the per beneficiary cost of care performance is aggregated and assessed across a shared savings entity. Per beneficiary cost of care is calculated as the risk- and time-adjusted average of the such entity's attributed beneficiaries' total fee-for-service claims (based on the published reimbursement methodology) during the annual performance period, with adjustments and exclusions as defined below.

One hundred percent of the dollar value of care coordination payments is included in the per beneficiary cost of care calculation, except for the performance period which begins January 1, 2014 for which fifty percent of the dollar value of care coordination payments is included.

As described in Section 232.000, beneficiaries not counted toward the minimum number of attributed beneficiaries for shared savings incentive payments will be excluded from the calculation of per beneficiary cost of care.

The following costs are excluded from the calculation of per beneficiary cost of care:

A. All costs in excess of $100,000 for any individual beneficiary.

B. Behavioral health costs for patients with the most complex behavioral health needs.

C. Select costs associated with developmental disabilities (DD) services, identified on the basis of DD provider types.

D. Select direct costs associated with Long-Term Support and Services (LTSS).

E. Select costs associated with nursing home fees, transportation fees, dental, and vision.

F. Select neonatal costs.

G. Other costs as determined by DMS.

For detailed information on specific exclusions, see www.paymentinitiative.org.

The following adjustments are made to costs for calculation of per beneficiary cost of care

A. Inpatient hospital claims will be adjusted to reflect a standard per diem.

B. Pharmacy costs will be adjusted to reflect rebates.

C. The per beneficiary cost of care for a shared savings entity is adjusted by the amount of supplemental payment incentives, both positive and negative, made under Episodes of Care for the beneficiaries attributed to practice(s) as described in Section 232.000.

D. Technical adjustments may be made by DHS and will be posted on www.paymentinitiative.org.

If the shared savings entity's per beneficiary cost of care falls below the current performance period total cost of care floor, the shared savings entity's per beneficiary cost of care will be set at the total cost of care floor, for purposes of calculating shared savings incentive payments. The 2014 cost of care floor is set at $1410, and will increase by 1.5% each subsequent year.

236.000 Baseline and Benchmark Cost Calculations 1-1-2014

For the performance period that begins in January 2014, DMS will calculate a historical baseline per beneficiary cost of care for each shared saving entity. This shared savings entity-specific

historical baseline will be calculated as a multi-year blended average of each shared savings entity's per beneficiary cost of care.

DMS will calculate benchmark costs for each shared savings entity by applying a 2.6% benchmark trend to the entity's historical baseline per beneficiary cost of care. DMS may reevaluate the value of this benchmark trend if the annual, system-average per beneficiary cost of care growth rate differs significantly from a benchmark, to be specified by DMS. DMS will publish on www.paymentinitiative.org any modification to the benchmark trend.

237.000 Shared Savings Incentive Payments Amounts 1-1-2014

A shared savings entity is eligible to receive a shared savings incentive payment that is the greater of: (A) a shared savings incentive payment for performance improvement; and (B) shared savings incentive payment for absolute performance.

A. Shared savings incentive payments for performance improvement are calculated as follows:

During each performance period, each shared savings entity's per beneficiary savings is calculated as: [benchmark cost for that performance period] – [per beneficiary cost of care for that performance period].

If the shared savings entity's per beneficiary cost of care falls below that entity's benchmark cost for that performance period by at least the minimum savings rate, only then may the shared savings entity be eligible for a shared savings incentive payment for performance improvement.

The per beneficiary shared savings incentive payment for performance improvement for which the shared savings entity may be eligible is calculated as follows: [per beneficiary savings for that performance period] * [shared saving entity's shared savings percentage for that performance period].

To establish shared savings percentages for a given performance period, DMS will compare the entity's previous year per beneficiary cost of care to the previous year's medium and high cost thresholds. For the performance period beginning January 2014, DMS will compare the entity's historical baseline cost to the base year thresholds to establish such entity's shared savings percentage.

If, in the previous performance period, a shared savings entity's per beneficiary cost of care was:

1. Below the medium cost threshold, the shared savings entity may receive 50% of per beneficiary savings created in the current performance period (i.e., the entity's shared savings percentage will be 50%).
2. Between the medium and high cost thresholds, the shared savings entity may receive 30% of per beneficiary savings created in the current performance period (i.e., the entity's shared savings percentage will be 30%);
3. Above the high cost threshold, the shared savings entity will not share in risk. Instead, the shared savings entity may receive 10% of per beneficiary savings created in the current performance period (i.e., the entity's shared savings percentage will be 10%);

B. Shared savings incentive payments for absolute performance are calculated as follows:

If the shared savings entity's per beneficiary cost of care falls below the current performance period medium cost threshold, the shared savings entity may be eligible for a shared savings incentive payment for absolute performance. The per beneficiary shared savings incentive payment for absolute performance for which the entity may be eligible is

calculated as follows: ([medium cost threshold for that performance period] – [per beneficiary cost of care for that performance period]) * [50%]

C. The High and Medium Cost thresholds for 2014 are:

Medium cost threshold: $2032

High cost threshold: $2718

These thresholds reflect an annual increase of 1.5% from the base year thresholds (base year medium cost threshold: $1972; base year high cost threshold: $2638) and will increase by 1.5% each subsequent year.

The minimum savings rate is 2%. DMS may adjust this rate based on new research, empirical evidence or experience from initial provider experience with shared savings. DMS will publish any such modification of the minimum savings rate at www.paymentinitiative.org.

If the per beneficiary shared savings incentive payment for which the shared savings entity is eligible exceeds the shared savings incentive payment cap, expressed as 10% of the shared savings entity's benchmark cost for that performance period, the shared savings entity will be eligible for a per beneficiary shared savings incentive payment equal to 10% of its benchmark cost for that performance period.

If the shared savings entity's per beneficiary cost of care falls above the current performance period high cost threshold, the shared savings entity is not eligible for a shared savings incentive payment for that performance period.

A shared savings entity's total shared savings incentive payment will be calculated as the per beneficiary shared savings incentive payment for which it is eligible multiplied by the number of attributed beneficiaries as described in Section 232.000, adjusted based on the amount of time beneficiaries were attributed to such entity's practice(s) and the risk profile of the attributed beneficiaries.

If participating practices have pooled their attributed beneficiaries together, shared savings incentive payments will be allocated to those practices in proportion to the number of attributed beneficiaries that each practice contributed to such pool.

A shared savings entity will not receive shared savings incentive payments unless it meets all the conditions described in Section 232.000.

DMS pays shared savings incentive payments on an annual basis for the most recent completed performance period and may withhold a portion of shared savings incentive payments to allow for final payment adjustment after a year of claims data is available.

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, DMS may recover the payment adjustment from the participating practice.

240.000 METRICS AND ACCOUNTABILITY FOR PAYMENT INCENTIVES

241.000 Activities Tracked for Practice Support 1-1-2014

Using the provider portal, participating practices must complete and document the activities as described in the table below by the deadline indicated in the table. The reference point for the deadlines is the first day of the first calendar year in which the participating practice is enrolled in the PCMH program.

	Activity	Deadline
A.	Identify top 10% of high-priority beneficiaries using: 1) DMS patient panel data that ranks beneficiaries by risk at beginning of performance period and/or 2) the practice's patient-centered assessment to determine which patients on this list are high priority. Submit this list to DMS via the provider portal.	3 months and again 3 months after the start of each subsequent performance period (If such list is not submitted by this deadline DMS will identify a default list of high-priority beneficiaries for the practice, based on risk scores.)
B.	Assess operations of practice and opportunities to improve and submit the assessment to DMS via the provider portal.	6 months and again at 24 months
C.	Develop and record strategies to implement care coordination and practice transformation. Submit the strategies to DMS via the provider portal.	6 months
D.	Identify and reduce medical neighborhood barriers to coordinated care at the practice-level. Describe barriers and approaches to overcome local challenges for coordinated care. Submit these descriptions of barriers and approaches to DMS via the provider portal.	6 months
E.	Make available 24/7 access to care. Provide telephone access to a live voice (for example, an employee of the primary care physician or an answering service) or to an answering machine that immediately pages an on-call medical professional 24 hours per day, 7 days a week. The on-call professional must Provide information and instructions for treating emergency and non-emergency conditions, Make appropriate referrals for non-emergency services and Provide information regarding accessing other services and handling medical problems during hours the PCP's office is closed. Response to non-emergency after-hours calls must occur within 30 minutes. A call must be treated as an emergency if made under circumstances where a prudent layperson with an average knowledge of health care would reasonably believe that treatment is immediately necessary to prevent death or serious health impairment. 1. PCPs must make the after-hours telephone number known by, at a minimum, providing the 24-hour emergency telephone number to all patients; posting the 24-hour emergency number on all public entries to each site; and including the 24-hour emergency phone number on answering machine greetings; 2. When employing an answering machine with recorded instructions for after-hours callers, PCPs should regularly check to ensure that the machine functions correctly and that the instructions are up to date. Practices must document completion of this activity by	6 months

	Activity	Deadline
	written report to DMS via the provider portal.	
F.	Track same-day appointment requests by: Using a tool to measure and monitor same-day appointment requests on a daily basis and Recording fulfillment of same-day appointment requests. Practices must document compliance by written report to DMS via the provider portal.	6 months
G.	Establish processes that result in contact with beneficiaries who have not received preventive care. Practices must document compliance by written report to DMS via the provider portal.	12 months
H.	Complete a short survey related to patients' ability to receive timely care, appointments, and information from specialists (including BH specialists)	12 months
I.	Invest in healthcare technology or tools that support practice transformation. Practices must document healthcare technology investments by written report to DMS via the provider portal.	12 months
J.	Join SHARE and be able to access inpatient discharge, and transfer information. Practices must document compliance by written report to DMS via the provider portal.	12 months
K.	Incorporate e-prescribing into practice workflows. Practices must document compliance by written report to DMS via the provider portal.	18 months
L.	Use Electronic Health Record (EHR) for care coordination. The EHR adopted must be one that is certified by Office of the National Coordinator for Health Information Technology and is used to store care plans. Practices are to document completion of this activity via the provider portal.	24 months

DMS may add, remove, or adjust these metrics or deadlines, including additions beyond 24 months, based on new research, empirical evidence or experience from initial metrics. DMS will publish such extension, addition, removal or adjustment on www.paymentinitiative.org.

242.000 Metrics Tracked for Practice Support 1-1-2014

DMS assesses practices on the following metrics tracked for practice support starting on the first day of the first calendar year in which the participating practice is enrolled in the PCMH program and continuing through the full calendar year. To receive practice support, participating practices must meet a majority of targets listed below.

	Metric	Target for calendar year beginning Jan. 1, 2014
A.	Percentage of high-priority beneficiaries (identified in Section 241.000) whose care plan as contained in the medical record includes: documentation of a patient's chief complaint and problems, plan of care integrating contributions from healthcare team (including behavioral	At least 70%

	Metric	Target for calendar year beginning Jan. 1, 2014
	health professionals) and from the patient; instructions for follow-up; assessment of progress to date. The care plan must be updated at least twice a year.	
B.	Percentage of a practice's high priority beneficiaries who have been seen by their attributed PCP at least twice in the past 12 months	At least 67%
C.	Percentage of beneficiaries who had an acute inpatient hospital stay who were seen by health care provider within 10 days of discharge	At least 33%
D.	Percentage of emergency visits categorized as non-emergent by the NYU ED algorithm	Less than 50%

DMS will publish on www.paymentinitiative.org targets for subsequent years calibrated based on experience from targets initially set. Such targets will escalate over time.

DMS may add, remove, or adjust these metrics based on new research, empirical evidence or experience from initial metrics.

243.000 Accountability for Practice Support 1-1-2014

If a practice does not meet deadlines and targets for a) activities tracked for practice support and b) metrics tracked for practice support as described in 241.000 and 242.000, the practice must remediate its performance to avoid suspension or termination of practice support. Practices must submit an improvement plan within 1 month of the date that a report provides notice that the practice failed to perform on the activities or metrics indicated above.

A. With respect to activities tracked for practice support, practices must remediate performance, before the end of the first full calendar quarter after the date the practice receives notice via the provider report that target(s) have not been met, except for activity A in Section 241.000 where no such remediation time will be provided.

B. With respect to metrics tracked for practice support, practices must remediate performance, before the end of the second full calendar quarter after the date the practice receives notice via the provider report that target(s) have not been met. For purposes of remediation, performance is measured on the most recent four calendar quarters.

If a practice fails to meet the deadlines or targets for activities and metrics tracked for practice support within this remediation time, DMS will terminate practice support. DMS may resume practice support when the practice meets the deadlines or targets for activities and metrics tracked for practice support in effect for that quarter.

DMS retains the right to confirm practices' performance against deadlines and targets for activities and metrics tracked for practices support.

