



Division of Medical Services
Program Development & Quality Assurance



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TO: Arkansas Medicaid Health Care Providers – All Providers
DATE: January 1, 2014
SUBJECT: Provider Manual Update Transmittal Sect-4-13

<u>REMOVE</u>		<u>INSERT</u>	
Section	Date	Section	Date
—	—	105.200	1-1-14

Explanation of Updates

Section 105.200 is added to include information regarding the Patient-Centered Medical Home (PCMH) program.

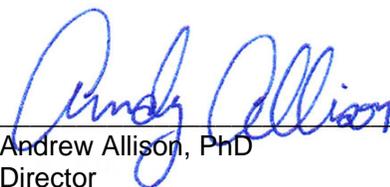
The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at 501-320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.


Andrew Allison, PhD
Director

TOC required

105.200 Patient-Centered Medical Home (PCMH)

1-1-14

DMS established the Patient-Centered Medical Home (PCMH) program to improve the health of the population, enhance the patient experience, and control the growth in healthcare costs. To achieve these goals, the PCMH program includes practice support and incentives to provide care coordination; promote practice transformation; increase performance transparency; and reward providers for delivery of economic, efficient, and quality care. Please refer to Section II of the Patient-Centered Medical Home Manual for information about eligibility, enrollment, and payment.



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TO: Arkansas Medicaid Health Care Providers – All Providers
DATE: January 1, 2014
SUBJECT: Provider Manual Update Transmittal PCMH-NEW-13

<u>REMOVE</u>		<u>INSERT</u>	
Section	Date	Section	Date
		ALL	1-1-14

Explanation of Updates

The Patient-Centered Medical Home (PCMH) manual is now available to participating Arkansas Medicaid providers as part of the Arkansas Health Care Payment Improvement Initiative. The PCMH program rewards providers who consistently deliver high-quality, coordinated and cost-effective patient-centered care.

If you have questions regarding this transmittal, please contact the Arkansas Payment Improvement Initiative Center at 1-866-322-4696 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 301-8311.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at 501-320-6429.

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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 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: <ul style="list-style-type: none"> 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	<p>A. The beneficiaries who are attributed to one or more participating practice(s) for the purpose of forming a shared savings entity; or</p> <p>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).</p>
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: <ol style="list-style-type: none"> 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	6 months

Activity	Deadline
care. Submit these descriptions of barriers and approaches to DMS via the provider portal.	
<p>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:</p> <ol style="list-style-type: none"> 1. Provide information and instructions for treating 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. 	6 months
<p>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.</p>	
<ol style="list-style-type: none"> 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. 	
<p>Practices must document completion of this activity by written report to DMS via the provider portal.</p>	
<p>F. Track same-day appointment requests by:</p> <ol style="list-style-type: none"> 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. 	6 months
<p>Practices must document compliance by written report to DMS via the provider portal.</p>	
<p>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.</p>	

Activity	Deadline
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 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 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
<p>A. Percentage of high-priority beneficiaries (identified in Section 241.000) whose care plan as contained in the medical record includes:</p> <ol style="list-style-type: none"> 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. <p>The care plan must be updated at least twice a year.</p>	At least 70%
B. Percentage of a practice's high priority beneficiaries seen by their attributed PCP at least twice in the past 12	At least 67%

Metric	Target for Calendar Year Beginning January 1, 2014
months	
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
----------------	--

Quality Metric	Target for Calendar year Beginning January 1, 2014
A. Percentage of beneficiaries 31 days to 15 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%
G. Percentage of women > 50 years who have had breast cancer screening in past 24 months	At 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.



Division of Medical Services
Program Development & Quality Assurance



P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-682-2480

TO: Arkansas Medicaid Health Care Providers – All Providers
DATE: January 1, 2014
SUBJECT: Provider Manual Update Transmittal SecV-7-13

<u>REMOVE</u>		<u>INSERT</u>	
Section	Date	Section	Date
500.000	—	500.00	—
—	—	DMS-844	1/14
—	—	DMS-845	1/14
—	—	DMS-846	1/14

Explanation of Updates

Section 500.000 is updated to add Form DMS-844 (Arkansas Medicaid Patient-Centered Medical Home Program Practice Participation Agreement), Form DMS-845 (Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form) and Form DMS-846 (Arkansas Medicaid Patient-Centered Medical Home Program Practice Withdrawal Form).

Form DMS-844 has been added to all provider manuals.

