ARKANSAS REGISTER

Transmittal Sheet

Use only for **FINAL** and **EMERGENCY RULES**

Secretary of State
Mark Martin
500 Woodlane, Suite 026
Little Rock, Arkansas 72201-1094
(501) 682-5070
www.sos.arkansas.gov

For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

Contact Lisa Smith E-mail lisa.smith2@arkansas.gov Phone 501-320-6432

Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-76-201

Rule Title: Patient Centered Medical Home (PCMH-1-17);Section V-4-17

Intended Effective Date (Check One)		**Date**
☐ Emergency (ACA 25-15-204)	Legal Notice Published	09/14/2017
☐ 10 Days After Filing (ACA 25-15-204)	Final Date for Public Comment	10/13/2017
☑ Other 01/18/2018 (Must be more than 10 days after filing date.)	Reviewed by Legislative Council	11/17/2017
	Adopted by State Agency	01/01/2018

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Lisa Smith (Contact Person) lisa.smith2@arkansas.gov (E-mail Address) 12/02/17 (Date)

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Rose Naff (Signature)

(501) 683-4997 (Phone Number) Rose Naff@dhs.arkansas.gov (E-mail Address)

Director (Title)

12/4/17 (Date)

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Medical Services

PERSON COMPLETING THIS STATEMENT Lynn Burton

TELEPHONE 501-682-1857 **FAX** 501-682-3889 **EMAIL:** Lynn.burton@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 (PCMH) -2-17 and Section V-4-17

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 Does this proposed, amended, or repealed rule have a financial impact?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		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

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

Current Fiscal Year		Next Fiscal Year	
General Revenue	$ 54,395	General Revenue	($298,796)
Federal Funds	$130,495	Federal Funds	($716,825)
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$184,890	Total	($1,015,621)

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
$ 54,395	$ (298,796)

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

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 – Patient-Centered Medical Home**

EFFECTIVE DATE: **January 1, 2018**

SUBJECT: **Provider Manual Update Transmittal PCMH-2-17**

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
200.000	1-1-16	200.000	1-1-18
211.000	1-1-16	211.000	1-1-18
212.000	1-1-16	212.000	1-1-18
221.000	7-1-17	221.000	1-1-18
223.000	1-1-16	223.000	1-1-18
232.000	1-1-16	232.000	1-1-18
233.000	1-1-16	233.000	1-1-18
234.000	1-1-16	234.000	1-1-18
235.000	1-1-16	235.000	1-1-18
236.000	1-1-16	236.000	1-1-18
237.000	1-1-16	237.000	1-1-18
241.000	1-1-16	241.000	1-1-18
243.000	1-1-16	243.000	1-1-18
244.000	1-1-16	244.000	1-1-18
250.000	—	—	—
251.000	1-1-14	—	—

Explanation of Updates

Section 200.000 has been updated to add new program definitions.

Section 211.000 has been updated to add Enrollment Eligibility information.

Section 212.000 has been updated to Practice Enrollment information.

Section 221.000 has been updated to change to Practice Support Scope.

Section 223.000 has been updated to change applicable web links.

Section 232.000 has been updated to change eligibility requirements for Shared Savings Incentive Payments.

Section 233.000 has been updated with new information regarding Pools of Attributed Beneficiaries.

Section 234.000 has been updated with new information regarding Joining and Leaving Pool Requirements.

Sections 235.000 and 236.000 have been updated to change applicable web links.

TOC required

200.000 DEFINITIONS 1-1-18

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.
Petite pool	Pool reserved for practices with less than 300 attributed beneficiaries that do not wish to participate in a voluntary pool.
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.
Quality Improvement Plan (QIP)	QIP is a plan of improvement that practices must submit to PCMH Quality Assurance team after receiving notice

	of attestation failure or validation failure.
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**.

210.000 ENROLLMENT AND CASELOAD MANAGEMENT

211.000 Enrollment Eligibility 1-1-18

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. Beginning in January 2018, practices participating in PCMH should work towards adopting an Electronic Health Record (EHR). The EHR adopted must be one that is certified by Office of the National Coordinator for Health Information Technology. Practices should adopt the certified health IT modules which meet the definition of CEHRT according to the timeline and requirements finalized for use in CMS programs supporting certified EHR use. DMS reserves the right to identify and implement EHR metrics in future performance periods.

E. The practice must have at least 150 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 1-1-18

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 **http://www.paymentinitiative.org/enrollment**.

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 with a practice are required to update in writing via email at **ARKPCMH@DXC.com** within 30 days of the change.

All practice site locations associated with a PCMH must be listed on the PCMH Program enrollment application. Each site listed on the enrollment application must complete practice support requirements as described in Section 241.000. If a site does not meet deadlines and targets for activities tracked for practice support, then the site must remediate its performance to avoid suspension or termination of practice support for the entire PCMH.

