PCMH Webinar
August 26, 2016

Dr. William Golden
Medicaid Medical Director
Department of Human Services
Dial in (650) 479-3207
Access code 665-006-947#
AGENDA

• General Program Updates
• HCP•LAN Update – Primary Care
• CPC+
  – Framework
  – Track 1 vs. Track 2
  – Enrollment
• Alternative Payment Mechanisms (APM)
  – Evolving Concepts
• PCMH Enrollment
General PCMH Program Updates

• Q3 2016 Reports
• Shared Savings preliminary payments
Primary Care Payment Model (PCPM) Work Group

Chairs

William E. Golden, MD, MACP - Professor of Medicine and Public Health, University of Arkansas for Medical Sciences; Medical Director, Arkansas DHS/Medicaid

Susan Edgman-Levitan, PA - Executive Director, John D. Stoeckle Center for Primary Care Innovation at Massachusetts General Hospital

Description

This group of experts will collaboratively develop recommendations on the critical components for primary care payment in category 3 or 4 alternative payment models (APMs) and make practical recommendations for accelerating adoption of these models, including steps to support implementation.
## Context: Overview of the Health Care Payment Learning and Action Network

### Mission

To accelerate the health care system’s transition to alternative payment models by combining the innovation, power, and reach of the private and public sectors.

Over 4,500 individuals and organizations have signed up to participate in the LAN.

### Goals

<table>
<thead>
<tr>
<th>Year</th>
<th>Goal</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>2016</td>
<td>30%</td>
<td>In 2016, at least 30% of U.S. health care payments are linked to quality and value through Alternative Payment Models (APMs).</td>
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<tr>
<td>2018</td>
<td>50%</td>
<td>In 2018, at least 50% of U.S. health care payments are so linked.</td>
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### LAN Priorities

- Define APM framework and concepts
- Develop consistent and aligned payment mechanisms
- Share best practices, early results and learning
- Design solutions and approaches
- Drive agreement, adoption, and action

### Work and Affinity Groups

- APM Framework and Progress Tracking Work Group
- Population-Based Payment Work Group
- Clinical Episode Payment Work Group
- Purchaser Affinity Group
- Consumer and Patient Affinity Group

For more information, visit: https://publish.mitre.org/hcplan
Guiding Principles

established by the Guiding Committee

- The goal of these work groups is to accelerate use of effective payment models that support better health outcomes at a lower cost, by identifying the best elements of payment reforms and aligning reforms within and across the private and public sectors.

- The work is about accelerating and aligning, not designing models de novo. Inherent in this approach is learning from best payment practices in the field—including what did not work—and developing a unifying framework and pathway to more widespread adoption.

- Emphasis will be placed on establishing guidelines that support implementation and reaching consensus around core components to align and execute upon. Work groups need to consider what is “good enough” alignment to drive appropriate behaviors/outcomes.

- Consistency will be needed to achieve alignment; however the approach taken can be tailored to market conduciveness, organizational readiness, and characteristics of particular models. That said, compromises will be necessary to achieve the goal of alignment as often as feasible and there should be solid reasons for divergence.

- Concrete implementation steps will be directed toward the primary actors with the ability to implement these initiatives—such as large payers and providers. Recommendations will also be directed to other vital stakeholders (purchasers, consumers, states) to act within their sphere of influence.
Draft Principles – Primary Care

• Payment To Promote Health, not Healthcare
  – Promote Patient Centered, Team Care
  – Promote “Joy in Practice”
  – Incent Effective Care While Maintaining Trust

• Metrics for High Value Care
Draft Principles

• Provide High Value Care for Vulnerable Pts
  – Support Care for Complex Clinical, Social Patients
  – Foster Health Care Equity

• Holistic Primary Care
  – Integrate Medical Neighborhood, esp BH

• Support Practices Capable of Transformation

• Payers Should Support Transformation Process
CPC+: What is it?

