FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services
DIVISION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Lech Matuszewski
TELEPHONE NO. 320-6220 **FAX NO.** 404-4619 **EMAIL:** lech.matuszewski@dhs.arkansas.gov

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

SHORT TITLE OF THIS RULE Patient-Centered Medical Home 1-15 and Section V-8-15

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☐ No ☒

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

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

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

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

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

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

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

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$0	General Revenue	$0
Federal Funds	$0	Federal Funds	$0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total	$0	Total	$0

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

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

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total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule?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

Current Fiscal Year	**Next Fiscal Year**
$	$

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

Current Fiscal Year	**Next Fiscal Year**
$ $0	$ $0

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

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

Yes ☐ No ☒

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

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

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

(3) a description of the factual evidence that:

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

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

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

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

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

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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TO: **Arkansas Medicaid Health Care Providers – Patient-Centered Medical Home**

EFFECTIVE DATE: **January 1, 2016**

SUBJECT: **Provider Manual Update Transmittal PCMH-1-15**

REMOVE		**INSERT**	
Section	**Effective Date**	**Section**	**Effective Date**
200.000	—	200.000	1-1-16
211.000	1-1-14	211.000	1-1-16
212.000	6-5-14	212.000	1-1-16
213.000	1-1-14	213.000	1-1-16
214.000	1-1-14	214.000	1-1-16
221.000	1-1-14	221.000	1-1-16
222.000	1-1-14	222.000	1-1-16
223.000	1-1-14	223.000	1-1-16
232.000	1-1-14	232.000	1-1-16
233.000	1-1-14	233.000	1-1-16
234.000	1-1-14	234.000	1-1-16
235.000	1-1-14	235.000	1-1-16
236.000	1-1-14	236.000	1-1-16
237.000	1-1-14	237.000	1-1-16
241.000	6-5-14	241.000	1-1-16
242.000	6-5-14	—	—
243.000	1-1-14	242.000	1-1-16
244.000	6-5-14	243.000	1-1-16
245.000	1-1-14	244.000	1-1-16

Explanation of Updates

Section 200.000 is updated to revise definitions related to shared savings. The PCP definition is also clarified.

Section 211.000 is updated to indicate the current enrollment eligibility criteria.

Section 212.000 is updated to reflect the current policy for practice enrollment.

Section 213.000 is updated to modify the enrollment schedule.

Section 214.000 is updated to indicate the current policy for caseload management.

Section 221.000 is updated to indicate the current scope of practice support.

Section 222.000 is updated to indicate the current eligibility criteria for practice support.

Section 223.000 is updated to indicate current care coordination payment amounts.

Section 232.000 is updated to reflect the current policy for shared savings incentive payments eligibility.

Section 233.000 is updated to reflect the current policy for pools of attributed beneficiaries.

Section 234.000 is updated to indicate the current requirements for joining and leaving pools.

Section 235.000 is updated to indicate the current per beneficiary cost of care calculation.

Section 236.000 is updated to indicate the current baseline and benchmark cost calculations.

Section 237.000 is updated to indicate the current shared savings incentive payments amounts.

Section 241.000 is updated to indicate the current activities tracked for practice support.

Section 242.000 is deleted and its content is removed.

Section 243.000 is updated to clarify accountability for practice support and is renumbered to Section 242.000.

Section 244.000 is updated to clarify quality metrics tracked for shared savings incentive payments and is renumbered to Section 243.000.

Section 245.000 is updated to indicate current policy for provider reports and is renumbered to Section 244.000.

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 Hewlett Packard Enterprise 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.

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Dawn Stehle
Director

TOC required

200.000 DEFINITIONS 1-1-16

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 the Arkansas Medicaid provider 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 PCMH or pooled PCMHs 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 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 the PCMH in a shared savings entity.
State Health Alliance for Records Exchange (SHARE)	The Arkansas Health Information Exchange. For more information, go to **http://ohit.arkansas.gov**.

211.000 Enrollment Eligibility 1-1-16

To be eligible to enroll in the PCMH program:

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.

E. The practice must meet eligibility criteria as specified in the conditions for enrollment as indicated in the PCMH activities and metrics list. These criteria are published at **www.paymentinitiative.org/referenceMaterials/Documents/2016PCMHProgramPolicyAddendum.pdf**.