244.000 Quality Metrics Tracked for Shared Savings Incentive Payments 1-1-2014

DMS assesses the following quality metrics tracked for shared savings incentive payments according to the targets below. The quality metrics are assessed at the level of shared savings entity, except for the default pool. The quality metrics are assessed only if the entity or practice has at least 25 attributed patients in the category described for the majority of the performance period. To receive a shared savings incentive payment, the shared savings entity or practice must meet at least two-thirds of the quality metrics on which the entity or practice is assessed, and also be eligible for practice support.

	Quality Metric	Target for calendar year beginning Jan. 1, 2014
A.	Percentage of patients 0-15 months of age who receive at least four wellness visits	At least 67%
B.	Percentage of patients 3 to 6 years of age who receive at least one wellness visit	At least 67%
C.	Percentage of patients 12-20 years of age who receive at least one wellness visit	At least 40%
D.	Percentage of diabetes patients who receive annual HbA1C testing	At least 75%
E.	Percentage of patients prescribed appropriate asthma medications	At least 70%
F.	Percentage of CHF patients on beta blockers	At least 40%
G.	Percentage of women > 50 years who have had breast cancer screening in past 24 months	At least 50%
H.	Percentage of patients on thyroid drugs with a TSH test in past 24 months	At least 80%
I.	Percentage of beneficiaries 6–12 years of age with an ambulatory prescription dispensed for ADHD medication that was prescribed by their attributed PCP, who had one follow-up visit with that PCP during the 30-day Initiation Phase.	At least 25%

DMS will publish on www.paymentinitiative.org targets for subsequent performance periods calibrated based on experience from targets initially set.

DMS may add, remove, or adjust these quality metrics based on new research, empirical evidence or experience from initial quality metrics.

245.000 Provider Reports 1-1-2014

DMS provides participating practices provider reports containing information about their practice performance on activities tracked for practice support, metrics tracked for practice support, quality metrics tracked for shared savings incentive payments, and their per beneficiary cost of care via the provide portal.

250.000 COMPREHENSIVE PRIMARY CARE (CPC) INITIATIVE PRACTICE PARTICIPATION IN THE PCMH PROGRAM

251.000 CPC Initiative Practice Participation 1-1-2014

Practices and physicians participating in the Comprehensive Primary Care Initiative (CPC) are not eligible to receive PCMH program practice support.

Practices participating in the CPC initiative may receive PCMH program shared savings incentive payments if they:

A. Enroll in the PCMH program;

B. Meet the requirements for shared savings incentive payments, except that a practice participating in CPC need not maintain eligibility for practice support described in Section 222.000; and

C. Achieve all CPC milestones and measures on time.

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

May 13, 2014

HAND DELIVERY

Ms. Donna Davis
Arkansas Legislative Council
Arkansas Bureau of Legislative Research
State Capitol, Suite 315
Little Rock, Arkansas 72201

RE: Proposed Rule 108: "Patient-Centered Medical Home Standards"

Dear Ms. Davis:

Enclosed for your review is Arkansas Insurance Department ("Department") proposed Rule 108 which requires "presentment" to the Legislative Council thirty (30) days before the Department begins the process of administrative rulemaking, pursuant to Act 1498 of 2013, under the "Health Care Independence Act."

Pursuant to my previous conversation with Ms. Sutton, the Department is advised that it will report to the Council or Rules Subcommittee the nature of the upcoming proposed Rule. Please calendar us to the next available meeting for this purpose so we can begin to get this out to the health plans. If you have any questions, please contact me at 501-371-2820.

Sincerely,

Booth Rand
Managing Attorney/Legal Division
booth.rand@arkansas.gov

RECEIVED
MAY 13 2014
BUREAU OF
LEGISLATIVE RESEARCH

cc: LoRraine Rowland, Administrative Analyst

cc: Jessica C. Sutton
Administrator, Administrative Rules Review
Bureau of Legislative Research
One Capitol Mall
5th Floor, Room L-516
Little Rock, AR 72201

EXHIBIT
13

PROPOSED RULE 108
PATIENT-CENTERED MEDICAL HOME STANDARDS

Table of Contents

Section 1. Authority
Section 2. Purpose
Section 3. Applicability & Scope
Section 4. Definitions
Section 5. Requirements
Section 6. Enforcement
Section 7. Effective Date

Section 1. Authority

This Rule is issued pursuant to Section One of Act 1498 of 2013 of the Arkansas Eighty-Ninth General Assembly, also known as the "Health Care Independence Act of 2013" (hereafter, the "Health Care Independence Program," or "HCIP"), now codified in Ark. Code Ann. §§ 20-77-2101 et seq. Pursuant to Ark. Code Ann. § 20-77-2105(g)(1) and Ark. Code Ann. § 20-77-2106(e), the Arkansas Insurance Department ("AID") and Arkansas Department of Human Services ("ADHS") are authorized to issue Rules to implement provisions under HCIP. In addition, this Rule is issued pursuant to Ark. Code Ann. § 23-61-108(b)(1) which states that the Arkansas Insurance Commissioner ("Commissioner") has authority to promulgate rules and regulations necessary for the effective regulation of the business of insurance.

Section 2. Purpose

The purpose of this Rule is to provide standards for patient-centered medical home ("PCMH") programs for Health Carriers in the Health Insurance Marketplace which issue Qualified Health Plans ("QHPs") on or after January 1, 2015.

Section 3. Applicability & Scope

This Rule applies to all Health Carriers issuing QHPs in the Health Insurance Marketplace on or after January 1, 2015. Under Ark. Code Ann. § 20-77-2106(d), Health Carriers participating in the Health Insurance Marketplace are required to participate in in Arkansas Payment Improvement Initiatives ("APII") including: (1) Assignment of primary care clinician; (2) Support for patient-centered medical home; and (3) Access of clinical performance

data for providers. The HCIP requires Health Carriers to participate in the APII as multi-payer participants and to attribute QHP beneficiaries to primary care providers, provide practice support for PCMH implementation, and enable provider access to clinical performance data. APII participation required by this Rule does not preclude Health Carriers from developing separate and distinct care delivery models and offering to providers financial or other support to promote practice transformation and care coordination and incentives on quality and cost of care through shared savings, so long as the standards for such delivery models and support reasonably follow the standards outlined in the APII. This Rule requires Health Carriers to participate in PCMH standards as one active or available option for primary care providers in Qualified Health Plan networks on or after January 1, 2015. Additionally, these standards set a floor for participation and do not preclude Health Carriers from developing and implementing standards that exceed the requirements set forth in this Rule.

Section 4. Definitions

The following definitions shall apply in this Rule, unless otherwise defined by HClP:

(1) "ADHS" means the Arkansas Department of Human Services;

(2) "AID" means the Arkansas Insurance Department;

(3) "APII" means the Arkansas Payment Improvement Initiatives, as referenced in Ark. Code Ann. § 20-77-2106(d), which is a multi-payer program that connects medical payment to medical providers to achieve high quality care at an appropriate cost for QHP Enrollees;

(4) "DMS" means the Arkansas Department of Medicaid Services under ADHS;

(5) "HCIP" means the Program established under Act 1498 of 2013 by the Arkansas State Legislature known as the "Health Care Independence Act of 2013";

(6) "Health Carrier" means a private entity certified by AID and offering plans through the Health Insurance Marketplace;

(7) "Healthcare coverage" shall mean healthcare benefits as defined under Ark. Code Ann. § 20-77-2104(4);

(8) "Health Insurance Marketplace" means the marketplace as defined by Ark. Code Ann. § 20-77-2104(5);

(9) "Qualified Health Plan" means an AID certified individual health insurance plan offered by a Health Carrier through the Health Insurance Marketplace;

(10) "QHP Enrollee" means a person insured under a Qualified Health Plan;

(11) "Patient Centered Medical Home" ("PCMH") means a local point of access to care that proactively looks after patients' health on a "24-7" basis. A PCMH bears responsibility for coordinating care to address the complete health needs of a patient population and supports patients to connect with other providers to form a health services team, customized for their patients' care needs with a focus on prevention and management of chronic disease through monitoring patient progress and coordination of care;

(12) "Primary care provider" means a participating health care provider practicing within their licensed scope of practice and designated by the Health Carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the Health Carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

Section 5. Requirements

For QHPs issued on or after January 1, 2015, Health Carriers shall adopt the following requirements and provide the opportunity for primary care .providers to participate in an approved PCMH model according to these standards:

(a) The Health Carrier must reasonably follow the standards or guidelines of a national or State standardized PCMH model as approved by the Commissioner;

(b) Health Carriers will prospectively attribute QHP enrollees to primary care practices either based on enrollee choice or according to the plurality of professional visits for primary care evaluation and management paid by the Health Carrier over the prior year. Health Carriers may develop their own method for attributing. enrollees for whom coverage was discontinuous during the prior year;

(c) Health Carriers will offer practice support to primary care .provider practices that have been identified by Medicaid as participating in the Arkansas PCMH model through the APII. Health Carriers may identify additional PCMH participants with at least three hundred (300) enrollees for inclusion in the Arkansas PCMH Model. Practice support will be provided in the form of care coordination payments equivalent to or greater than an average of five dollars ($5.00) per .enrollee per month. Health Carriers may use a risk adjustment method of their choosing for determining the actual payment, so long as the average payment per enrollee is no less than five dollars ($5.00) per month;

(d) Health Carriers may terminate payment of practice support for provider failure to meet milestones or deadlines for practice transformation activities and benchmarks or targets for clinical quality. In order to minimize provider administrative burden and encourage meaningful data reporting, quality metrics collected and reported by Health Carriers must incorporate Arkansas PCMH model requirements;

(e) Health Carriers shall provide performance reports for PCMH practice transformation and quality on a quarterly basis. A standardized report form shall be made available to Health Carriers from the Arkansas Health Care Payment Improvement Initiative Web Site (www.paymentinitiative.org) and reporting

should include total cost of patient care and care categories (not shown in referenced report);

(f) Health Carriers shall share statistics with AID or its designee(s) (output of analyzed claims data used to create above reports) for streamlined provider use at an aggregate multi-payer level;

(g) On or after January 1, 2016, Health Carriers should expect to participate in development of mechanisms to share savings with PCMH practices for achieving a per issuer enrollee cost of care that is below its benchmark cost.

(h) Health Carriers shall educate QHP enrollees about the Health Carrier's PCMH program and indicate which practices are participating in the program.

Section 6. Enforcement

AID shall review a Health Carrier's compliance with the provisions of this Rule in its role of recommending approval or non-approval for certification of qualified health plans sold in the Health Insurance Marketplace.

Section 7. Effective Date

The effective date of this Rule shall be January 1, 2015.

_____

JAY BRADFORD
INSURANCE COMMISSIONER

_____

DATE

ARKANSAS ACADEMY OF
FAMILY PHYSICIANS

500 Pleasant Valley Drive
Building D, Suite 102
Little Rock, Arkansas 72227

July 31, 2014

Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201

RE: Proposed Rule 108

Dear Commissioner Bradford,

Representing over 1100 Family Practice Physicians in the State of Arkansas, the Arkansas Chapter, American Academy of Family Physicians offers the following commentary:

Regarding Section 3, Item (1) Assignment of Primary Care Clinician
Regarding Section 4, Item (12) Primary Care "Provider"

The Patient Centered Medical Home (PCMH) concept was created by our colleagues in Pediatrics for application to complex, chronically-ill patients. The AAFP has a long,proud history of developing a more comprehensive model of the PCMH concept , appropriate for broader application in primary care. It is the policy of our national organization, the American Academy of Family Physicians, one which we wholly endorse as a state chapter, that the Patient Centered Medical Home (PCMH) should be a team consisting of many different and valued members of the healthcare sytem, but that it should remain Physician Led. Please see the AAFP position paper on use of generic term, "provider" or "clinician". http://www.aafp.org/about/policies/all/Provider-term-position.html.

We believe that the use of the generic terms "clinician" and "Provider" will open the door for non-physician led PCMH, and in our opinion, such entities would create an environment that is sub-optimal for patient care. Each member of the PCMH team brings their own value to the team based approach, but the intensity and breadth of training for physicians uniquely qualifies them to lead the effort to provide high quality, low cost, patient centered care. It is our opinion that patients deserve the competency and comprehensive care that is provided by a physician-led team operating within the context of a PCMH. More detailed information about the AAFP's policy on physician leadership of the PCMH can be found at the following links (http://www.aafp.org/dam/AAFP/documents/about_us/initiatives/AAFP-PCMHWhitePaper.pdf And http://blogs.aafp.org/cfr/leadervoices/entry/nps_no_substitute_for_physician).

Thank you for your consideration of our concerns.

Sincerely,

Lonnie Robinson, M.D.
Delegate to the AAFP Congress

Phone: (501) 223-2272

Fax: (501-223-2280

Email:
arafp@sbcglobal.net

EXHIBIT

ARKANSAS MEDICAL SOCIETY
P.O. Box 55088 • Little Rock, AR • 72215-5088
Telephone (501) 224-8967 • WATS 1-800-542-1058 • FAX (501) 224-6489 • E-MAIL ams@arkmed.org • WEB PAGE www.arkmed.org

July 30, 2014

Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

Re: Proposed Rule 108

Commissioner Bradford:

On behalf of the 4,500 physician-members of the Arkansas Medical Society, we would like to comment regarding proposed Rule 108.