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@DCX.com**. View or print the Arkansas Patient-Centered Medical Home Withdrawal Form (DMS-846) on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources** or download the form from the AHIN provider portal.

A practice may return to the PCMH Program beginning on the first day of the following performance year (January 1st) after suspension or termination of practice support. Such application for reinstatement is contingent on documentation of successful implementation of all previously deficient requirements and upon meeting the following requirements:

A. Submitting a complete PCMH Program enrollment application during the designated enrollment period

B. Successful implementation of the activity(s) which the practice failed and which resulted in suspension or termination from the program

Practices who withdraw while on remediation will also have to meet the re-instatement requirements. Successful implementation of the activity(s) will be determined by the Quality Assurance Team.

220.000 PRACTICE SUPPORT

221.000 Practice Support Scope 1-1-18

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.

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.

However, no practice transformation may extend beyond December 31, 2018, regardless of the number of months practice support was received by a practice.

223.000 Care Coordination Payment Amount 1-1-18

The care coordination payment is risk adjusted based on factors including demographics (age, sex), diagnoses and utilization. DMS will publish the current payment scale on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**.

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 1-1-18

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 the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**.

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.

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 1-1-18

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

A. Meet minimum pool size independently;

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

C. Be assigned to the default pool as described in Section 234.000. Practices with beneficiaries in this pool will have their performance measured together by aggregating performance of the per beneficiary cost of care however the Quality metrics are tracked for shared savings incentive payments are measured at the individual PCMH; or

D. Be assigned to the petite pool as described in Section 234.000. In this method, practices will have their performance measured together by aggregating both per beneficiary cost of care and quality metrics tracked for shared savings incentive payments across all practices in the pool. For the 2018 performance year, all practices with less than 300 beneficiaries will be assigned to the petite pool. In subsequent years, practices with less than 300 beneficiaries may be able to voluntarily pool with other PCMHs to reach the 5,000 minimum requirement.

A shared savings entity's pool configuration (A, B, C, or D) 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 1-1-18

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@DXC.com**. View or print the Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form on the APII

website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**. 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. Practices with less than 300 attributed beneficiaries that do not wish to participate in a voluntary pool will be placed in the petite pool. Individual PCMHs whose attribution changes during the performance period will be classified as standalone, default, or petite pool members according to their attribution count at the end of the performance period.

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 a voluntary pool withdraws, is suspended, or otherwise leaves the PCMH program, any and all PCMHs in the shared savings entity will have their performance measured as if the withdrawn or suspended PCMH had never participated in the pool. This provision does not apply to PCMHs which leave the program in the last calendar quarter. If the PCMH leaves the program in the last calendar quarter, the departing PCMH, and its performance will be treated as if the PCMH has not left the program.

235.000 Per Beneficiary Cost of Care Calculation 1-1-18

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 on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**.

236.000 Baseline and Benchmark Cost Calculations 1-1-18

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 on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**.

237.000 Shared Savings Incentive Payment Amounts 1-1-18

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:

Cost thresholds reflect an annual increase of 1.5% from the base year 2018 (base year medium cost threshold: $2,150; base year high cost threshold: $2,444) and will increase by 1.5% each subsequent year. Adjustments to the thresholds will be posted on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**.

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 on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**.

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 below 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 2018 cost of care floor is set at $1,481and 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.

240.000 METRICS AND ACCOUNTABILITY FOR PAYMENT INCENTIVES

241.000 Activities Tracked for Practice Support 1-1-18

Using the provider portal, participating PCMHs must complete and document the activities as announced by DMS on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**. The reference point for the deadlines is the first day of the calendar year.

243.000 Quality Metrics Tracked for Shared Savings Incentive Payments 1-1-18

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 on the APII website at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**.

244.000 Provider Reports 1-1-18

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.

Failing to submit any updated license, address changes or changes to the Provider Id number, may result in provider reports with no beneficiary attribution. Providers may update at any time their licenses, address changes, or changes to their Provider ID number by submitting documentation to the Provider Enrollment unit via fax at (501) 374-0746. 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@DXC.com**.

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. During the remediation period, and prior to the notice of adverse action, practices continue receiving practice support payments. However, DMS will not pay practice support payments after the notice of adverse action. If the practice prevails during the appeal, or reconsideration, the practice support payments will resume retroactively from the date of the adverse action notice.

A. 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 Arkansas Department of Human Services, Division of Medical Services, Health Care Innovation P.O. Box 1437, Slot S425, Little Rock, AR 72203.