212.000 Practice Enrollment 1-1-16

Enrollment in the PCMH program is voluntary and practices must re-enroll annually. To enroll, practices must access the Advanced Health Information Network (AHIN) provider portal and submit a complete and accurate Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement (DMS-844). The AHIN portal can be accessed at **www.paymentinitiative.org/medicalHomes/Pages/Enrollment-Process.aspx**. Once enrolled, a participating PCMH remains in the PCMH program until:

A. The PCMH withdraws;

B. The practice or provider changes ownership, 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. Physicians who are no longer participating within a practice are required to update in writing via email at **ARKPCMH@hp.com** within 30 days of the change.

To withdraw from the PCMH program, the participating practice must email a complete and accurate Arkansas Patient-Centered Medical Home Withdrawal Form (DMS-846) to **ARKPCMH@hp.com**. **View or print the Arkansas Patient-Centered Medical Home Withdrawal Form (DMS-846)** or download the form from the AHIN provider portal.

213.000 Enrollment Schedule 1-1-16

Enrollment is open for approximately 3 months in Quarter 3 and Quarter 4 of the preceding calendar year.

DMS will not accept any enrollment documents received other than during an enrollment period.

214.000 Caseload Management 1-1-16

A participating practice must manage its caseload of attributed beneficiaries, including removal of a beneficiary from its panel. DMS retains the right to disallow beneficiary removals if it was determined it was done so to dismiss high costs and/or high-risk patients from the panel.

221.000 Practice Support Scope 1-1-16

Practice support includes both care coordination payments made to a PCMH and practice transformation support provided by a Division of Medical Services (DMS) contracted vendor and is subject to funding limitations on the part of DMS.

Receipt and use of the care coordination payments is not conditioned on the PCMH 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 PCMHs that require additional support to catalyze practice transformation and retain and use such vendor. PCMHs 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 PCMH. Payments to a practice transformation vendor on behalf of a participating practice may continue for up to 24 months.

However, no practice support may extend beyond June 30, 2017, regardless of the number of months practice support was received by a practice. PCMHs may contract with only one vendor at a given time. PCMHs are able to change vendors at any time with notification in writing to the outgoing vendor and DMS. Failure to provide written notification will result in the PCMH being liable for any duplicate payments.

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

DMS will also support PCMHs through improved access to information through the reports described in Section 244.000.

222.000 Practice Support Eligibility 1-1-16

In addition to the enrollment eligibility requirements listed in Section 211.000, in order for PCMHs to receive practice support, DMS measures PCMH performance against activities tracked for practice support identified in Section 241.000. PCMHs must meet the requirements of this section to receive practice support.

Each PCMH in a shared entity will, if individually qualified, receive practice support even if another PCMH in a shared savings entity does not qualify for practice support.

223.000 Care Coordination Payment Amount 1-1-16

The care coordination payment is risk adjusted based on factors including demographics (age, sex), diagnoses and utilization. DMS will publish the current payment scale at **www.paymentinitiative.org/referenceMaterials/Documents/2016PCMHProgramPolicyAddendum.pdf**.

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

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

232.000 Shared Savings Incentive Payments Eligibility 1-1-16

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

A. The following beneficiaries shall not be counted toward the 5,000 attributed beneficiary requirements.

1. Beneficiaries that have been attributed to that entity's PCMH(s) for less than half of the performance period.
2. Beneficiaries that a PCMH 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 PCMH may not update selection for the duration of the performance period. The total number of physician-selected exclusions will be directly proportional to the PCMH'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, provider experience with select beneficiary populations or inclusion of new payers. DMS will publish such an addition, removal or modification on **www.paymentinitiative.org/referenceMaterials/Documents/2016PCMHProgramPolicyAddendum.pdf**.

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 Section 241.000 requirements for activities tracked for practice support;
3. Meeting requirements for metrics tracked for shared savings incentive payments in Section 243.000 based on the performance for beneficiaries attributed to the shared savings entity for the majority of the performance period; and

4. Maintaining eligibility for practice support as described in Section 222.000.

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

Shared savings payments are made to the individual PCMHs which are part of a shared savings entity. These payments are risk- and time- adjusted and prorated based on the number of beneficiaries of each PCMH. These payments are predicated on each PCMH maintaining eligibility for practice support as described in Section 222.000.

233.000 Pools of Attributed Beneficiaries 1-1-16

Shared savings entities will meet the minimum pool size of 5,000 attributed beneficiaries as described in Section 232.000 in one of three ways:

A. Meet minimum pool size independently;

B. Pool attributed beneficiaries voluntarily with other participating PCMHs as described in Section 234.000; or

C. Be assigned to the default pool as described in Section 234.000.

In the methods B and C listed above, PCMHs have their performance measured together by aggregating performance of the per beneficiary cost of care. In the method B, the quality metrics are tracked for shared savings incentive payments across all the PCMHs in the pool. In the method C, the quality metrics are tracked for shared savings incentive payments on an individual PCMH level. A shared savings entity's configuration (A, B or C) is established during the enrollment period and cannot be changed after the end of the enrollment period.