We are opposed to the rule's lack of specificity regarding who can lead a Patient Centered Medical Home (PCMH). The proposed rule's definition of primary care provider (PCP) does not specifically refer to physicians or primary care specialties. All other provider types, while excellent at what they do, have limited scopes of practice. Our strong belief is that only physicians are qualified to manage the full range of requirements and challenges posed by a PCMH.

A "team-based" care construct is at the very cornerstone of a PCMH, and the team should be led by a designated physician PCP because physicians have the most extensive, broadest education with the highest level of training. The rule's vagueness, in possibly allowing one with a limited scope of practice to attain PCP designation, is not in the best interest of either the patients or the health care team providing care to those patients.

Limited scope practitioners, although vitally important to each of these teams, are not fully equipped to clearly and successfully lead such a team in providing care in the broadest range of circumstances. One significant limitation is the ability to admit and discharge patients from a hospital. Currently, Arkansas rules allow only physicians to handle this important responsibility

Physician-designated PCPs leading the PCMH is already a successful model and provides the highest quality of care possible. Medicaid standards for PCMHs recognize that physicians should be leading the team as PCP (see Medicaid Manual 171.100). Rule 108, although not changing Medicaid's approach, as proposed would conflict with those Medicaid standards. Carriers are required by rule to support Medicaid PCMHs, which are led by physician PCPs.

Section 5 (a) of this proposed rule states that, "[t]he Health Carrier must reasonably follow the standards or guidelines of a national or State standardized PCMH model as approved by the Commissioner…"

Standards for PCMHs on both the national level and in Arkansas have physicians as the PCP. We believe the previously mentioned standards were carefully adopted with the needs of Arkansas specifically in mind. These standards provide the clearest, and most appropriate guidance for Rule 108. The Arkansas Health Care Payment Improvement Initiative has set a clear statewide standard with physicians as PCPs. This statewide standard is already working well and should be followed to provide consistency, which in turn will improve coordination and efficiency.

"Practice Support" link: http://www.paymentinitiative.org/medicalHomes/Pages/Practice-Support.aspx
"Eligibility Requirements" link: http://www.paymentinitiative.org/medicalHomes/Pages/Requirements-of-Becoming-PCMH.aspx.

Finally, it should be noted that the Arkansas legislature, on numerous occasions now has had the opportunity to pass filed legislation designating non-physicians as Medicaid PCPs. Not once has such legislation come close to passage. It appears to us that the will of the legislature has been to NOT grant PCP designation to non-physician providers through such legislation, and we believe this rule specifically goes against that general legislative sentiment expressed in recent sessions.

Our proposed language would change the paragraph (12) definition of "Primary Care Provider" in Section 4.

"Primary Care Provider" means a participating ~~health care provider practicing within their licensed scope of practice~~ physician licensed by the Arkansas State Medical Board whose sole or primary specialty is family practice, general practice, internal medicine, pediatrics and adolescent medicine or obstetrics and gynecology, and designated by the Health Carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the Health Carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

Thank you for your consideration.

Sincerely,

H. Scott Smith, JD
Director of Governmental Affairs
Arkansas Medical Society

ARKANSAS ACADEMY OF
FAMILY PHYSICIANS

500 Pleasant Valley Drive
Building D, Suite 102
Little Rock, Arkansas 72227

July 31, 2014

Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201

RE: Proposed Rule 108

Dear Commissioner Bradford,

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We believe that the use of the generic terms "clinician" and "Provider" will open the door for non-physician led PCMH, and in our opinion, such entities would create an environment that is sub-optimal for patient care. Each member of the PCMH team brings their own value to the team based approach, but the intensity and breadth of training for physicians uniquely qualifies them to lead the effort to provide high quality, low cost, patient centered care. It is our opinion that patients deserve the competency and comprehensive care that is provided by a physician-led team operating within the context of a PCMH. More detailed information about the AAFP's policy on physician leadership of the PCMH can be found at the following links (http://www.aafp.org/dam/AAFP/documents/about_us/initiatives/AAFP-PCMHWhitePaper.pdf And http://blogs.aafp.org/cfr/leadervoices/entry/nps_no_substitute_for_physician).

Thank you for your consideration of our concerns.

Sincerely,

Lonnie Robinson

Lonnie Robinson, M.D.
Delegate to the AAFP Congress

Ph **e:** (501) 223-2272

Fax: (501-223-2280

Email:
arafp@sbcglobal.net

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Arkansas Chapter
#1 Children's Way, Slot 900
Little Rock, AR 72202-3510
Phone: 501/364-4410
Fax: 501/364-1561
E-mail: berryaimee@sbcglobal.net

August 1, 2014

The Honorable Jay Bradford
Insurance Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

Dear Commissioner Bradford:

The Arkansas Chapter, American Academy of Pediatrics is asking you to amend the proposed Rule 108 which provides standards for Patient-Centered Medical Homes (PCMH) because of vague language in regard to whether non-physician clinicians would be eligible to lead comprehensive healthcare teams providing care under the PCMH model. We strongly agree with the "Joint Principles of the Patient-Centered Medical Home" (Joint Principles) published by the Patient Centered Primary Care Collaborative and developed by the several national medical organizations with a focus on providing primary care, including the AAP. While the Joint Principles recognize the value of interprofessional healthcare teams, it is clear states that the physician should be the leader of that team. Allowing non-physicians to lead teams of healthcare providers providing comprehensive care through the PCMH model has significant risks that could negatively impact the quality of care provided to patients. The physician-led medical model ensures that professionals with complete medical education and training are adequately involved in patient care.

While we support the intent of this proposal to establish rules for the operation of PCMH in the state, and appropriate payment for care provided under this model, the current definition of "Primary Care Provider" in Proposed Rule 108 section (4)(12) needs to be clear. This ambiguity leaves it up to the carrier to decide the definition of primary care provider for the purposes of the PCMH which could lead to non-physician clinicians inappropriately leading comprehensive patient care, which is beyond their education and training. This could also create incongruity in state regulation of medical practice whereby the scope of practice for nurse practitioners and other healthcare professionals may greatly expand without appropriate oversight and supervision. The definition of "Primary care provider" under the proposed rule should instead be amended to specifically define this healthcare professional as a physician.

Making this change would be inline with The Joint Principles which clearly state that the physician should lead the care provided under the PCMH model. In fact, the first two principles are: "Personal Physician," recognizing the need for each patient to have an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care, and "Physician Directed Medical Practice," supporting the concept of a physician led team of healthcare professionals at the practice level who collectively take responsibility for the ongoing care of patients.

Additionally, section (5)(a) of Proposed Rule 108 specifies that the Health Carrier must reasonably follow the standards or guidelines for a national or state standardized PCMH model as approved by the Commissioner. The national standard, as established by the Joint Principles, clearly maintains that physicians must be in the role of "Primary Care

Provider" and leader of the comprehensive care team. This mirrors the PCMH standards

in Arkansas as defined in the Arkansas Medicaid Provider Manual which states that PCMH is: "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." In fact, in section 171.630 of the manual it states that "Licensed nurse practitioners or licensed physician assistants employed by a Medicaid-enrolled RHC provider may not function as PCP substitutes."

We are specifically requesting that Section 4, Paragraph 12 be amended (in approximate wording) to the following: "Primary Care Provider" means a participating health care provider practicing within their licensed scope of practice physician licensed by the Arkansas State Medical Board and designated by the Health Carrier to supervise, coordinate or provide initial care or continuing care to a covered person, who may be required by the Health Carrier to initiate a referral for a specialty care and maintain supervision of health care services rendered to the covered person.

Potentially allowing non-physician clinicians to serve as a "Primary Care Provider" within the PCMH model would run counter to existing state policy and national PCMH principles, and may deteriorate the quality of care provided to Arkansas patients through this model. We urge you to protect the safety of Arkansas' patients and the integrity of the PCMH model by defining "Primary Care Provider" as a physician. Should you need any additional information, please feel free to contact me at your convenience. Thank you in advance for your attention to this matter.

Sincerely,

Aimee Olinghouse

Aimee Olinghouse
Executive Director
Arkansas Chapter, American Academy of Pediatrics
1 Children's Way, Slot 900
Little Rock, Arkansas 72202
501.831.3057
berryaimee@sbcglobal.net

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Frank B. Sewall
Senior Counsel, Regulatory
501-378-3297
501-378-2975 fax

320 West Capitol – Suite 211
P.O. Box 2181
Little Rock, AR 72203-2181
fbsewall@arkbluecross.com

August 4, 2014

The Honorable Booth Rand
Managing Attorney
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

Re: Proposed Rule 108 Patient-Centered Medical Home Standards

Dear Mr. Rand:

In response to the notice of public hearing issued by the Arkansas Insurance Department on June 26, 2014 in connection with the proposed Rule 108, "Patient-Centered Medical Home Standards," I am writing to provide comments on behalf of Arkansas Blue Cross and Blue Shield.

Arkansas Blue Cross is an enthusiastic supporter of patient-centered medical homes as a way to effectively provide comprehensive medical care. We began piloting PCMH programs at ten locations in Arkansas in 2010. Since then we have expanded this team approach to medical care throughout the state. We appreciate the opportunity to comment on the proposed rule. I hope that you take our comments in the context of our wanting to assure that patient-centered medical homes will continue and improve in our state in the coming years.

As you know, the patient-centered medical home concept is mentioned in the federal Affordable Care Act of 2010 as one of the quality through marketplace incentives, along with quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives.[1] Although the rule issued by the federal agencies requires that an insurance issuer must implement and report a quality improvement strategy or strategies consistent with the standards of section 1311(g) of the Affordable Care Act,[2] neither the Act nor the rules issued by the federal agencies specifically require that an insurance issuer implement patient-centered medical home.

However, the Arkansas Health Care Independence Act, which established the Health Care Independence Program, commonly called "the Private Option," for persons

[1] Pub.L. 111-148, Title I §1311(g)(1)(A); 42 U.S.C. §18031(g)(1)(A).
[2] 45 C.F.R. §156.200(b)(5).

EXHIBIT
PC 1

who qualify for Medicaid, does require carriers that sell insurance coverage through the Private Option to support patient-centered medical home.[3]

PROPOSED RULE 108 IS OVERBROAD IN ITS APPLICATION AND SCOPE.

Section 2 of the proposed rule provides that the purpose of the rule is to provide standards for patient-centered medical home programs for Health Carriers in the Health Insurance Marketplace which issue Quality Health Plans.

Section 3 of the proposed rule applies the rule to all Health Carriers issuing Quality Health Plans in the Health Insurance Marketplace. This section, citing Ark. Code Ann. §20-77-2106(d) [sic.] erroneously states that Health Carriers participating in the Health Insurance Marketplace are required to participate in the Arkansas Payment Improvement Initiatives including. . . support for patient-centered medical home. The statute provision, properly cited as Ark. Code Ann. §20-77-2406(d), requires that health insurance carriers offering health coverage for Health Care Independence Program eligible individuals must support patient-centered medical home.

Section 6 of the proposed rule specifies that the Insurance Department will review a Health Carrier's compliance with the proposed rule in its role of recommending approval or non-approval for certification of qualified health plans sold in the Health Insurance Marketplace.

Each of these provisions goes beyond the statutory authority granted to the Insurance Department to implement the rule. The Health Care Independence Act deals only with health plans sold to individuals participating in the Private Option. Although the Affordable Care Act authorizes Exchanges or Marketplaces to evaluate quality improvement strategies, neither the Act nor the federal rules require that a carrier implement patient-centered medical home to obtain certification by the exchange.[4]

PROPOSED RULE 108 DOES NOT CLEARLY SPECIFY EITHER THE ACTIONS OR THE STANDARDS A CARRIER MUST MEET IN ORDER TO BE IN COMPLIANCE WITH THE RULE.

Section 5 of the proposed rule, "Requirements" sets forth requirements in "an approved patient-centered medical home model."

Subsection 5(a) is extremely vague. What "national or State standardized patient-centered medical home models" will the Commissioner approve? If the Department has determined the models, those models should be listed in the rule. If the Commissioner

[3] Ark. Code Ann. §20-77-2406(d)(2).
[4] See 45 CFR §155.200(d).

anticipates approving any model, this requirement is irrelevant and possibly unconstitutional.

Subsection 5(b) appears to be over restrictive in that it limits a carrier's ability to attribute primary care provider selection for individuals who do not make a PCP selection, according to the plurality of professional visits for primary care evaluation and management over the prior year. This attribution standard on its surface does not appear unreasonable; however, other attribution methods may be just as reasonable.

Because the proposed rule is written to cover patient-centered medical home models in connection with all health plans issued in the Health Insurance Marketplace, the requirement in Subsection 5(d) that carriers incorporate quality metrics collected and reported in the Arkansas patient-centered medical home model does not make sense. At the very least, it appears to contradict Subsection 5(a), which allows carrier to follow the standards of national models.