Form DMS-845 has been added to all provider manuals.

Form DMS-846 has been added to all provider manuals.

This transmittal and the enclosed forms are for informational purposes only. **Please do not complete the enclosed form.**

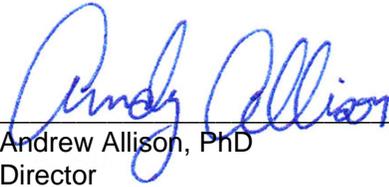
The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at 501-320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.



Andrew Allison, PhD
Director

SECTION V – FORMS**500.000****Claim Forms****Red-ink Claim Forms**

The following is a list of the red-ink claim forms required by Arkansas Medicaid. The forms below cannot be printed from this manual for use. Information about where to get the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
<u>Professional – CMS-1500</u>	Business Form Supplier
<u>Institutional – CMS-1450*</u>	Business Form Supplier
<u>Visual Care – DMS-26-V</u>	1-800-457-4454
<u>Inpatient Crossover – HP-MC-001</u>	1-800-457-4454
<u>Long Term Care Crossover – HP-MC-002</u>	1-800-457-4454
<u>Outpatient Crossover – HP-MC-003</u>	1-800-457-4454
<u>Professional Crossover – HP-MC-004</u>	1-800-457-4454

* For dates of service after 11/30/07 – ALL HOSPICE PROVIDERS USE ONLY FORM CMS-1450 (formerly UB-04) for billing.

Claim Forms

The following is a list of the non-red-ink claim forms required by Arkansas Medicaid. Information about where to get a supply of the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
<u>Alternatives Attendant Care Provider Claim Form - AAS-9559</u>	Client Employer
<u>Dental – ADA-J400</u>	Business Form Supplier

Arkansas Medicaid Forms

The forms below can be printed from this manual for use.

In order by form name:

Form Name	Form Link
Acknowledgement of Hysterectomy Information	<u>DMS-2606</u>
Address Change Form	<u>DMS-673</u>
Adjustment Request Form – Medicaid XIX	<u>HP-AR-004</u>
Adverse Effects Form	<u>DMS-2704</u>

Form Name	Form Link
AFMC Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components	DMS-679A
Amplification/Assistive Technology Recommendation Form	DMS-686
Application for WebRA Hardship Waiver	DMS-7736
Approval/Denial Codes for Inpatient Psychiatric Services	DMS-2687
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	DDS/FS#0001.a
Arkansas Medicaid Patient-Centered Medical Home Program Practice Participation Agreement	DMS-844
Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form	DMS-845
Arkansas Medicaid Patient-Centered Medical Home Program Practice Withdrawal Form	DMS-846
ARKids First Mental Health Services Provider Qualification Form	DMS-612
Authorization for Automatic Deposit	autodeposit
Authorization for Payment for Services Provided	MAP-8
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2633
Certification of Schools to Provide Comprehensive EPSDT Services	CSPC-EPSDT
Certification Statement for Abortion	DMS-2698
Change of Ownership Information	DMS-0688
Child Health Management Services Enrollment Orders	DMS-201
Child Health Management Services Discharge Notification Form	DMS-202
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	DMS-699A
CHMS Request for Prior Authorization	DMS-102
Claim Correction Request	DMS-2647
Consent for Release of Information	DMS-619
Contact Lens Prior Authorization Request Form	DMS-0101
Contract to Participate in the Arkansas Medical Assistance Program	DMS-653
DDTCS Transportation Log	DMS-638
DDTCS Transportation Survey	DMS-632
Dental Treatment Additional Information	DMS-32-A
Disclosure of Significant Business Transactions	DMS-689
Disproportionate Share Questionnaire	DMS-628
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	DMS-693