B. 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.

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: 501-682-6739

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

EFFECTIVE DATE: January 1, 2018

SUBJECT: Provider Manual Update Transmittal PCMH-2-17

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
200.000	1-1-16	200.000	1-1-18
211.000	1-1-16	211.000	1-1-18
212.000	1-1-16	212.000	1-1-18
221.000	7-1-17	221.000	1-1-18
223.000	1-1-16	223.000	1-1-18
232.000	1-1-16	232.000	1-1-18
233.000	1-1-16	233.000	1-1-18
234.000	1-1-16	234.000	1-1-18
235.000	1-1-16	235.000	1-1-18
236.000	1-1-16	236.000	1-1-18
237.000	1-1-16	237.000	1-1-18
241.000	1-1-16	241.000	1-1-18
243.000	1-1-16	243.000	1-1-18
244.000	1-1-16	244.000	1-1-18
250.000	—	—	—
251.000	1-1-14	—	—

Explanation of Updates

Section 200.000 has been updated to add new program definitions.

Section 211.000 has been updated to add Enrollment Eligibility information.

Section 212.000 has been updated to Practice Enrollment information.

Section 221.000 has been updated to change to Practice Support Scope.

Section 223.000 has been updated to change applicable web links.

Section 232.000 has been updated to change eligibility requirements for Shared Savings Incentive Payments.

Section 233.000 has been updated with new information regarding Pools of Attributed Beneficiaries.

Section 234.000 has been updated with new information regarding Joining and Leaving Pool Requirements.

Sections 235.000 and 236.000 have been updated to change applicable web links.

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, 2018**

SUBJECT: **Provider Manual Update Transmittal SecV-4-17**

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
500.000	—	500.000	—
DMS-801	1/16	—	—
DMS-844	—	DMS-844	—

Explanation of Updates

Section 500.000 has been updated to remove Arkansas Medicaid Patient-Centered Medical Home Program Practice Update/Change Request Form (DMS-801).

Form DMS-801 has been removed.

Form DMS-844 has been updated.

This transmittal and the enclosed form 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 Provider Assistance Center 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.

Rose M. Naff
Director

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Arkansas Patient-Centered Medical Home
Enrollment Unit
1-866-322-4696 (in-state) or 1-501-301-8311 (local and out of state)
Fax: 501-374-0549 TDD/TTY: 501-682-6789
Email: ARKPCMH@hpe.com

Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement

Section I Primary Location

This document must be completed for each practice enrolling in the Arkansas Patient-Centered Medical Home (PCMH) program. Each PCMH must complete and submit all pages at one time before the participation agreement will be processed. All participation agreements must be submitted via email to ARKPCMH@dxc.com. PCMH's are responsible for submitting notice of any change to the information contained in this document within 30 days of the change. The program requirements are described in the PCMH Manual and Addendum located on the Arkansas Payment Improvement Initiative website www.paymentinitiative.org.

Patient-Centered Medical Home

Practice Name:		Medicaid Billing ID Number:	National Provider Number (NPI):
Physical Address:		City/State:	Zip:
Primary Lead Contact:	E-mail:	Secondary Lead Contact:	E-mail:
Phone Number:	Title:	Phone Number:	Title:

☐ New Enrollment **PCP Enrollment** ☐ Update/Change Request

In this section, list all Primary Care Physicians (PCP) in your clinic. Refer to Section 200.00 in the PCMH Manual for PCP enrollment guidelines. If a PCP is associated with a satellite location, complete Section II for every satellite location. Signature is not required from a physician being removed from your PCMH enrollment. All signatures must be completed in ink. No e-signatures accepted. Print additional pages as needed.

First/Last Name:	
Individual Provider ID:	NPI:
Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal

First/Last Name:	
Individual Provider ID:	NPI:
Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal

First/Last Name:	
Individual Provider ID:	NPI:
Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal

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Individual Provider ID:	NPI:
Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal

First/Last Name:	
Individual Provider ID::	NPI:
Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal

First/Last Name:	
Individual Provider ID::	NPI:
Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal

Practice Lead Signature:	Date:

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Arkansas Patient-Centered Medical Home
Enrollment Unit
1-866-322-4696 (in-state) or 1-501-301-8311 (local and out of state)
Fax: 501-374-0549 TDD/TTY: 501-682-6789
Email: ARKPCMH@hpe.com

Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement

Section II Satellite Location

Patient-Centered Medical Home

Practice Name:	Medicaid Billing ID Number:	National Provider Number (NPI):

PCMH Satellite Location

This section should be completed for satellite locations where your participating PCP's practice. Refer to the PCMH Manual and Addendum located on the Arkansas Payment Improvement Initiative website www.paymentinitiative.org for enrollment guidelines. Please print additional pages as needed for each additional satellite location.