Subsection 5(e) requires carriers to provide performance reports and references standardized reports available from the Arkansas Health Care Payment Improvement Initiative. The Arkansas Health Care Payment Improvement Initiative is a collaboration among the Department of Human Services, Arkansas Blue Cross and QualChoice. We wonder why this organization is referenced in this Insurance Department rule. It appears that if there is a need for state regulation, it should be carried out by the Department of Human Services.

Subsection 5(f) requires carriers to share statistics with the Insurance Department. What statistics? Here again, we think this requirement is too vague.

Subsection 5(g) provides that on or after January 1, 2016 carriers should expect to participate in development of mechanisms to share savings with patient-centered medical home practices for achieving a per enrollee cost of care that is below its benchmark. What is meant by this provision? What benchmark cost? Is a carrier limited to one shared saving method?

Subsection 5(h) requires carriers to educate their QHP enrollees about the carrier's patient-centered medical home program and indicate which practices are participating in the program. Although Arkansas Blue Cross appreciates the need for education about patient-centered medical home, this subsection of the rule provides no standards. We do not believe that it is necessary to require such education through an Insurance Department rule, unless the Department has developed specific standards.

PROPOSED RULE 108 SETS OUT STANDARDS FOR PATIENT-CENTERED MEDICAL HOME MODEL OPERATION. SUCH STANDARDS SHOULD FALL WITHIN THE PURVIEW OF THE DEPARTMENT OF HUMAN SERVICES.

Proposed Rule 108 contains numerous general statements concerning the operating standards for a Patient-Center Medical Home model. We believe that standards connected with the operation of the Arkansas Patient-Centered Medical Home model, which is required for health plans providing coverage through the Private Option, would best be handled by the Department of Human Services. The Health Care Independence Act provides co-regulatory responsibility to the Department of Human Services and the Insurance Department. The Department of Human Services has already developed standards for the Arkansas Patient-Centered Medical Home model as it applies to the standard Medicaid program. The Department of Human Services is currently collaborating with Arkansas Blue Cross and QualChoice in the Arkansas Health Care Payment Improvement Initiative. The Department of Human Services has medical personnel on staff who are familiar with the issues involved in patient-centered medical home operation.

PROPOSED RULE 108 SETS OUT STANDARDS FOR PATIENT-CENTERED MEDICAL HOME WHEN CURRENTLY THERE APPEARS NO NEED FOR SUCH STANDARDS.

Earlier in this letter I mentioned that legally the proposed rule is overbroad in as much as it would apply a requirement for patient-centered medical home on all health plans sold in the marketplace, rather than those products sold to individuals through the Private Option.

We at Arkansas Blue Cross are also concerned because the proposed rule imposes standards of patient-centered operation on health plans when to date there is no indication that health plans, in assisting primary care providers to develop patient-centered medical home practices, are not going to develop standards that are just as good or better than those imposed by the proposed rule, e.g. enrollee attribution, performance reports, and shared savings methodologies.

The concept of patient-centered medical home is relatively new to Arkansas. We are concerned that the proposed rule will hinder the development of patient-centered medical home.

ALTERNATIVE DRAFT TO PROPOSED RULE 108

This draft differs from Proposed Rule 108 in the following ways:

1. The purpose and scope of this draft are limited to health plans sold through the Health Care Independence Program.

2. This draft sets out a clear, specific standard, certification by a carrier to the Commissioner that the carrier is promoting and participating in the Arkansas Patient-Centered Medical Home model in connection with its health plans through the Health Care-Independence Program, in order to comply with the rule.

3. This draft provides that the Department of Human Services will set forth standards for the Arkansas model Patient-Centered Medical Home.

4. This draft provides that the Department of Human Services will provide the Commissioner documentation to support a carrier's certification of participation in the Arkansas Patient-Centered Medical Home.

5. This draft provides that a carrier is not required to certify a patient-centered medical home model for health plans not issued to individuals receiving coverage through the Health Care Independence Program.

6. This draft provides for an effective date prior to January 1, 2015 in as much as the proposed rule envisions carriers being in compliance on or after January 1, 2015.

7. This draft provides the correct citation of the codification of the Arkansas Health Care Independence Act of 2013, i.e. Ark. Code Ann. §20-77-2401 *et seq.*

Mr. Rand, I plan to be present at the hearing on August 5, 2014. Accompanying me will be Alicia Berkemeyer, Arkansas Blue Cross and Blue Shield Vice President for Primary Care Initiatives.

Cordially yours,

Frank B. Sewall

FBS:rt

cc: Alicia Berkemeyer

enclosure

DRAFT OF August 1, 2014
ARKANSAS BLUE CROSS AND BLUE SHIELD
FOR FURTHER STUDY AND CONSIDERATION

PROPOSED RULE 108
ARKANSAS PATIENT-CENTERED MEDICAL HOME MODEL FOR QUALIFIED HEALTH PLANS ISSUED THROUGH HEALTH CARE INDEPENDENCE PROGRAM

Table of Contents

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Section 4. Definitions
Section 5. Requirements
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Section 1. Authority

This Rule is issued pursuant to Section One of Act 1498 of 2013 of the Arkansas Eighty-Ninth General Assembly, also known as the "Health Care Independence Act of 2013," which is codified in Ark. Code Ann. §§ 20-77-2401 et seq., and which established the Health Care Independence Program ("HCIP"). Pursuant to Ark. Code Ann. § 20-77-2405(g)(1) and Ark. Code Ann. § 20-77-2406(d), the Arkansas Insurance Department ("AID") and Arkansas Department of Human Services ("ADHS") are authorized to issue Rules to implement the HCIP. In addition, this Rule is issued pursuant to Ark. Code Ann. § 23-61-108(b)(1) which states that the Arkansas Insurance Commissioner ("Commissioner") has authority to promulgate rules and regulations necessary for the effective regulation of the business of insurance.

Section 2. Purpose

The purpose of this Rule is to require Carriers to participate in and promote the Arkansas Patient-Centered Medical Home Model in order to have their health plans certified as Qualified Health Plans sold through the Health Care Independence Program on or after January 1, 2015.

Section 3. Applicability & Scope

Under Ark. Code Ann. § 20-77-2406(d), Carriers offering coverage to individuals through the HCIP are required to participate in Arkansas Payment Improvement Initiatives ("APII") including: (1) Assignment of primary care clinician; (2) Support for patient-centered medical home; and (3) Access of clinical performance data for providers.

This Rule sets forth the Commissioner's role in assuring Carriers that issue QHPs to individuals through the HCIP support the Arkansas Patient-Centered Medical Home model, the

standards for which have been developed by the Department of Human Services and [are] [will be] described in a separate rule promulgated by the Department of Human Services.

This Rule does not and is not intended to hinder Carriers in developing Patient-Centered Medical Home models to be used in connection with health plans, including QHPs, which are not issued to individuals receiving coverage through the Health Care Independence Program.

Section 4. Definitions

As used in this rule:

(1) "Arkansas Patient-Centered Medical Home model" means the Patient-Centered Medical Home model developed by the Department of Human Services in connection with delivering health care services to Medicaid beneficiaries.

(2) Arkansas Payment Improvement Initiatives, referenced in Ark. Code Ann. § 20-77-2406(d), is a multi-payer program that connects medical payment to medical providers to achieve high quality care at an appropriate cost for individuals receiving coverage through the Health Care Independence Program.

(3) "Carrier" means a private entity certified by Arkansas Insurance Department and offering plans through the Health Insurance Marketplace.

(4) "Health Care Independence Program" means the program established by Act 1498 of 2013 whereby individuals who are qualified for the Arkansas State Medicaid Program may receive coverage through the Arkansas Health Insurance Marketplace.

(5) "Health Insurance Marketplace" means the agency or entity established in accordance with the Affordable Care Act[1] that makes QHPs available to qualified individuals and qualified employers domiciled in Arkansas.

(6) "Patient-Centered Medical Home" means a team based health care delivery model led by a primary care provider that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes. The key attributes to Patient-Centered Medical Home are 24/7 access for all individuals, evidence-informed care, providers with responsibility for the practice's entire population, coordinated and integrated care across multidisciplinary provider teams, focus on prevention and management of chronic disease, referrals to specialists, improved wellness and preventive care.

(7) "Qualified Health Plan" means a health insurance plan offered by a Carrier which has received Commissioner's certification to be offered on the Health Insurance Marketplace.

Section 5. Requirements

(a) In order to have its health plans certified as Qualified Health Plans and to sell such health plans to individuals receiving coverage through the Health Care Independence Program, a Carrier must certify to the Commissioner that the Carrier is promoting and

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[1] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148 as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; 42 USC §18001 *et seq.*

participating in the Arkansas Patient-Centered Medical Home model. Such certification must be submitted annually. For QHPs to be issued on or after January 1, 2015, the certification must be submitted no later than _____, 2014. For QHPs issued in calendar years 2016 and beyond, the Carrier must include its certification of support for the Arkansas Patient-Centered Medical Home in its annual QHP certification application.

(b) As part of its Certification, a Carrier shall certify that it will provide care coordination payments medical practices participating in the Arkansas Patient-Centered Medical Home model equivalent to or greater than an average of five dollars ($5.00) per individual receiving the Carrier's coverage through the Health Care Independence Program per month. Carriers may use a risk adjustment method of their own choosing for determining the actual payment, so long as the average payment per insured individual is no less than five dollars ($5.00) per month.

(c) The Department of Human Services, by separate rule, will set forth the standards for the Arkansas model Patient-Centered Medical Home.

(d) The Department of Human Services shall provide the Commissioner documentation to support a Carrier's certification of participation in the Arkansas Patient-Centered Medical Home model.

(e) The Commissioner shall not require Carrier certification of a Patient-Centered Medical Home model to certify QHPs that are not issued to individuals receiving coverage through the Health Care Independence Program.

Section 6. Enforcement

Commissioner shall review a Carrier's compliance with the provisions of this Rule in his role as one of the agencies tasked with enforcement of the Health Care Independence Act.

Section 7. Effective Date

The effective date of this Rule shall be _____, 2014.

_____

JAY BRADFORD
INSURANCE COMMISSIONER

_____

DATE

August 2, 2014

The Honorable Jay Bradford, Commissioner

Arkansas Insurance Department

1200 West Third Street

Little Rock, AR 72201

Re: Proposed Rule 108

Commissioner Bradford:

On behalf of the over 500 physician members of the Arkansas Chapter of the American College of Physicians (the nation's largest specialty physician organization) I wish to comment on proposed Rule 108.

The American College of Physicians is a strong proponent of PCMH's and of team-based care and has done much to promote their use. The proposed Rule is; however, open to interpretation such that a non-physician could be classified as a PCP.

We have great respect for limited scope practitioners, including APN's, NP's and PA's. But it is our feeling that the best person to lead the teams is a physician PCP. The physician has the best training to function in this role and, we believe, is the most qualified to do so. Every team needs a captain and that person needs to be the one with the most training and experience so that patients ultimately receive the most benefit from these new avenues with which to deliver quality care.

I have read the letter from Scott Smith at the Arkansas Medical Society and agree with it in every particular. I have also consulted my governing council and have received strong support from them to express this opinion regarding physician leadership in the PCMH.

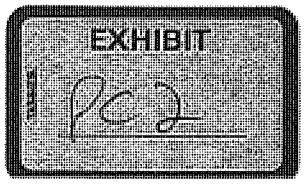
We agree with the Medical Society that PCP's should be physicians who are licensed in the specialties of family practice, general practice, internal medicine, pediatrics and adolescent medicine or obstetrics and gynecology.

We look forward to working with all team members to develop a better system for delivery of care and appreciate your consideration of these comments.

Sincerely,

Clark Fincher, MD, FACP

Governor, Arkansas Chapter, American College of Physicians



American Academy of Pediatrics

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August 1, 2014

The Honorable Jay Bradford
Insurance Commissioner
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1200 West Third Street
Little Rock, AR 72201

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Making this change would be inline with The Joint Principles which clearly state that the physician should lead the care provided under the PCMH model. In fact, the first two principles are: "Personal Physician," recognizing the need for each patient to have an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care, and "Physician Directed Medical Practice," supporting the concept of a physician led team of healthcare professionals at the practice level who collectively take responsibility for the ongoing care of patients.