Form Name	Form Link
Early Childhood Special Education Referral Form	ECSE-R
EPSDT Provider Agreement	DMS-831
Explanation of Check Refund	HP-CR-002
Gait Analysis Full Body	DMS-647
Home Health Certification and Plan of Care	CMS-485
Hospital/Physician/Certified Nurse Midwife Referral for Newborn Infant Medicaid Coverage	DCO-645
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	DMS-2685
Individual Renewal Form for School-Based Audiologists	DMS-7782
Lower-Limb Prosthetic Evaluation	DMS-650
Lower-Limb Prosthetic Prescription	DMS-651
Media Selection/E-Mail Address Change Form	HP-MS-005
Medicaid Claim Inquiry Form	HP-CI-003
Medicaid Form Request	HP-MFR-001
Medical Equipment Request for Prior Authorization & Prescription	DMS-679
Medical Transportation and Personal Assistant Verification	DMS-616
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	DMS-633
Notice Of Noncompliance	DMS-635
NPI Reporting Form	DMS-683
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	DMS-640
Ownership and Conviction Disclosure	DMS-675
Personal Care Assessment and Service Plan	DMS-618 English DMS-618 Spanish
Practitioner Identification Number Request Form	DMS-7708
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	DMS-2615
Primary Care Physician Managed Care Program Referral Form	DMS-2610
Primary Care Physician Participation Agreement	DMS-2608
Primary Care Physician Selection and Change Form	DMS-2609
Procedure Code/NDC Detail Attachment Form	DMS-664
Provider Application	DMS-652
Provider Communication Form	AAS-9502
Provider Data Sharing Agreement – Medicare Parts C & D	DMS-652-A
Provider Enrollment Application and Contract Package	Application Packet

Form Name	Form Link
Quarterly Monitoring Form	AAS-9506
Referral for Audiology Services – School-Based Setting	DMS-7783
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2634
Referral for Medical Assistance	DMS-630
Request for Appeal	DMS-840
Request for Extension of Benefits	DMS-699
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	DMS-671
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	DMS-602
Request for Molecular Pathology Laboratory Services	DMS-841
Request For Orthodontic Treatment	DMS-32-0
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	DMS-2692
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	DMS-601
Research Request Form	HP-0288
Service Log – Personal Care Delivery and Aides Notes	DMS-873
Sterilization Consent Form	DMS-615 English DMS-615 Spanish
Sterilization Consent Form – Information for Men	PUB-020
Sterilization Consent Form – Information for Women	PUB-019
Upper-Limb Prosthetic Evaluation	DMS-648
Upper-Limb Prosthetic Prescription	DMS-649
Vendor Performance Report	Vendorperformreport
Verification of Medical Services	DMS-2618

In order by form number:

AAS-9502	DMS-2618	DMS-618	DMS-675	DMS-873
AAS-9506	DMS-2633	Spanish	DMS-673	ECSE-R
AAS-9559	DMS-2634	DMS-619	DMS-679	HP-0288
Address Change	DMS-2647	DMS-628	DMS-679A	HP-AR-004
Autodeposit	DMS-2685	DMS-630	DMS-683	HP-CI-003
CMS-485	DMS-2687	DMS-632	DMS-686	HP-CR-002
CSPC-EPSDT	DMS-2692	DMS-633	DMS-689	HP-MFR-001
DCO-645	DMS-2698	DMS-635	DMS-693	HP-MS-005
DDS/FS#0001.a	DMS-2704	DMS-638	DMS-699	MAP-8
DMS-0101	DMS-32-A	DMS-640	DMS-699A	Performance Report
DMS-0688	DMS-32-0	DMS-647	DMS-7708	Provider Enrollment Application and Contract Package
DMS-102	DMS-601	DMS-648	DMS-7736	PUB-019
DMS-201	DMS-602	DMS-649	DMS-7782	PUB-020
DMS-202	DMS-612	DMS-650	DMS-7783	
DMS-202	DMS-615	DMS-651	DMS-831	
DMS-2606	English	DMS-652	DMS-840	
DMS-2608	DMS-615	DMS-652-A	DMS-841	
DMS-2609	Spanish	DMS-653	DMS-844	
DMS-2610	DMS-616	DMS-664	DMS-845	
DMS-2615	DMS-618	DMS-671	DMS-846	
	English			

Arkansas Medicaid Contacts and Links

Click the link to view the information.

[American Hospital Association](#)

[Americans with Disabilities Act Coordinator](#)

[Arkansas Department of Education, Health and Nursing Services Specialist](#)

[Arkansas Department of Education, Special Education](#)

[Arkansas Department of Human Services, Division of Aging and Adult Services](#)

[Arkansas Department of Human Services, Appeals and Hearings Section](#)

[Arkansas Department of Human Services, Division of Behavioral Health Services](#)

[Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit](#)

[Arkansas Department of Human Services, Division of Children and Family Services, Contracts Management Unit](#)

[Arkansas Department of Human Services, Children's Services](#)

[Arkansas Department of Human Services, Division of County Operations, Customer Assistance Section](#)

[Arkansas Department of Human Services, Division of Medical Services](#)