Practice Name:	Medicaid Billing Number:	National Provider Number (NPI):
Physical Address:	City/State:	Zip:

☐New Enrollment — PCP Enrollment — ☐Update/Change Request

Complete this section for every satellite location. Refer to Section 200.00 in the PCMH Manual for PCP enrollment guidelines. Signature is not required from a physician being removed from your PCMH enrollment. All signatures must be in ink. No e-signatures accepted. Print additional pages as needed.

First/Last Name:	
Individual Provider ID:	NPI:
Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal

First/Last Name:	
Individual Provider ID:	NPI:
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First/Last Name:	
Individual Provider ID:	NPI:
Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal

First/Last Name:	
Individual Provider ID:	NPI:
Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal

Practice Lead Signature:	Date:

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
Adjustment Request Form – Medicaid XIX – Pharmacy Program	DMS-802

Form Name	Form Link
EPSDT Provider Agreement	DMS-831
Evaluation for Wheelchair and Wheelchair Seating	DMS-0843
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

In order by form number:

AAS-9502
AAS-9506
AAS-9559
Address Change
Autodeposit
CMS-485
CSPC-EPSDT
DCO-645
DDS/FS#0001.a
DMS-0101
DMS-0688
DMS-0843
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-6
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-683
DMS-686
DMS-689
DMS-690
DMS-693
DMS-699
DMS-699A
DMS-7708
DMS-7736
DMS-7782
DMS-7783
DMS-802
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

DXC Technology Claims Department

DXC Technology EDI Support Center (formerly AEVCS Help Desk)

DXC Technology Inquiry Unit

DXC Technology Manual Order

DXC Technology Provider Assistance Center (PAC)

DXC Technology 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

U.S. Government Printing Office

Vendor Performance Report

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Arkansas Patient-Centered Medical Home
Enrollment Unit
1-866-322-4696 (in-state) or 1-501-301-8311 (local and out of state)
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Email: ARKPCMH@hpe.com

Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement

Section I Primary Location

This document must be completed for each practice enrolling in the Arkansas Patient-Centered Medical Home (PCMH) program. Each PCMH must complete and submit all pages at one time before the participation agreement will be processed. All participation agreements must be submitted via email to ARKPCMH@dxc.com. PCMH's are responsible for submitting notice of any change to the information contained in this document within 30 days of the change. The program requirements are described in the PCMH Manual and Addendum located on the Arkansas Payment Improvement Initiative website www.paymentinitiative.org.

Patient-Centered Medical Home

Practice Name:		Medicaid Billing ID Number:	National Provider Number (NPI):
Physical Address:		City/State:	Zip:
Primary Lead Contact:	E-mail:	Secondary Lead Contact:	E-mail:
Phone Number:	Title:	Phone Number:	Title:

☐ New Enrollment **PCP Enrollment** ☐ Update/Change Request

In this section, list all Primary Care Physicians (PCP) in your clinic. Refer to Section 200.00 in the PCMH Manual for PCP enrollment guidelines. If a PCP is associated with a satellite location, complete Section II for every satellite location. Signature is not required from a physician being removed from your PCMH enrollment. All signatures must be completed in ink. No e-signatures accepted. Print additional pages as needed.

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Individual Provider ID:	NPI:
Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal

First/Last Name:	
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First/Last Name:	
Individual Provider ID::	NPI:
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First/Last Name:	
Individual Provider ID::	NPI:
Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal

Practice Lead Signature:	Date:

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Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement

Section II Satellite Location

Patient-Centered Medical Home

Practice Name:	Medicaid Billing ID Number:	National Provider Number (NPI):

PCMH Satellite Location

This section should be completed for satellite locations where your participating PCP's practice. Refer to the PCMH Manual and Addendum located on the Arkansas Payment Improvement Initiative website www.paymentinitiative.org for enrollment guidelines. Please print additional pages as needed for each additional satellite location.

Practice Name:	Medicaid Billing Number:	National Provider Number (NPI):
Physical Address:	City/State:	Zip:

☐New Enrollment PCP Enrollment ☐Update/Change Request

Complete this section for every satellite location. Refer to Section 200.00 in the PCMH Manual for PCP enrollment guidelines. Signature is not required from a physician being removed from your PCMH enrollment. All signatures must be in ink. No e-signatures accepted. Print additional pages as needed.

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Individual Provider ID:	NPI:
Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal

First/Last Name:	
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Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal

First/Last Name:	
Individual Provider ID:	NPI:
Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal

First/Last Name:	
Individual Provider ID:	NPI:
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First/Last Name:	
Individual Provider ID:	NPI:
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Individual Provider ID:	NPI:
Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal

Practice Lead Signature:	Date: