



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, 2018

SUBJECT: Provider Manual Update Transmittal PCMH-2-17

REMOVE

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

INSERT

Section	Effective Date
200.000	1-1-18
211.000	1-1-18
212.000	1-1-18
221.000	1-1-18
223.000	1-1-18
232.000	1-1-18
233.000	1-1-18
234.000	1-1-18
235.000	1-1-18
236.000	1-1-18
237.000	1-1-18
241.000	1-1-18
243.000	1-1-18
244.000	1-1-18
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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.

Section 237.000 has been updated with new Shared Savings Incentive Payment Amounts.

Sections 241.000 and 243.000 have been updated to change applicable web links.

Section 244.000 has been updated with changes regarding Provider Reports.

Sections 250.000 and 251.000 have been removed and their contents deleted. (Comprehensive Primary Care Initiative Practice Participation)

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 Arkansas Payment Improvement Initiative Center at 1-866-322-4696 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 301-8311.

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

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

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: <ul style="list-style-type: none"> A. An individual primary care physician (Provider Type 01 or 03);

	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 \$1,481 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.

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.



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TO: Arkansas Medicaid Health Care Providers – All Providers

EFFECTIVE DATE: January 1, 2018

SUBJECT: Provider Manual Update Transmittal SecV-4-17

REMOVE

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

INSERT

Section	Effective Date
500.000	—
—	—
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

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

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

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

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

Claim Forms

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

Claim Type	Where To Get Them
<u>Alternatives Attendant Care Provider Claim Form – AAS-9559</u>	Client Employer
<u>Dental – ADA-J430</u>	Business Form Supplier

Arkansas Medicaid Forms

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

In order by form name:

Form Name	Form Link
Acknowledgement of Hysterectomy Information	<u>DMS-2606</u>
Address Change Form	<u>DMS-673</u>
Adjustment Request Form – Medicaid XIX	<u>HP-AR-004</u>
Adjustment Request Form – Medicaid XIX – Pharmacy Program	<u>DMS-802</u>

Form Name	Form Link
Adverse Effects Form	<u>DMS-2704</u>
Amplification/Assistive Technology Recommendation Form	<u>DMS-686</u>
Application for WebRA Hardship Waiver	<u>DMS-7736</u>
Approval/Denial Codes for Inpatient Psychiatric Services	<u>DMS-2687</u>
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	<u>DDS/FS#0001.a</u>
Arkansas Medicaid Patient-Centered Medical Home Program Practice Participation Agreement	<u>DMS-844</u>
Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form	<u>DMS-845</u>
Arkansas Medicaid Patient-Centered Medical Home Program Practice Withdrawal Form	<u>DMS-846</u>
ARKids First Behavioral Health Services Provider Qualification Form	<u>DMS-612</u>
Authorization for Automatic Deposit	<u>autodeposit</u>
Authorization for Payment for Services Provided	<u>MAP-8</u>
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	<u>DMS-2633</u>
Certification of Schools to Provide Comprehensive EPSDT Services	<u>CSPC-EPSDT</u>
Certification Statement for Abortion	<u>DMS-2698</u>
Change of Ownership Information	<u>DMS-0688</u>
Child Health Management Services Enrollment Orders	<u>DMS-201</u>
Child Health Management Services Discharge Notification Form	<u>DMS-202</u>
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	<u>DMS-699A</u>
CHMS Request for Prior Authorization	<u>DMS-102</u>
Claim Correction Request	<u>DMS-2647</u>
Consent for Release of Information	<u>DMS-619</u>
Contact Lens Prior Authorization Request Form	<u>DMS-0101</u>
Contract to Participate in the Arkansas Medical Assistance Program	<u>DMS-653</u>
DDTCS Transportation Log	<u>DMS-638</u>
DDTCS Transportation Survey	<u>DMS-632</u>
Dental Treatment Additional Information	<u>DMS-32-A</u>
Disclosure of Significant Business Transactions	<u>DMS-689</u>
Disproportionate Share Questionnaire	<u>DMS-628</u>
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	<u>DMS-693</u>
Early Childhood Special Education Referral Form	<u>ECSE-R</u>

Form Name	Form Link
EPSDT Provider Agreement	<u>DMS-831</u>
Evaluation for Wheelchair and Wheelchair Seating	<u>DMS-0843</u>
Explanation of Check Refund	<u>HP-CR-002</u>
Gait Analysis Full Body	<u>DMS-647</u>
Home Health Certification and Plan of Care	<u>CMS-485</u>
Hospital/Physician/Certified Nurse-Midwife Referral for Newborn Infant Medicaid Coverage	<u>DCO-645</u>
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	<u>DMS-2685</u>
Individual Renewal Form for School-Based Audiologists	<u>DMS-7782</u>
Lower-Limb Prosthetic Evaluation	<u>DMS-650</u>
Lower-Limb Prosthetic Prescription	<u>DMS-651</u>
Media Selection/E-Mail Address Change Form	<u>HP-MS-005</u>
Medicaid Claim Inquiry Form	<u>HP-CI-003</u>
Medicaid Form Request	<u>HP-MFR-001</u>
Medical Equipment Request for Prior Authorization & Prescription	<u>DMS-679</u>
Medical Transportation and Personal Assistant Verification	<u>DMS-616</u>
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	<u>DMS-633</u>
Notice Of Noncompliance	<u>DMS-635</u>
NPI Reporting Form	<u>DMS-683</u>
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	<u>DMS-640</u>
Ownership and Conviction Disclosure	<u>DMS-675</u>
Personal Care Assessment and Service Plan	<u>DMS-618 English</u> <u>DMS-618 Spanish</u>
Practitioner Identification Number Request Form	<u>DMS-7708</u>
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	<u>DMS-2615</u>
Primary Care Physician Managed Care Program Referral Form	<u>DMS-2610</u>
Primary Care Physician Participation Agreement	<u>DMS-2608</u>
Primary Care Physician Selection and Change Form	<u>DMS-2609</u>
Procedure Code/NDC Detail Attachment Form	<u>DMS-664</u>
Provider Application	<u>DMS-652</u>
Provider Communication Form	<u>AAS-9502</u>
Provider Data Sharing Agreement – Medicare Parts C & D	<u>DMS-652-A</u>
Provider Enrollment Application and Contract Package	<u>Application Packet</u>

Form Name	Form Link
Quarterly Monitoring Form	<u>AAS-9506</u>
Referral for Audiology Services – School-Based Setting	<u>DMS-7783</u>
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	<u>DMS-2634</u>
Referral for Medical Assistance	<u>DMS-630</u>
Request for Appeal	<u>DMS-840</u>
Request for Extension of Benefits	<u>DMS-699</u>
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	<u>DMS-671</u>
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	<u>DMS-602</u>
Request for Molecular Pathology Laboratory Services	<u>DMS-841</u>
Request for Orthodontic Treatment	<u>DMS-32-0</u>
Request for Prior Approval for the Special Pharmacy Therapeutic Agents and Treatments	<u>DMS-6</u>
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	<u>DMS-2692</u>
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	<u>DMS-601</u>
Research Request Form	<u>HP-0288</u>
Service Log – Personal Care Delivery and Aides Notes	<u>DMS-873</u>
Sterilization Consent Form	<u>DMS-615 English</u> <u>DMS-615 Spanish</u>
Sterilization Consent Form – Information for Men	<u>PUB-020</u>
Sterilization Consent Form – Information for Women	<u>PUB-019</u>
Targeted Case Management Contact Monitoring Form	<u>DMS-690</u>
Upper-Limb Prosthetic Evaluation	<u>DMS-648</u>
Upper-Limb Prosthetic Prescription	<u>DMS-649</u>
Vendor Performance Report	<u>Vendorperformreport</u>
Verification of Medical Services	<u>DMS-2618</u>

In order by form number:

<u>AAS-9502</u>	<u>DMS-2618</u>	<u>DMS-618</u>	<u>DMS-673</u>	<u>ECSE-R</u>
<u>AAS-9506</u>	<u>DMS-2633</u>	<u>Spanish</u>	<u>DMS-679</u>	<u>HP-0288</u>
<u>AAS-9559</u>	<u>DMS-2634</u>	<u>DMS-619</u>	<u>DMS-683</u>	<u>HP-AR-004</u>
<u>Address</u>	<u>DMS-2647</u>	<u>DMS-628</u>	<u>DMS-686</u>	<u>HP-CI-003</u>
<u>Change</u>	<u>DMS-2685</u>	<u>DMS-630</u>	<u>DMS-689</u>	<u>HP-CR-002</u>
<u>Autodeposit</u>	<u>DMS-2687</u>	<u>DMS-632</u>	<u>DMS-690</u>	<u>HP-MFR-001</u>
<u>CMS-485</u>	<u>DMS-2692</u>	<u>DMS-633</u>	<u>DMS-693</u>	<u>HP-MS-005</u>
<u>CSPC-EPSDT</u>	<u>DMS-2698</u>	<u>DMS-635</u>	<u>DMS-699</u>	<u>MAP-8</u>
<u>DCO-645</u>	<u>DMS-2704</u>	<u>DMS-638</u>	<u>DMS-699A</u>	<u>Performance</u>
<u>DDS/FS#0001.a</u>	<u>DMS-32-A</u>	<u>DMS-640</u>	<u>DMS-7708</u>	<u>Report</u>
<u>DMS-0101</u>	<u>DMS-32-0</u>	<u>DMS-647</u>	<u>DMS-7736</u>	<u>Provider</u>
<u>DMS-0688</u>	<u>DMS-6</u>	<u>DMS-648</u>	<u>DMS-7782</u>	<u>Enrollment</u>
<u>DMS-0843</u>	<u>DMS-601</u>	<u>DMS-649</u>	<u>DMS-7783</u>	<u>Application</u>
<u>DMS-102</u>	<u>DMS-602</u>	<u>DMS-650</u>	<u>DMS-802</u>	<u>and Contract</u>
<u>DMS-201</u>	<u>DMS-612</u>	<u>DMS-651</u>	<u>DMS-831</u>	<u>Package</u>
<u>DMS-202</u>	<u>DMS-615</u>	<u>DMS-652</u>	<u>DMS-840</u>	<u>PUB-019</u>
<u>DMS-2606</u>	<u>English</u>	<u>DMS-652-A</u>	<u>DMS-841</u>	<u>PUB-020</u>
<u>DMS-2608</u>	<u>DMS-615</u>	<u>DMS-653</u>	<u>DMS-844</u>	
<u>DMS-2609</u>	<u>Spanish</u>	<u>DMS-664</u>	<u>DMS-845</u>	
<u>DMS-2610</u>	<u>DMS-616</u>	<u>DMS-671</u>	<u>DMS-846</u>	
<u>DMS-2615</u>	<u>DMS-618</u>	<u>DMS-675</u>	<u>DMS-873</u>	
	<u>English</u>			

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

Arkansas Department of Human Services, Children's Services

Arkansas Department of Human Services, Division of County Operations, Customer Assistance Section

Arkansas Department of Human Services, Division of Medical Services

Arkansas DHS, Division of Medical Services Director

Arkansas DHS, Division of Medical Services, Benefit Extension Requests, UR Section

Arkansas DHS, Division of Medical Services, Dental Care Unit

Arkansas DHS, Division of Medical Services, DXC Technology Provider Enrollment Unit

Arkansas DHS, Division of Medical Services, Financial Activities Unit

Arkansas DHS, Division of Medical Services, Hearing Aid Consultant

Arkansas DHS, Division of Medical Services, Medical Assistance Unit

Arkansas DHS, Division of Medical Services, Medical Director for Clinical Affairs

Arkansas DHS, Division of Medical Services, Pharmacy Unit

Arkansas DHS, Division of Medical Services, Program Communications Unit

Arkansas DHS, Division of Medical Services, Provider Reimbursement Unit

Arkansas DHS, Division of Medical Services, Third-Party Liability Unit

Arkansas DHS, Division of Medical Services, UR/Home Health Extensions

Arkansas DHS, Division of Medical Services, Utilization Review Section

Arkansas DHS, Division of Medical Services, Visual Care Coordinator

Arkansas Department of Health

Arkansas Department of Health, Health Facility Services

Arkansas Department of Human Services, Accounts Receivable

Arkansas Foundation for Medical Care

Arkansas Foundation for Medical Care, Retrospective Review for Therapy and Prior Authorization for Personal Care for Under Age 21

Arkansas Foundation for Medical Care, Provider Relations Representative

Arkansas Hospital Association

Arkansas Office of Medicaid Inspector General (OMIG)

ARKids First-B

ARKids First-B ID Card Example

Beacon Health Options (Formerly ValueOptions)

Central Child Health Services Office (EPSDT)

ConnectCare Helpline

County Codes

Dental Contractor

[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](#)