CPC+ a New Advanced Primary Care Medical Home Model

CPC+ By the Numbers

5 Years
Beginning January 2017, progress monitored quarterly

2 Program Tracks
Based on practices’ readiness for transformation

Up to 2,500 Practices Per Track
Dependent upon interest and eligibility
CPC+ Offered in Fourteen Regions

Only Practices in Selected States/Counties May Apply

Arkansas Participants are:
Arkansas Medicaid
Arkansas Blue Cross Blue Shield
QualChoice Health Plan Services, Inc.
Arkansas Superior Select, Inc.
Arkansas Health & Wellness Solutions
HealthSCOPE Benefits
CPC+ Applicants Must Have Practice Transformation Experience

Practice Eligibility Criteria

- Must have at least 150 attributed Medicare beneficiaries
- Must have support from CPC+ payer partners
- Must use CEHRT
- Existing care delivery activities must include:

  Track 1

  - Assigning patients to provider panel
  - Providing 24/7 access for patients
  - Supporting quality improvement activities
  - Developing and recording care plans
  - Following up with patients after ED or hospital discharge

  Track 2

  - Implementing a process to link patients to community-based resources

  - Must apply with a letter of support from health IT vendor that outlines the vendor’s commitment to support the practice in optimizing health IT.

Track 2 applicants will indicate on their applications if they would like to join CPC+ in the event that CMS deems them eligible only for Track 1.
Five Functions Guide CPC+
Care Delivery Transformation

Access and Continuity
Care Management
Comprehensiveness and Coordination
Patient and Caregiver Engagement
Planned Care and Population Health
# CPC+ Practices Will Enhance Care Delivery Capabilities in 2017

Track 2 capabilities are inclusive of and build upon Track 1 requirements.

<table>
<thead>
<tr>
<th>Access and Continuity</th>
<th>Requirements for Track 1</th>
<th>Requirements for Track 2</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Empanelment</td>
<td>Alternative to traditional office visits, e.g., e-visits, phone visits, group visits, home visits, alternate location visits, and/or expanded hours.</td>
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<tr>
<td></td>
<td>24/7 patient access</td>
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<td></td>
<td>Assigned care teams</td>
<td></td>
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<tr>
<td>Care Management</td>
<td>Risk stratified patient population</td>
<td>Two-step risk stratification process for all empanelled patients</td>
</tr>
<tr>
<td></td>
<td>Short-term and targeted, proactive, relationship-based care management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ED visit and hospital follow-up</td>
<td>Care plans for high-risk chronic disease patients</td>
</tr>
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</table>
CPC+ Practices Will Enhance Care Delivery Capabilities in 2017

### Requirements for Track 1

**Comprehensiveness and Coordination**
- Identification of high volume/cost specialists
- Improved timeliness of notification and information transfer from EDs and hospitals

**Patient and Caregiver Engagement**
- At least annual Patient and Family Advisory Council
- Assessment of practice capabilities to support patient self-management

**Planned Care and Population Health**
- At least quarterly review of payer utilization reports and practice eCQM data to inform improvement strategy

### Requirements for Track 2

- Behavioral health integration
- Psychosocial needs assessment and inventory of resources and supports to meet psychosocial needs
- Collaborative care agreements
- Development of practice capability to meet needs of high-risk populations
- At least biannual Patient and Family Advisory Council
- Patient self-management support for at least three high-risk conditions
- At least weekly care team review of all population health data
Three Payment Innovations Support CPC+ Practice Transformation

<table>
<thead>
<tr>
<th>Objective</th>
<th>Care Management Fee (PBPM)</th>
<th>Performance-Based Incentive Payment (PBPM)</th>
<th>Payment Structure Redesign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Track 1</td>
<td>Support augmented staffing and training for delivering comprehensive primary care</td>
<td>Reward practice performance on utilization and quality of care</td>
<td>Reduce dependence on visit-based fee-for-service to offer flexibility in care setting</td>
</tr>
<tr>
<td></td>
<td>$15 average</td>
<td>$2.50 opportunity</td>
<td>N/A (Standard FFS)</td>
</tr>
<tr>
<td>Track 2</td>
<td>$28 average, including $100 to support patients with complex needs</td>
<td>$4.00 opportunity</td>
<td>Reduced FFS with prospective “Comprehensive Primary Care Payment” (CPCP)</td>
</tr>
</tbody>
</table>
PBPM Care Management Fees Determined by Patient Risk Levels
Payments Support Practice Capabilities to Better Manage Care

Track 1: Four Risk Tiers (Average $15)

Track 2: Five Risk Tiers (Average $28)

- Risk adjusted, PBPM (non-visit-based) payment
- Designed to augment staffing and training, according to specific needs of patient population
- No beneficiary cost sharing
- Risk tiers relative to regional population

Complex Tier: $100
Top 10% of risk or dementia diagnosis
Opportunity to Earn Performance-Based Incentive Payments