234.000 Requirements for Joining and Leaving Pools 1-1-16

PCMHs may voluntarily pool for purposes described in Section 233.000 before the end of the enrollment period that precedes the start of the performance period. To pool, the participating practice must email a complete and accurate Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form (DMS-845) to **ARKPCMH@hp.com**. **View or print the Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form.** You can also download the form from the AHIN provider portal.

The DMS-845 Pooling form must be executed by all PCMHs participating in the pool. Before the end of the enrollment period, PCMHs that are on their own or through pooling do not reach a minimum of 5,000 attributed beneficiaries will be assigned to the default pool. Individual PCMHs whose attribution changes during the performance period will be classified as standalone or default pool members according to their attribution count at the end of the performance period. This exception does not apply to voluntary pools.

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

When a PCMH has voluntarily 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 PCMH in the voluntary pool withdraws from the PCMH program, any and all PCMHs in the shared savings entity will have their performance measured as if the withdrawn PCMH had never participated in the pool.

235.000 Per Beneficiary Cost of Care Calculation 1-1-16

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.

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.

Some costs are excluded from the calculation of per beneficiary cost of care. Each year DMS will announce which costs are excluded at **www.paymentinitiative.org/referenceMaterials/Documents/2016PCMHProgramPolicyAddendum.pdf**.

236.000 Baseline and Benchmark Cost Calculations 1-1-16

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/referenceMaterials/Documents/2016PCMHProgramPolicyAddendum.pdf**.

237.000 Shared Savings Incentive Payments Amounts 1-1-16

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 performance improvement in 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.
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, 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%) unless the shared savings entity's per beneficiary cost of care falls above the current performance period high cost incentive payment for that performance period.

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%].

Shared savings calculations under absolute performance and performance improvements are subject to the following criteria:

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. Adjustments to the thresholds will be posted at **www.paymentinitiative.org/referenceMaterials/Documents/2016PCMHProgramPolicyAddendum.pdf**.

1. 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/referenceMaterials/Documents/2016PCMHProgramPolicyAddendum.pdf**.

2. 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.

3. If the shared savings entity's per beneficiary cost of care falls above the current performance period total cost of care floor, then the shared savings entity's per beneficiary cost of care will be set as 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, or as specified at **www.paymentinitiative.org**.

4. 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 PCMHs 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 based on risk- and time-adjustment and in proportion to the number of attributed beneficiaries that each PCMH contributed to such pool.

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

2. 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.

3. 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 PCMH.

241.000 Activities Tracked for Practice Support 1-1-16

Using the provider portal, participating PCMHs must complete and document the activities as announced by DMS at **www.paymentinitiative.org/referenceMaterials/Documents/2016PCMHProgramPolicyAddendum.pdf**. The reference point for the deadlines is the first day of the calendar year.

242.000 Accountability for Practice Support 1-1-16

If a PCMH does not meet deadlines and targets for activities tracked for practice support as described in Section 241.000, then the practice must remediate its performance to avoid suspension or termination of practice support.

DMS will verify whether attestation and required documentation was submitted as required by the PCMH program. Failure to comply with this requirement will result in a Notice of Attestation Failure.

DMS will also validate whether attested activities met the PCMH program requirements. Failure to pass validation will result in a Notice of Validation Failure.

PCMHs which received a Notice of Attestation Failure and/or PCMHs which received a Notice of Validation Failure will have 15 calendar days to submit sufficient QIP. Failure to submit sufficient QIP within 15 days of receiving a Notice of Attestation Failure and/or a Notice of Validation Failure will result in suspension or termination of practice support. PCMHs which receive a Notice of Attestation Failure will have 90 days to remediate their performance from the date of the Notice of Attestation Failure. PCMHs which received a Notice of Validation Failure will have 45 days to remediate their performance from the date of the Notice of Validation Failure.

If a PCMH fails to meet the deadlines or targets for activities within the specified remediation time, then DMS will suspend or terminate practice support.

243.000 Quality Metrics Tracked for Shared Savings Incentive Payments 1-1-16

DMS assesses quality metrics tracked for shared savings incentive payments according to the targets announced by DMS at **www.paymentinitiative.org**. To receive a shared savings incentive payment, the shared savings entity or PCMH must meet the quality metrics on which the entity or PCMH is assessed and which are published at **www.paymentinitiative.org/referenceMaterials/Documents/2016PCMHProgramPolicyAddendum.pdf**.