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Little Rock, AR 72202-3510
Phone: 501/364-4410
Fax: 501/364-1561
E-mail: berryaimee@sbcglobal.net

Arkansas Chapter Executive Committee

President
Orrin Davis, MD, FAAP
3380 N. Futrall
Fayetteville, Arkansas 72703
Phone: 479-443-3471
E-mail: orrin.davis@mana.md

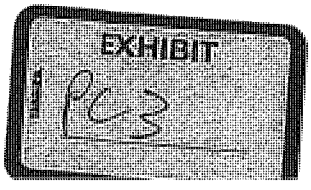
Vice President
Dennis Kuo, MD, FAAP
#1 Children's Way, Slot 900
Little Rock, Arkansas 72202
Phone: 501-364-1100
E-mail: dzkuo@uams.edu

Secretary
Chad Rodgers MD, FAAP
500 South University, Ste. Ste 302
Little Rock, Arkansas 72205
Phone: 501-664-4044
E-mail: drchadlnlr.@comcast.net

Treasurer
Chris Schluterman, MD, FAAP
7303 Rogers Ave
Fort Smith, Arkansas 72903
Phone: 479-478-7200
E-mail: cschluterman@hotmail.com

Immediate Past President
David Matthews, MD, FAAP
800 S. Church Street
Jonesboro, AR 72401-4176
Phone: 870-935-6012
Fax: 870-934-3152
E-mail: dmatthews@tccjbr.com

Chapter Executive Director
Aimee S. Olinghouse
#1 Children's Way, Slot 900
Little Rock, AR 72202-3510
Phone: 501/364-4410
Fax: 501/364-1561
Cell: 501/831-3057
E-mail: berryaimee@sbcglobal.net



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American Academy of Pediatrics
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in Arkansas as defined in the Arkansas Medicaid Provider Manual which states that PCMH is: "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." In fact, in section 171.630 of the manual it states that "Licensed nurse practitioners or licensed physician assistants employed by a Medicaid-enrolled RHC provider may not function as PCP substitutes."

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Potentially allowing non-physician clinicians to serve as a "Primary Care Provider" within the PCMH model would run counter to existing state policy and national PCMH principles, and may deteriorate the quality of care provided to Arkansas patients through this model. We urge you to protect the safety of Arkansas' patients and the integrity of the PCMH model by defining "Primary Care Provider" as a physician. Should you need any additional information, please feel free to contact me at your convenience. Thank you in advance for your attention to this matter.

Sincerely,

Aimee Olinghouse

Aimee Olinghouse
Executive Director
Arkansas Chapter, American Academy of Pediatrics
1 Children's Way, Slot 900
Little Rock, Arkansas 72202
501.831.3057
berryaimee@sbcglobal.net

Booth Rand

From: Booth Rand
Sent: Friday, August 01, 2014 2:27 PM
To: Seth Blomeley
Subject: FW: Proposed rule 108

-----Original Message-----
From: Kimberly Joy L. Carney [mailto:kjbcnp@yahoo.com]
Sent: Thursday, July 10, 2014 9:11 PM
To: Booth Rand
Subject: Proposed rule 108

July 10, 2014

Mr. Booth Rand

Arkansas Insurance Department

1220 West Third Street

Little Rock, AR 72201-1904

Booth.rand@arkansas.gov

RE: Proposed rule 108: "Patient Centered Medical Home (PCMH) Standards."

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. This is another important reason to have provider neutral language in this rule.

Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

Dr. Kimberly Carney
DNP, APRN, FNP-BC, CDE

EXHIBIT
KC 4

email: cxp027@email.uark.edu

Thank you for the opportunity to comment on proposed rule 108.

Sincerely,

ARKANSAS MEDICAL SOCIETY
P.O. Box 55088 • Little Rock, AR • 72215-5088
Telephone (501) 224-8967 • WATS 1-800-542-1058 • FAX (501) 224-6489 • E-MAIL ams@arkmed.org • WEB PAGE www.arkmed.org

July 30, 2014

Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

Re: Proposed Rule 108

Commissioner Bradford:

On behalf of the 4,500 physician-members of the Arkansas Medical Society, we would like to comment regarding proposed Rule 108.

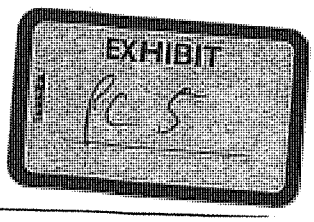
We are opposed to the rule's lack of specificity regarding who can lead a Patient Centered Medical Home (PCMH). The proposed rule's definition of primary care provider (PCP) does not specifically refer to physicians or primary care specialties. All other provider types, while excellent at what they do, have limited scopes of practice. Our strong belief is that only physicians are qualified to manage the full range of requirements and challenges posed by a PCMH.

A "team-based" care construct is at the very cornerstone of a PCMH, and the team should be led by a designated physician PCP because physicians have the most extensive, broadest education with the highest level of training. The rule's vagueness, in possibly allowing one with a limited scope of practice to attain PCP designation, is not in the best interest of either the patients or the health care team providing care to those patients.

Limited scope practitioners, although vitally important to each of these teams, are not fully equipped to clearly and successfully lead such a team in providing care in the broadest range of circumstances. One significant limitation is the ability to admit and discharge patients from a hospital. Currently, Arkansas rules allow only physicians to handle this important responsibility.

Physician-designated PCPs leading the PCMH is already a successful model and provides the highest quality of care possible. Medicaid standards for PCMHs recognize that physicians should be leading the team as PCP (see Medicaid Manual 171.100). Rule 108, although not changing Medicaid's approach, as proposed would conflict with those Medicaid standards. Carriers are required by rule to support Medicaid PCMHs, which are led by physician PCPs.

Section 5 (a) of this proposed rule states that, "[t]he Health Carrier must reasonably follow the standards or guidelines of a national or State standardized PCMH model as approved by the Commissioner..."



Standards for PCMHs on both the national level and in Arkansas have physicians as the PCP. We believe the previously mentioned standards were carefully adopted with the needs of Arkansas specifically in mind. These standards provide the clearest, and most appropriate guidance for Rule 108. The Arkansas Health Care Payment Improvement Initiative has set a clear statewide standard with physicians as PCPs. This statewide standard is already working well and should be followed to provide consistency, which in turn will improve coordination and efficiency.

"Practice Support" link: http://www.paymentinitiative.org/medicalHomes/Pages/Practice-Support.aspx
"Eligibility Requirements" link:
http://www.paymentinitiative.org/medicalHomes/Pages/Requirements-of-Becoming-PCMH.aspx.

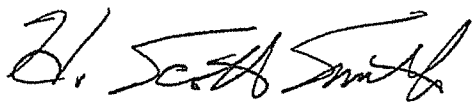
Finally, it should be noted that the Arkansas legislature, on numerous occasions now has had the opportunity to pass filed legislation designating non-physicians as Medicaid PCPs. Not once has such legislation come close to passage. It appears to us that the will of the legislature has been to NOT grant PCP designation to non-physician providers through such legislation, and we believe this rule specifically goes against that general legislative sentiment expressed in recent sessions.

Our proposed language would change the paragraph (12) definition of "Primary Care Provider" in Section 4.

"Primary Care Provider" means a participating ~~health care provider practicing within their licensed scope of practice~~ physician licensed by the Arkansas State Medical Board whose sole or primary specialty is family practice, general practice, internal medicine, pediatrics and adolescent medicine or obstetrics and gynecology, and designated by the Health Carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the Health Carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

Thank you for your consideration.

Sincerely,



H. Scott Smith, JD
Director of Governmental Affairs
Arkansas Medical Society

ARKANSAS ACADEMY OF
FAMILY PHYSICIANS

500 Pleasant Valley Drive
Building D, Suite 102
Little Rock, Arkansas 72227

July 31, 2014

Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201

RE: Proposed Rule 108

Dear Commissioner Bradford,

Representing over 1100 Family Practice Physicians in the State of Arkansas, the Arkansas Chapter, American Academy of Family Physicians offers the following commentary:

Regarding Section 3, Item (1) Assignment of Primary Care Clinician
Regarding Section 4, Item (12) Primary Care "Provider"

The Patient Centered Medical Home (PCMH) concept was created by our colleagues in Pediatrics for application to complex, chronically-ill patients. The AAFP has a long,proud history of developing a more comprehensive model of the PCMH concept , appropriate for broader application in primary care. It is the policy of our national organization, the American Academy of Family Physicians, one which we wholly endorse as a state chapter, that the Patient Centered Medical Home (PCMH) should be a team consisting of many different and valued members of the healthcare sytem, but that it should remain Physician Led. Please see the AAFP position paper on use of generic term, "provider" or "clinician". http://www.aafp.org/about/policies/all/Provider-term-position.html.

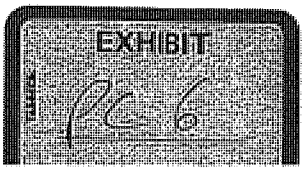
We believe that the use of the generic terms "clinician" and "Provider" will open the door for non-physician led PCMH, and in our opinion, such entities would create an environment that is sub-optimal for patient care. Each member of the PCMH team brings their own value to the team based approach, but the intensity and breadth of training for physicians uniquely qualifies them to lead the effort to provide high quality, low cost, patient centered care. It is our opinion that patients deserve the competency and comprehensive care that is provided by a physician-led team operating within the context of a PCMH. More detailed information about the AAFP's policy on physician leadership of the PCMH can be found at the following links (http://www.aafp.org/dam/AAFP/documents/about_us/initiatives/AAFP-PCMHWhitePaper.pdf And http://blogs.aafp.org/cfr/leadervoices/entry/nps_no_substitute_for_physician).

Thank you for your consideration of our concerns.

Sincerely,

Lonnie Robinson, M.D.
Delegate to the AAFP Congress

Phone: (501) 223-2272
Fax: (501-223-2280
Email:
arafp@sbcglobal.net



Booth Rand

From: Booth Rand
Sent: Friday, August 01, 2014 2:27 PM
To: Seth Blomeley
Subject: FW: Proposed Rule 108: "Patient Centered Medical Home Standards"

-----Original Message-----
From: Cheryl Perry [mailto:cxp027@email.uark.edu]
Sent: Friday, July 11, 2014 2:01 PM
To: Booth Rand
Subject: RE: Proposed Rule 108: "Patient Centered Medical Home Standards"

Dear Mr. Rand,

I am pleased to see the continuation of provider neutral language (i.e. primary care provider) in the PCMH Proposed Rule 108. This language is consistent with the provider neutral language in the Arkansas Health Care Independence Act (ACA 20-17-2106 (d) (1)) and the Department of Health and Human Services Section 1115 Demonstration Waiver. In Arkansas, having the opportunity for APRNs to be recognized as a primary care provider and team leader in patient centered medical homes would create the potential for new access points for primary care across the state. According to the Healthy Workforce in Arkansas Study (2013), the state is facing a shortage of 1,000 primary care physicians within the next five years which will seriously jeopardize access to care in all communities. This is another important reason to have provider neutral language in this rule.

Thank you so much for the opportunity to comment on Proposed Rule 108.

Sincerely,

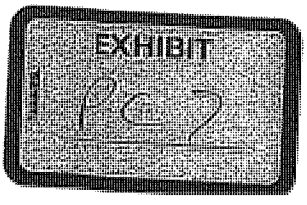
Cheryl Perry, BSN, RN

Doctor of Nursing Practice Graduate Student

University of Arkansas - Fayetteville

Home Address: 1327 Kelly Road, Alma, AR 72921

Cell: 479-651-6187



Booth Rand

From: Booth Rand
Sent: Friday, August 01, 2014 2:26 PM
To: Seth Blomeley
Subject: FW: Provider neutral language

-----Original Message-----
From: Katherine Darling [mailto:katherinedarlingllc@gmail.com]
Sent: Friday, July 11, 2014 4:37 PM
To: Booth Rand
Subject: Provider neutral language

Dear Mr. Rand,

Please find my letter expressing my thoughts in favor of provider neutral language. I appreciate your support and forward thinking. As we all work together to build a healthier Arkansas, we will accomplish great things!

Thank you for your support. If I can be of any assistance to you, please don't hesitate to contact me.

Kind Regards,

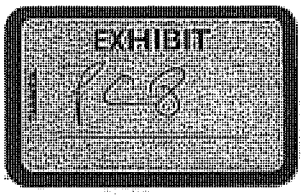
Katherine Darling

--

Dr. Katherine Darling, DNP, PMHNP/FNP-BC, APRN Katherine Darling, PLLC

637 Cougar Lane
Mountain Home, AR 72653
870 421-5875 (C)
870 425-4849 (H)
katherinedarlingllc@gmail.com

Practice Kindness - You won't regret it!



Stricken language would be deleted from and underlined language would be added to present law.
Act 1498 of the Regular Session

State of Arkansas *As Engrossed: H4/3/13 H4/6/13 H4/10/13 S4/17/13*
89th General Assembly
Regular Session, 2013

A Bill

HOUSE BILL 1143

By: Representatives J. Burris, Carter, Biviano
By: Senators J. Dismang, Bookout, D. Sanders, *Irvin*

For An Act To Be Entitled

AN ACT CONCERNING HEALTH INSURANCE FOR CITIZENS OF THE STATE OF ARKANSAS; TO CREATE THE HEALTH CARE INDEPENDENCE ACT OF 2013; TO DECLARE AN EMERGENCY; AND FOR OTHER PURPOSES.