[Arkansas DHS, Division of Medical Services Director](#)

[Arkansas DHS, Division of Medical Services, Benefit Extension Requests, UR Section](#)

[Arkansas DHS, Division of Medical Services, Dental Care Unit](#)

[Arkansas DHS, Division of Medical Services, HP Enterprise Services Provider Enrollment Unit](#)

[Arkansas DHS, Division of Medical Services, Financial Activities Unit](#)

[Arkansas DHS, Division of Medical Services, Hearing Aid Consultant](#)

[Arkansas DHS, Division of Medical Services, Medical Assistance Unit](#)

[Arkansas DHS, Division of Medical Services, Medical Director for Clinical Affairs](#)

[Arkansas DHS, Division of Medical Services, Pharmacy Unit](#)

[Arkansas DHS, Division of Medical Services, Program Communications Unit](#)

[Arkansas DHS, Division of Medical Services, Program Integrity Unit \(PI\)](#)

[Arkansas DHS, Division of Medical Services, Provider Reimbursement Unit](#)

[Arkansas DHS, Division of Medical Services, Third-Party Liability Unit](#)

[Arkansas DHS, Division of Medical Services, UR/Home Health Extensions](#)

[Arkansas DHS, Division of Medical Services, Utilization Review Section](#)

[Arkansas DHS, Division of Medical Services, Visual Care Coordinator](#)

[Arkansas Department of Health](#)

[Arkansas Department of Health, Health Facility Services](#)

[Arkansas Department of Human Services, Accounts Receivable](#)

[Arkansas Foundation For Medical Care](#)

[Arkansas Hospital Association](#)

[ARKids First-B](#)

[ARKids First-B ID Card Example](#)

[Central Child Health Services Office \(EPSDT\)](#)

[ConnectCare Helpline](#)

[County Codes](#)

[CPT Ordering](#)

[Dental Contractor](#)

[HP Enterprise Services Claims Department](#)

[HP Enterprise Services EDI Support Center \(formerly AEVCS Help Desk\)](#)

[HP Enterprise Services Inquiry Unit](#)

[HP Enterprise Services Manual Order](#)

[HP Enterprise Services Pharmacy Help Desk](#)

[HP Enterprise Services Provider Assistance Center \(PAC\)](#)

[HP Enterprise Services Supplied Forms](#)

[Example of Beneficiary Notification of Denied ARKids First-B Claim](#)

[Example of Beneficiary Notification of Denied Medicaid Claim](#)

[First Connections Infant & Toddler Program, Developmental Disabilities Services](#)

[Flow Chart of Intake and Prior Authorization Process For Intervention/Treatment](#)

[Health Care Declarations](#)

[ICD-9-CM, CPT, and HCPCS Reference Book Ordering](#)

[Immunizations Registry Help Desk](#)

[Medicaid ID Card Example](#)

[Medicaid Managed Care Services \(MMCS\)](#)

[Medicaid Reimbursement Unit Communications Hotline](#)

[Medicaid Tooth Numbering System](#)

[National Supplier Clearinghouse](#)

[Partners Provider Certification](#)

[Primary Care Physician \(PCP\) Enrollment Voice Response System](#)

[Provider Qualifications, Division of Behavioral Health Services](#)

[QSource of Arkansas](#)

[Select Optical](#)

[Standard Register](#)

[Table of Desirable Weights](#)

[U.S. Government Printing Office](#)

[ValueOptions](#)

[Vendor Performance Report](#)

ARKANSAS MEDICAID PATIENT-CENTERED MEDICAL HOME PROGRAM
PRACTICE PARTICIPATION AGREEMENT

This agreement is made and entered into between _____,
(Please print, stamp or type practice name)

hereinafter called Practice, and the Arkansas Division of Medical Services, hereinafter called Department. This agreement supplements and is controlled by the terms of the parties' "Contract to Participate in the Arkansas Medical Assistance Program Administered by the Division of Medical Services Under Title XIX (Medicaid)" (Form DMS-653, hereinafter called Provider Enrollment Agreement), and any successor agreement.

Practice, in consideration of the mutual covenants set forth herein and in the Provider Enrollment Agreement, requests to be a Medicaid enrolled Patient-Centered Medical Home (PCMH) participating practice in compliance with all pertinent Medicaid policies, regulations, and State Plan standards.

This agreement may be terminated or renewed in accordance with the following provisions:

- A. This agreement may be voluntarily terminated by either party by giving written notice as required by section 211.100 of the PCMH Provider Manual;
- B. This agreement may be terminated immediately by the Department for the following reasons:
 - 1) Returned mail;
 - 2) Death of provider;
 - 3) Change of ownership; or
 - 4) Other reason for which a sanction may be issued as set forth under the applicable Medicaid Provider Manual; and
- C. Should the Provider Enrollment Agreement be terminated, suspended, or otherwise nullified, this agreement shall be terminated on the same terms and at the same time as the Provider Enrollment Agreement.

If the Practice is a legal entity other than a person, the person signing this Practice Participation Agreement on behalf of the Practice warrants that he/she has legal authority to bind the Practice. The signature of the Practice or the person with the legal authority to bind the Practice on this contract certifies the Practice understands that payment and satisfaction of these claims will be made from Federal and State funds, and that any false claims, statements, or documents, or concealment of material fact, may be prosecuted under applicable Federal and State laws.

Please indicate your office lead(s) for practice transformation and care coordination. These individuals will serve as the administrative points-of-contact for the program:

Office lead for Practice Transformation: _____

Title: _____

Email: _____

Signature: _____

Office lead for Care Coordination: _____

Title: _____

Email: _____

Signature: _____

Please indicate the Medicaid Billing ID Number to which care coordination and shared savings payments will be made for the providers named below:

Medicaid Billing ID Number

For the practice

Title

Date

Phone number: _____

Email address: _____

Division of Medical Services Signature

Title

Date

Please list the physicians who are part of your practice:

1. Physician Name: _____
Individual Medicaid Provider ID: _____
NPI: _____
Signature: _____

2. Physician Name: _____
Individual Medicaid Provider ID: _____
NPI: _____
Signature: _____

3. Physician Name: _____
Individual Medicaid Provider ID: _____
NPI: _____
Signature: _____

4. Physician Name: _____
Individual Medicaid Provider ID: _____
NPI: _____
Signature: _____

Please add additional pages as necessary to list all physicians who are part of your practice. The practice must update DHS of changes to the list of physicians who are part of your practice in writing within 30 days. If such change includes the addition of a physician to your practice, such notice must include the information listed above.

ARKANSAS MEDICAID PATIENT-CENTERED MEDICAL HOME PROGRAM
POOLING REQUEST FORM

Practices wishing to pool attributed beneficiaries for purposes of the PCMH program, as described in the pooling section of the Arkansas Medicaid PCMH provider manual, must submit the pooling request form.

During the performance period beginning January 1, 2014 no more than 2 practices may pool to create a shared savings entity.

First Practice

1	Practice name (must match name on PCMH enrollment contract): _____ (Please print, stamp or type practice name)
2	Practice address: _____ _____
3	Practice Medicaid Billing ID Number:
4	National Provider Identifier:

Second Practice

6	Practice name (must match name on PCMH enrollment contract): _____ (Please print, stamp or type practice name)
7	Practice address: _____ _____
8	Practice Medicaid Billing ID Number:
9	National Provider Identifier:

Pooling Request

By signing this form, _____ and
(Please print, stamp or type first practice name)

(Please print, stamp or type second practice name)

hereafter called the practices, are requesting to pool their attributed beneficiaries as a common shared savings entity for purposes of the Patient-Centered Medical Home (PCMH) program as described in Section 222.210 of the Arkansas Medicaid PCMH provider manual. The practices request to have their performance measured together by aggregating performance across the practices. Specifically, performance (both for Per Beneficiary Cost of Care and Shared Savings Quality Metrics as described the Arkansas Medicaid PCMH provider manual) is measured across the beneficiaries attributed to the practices identified above as a shared savings entity. The practices' attributed beneficiaries shall remain pooled in a shared savings entity only for the performance period in the next calendar year. In order to remain pooled, the practices must resubmit this section of the practice participation agreement annually.

For the first practice Title Date _____
Practice name: _____
Phone number: _____
Email address: _____

For the second practice Title Date _____
Practice name: _____
Phone number: _____
Email address: _____

- For the performance period beginning in 2015:
- 1. Please add additional pages as required to list all practices requesting to pool their attributed beneficiaries.
 - 2. Practices that do not voluntarily pool will, based on their number of attributed beneficiaries, be either
 - a. Considered a shared savings entity independently; or
 - b. Included in the default pool.

Division of Medical Services Signature Title Date _____