244.000 Provider Reports 1-1-16

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

Providers who have concerns about information included in their reports should send an email to **PCMH@AFMC.org**. The PCMH Quality Assurance Manager will respond to the

provider/practice with a review of their inquiry. If the review leads to a discovery that the provider report is inaccurate or does not reflect actual performance, DMS will take the necessary steps to correct the inaccuracies including those that are a result of a systems and/or algorithm error. Providers can also call the APII help desk at 501-301-8311 or 866-322-4698 and by email at **ARKPII@HPE.com**.

A. Appeals

If you disagree with DMS' decision regarding program participation, payment or other adverse action, you have the right to request reconsideration and you have the right to request an administrative appeal.

B. Request Reconsideration

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

C. Request an Administrative Appeal

The Arkansas Department of Health must receive a written appeals request within (30) calendar days of the date of the adverse action notice, or within (10) calendar days of receiving a reconsideration decision. Send your request to Arkansas Department of Health: Attention: Medicaid Provider Appeals Office, 4815 West Markham Street, Slot 31, Little Rock, AR 72205.

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
Professional – CMS-1500	Business Form Supplier
Institutional – CMS-1450*	Business Form Supplier
Visual Care – DMS-26-V	1-800-457-4454
Inpatient Crossover – HP-MC-001	1-800-457-4454
Long Term Care Crossover – HP-MC-002	1-800-457-4454
Outpatient Crossover – HP-MC-003	1-800-457-4454
Professional Crossover – HP-MC-004	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
Alternatives Attendant Care Provider Claim Form - AAS-9559	Client Employer
Dental – ADA-J430	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	DMS-2606
Address Change Form	DMS-673
Adjustment Request Form – Medicaid XIX	HP-AR-004
Adverse Effects Form	DMS-2704

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 Practice Update/Change Request Form	DMS-801
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 Behavioral 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

Form Name	Form Link
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
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
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

Form Name	Form Link
Provider Enrollment Application and Contract Package	Application Packet
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
AAS-9506
AAS-9559
Address Change
Autodeposit
CMS-485
CSPC-EPSDT
DDS/FS#0001.a
DMS-0101
DMS-0688
DMS-102
DMS-201
DMS-202
DMS-2606
DMS-2608
DMS-2609
DMS-2610
DMS-2615
DMS-2618
DMS-2633
DMS-2634
DMS-2647
DMS-2685
DMS-2687
DMS-2692
DMS-2698
DMS-2704
DMS-32-A
DMS-32-0
DMS-601
DMS-602
DMS-612
DMS-615 English
DMS-615 Spanish
DMS-616
DMS-618 English
DMS-618 Spanish
DMS-619
DMS-628
DMS-630
DMS-632
DMS-633
DMS-635
DMS-638
DMS-640
DMS-647
DMS-648
DMS-649
DMS-650
DMS-651
DMS-652
DMS-652-A
DMS-653
DMS-664
DMS-671
DMS-675
DMS-673
DMS-679
DMS-679A
DMS-683
DMS-686
DMS-689
DMS-693
DMS-699
DMS-699A
DMS-7708
DMS-7736
DMS-7782
DMS-7783
DMS-801
DMS-831
DMS-840
DMS-841
DMS-844
DMS-845
DMS-846
DMS-873
ECSE-R
HP-0288
HP-AR-004
HP-CI-003
HP-CR-002
HP-MFR-001
HP-MS-005
MAP-8
Performance Report
Provider Enrollment Application and Contract Package
PUB-019
PUB-020

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 Finance Administration, Sales and Tax Use Unit

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

HP Enterprise Services Manual Order

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

First Connections Infant & Toddler Program, Developmental Disabilities Services, Appeals

Flow Chart of Intake and Prior Authorization Process For Intervention/Treatment

Health Care Declarations

Immunizations Registry Help Desk

Magellan Pharmacy Call Center

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

Select Optical

Standard Register

Table of Desirable Weights

UAMS College of Pharmacy Evidence-Based Prescription Drug Program Help Desk

U.S. Government Printing Office

ValueOptions

Vendor Performance Report

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers – All Providers**

EFFECTIVE DATE: **January 1, 2016**

SUBJECT: **Provider Manual Update Transmittal SecV-8-15**

REMOVE		**INSERT**	
Section	**Effective Date**	**Section**	**Effective Date**
500.000	—	500.000	—
—	—	DMS-801	1-16
DMS-844	1-14	DMS-844	1-16
DMS-845	1-14	DMS-845	1-16
DMS-846	1-14	DMS-846	1-16

Explanation of Updates

Section 500.000 is updated to add form DMS-801 for the Patient-Centered Medical Home (PCMH) program.

Form DMS-801 is added to allow practices in the PCMH program to add and withdraw physicians from a practice.

Form DMS-844 is updated to revise a reference to the PCMH provider manual.

Form DMS-845 is updated to revise requirements for practices to pool attributed beneficiaries for the PCMH program. It is also updated to allow more practices to be listed on the form.

Form DMS-846 is updated to modify the revision date.

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

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.

Dawn Stehle
Director

ARKANSAS MEDICAID PATIENT-CENTERED MEDICAL HOME PROGRAM
PRACTICE UPDATE/CHANGE REQUEST FORM

As a facility involved in the Arkansas Medicaid PCMH program, we understand that changes come quickly and frequently. With that in mind, we always want to make sure that we contact you with any changes and maintain changes which occur in your practice that may affect your participation in the PCMH program. In order to do that, we need your most current contact information including the office leads responsible for updating this information as well as changes to your physician enrollment roster. To make sure we can best assist you in your participation with this program, please update the following information below as necessary.

Office lead for Practice Transformation: _____

Title: _____

Email: _____

Signature: _____

Office lead for Care Coordination: _____

Title: _____

Email: _____

Signature: _____

ADD PHYSICIAN

Please list the required information for the physicians you wish to enroll under your practice:

NOTE: The only physicians who need to be added to the PCMH enrollment are those who recently joined your practice. For this reason, please include the date the physician joined.

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

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

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

Please add additional pages as necessary to list all physicians who are part of your practice.

_____ _____ _____
For the practice Title Date

Phone number: _____

DMS-801 (1/16)

Email Address: _____

WITHDRAW PHYSICIAN

Please list the required information for the physicians you wish to withdraw from your practice:

NOTE: The only physicians who need to be removed from the PCMH enrollment are those who recently left your practice. For this reason, please include the date the physician left.

1. Physician Name: _____

   Individual Medicaid Provider ID: _____

   NPI: _____

   Date left: _____

2. Physician Name: _____

   Individual Medicaid Provider ID: _____

   NPI: _____

   Date left: _____

3. Physician Name: _____

   Individual Medicaid Provider ID: _____

   NPI: _____

   Date left: _____

4. Physician Name: _____

   Individual Medicaid Provider ID: _____

   NPI: _____

   Date left: _____

Please add additional pages as necessary to list all physicians who are part of your practice.

_____ _____ _____

For the practice Title Date

Phone number: _____

Email Address: _____

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 212.000 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.

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.

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

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

Third Practice

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

Fourth Practice

13	Practice name (must match name on PCMH enrollment contract):_____ (Please print, stamp or type practice name)
14	Practice address: _____ _____
15	Practice Medicaid Billing ID Number:
16	National Provider Identifier:

Pooling Request

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

_____ and
(Please print, stamp or type second practice name)

_____ and
(Please print, stamp or type third practice name)

_____
(Please print, stamp or type fourth 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 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 in 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 third practice Title Date

Practice name: _____

Phone number: _____

Email address: _____

_____ _____ _____

For the fourth 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

ARKANSAS MEDICAID PATIENT-CENTERED MEDICAL HOME PROGRAM
PRACTICE WITHDRAWAL FORM

1	Practice name (must match Practice Participation Agreement):_____ (Please print, stamp or type practice name)
2	Practice address: _____ _____
3	Practice Medicaid Billing ID Number:
4	National Provider Identifier:
5	Name of other practice in shared savings pool (if applicable):

Withdrawal Statement

By signing this withdrawal form, _____, hereafter called practice, is requesting to
(Please print, stamp or type practice name)

withdraw from the Arkansas Medicaid Patient-Centered Medical Home program, understanding that all potential practice support per member per month payments and shared savings payments under the Patient-Centered Medical Home program will cease immediately. This withdrawal form serves to terminate the Patient-Centered Medical Home contract that exists between Arkansas Medicaid and the practice. The practice acknowledges that the Arkansas Medicaid program may reconcile any outstanding overpayment through reduction of future Medicaid fee-for-service reimbursement.

_____ _____ _____
For the practice Title Date

Phone number: _____

Email address: _____

_____ _____ _____
Division of Medical Services Signature Title Date