Subtitle

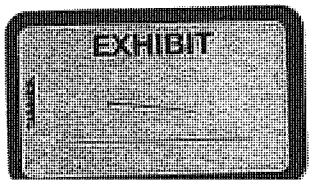
TO CREATE THE HEALTH CARE INDEPENDENCE ACT OF 2013; AND TO DECLARE AN EMERGENCY.

WHEREAS, Arkansas has historically addressed state-specific needs to achieve personal responsibility and affordable health care for its citizens such as the ARHealthNetworks partnership between the state and small businesses; and

WHEREAS, Arkansas has initiated nationally recognized and transformative changes in the healthcare delivery system through alignment of payment incentives, health care delivery system improvements, enhanced rural health care access, initiatives to reduce waste, fraud and abuse, policies and plan structures to encourage the proper utilization of the healthcare system, and policies to advance disease prevention and health promotion; and

WHEREAS, Arkansas is uniquely situated to serve as a laboratory of comprehensive and innovative healthcare reform that can reduce the state and federal obligations to entitlement spending; and

WHEREAS, faced with the disruptive challenges from federal legislation



and regulations, the General Assembly asserts its responsibility for local control and innovation to achieve health care access, improved health care quality, reduce traditional Medicaid enrollment, remove disincentives for work and social mobility, and required cost-containment; and

WHEREAS, the General Assembly hereby creates the Health Care Independence Act of 2013;

NOW THEREFORE,
BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 20, Chapter 77, is amended to create a new subchapter to read as follows:

Subchapter 21 — Health Care Independence Act of 2013

20-77-2101. Title.

This act shall be known and may be cited as the "Health Care Independence Act of 2013".

20-77-2102. Legislative intent.

(a) Notwithstanding any general or specific laws to the contrary, the Department of Human Services is to explore design options that reform the Medicaid Program utilizing the Health Care Independence Act of 2013 so that it is a fiscally sustainable, cost-effective, personally responsible, and opportunity-driven program utilizing competitive and value-based purchasing to:

(1) Maximize the available service options;

(2) Promote accountability, personal responsibility, and transparency;

(3) Encourage and reward healthy outcomes and responsible choices; and

(4) Promote efficiencies that will deliver value to the taxpayers.

(b)(1) It is the intent of the General Assembly that the State of Arkansas through the Department of Human Services shall utilize a private

insurance option for "low-risk" adults.

(2) The Health Care Independence Act of 2013 shall ensure that:

(A) Private health care options increase and government-operated programs such as Medicaid decrease; and

(B) Decisions about the design, operation and implementation of this option, including cost, remain within the purview of the State of Arkansas and not with Washington, D.C.

20-77-2103. Purpose.

(a) The purpose of this subchapter is to:

(1) Improve access to quality health care;

(2) Attract insurance carriers and enhance competition in the Arkansas insurance marketplace;

(3) Promote individually-owned health insurance;

(4) Strengthen personal responsibility through cost-sharing;

(5) Improve continuity of coverage;

(6) Reduce the size of the state-administered Medicaid program;

(7) Encourage appropriate care, including early intervention, prevention, and wellness;

(8) Increase quality and delivery system efficiencies;

(9) Facilitate Arkansas's continued payment innovation, delivery system reform, and market-driven improvements;

(10) Discourage over-utilization; and

(11) Reduce waste, fraud, and abuse.

(b) The State of Arkansas shall take an integrated and market-based approach to covering low-income Arkansans through offering new coverage opportunities, stimulating market competition, and offering alternatives to the existing Medicaid program.

20-77-2104. Definitions.

As used in this subchapter:

(1) "Carrier" means a private entity certified by the State Insurance Department and offering plans through the Health Insurance Marketplace;

(2) "Cost sharing" means the portion of the cost of a covered medical service that must be paid by or on behalf of eligible individuals,

consisting of copayments or coinsurance but not deductibles;

(3) "Eligible individuals" means individuals who:

(A) Are adults between nineteen (19) years of age and sixty-five (65) years of age with an income that is equal to or less than one hundred thirty-eight percent (138%) of the federal poverty level, including without limitation individuals who would not be eligible for Medicaid under laws and rules in effect on January 1, 2013;

(B) Have been authenticated to be a United States citizen or documented qualified alien according to the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, as existing on January 1, 2013; and

(C) Are not determined to be more effectively covered through the standard Medicaid program, such as an individual who is medically frail or other individuals with exceptional medical needs for whom coverage through the Health Insurance Marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care;

(4) "Healthcare coverage" means healthcare benefits as defined by certification or rules, or both, promulgated by the State Insurance Department for the Qualified Health Plans or available on the marketplace;

(5) "Health Insurance Marketplace" means the vehicle created to help individuals, families, and small businesses in Arkansas shop for and select health insurance coverage in a way that permits comparison of available Qualified Health Plan based upon price, benefits, services, and quality, regardless of the governance structure of the marketplace;

(6) "Premium" means a charge that must be paid as a condition of enrolling in health care coverage;

(7) "Program" means the Health Care Independence Program established by this subchapter;

(8) "Qualified Health Plan" means a State Insurance Department certified individual health insurance plan offered by a carrier through the Health Insurance Marketplace; and

(9) "Independence account" mean individual financing structures that operate similar to a health savings account or a medical savings account.

20-77-2105. Administration of the Health Care Independence Program.

(a) The Department of Human Services shall:

(1) Create and administer the Health Care Independence Program; and

(2)(A) Submit and apply for any:

(i) Federal waivers necessary to implement the program in a manner consistent with this subchapter, including without limitation approval for a comprehensive waiver under Section 1115 of the Social Security Act, 42 U.S.C. § 1315; and

(ii)(a) Medicaid State Plan Amendments necessary to implement the program in a manner consistent with this subchapter.

(b) The Department of Human Services shall submit only those Medicaid State Plan Amendments under subdivision (a)(2)(A)(ii)(a) of this section that are optional and therefore may be revoked by the state at its discretion.

(B)(i) As part of its actions under subdivision (a)(2)(A) of this section, the Department of Human Services shall confirm that employers shall not be subject to the penalties, including without limitation an assessable payment, under Section 1513 of Pub. L. No. 111-148, as existing on January 1, 2013, concerning shared responsibility, for employees who are eligible individuals if the employees:

(a) Are enrolled in the program; and

(b) Enroll in a Qualified Health Plan through the Health Insurance Marketplace.

(ii) If the Department of Human Services is unable to confirm provisions under subdivision (a)(2)(B)(i) of this section, the program shall not be implemented.

(b)(1) Implementation of the program is conditioned upon the receipt of necessary federal approvals.

(2) If the Department of Human Services does not receive the necessary federal approvals, the program shall not be implemented.

(c) The program shall include premium assistance for eligible individuals to enable their enrollment in a Qualified Health Plan through the Health Insurance Marketplace.

(d)(1) The Department of Human Services is specifically authorized to pay premiums and supplemental cost-sharing subsidies directly to the

Qualified Health Plans for enrolled eligible individuals.

(2) The intent of the payments under subdivision (d)(1) of this section is to increase participation and competition in the health insurance market, intensify price pressures, and reduce costs for both publicly and privately funded health care.

(e) To the extent allowable by law:

(1) The Department of Human Services shall pursue strategies that promote insurance coverage of children in their parents' or caregivers' plan, including children eligible for the ARKids First Program Act, § 20-77-1101 et seq., commonly known as the "ARKids B program"; and

(2) Upon the receipt of necessary federal approval, during calendar year 2015 the Department of Human Services shall include and transition to the Health Insurance Marketplace:

(A) Children eligible for the ARKids First Program Act, § 20-77-1101 et seq.; and

(B) Populations under Medicaid from zero percent (0%) of the federal poverty level to seventeen percent (17%) of the federal poverty level.

(3) The Department of Human Services shall develop and implement a strategy to inform Medicaid recipient populations whose needs would be reduced or better served through participation in the Health Insurance Marketplace.

(f) The program shall include allowable cost sharing for eligible individuals that is comparable to that for individuals in the same income range in the private insurance market and is structured to enhance eligible individuals' investment in their health care purchasing decisions.

(g)(1) The State Insurance Department and Department of Human Services shall administer and promulgate rules to administer the program authorized under this subchapter.

(2) No less than thirty (30) days before the State Insurance Department and Department of Human Services begin promulgating a rule under this subchapter, the proposed rule shall be presented to the Legislative Council.

(h) The program authorized under this subchapter shall terminate within one hundred twenty (120) days after a reduction in any of the following federal medical assistance percentages:

(1) One hundred percent (100%) in 2014, 2015, or 2016;

(2) Ninety-five percent (95%) in 2017;

(3) Ninety-four percent (94%) in 2018;

(4) Ninety-three percent (93%) in 2019; and

(5) Ninety percent (90%) in 2020 or any year after 2020.

(i) An eligible individual enrolled in the program shall affirmatively acknowledge that:

(1) The program is not a perpetual federal or state right or a guaranteed entitlement;

(2) The program is subject to cancellation upon appropriate notice; and

(3) The program is not an entitlement program.

(j)(1) The Department of Human Services shall develop a model and seek from the Center for Medicare and Medicaid Services all necessary waivers and approvals to allow non-aged, non-disabled program-eligible participants to enroll in a program that will create and utilize Independence Accounts that operate similar to a Health Savings Account or Medical Savings Account during the calendar year 2015.

(2) The Independence Accounts shall:

(A) Allow a participant to purchase cost-effective high-deductible health insurance; and

(B) Promote independence and self-sufficiency.

(3) The state shall implement cost sharing and co-pays and, as a condition of participation, earnings shall exceed fifty percent (50%) of the federal poverty level.

(4) Participants may receive rewards based on healthy living and self-sufficiency.

(5)(A) At the end of each fiscal year, if there are funds remaining in the account, a majority of the state's contribution will remain in the participant's control as a positive incentive for the responsible use of the health care system and personal responsibility of health maintenance.

(B) Uses of the funds may include without limitation rolling the funds into a private sector health savings account for the participant according to rules promulgated by the Department of Human Services.

(6) The Department of Human Services shall promulgate rules to implement this subsection (j).

(k)(1) State obligations for uncompensated care shall be projected, tracked, and reported to identify potential incremental future decreases.

(2) The Department of Human Services shall recommend appropriate adjustments to the General Assembly.

(3) Adjustments shall be made by the General Assembly as appropriate.

(l) The Department of Human Services shall track the Hospital Assessment Fee as defined in § 20-77-1902 and report to the General Assembly subsequent decreases based upon reduced uncompensated care.

(m) On a quarterly basis, the Department of Human Services and the State Insurance Department shall report to the Legislative Council or to the Joint Budget Committee if the General Assembly is in session, available information regarding:

(1) Program enrollment;

(2) Patient experience;

(3) Economic impact including enrollment distribution;

(4) Carrier competition; and

(5) Avoided uncompensated care.

20-77-2106. Standards of healthcare coverage through the Health Insurance Marketplace.

(a) Healthcare coverage shall be achieved through a qualified health plan at the silver level as provided in 42 U.S.C. §§ 18022 and 18071, as existing on January 1, 2013, that restricts cost sharing to amounts that do not exceed Medicaid cost-sharing limitations.

(b)(1) All participating carriers in the Health Insurance Marketplace shall offer healthcare coverage conforming to the requirements of this subchapter.

(2) A participating carrier in the Health Insurance Marketplace shall maintain a medical loss ratio of at least eighty percent (80%) for an individual and small group market policy and at least eighty-five percent (85%) for a large group market policy as required under Pub. L. No. 111-148, as existing on January 1, 2013.

(c) To assure price competitive choice among healthcare coverage

options, the State Insurance Department shall assure that at least two (2) qualified health plans are offered in each county in the state.

(d) Health insurance carriers offering health care coverage for program eligible individuals shall participate in Arkansas Payment Improvement Initiatives including:

(1) Assignment of primary care clinician;

(2) Support for patient-centered medical home; and

(3) Access of clinical performance data for providers.

(e) On or before July 1, 2013, the State Insurance Department shall implement through certification requirements, rule, or both the applicable provisions of this subchapter.

20-77-2107. Enrollment.

(a) The General Assembly shall assure that a mechanism within the Health Insurance Marketplace is established and operated to facilitate enrollment of eligible individuals.

(b) The enrollment mechanism shall include an automatic verification system to guard against waste, fraud, and abuse in the program.

20-77-2108. Effective date.

This subchapter shall be in effect until June 30, 2017, unless amended or extended by the General Assembly.

SECTION 2. Arkansas Code Title 19, Chapter 5, Subchapter 11, is amended to add an additional section to read as follows:

19-5-1140. Health Care Independence Program Trust Fund.

(a) There is created on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State a trust fund to be known as the "Health Care Independence Program Trust Fund".

(b)(1) The Health Care Independence Program Trust Fund may consist of moneys saved and accrued under the Health Care Independence Act of 2013, § 20-77-2101 et seq., including without limitation:

(A) Increases in premium tax collections;

(B) Reductions in uncompensated care; and

(C) Other spending reductions resulting from the Health Care Independence Act of 2013, 20-77-2101 et seq.

(2) The fund shall also consist of other revenues and funds authorized by law.

(c) The fund may be used by the Department of Human Services to pay for future obligations under the Health Care Independence Program created by the Health Care Independence Act of 2013, § 20-77-2101 et seq.

SECTION 3. NOT TO BE CODIFIED. (a) The implementation of this act is suspended until an appropriation for the implementation of this act is passed by a three-fourths vote of both houses of the Eighty-Ninth General Assembly.

(b) If an appropriation for the implementation of this act is not passed by the Eighty-Ninth General Assembly, this act is void.

SECTION 4. NOT TO BE CODIFIED. The enactment and adoption of this act shall supersede Section 21 of HB1219 of the Eighty-Ninth General Assembly, if Section 21 of HB1219 of the Eighty-Ninth General Assembly is enacted and adopted.

SECTION 5. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that the Health Care Independence Program requires private insurance companies to create, present to the Department of Human Services for approval, implement, and market a new kind of insurance policy; and that the private insurance companies need certainty about the law creating the Health Care Independence Program before fully investing time, funds, personnel, and other resources to the development of the new insurance policies. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.

/s/J. Burris

APPROVED: 04/23/2013

SECTION II PATIENT CENTERED MEDICAL HOME (PCMH)
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200.000 DEFINITIONS

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 shared savings incentive payments.
Benchmark cost	The projected cost of care for a specific shared savings entity against which savings are measured. Benchmark costs are expressed as an average amount per beneficiary.
Benchmark trend	The fixed percentage growth applied to PCMH historical baseline fixed costs of care to projec

	benchmark cost.
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.
Cost thresholds	Cost thresholds are the per beneficiary cost of care values (high and medium) against which a shared savings entity's per beneficiary cost is measured.
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.
Historical baseline cost of care	A multi-year weighted average of a shared savings entity's per beneficiary cost of care.
Medical neighborhood barriers	Obstacles to the delivery of coordinated care that exist in areas of the health system external to PCMH.
Minimum savings rate	A fixed percentage set by DMS. In order to receive shared savings incentive payments for performance improvement described in Section 237.000, part A, a shared savings entity must achieve a per beneficiary cost of care that is below its benchmark cost by at least the minimum savings rate.
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.
Per beneficiary cost of care	The risk- and time-adjusted average of attributed beneficiaries' total Medicaid fee-for-service claims (based on the published reimbursement methodology) during the performance period, net of exclusions.
Per beneficiary cost of care floor	The lowest per beneficiary cost of care for which practices within a shared savings entity can receive shared savings incentive payments.
Per beneficiary savings	The difference between a shared savings entity's benchmark cost and its per beneficiary cost of care in a given performance period.

Performance period	The period of time over which performance is aggregated and assessed.
Pool	A. The beneficiaries who are attributed to one or more participating practice(s) for the purpose of forming a shared savings entity; or B. The action of aggregating beneficiaries for the purposes of shared savings incentive payment calculations (i.e., the action of forming a shared savings entity).
Practice support	Support provided by Medicaid in the form of care coordination payments to a participating practice and practice transformation support provided by a DMS contracted vendor.
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 this 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.
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.
Risk adjustment	An adjustment to the cost of beneficiary care to account for patient risk.
Same-day appointment request	A beneficiary request to be seen by a clinician within 24 hours.
Shared savings entity	A participating practice or participating practices that, contingent on performance, may receive shared savings incentive payments.
Shared savings incentive payment cap	The maximum shared savings incentive payment that DMS will pay to practices in a shared savings entity, expressed as a percentage of that entity's benchmark cost for the performance period.
Shared savings incentive payments	Annual payments made to reward cost-efficient and quality care.
Shared savings percentage	The percentage of a shared savings entity's total savings that is paid to practice(s) in a shared savings entity as a shared savings incentive payment for performance improvement.
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

1-1-14

To be eligible to enroll in the PCMH Program initially:

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. The practice must have at least 300 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

1-1-14

Enrollment in the PCMH program is voluntary and practices must re-enroll annually. To enroll, practices must access the provider portal and submit a complete and accurate Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement (DMS-844) available at **www.paymentinitiative.org**. Once enrolled, a participating practice remains in the PCMH program until:

A. The practice withdraws;

B. The practice or provider 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. This update must be submitted in writing within 30 days.

To withdraw from the PCMH program, the participating practice must deliver to DMS a signed and accurate Arkansas Patient-Centered Medical Home Withdrawal Form (DMS-846), available at **www.paymentinitiative.org**.

213.000 Enrollment Schedule

1-1-14

Initial enrollment periods are October 1, 2013 through December 15, 2013 and January 1, 2014 through May 15, 2014.

Beginning with the 2015 calendar year, enrollment is open for approximately 3 months in Q3 and Q4 of the preceding year.

DMS will return any enrollment documents received other than during an enrollment period.

214.000 Caseload Management

1-1-14

A participating practice must manage its caseload of attributed beneficiaries, including removal of a beneficiary from its panel, according to the rules described in Section 171.200 of this manual. Additionally, a participating practice must submit, in writing at the end of every calendar quarter, an explanation of each beneficiary removal during such quarter. DMS retains the right

to disallow these beneficiary removals. If a participating practice removes a beneficiary from its PCMH panel, then that beneficiary is also removed from its ConnectCare panel.

220.000 PRACTICE SUPPORT

221.000 Practice Support Scope 1-1-14

Practice support includes both care coordination payments made to a participating practice and practice transformation support provided by a DMS contracted vendor.

Receipt and use of the care coordination payments is not conditioned on the practice 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 will contract with a practice transformation vendor on behalf of participating practices that require additional support to catalyze practice transformation and retain and use such vendor. Practices must maintain documentation of the months they have contracted with a practice transformation vendor. Practice transformation vendors must report to DMS the level and type of service delivered to each practice. Payments to a practice transformation vendor on behalf of a participating practice may continue for up to 24 months.

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

DMS will also support practices through improved access to information through the reports described in Section 245.000.

222.000 Practice Support Eligibility 1-1-14

In addition to the enrollment eligibility requirements listed in Section 211.000, in order for practices to receive practice support, DMS measures participating practice performance against activities tracked for practice support identified in Section 241.000 and the metrics tracked for practice support identified in 242.000. Participating practices must meet the requirements of these sections to receive practice support.

Each participating practice that has pooled its attributed beneficiaries with other participating practices in a shared savings entity:

A. Has its performance individually compared to activities tracked for practice support and metrics tracked for practice support.

B. Will, if qualified, receive practice support even if other practices in a shared savings entity do not qualify for practice support.

223.000 Care Coordination Payment Amount 1-1-14

The care coordination payment is risk adjusted (e.g., ranging from $1 to $30 per attributed beneficiary per month) based on factors including demographics (age, sex), diagnoses and utilization.

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

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

In order to begin receiving care coordination payments for the quarter starting January 1, 2014, a practice must submit a complete PCMH Practice Participation Agreement on or before December 15, 2013. In order to begin receiving care coordination payments for the quarter starting July 1, 2014, a practice must submit the PCMH Practice Participation Agreement on or before May 15, 2014. For all subsequent years, in order to participate in the PCMH program, a practice must submit the PCMH Practice Participation Agreement before the end of the enrollment period of the preceding year.

230.000 SHARED SAVINGS INCENTIVE PAYMENTS

231.000 Shared Savings Incentive Payments Scope 1-1-14

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

232.000 Shared Savings Incentive Payments Eligibility 1-1-14

To receive shared savings incentive payments, a shared savings entity must have a minimum of 5,000 attributed beneficiaries once the below exclusions have been applied. A shared savings entity may meet this requirement as a single practice or by pooling attributed beneficiaries across more than one practice as described in Section 233.000.

A. For purposes of calculating shared savings incentive payments only, the following beneficiaries shall not be counted toward the 5,000 attributed beneficiary requirement.

1. Beneficiaries that have been attributed to that entity's practice(s) for less than half of the performance period.
2. Beneficiaries that a practice prospectively designates for exclusion from per beneficiary cost of care (also known as physician-selected exclusions) on or before the 90th day of the performance period. Once a beneficiary is designated for exclusion, a practice may not update selection for the duration of the performance period. The total number of physician-selected exclusions will be directly proportional to the practice'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 or provider experience with select beneficiary populations. DMS will publish such addition, removal or modification on **www.paymentinitiative.org**.

B. Shared savings incentive payments are conditioned upon a shared savings entity:

1. Enrolling during the enrollment period prior to the beginning of the performance period;
2. Meeting requirements for metrics tracked for shared savings incentive payments in section 244.000 based on the aggregate performance for beneficiaries attributed to the shared savings entity for the majority of the performance period; and
3. Maintaining eligibility for practice support as described in Section 251.000.

Eligibility requirements for shared savings for Comprehensive Primary Care (CPC) practices are described in Section 251.000.

233.000 Pools of Attributed Beneficiaries 1-1-14

Participating practices will meet the minimum pool size of 5,000 attributed beneficiaries as described in 232.000 by forming a shared savings entity in one of three ways:

A. Meet minimum pool size independently;

B. Pool attributed beneficiaries with other participating practices as described in 234.000. In this method, practices voluntarily agree to have their performance measured together by aggregating performance (both per beneficiary cost of care and quality metrics tracked for shared savings incentive payments) across the practices; or

C. Participate in a default pool if the practice does not meet the requirements for A or B of this section. Practices with beneficiaries in a default pool will have per beneficiary cost of care performance measured across the combined pool of all attributed beneficiaries in the default pool. There is no default pool in the first performance period beginning January 1, 2014.

234.000 Requirements for Joining and Leaving Pools 1-1-14

Practices may pool for purposes described in 233.000, part B, before the end of the enrollment period that precedes the start of the performance period. To pool, practices must submit to DMS a signed Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement with a completed and accurate Arkansas Medicaid Patient-Centered Medical Home Pooling Request Form, available at **www.paymentinitiative.org**, executed by all practices participating in the pool.

In the first performance period beginning January 1, 2014, a maximum of two practices may agree to voluntarily pool their attributed beneficiaries.

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

When a practice has pooled, its performance is measured in the associated shared savings entity throughout the duration of the performance period unless it withdraws from the PCMH program during the performance period. When a practice that has pooled withdraws from the PCMH program, the other practice or practices in the shared savings entity will have performance measured as if the withdrawn practice had never participated in the pool.

235.000 Per Beneficiary Cost of Care Calculation 1-1-14

Each year the per beneficiary cost of care performance is aggregated and assessed across a shared savings entity. Per beneficiary cost of care is calculated as the risk- and time-adjusted average of such entity's attributed beneficiaries' total fee-for-service claims (based on the published reimbursement methodology) during the annual performance period, with adjustments and exclusions as defined below.

One hundred percent of the dollar value of care coordination payments is included in the per beneficiary cost of care calculation, except for the performance period which begins January 1, 2014, for which fifty percent of the dollar value of care coordination payments is included.

As described in Section 232.000, beneficiaries not counted toward the minimum number of attributed beneficiaries for shared savings incentive payments will be excluded from the calculation of per beneficiary cost of care.

A. The following costs are excluded from the calculation of per beneficiary cost of care:

1. All costs in excess of $100,000 for any individual beneficiary.
2. Behavioral health costs for beneficiaries with the most complex behavioral health needs.
3. Select costs associated with developmental disabilities (DD) services, identified on the basis of DD provider types.

4. Select direct costs associated with Long-Term Support and Services (LTSS).
5. Select costs associated with nursing home fees, transportation fees, dental and vision.
6. Select neonatal costs.
7. Other costs as determined by DMS.

Detailed information on specific exclusions are at **www.paymentinitiative.org**.

A. The following adjustments are made to costs for calculation of per beneficiary cost of care:

1. Inpatient hospital claims will be adjusted to reflect a standard per diem.
2. Pharmacy costs will be adjusted to reflect rebates.
3. The per beneficiary cost of care for a shared savings entity is adjusted by the amount of supplemental payment incentives, both positive and negative, made under Episodes of Care for the beneficiaries attributed to practice(s) as described in Section 232.000.
4. Technical adjustments may be made by DHS and will be posted at **www.paymentinitiative.org**

If the shared savings entity's per beneficiary cost of care falls below the current performance period total cost of care floor, then the shared savings entity's per beneficiary cost of care will be set at the total cost of care floor, for purposes of calculating shared savings incentive payments. The 2014 cost of care floor is set at $1,400 and will increase by 1.5% each subsequent year.

236.000 Baseline and Benchmark Cost Calculations 1-1-14

For the performance period that begins in January 2014, DMS will calculate a historical baseline per beneficiary cost of care for each shared savings entity. This shared savings entity-specific historical baseline will be calculated as a multi-year blended average of each shared savings entity's per beneficiary cost of care.

DMS will calculate benchmark costs for each shared savings entity by applying a 2.6% benchmark trend to the entity's historical baseline per beneficiary cost of care. DMS may reevaluate the value of this benchmark trend if the annual, system-average per beneficiary cost of care growth rate differs significantly from a benchmark, to be specified by DMS. DMS will publish any modification to the benchmark trend at **www.paymentinitiative.org**.

237.000 Shared Savings Incentive Payments Amounts 1-1-14

A shared savings entity is eligible to receive a shared savings incentive payment that is the greater of: (A) a shared savings incentive payment for performance improvement; or (B) a shared savings incentive payment for absolute performance.

A. Shared savings incentive payments for performance improvement are calculated as follows:

1. During each performance period, each shared savings entity's per beneficiary savings is calculated as: [benchmark cost for that performance period] – [per beneficiary cost of care for that performance period].
2. If the shared savings entity's per beneficiary cost of care falls below that entity's benchmark cost for that performance period by at least the minimum savings rate, only then may the shared savings entity be eligible for a shared savings incentive payment for performance improvement.
3. The per beneficiary shared savings incentive payment for performance improvement for which the shared savings entity may be eligible is calculated as follows: [per beneficiary savings for that performance period] * [shared savings entity's shared savings percentage for that performance period].

4. To establish shared savings percentages for a given performance period, DMS will compare the entity's previous year per beneficiary cost of care to the previous year's medium and high cost thresholds. For the performance period beginning January 2014, DMS will compare the entity's historical baseline cost to the base year thresholds to establish such entity's shared savings percentage.
5. If, in the previous performance period, a shared savings entity's per beneficiary cost of care was:
    a. Below the medium cost threshold, then the shared savings entity may receive 50% of per beneficiary savings created in the current performance period (i.e., the entity's shared savings percentage will be 50%);
    b. Between the medium and high cost thresholds, then the shared savings entity may receive 30% of per beneficiary savings created in the current performance period (i.e., the entity's shared savings percentage will be 30%);
    c. Above the high cost threshold, then the shared savings entity will not share in risk. Instead, the shared savings entity may receive 10% of per beneficiary savings created in the current performance period (i.e., the entity's shared savings percentage will be 10%).

B. Shared savings incentive payments for absolute performance are calculated as follows:

If the shared savings entity's per beneficiary cost of care falls below the current performance period medium cost threshold, then the shared savings entity may be eligible for a shared savings incentive payment for absolute performance. The per beneficiary shared savings incentive payment for absolute performance for which the entity may be eligible is calculated as follows: ([medium cost threshold for that performance period] – [per beneficiary cost of care for that performance period]) * [50%].

The medium and high cost thresholds for 2014 are:

A. Medium cost threshold: $2,032

B. High cost threshold: $2,718

These thresholds reflect an annual increase of 1.5% from the base year thresholds (base year medium cost threshold: $1,972; base year high cost threshold: $2,638) and will increase by 1.5% each subsequent year.

The minimum savings rate is 2%. DMS may adjust this rate based on new research, empirical evidence or experience from initial provider experience with shared savings incentive payments. DMS will publish any such modification of the minimum savings rate at **www.paymentinitiative.org**.

If the per beneficiary shared savings incentive payment for which the shared savings entity is eligible exceeds the shared savings incentive payment cap, expressed as 10% of the shared savings entity's benchmark cost for that performance period, the shared savings entity will be eligible for a per beneficiary shared savings incentive payment equal to 10% of its benchmark cost for that performance period.

If the shared savings entity's per beneficiary cost of care falls above the current performance period high cost threshold, then the shared savings entity is not eligible for a shared savings incentive payment for that performance period.

A shared savings entity's total shared savings incentive payment will be calculated as the per beneficiary shared savings incentive payment for which it is eligible multiplied by the number of attributed beneficiaries as described in Section 232.000, adjusted based on the amount of time beneficiaries were attributed to such entity's practice(s) and the risk profile of the attributed beneficiaries.

If participating practices have pooled their attributed beneficiaries together, then shared savings incentive payments will be allocated to those practices in proportion to the number of attributed beneficiaries that each practice contributed to such pool.

A shared savings entity will not receive shared savings incentive payments unless it meets all the conditions described in Section 232.000.

DMS pays shared savings incentive payments on an annual basis for the most recently completed performance period and may withhold a portion of shared savings incentive payments to allow for final payment adjustment after a year of claims data is available.

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 practice.

240.000 METRICS AND ACCOUNTABILITY FOR PAYMENT INCENTIVES

241.000 Activities Tracked for Practice Support 1-1-14

Using the provider portal, participating practices must complete and document the activities as described in the table below by the deadline indicated in the table. The reference point for the deadlines is the first day of the first calendar year in which the participating practice is enrolled in the PCMH program.

Activity	Deadline
A. Identify top 10% of high-priority beneficiaries using: 1. DMS patient panel data that ranks beneficiaries by risk at beginning of performance period and/or 2. The practice's patient-centered assessment to determine which beneficiaries on this list are high-priority. Submit this list to DMS via the provider portal.	3 months and again 3 months after the start of each subsequent performance period (If such list is not submitted by this deadline, DMS will identify a default list of high-priority beneficiaries for the practice, based on risk scores).
B. Assess operations of practice and opportunities to improve and submit the assessment to DMS via the provider portal.	6 months and again at 24 months
C. Develop and record strategies to implement care coordination and practice transformation. Submit the strategies to DMS via the provider portal.	6 months
D. Identify and reduce medical neighborhood barriers to coordinated care at the practice level. Describe barriers and approaches to overcome local challenges for coordinated care. Submit these descriptions of barriers and approaches to DMS via the provider portal.	6 months
E. Make available 24/7 access to care. Provide telephone access to a live voice (e.g., an employee of the primary care physician or an answering service) or to an answering machine that immediately pages an on-call medical professional 24 hours per day, 7 days per week. The on-call professional must: 1. Provide information and instructions for treating	6 months

Activity	Deadline
emergency and non-emergency conditions, 2. Make appropriate referrals for non-emergency services and 3. Provide information regarding accessing other services and handling medical problems during hours the PCP's office is closed. Response to non-emergency after-hours calls must occur within 30 minutes. A call must be treated as an emergency if made under circumstances where a prudent layperson with an average knowledge of health care would reasonably believe that treatment is immediately necessary to prevent death or serious health impairment. 1. PCPs must make the after-hours telephone number known by, at a minimum, providing the 24-hour emergency number to all beneficiaries; posting the 24-hour emergency number on all public entries to each site; and including the 24-hour emergency phone number on answering machine greetings. 2. When employing an answering machine with recorded instructions for after-hours callers, PCPs should regularly check to ensure that the machine functions correctly and that the instructions are up to date. Practices must document completion of this activity by written report to DMS via the provider portal.	
F. Track same-day appointment requests by: 1. Using a tool to measure and monitor same-day appointment requests on a daily basis and 2. Recording fulfillment of same-day appointment requests. Practices must document compliance by written report to DMS via the provider portal.	6 months
G. Establish processes that result in contact with beneficiaries who have not received preventive care. Practices must document compliance by written report to DMS via the provider portal.	
H. Complete a short survey related to beneficiaries' ability to receive timely care, appointments and information from specialists, including Behavioral Health (BH) specialists.	12 months
I. Invest in health care technology or tools that support practice transformation. Practices must document health care technology investments by written report to DMS via the provider portal.	12 months
J. Join SHARE and be able to access inpatient discharge and transfer information. Practices must document compliance	12 months

Activity	Deadline
by written report to DMS via the provider portal.	
K. Incorporate e-prescribing into practice workflows. Practices must document compliance by written report to DMS via the provider portal.	18 months
L. Use Electronic Health Record (EHR) for care coordination. The EHR adopted must be one that is certified by Office of the National Coordinator for Health Information Technology and is used to store care plans. Practices are to document completion of this activity via the provider portal.	24 months

DMS may add, remove, or adjust these metrics or deadlines, including additions beyond 24 months, based on new research, empirical evidence or experience from initial metrics. DMS will publish such extension, addition, removal or adjustment at **www.paymentinitiative.org**.

242.000 Metrics Tracked for Practice Support 1-1-14

DMS assesses practices on the following metrics tracked for practice support starting on the first day of the first calendar year in which the participating practice is enrolled in the PCMH program and continuing through the full calendar year. To receive practice support, participating practices must meet a majority of targets listed below.

Metric	Target for Calendar Year Beginning January 1, 2014
A. Percentage of high-priority beneficiaries (identified in Section 241.000) whose care plan as contained in the medical record includes: 1. Documentation of a beneficiary's chief complaint and problems; 2. Plan of care integrating contributions from health care team (including behavioral health professionals) and from the beneficiary; 3. Instructions for follow-up and 4. Assessment of progress to date. The care plan must be updated at least twice a year.	At least 70%
B. Percentage of a practice's high priority beneficiaries seen by their attributed PCP at least twice in the past 12 months	At least 67%
C. Percentage of beneficiaries who had an acute inpatient hospital stay and were seen by health care provider within 10 days of discharge	At least 33%
D. Percentage of emergency visits categorized as non-emergent by the NYU ED algorithm	Less than or equal to 50%

DMS will publish targets for subsequent years, calibrated based on experience from targets initially set, at **www.paymentinitiative.org**. Such targets will escalate over time.

DMS may add, remove, or adjust these metrics based on new research, empirical evidence or experience from initial metrics.

243.000 Accountability for Practice Support 1-1-14

If a practice does not meet deadlines and targets for A) activities tracked for practice support and B) metrics tracked for practice support as described in Sections 241.000 and 242.000, then the practice must remediate its performance to avoid suspension or termination of practice support. Practices must submit an improvement plan within 1 month of the date that a report provides notice that the practice failed to perform on the activities or metrics indicated above.

A. With respect to activities tracked for practice support, practices must remediate performance before the end of the first full calendar quarter after the date the practice receives notice via the provider report that target(s) have not been met, except for activity A in Section 241.000 where no such remediation time will be provided.

B. With respect to metrics tracked for practice support, practices must remediate performance before the end of the second full calendar quarter after the date the practice receives notice via the provider report that target(s) have not been met. For purposes of remediation, performance is measured on the most recent four calendar quarters.

If a practice fails to meet the deadlines or targets for activities and metrics tracked for practice support within this remediation time, then DMS will terminate practice support. DMS may resume practice support when the practice meets the deadlines or targets for activities and metrics tracked for practice support in effect for that quarter.

DMS retains the right to confirm practices' performance against deadlines and targets for activities and metrics tracked for practice support.

244.000 Quality Metrics Tracked for Shared Savings Incentive Payments 1-1-14

DMS assesses the following quality metrics tracked for shared savings incentive payments according to the targets below. The quality metrics are assessed at the level of shared savings entity, except for the default pool. The quality metrics are assessed only if the entity or practice has at least 25 attributed beneficiaries in the category described for the majority of the performance period. To receive a shared savings incentive payment, the shared savings entity or practice must meet at least two-thirds of the quality metrics on which the entity or practice is assessed.

Quality Metric	Target for Calendar year Beginning January 1, 2014
A. Percentage of beneficiaries 31 days to15 months of age who complete at least four wellness visits	At least 67%
B. Percentage of beneficiaries 3-6 years of age who complete at least one wellness visit	At least 67%
C. Percentage of beneficiaries 12-21 years of age who complete at least one wellness visit	At least 40%
D. Percentage of diabetes beneficiaries who complete annual HbA1C testing	At least 75%
E. Percentage of beneficiaries prescribed appropriate asthma medications	At least 70%
F. Percentage of CHF beneficiaries on beta blockers	At least 40%

Quality Metric	Target for Calendar year Beginning January 1, 2014
G. Percentage of women > 50 years who have had breast cancer screening in past 24 months	A least 50%
H. Percentage of beneficiaries on thyroid drugs who had a TSH test in past 24 months	At least 80%
I. Percentage of beneficiaries 6-12 years of age with an ambulatory prescription dispensed for ADHD medication that was prescribed by their attributed PCP, and who had one follow-up visit with that PCP during the 30-day Initiation Phase.	At least 25%

DMS will publish targets for subsequent performance periods, calibrated based on experience from targets initially set, at **www.paymentinitiative.org**.

DMS may add, remove or adjust these quality metrics based on new research, empirical evidence or experience from initial quality metrics.

245.000 Provider Reports 1-1-14

DMS provides participating practices provider reports containing information about their practice performance on activities tracked for practice support, metrics tracked for practice support, quality metrics tracked for shared saving incentive payments and their per beneficiary cost of care via the provider portal.

250.000 COMPREHENSIVE PRIMARY CARE (CPC) INITIATIVE PRACTICE PARTICIPATION IN THE PCMH PROGRAM

251.000 CPC Initiative Practice Participation 1-1-14

Practices and physicians participating in the CPC initiative are not eligible to receive PCMH program practice support.

Practices participating in the CPC initiative may receive PCMH program shared savings incentive payments if they:

A. Enroll in the PCMH program;

B. Meet the requirements for shared savings incentive payments, except that a practice participating in CPC need not maintain eligibility for practice support described in Section 222.000; and

C. Achieve all CPC milestones and measures on time.