Practices Will Keep Percentage of Upfront Payment

Two Components of Incentive Payment

**Quality** and patient experience measures
- Examples: eCQMs, CAHPS
- Measured at practice level

**Utilization** measures that drive total cost of care
- Examples: inpatient admissions, ED visits
- Measured at practice level

<table>
<thead>
<tr>
<th></th>
<th>Track 1</th>
<th>Track 2</th>
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<tbody>
<tr>
<td><strong>Quality</strong> (PBPM)</td>
<td>$1.25</td>
<td>$2.00</td>
</tr>
<tr>
<td><strong>Utilization</strong> (PBPM)</td>
<td>$1.25</td>
<td>$2.00</td>
</tr>
<tr>
<td><strong>Total</strong> (PBPM)</td>
<td>$2.50</td>
<td>$4.00</td>
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</tbody>
</table>

**Prospectively paid PBPM incentive; retrospectively reconciled** based on practice performance
Track 2 Reimbursement Redesign Offers Flexibility in Care Delivery

Designed to Promote Population Health Beyond Office Visits

Hybrid of FFS and Upfront “Comprehensive Primary Care Payment” (CPCP) for Evaluation & Management

Total CPCP/FFS is ~10% larger than historical FFS to compensate for more comprehensive services

- Practices receive enhanced fees with roughly half of expected FFS payments upfront and subsequent FFS billings reduced by the prepaid amount
- CPCP reduces incentive to bring patients into the office for a visit but maintenance of some FFS allows for flexibility to treat patients in accordance with their preferences
- Practices select the pace at which they will progress towards one of two hybrid payment options (both roughly 50/50) by 2019
CPC+: Which Track?

CMS and Partner Payers Will Support Practices in Both Program Tracks

**Track 1**
- Up to 2,500 primary care practices.
- Choice for practices ready to build the capabilities to deliver comprehensive primary care.

**Track 2**
- Up to 2,500 primary care practices.
- Choice for practices poised to increase the comprehensiveness of care through enhanced health IT, improve care of patients with complex needs, and inventory resources and supports to meet patients' psychosocial needs.
Practices Will Use Advanced Health IT to Improve Patient Care

All Practices Must Adopt Certified EHR Technology

General Requirements

• Adopt 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 (e.g. EHR Incentive Programs, proposed Quality Payment Program)

• Use 2015 Edition technology (may use 2014 Edition in 2017 only)

Quality Reporting Requirements

• Adopt health IT certified to the (c)(1) – (c)(3) certification criteria for all eCQMs in the CPC+ measure set

• Use the latest annual measure update for the CPC+ measures

• Be able to filter eCQM data by practice site location and TIN/NPI beginning in 2017. Beginning in 2018, adopt 2015 Edition health IT certified to the criterion 45 CFR 170.315(c)(4) to filter eCQMs.

Additional for Track 2

By January 1, 2019 (beginning of CPC+ PY3), adopt health IT certified to the 2015 Edition “Care Plan” criterion found at 45 CFR 170.315(b)(9) and the 2015 Edition “Social, Behavioral, and Psychosocial Data” criterion found at 45 CFR 170.315(a)(15)
Affiliated Practices May Apply but Must Apply Independently

- CMS encourages **all practices**, including those with the same owner or those in the same ACO, to apply to CPC+.

- Every practice must submit a **separate application**; eligibility will be determined at the practice level.

- CMS will accept affiliated practices (e.g., in a health system, ACO, etc.) as a group **to the extent possible**.

- Affiliated practices (including practices in the same health system) may participate in **different tracks** of CPC+.

- Up to 1,500 primary care practices participating in a Medicare Shared Savings Program **ACO may participate** in CPC+.

- CPC+ practices must use **one billing TIN** for all primary care services. This TIN may be shared with other practices in a medical group or organization; CMS will identify specific CPC+ practitioners by their National Provider Identifier (NPI).
Practice Types Ineligible for CPC+

CPC+ is designed to test payment reform for traditional fee-for-service payment under the Medicare Physician Fee Schedule. Therefore, the following practices are not eligible to apply:

- **Pediatric Practices**
  CPC+ practices must include at least 150 eligible Medicare fee-for-service beneficiaries and pediatricians generally do not treat Medicare patients.

- **Concierge Practices**
  Retainer fees usually replace traditional co-insurance under Medicare fee-for-service and/or conflict with CPC+ Care Management Fees.

- **Rural Health Clinics**
  RHCs do not submit claims on a Medicare Physician/Supplier claim form and are not paid according to the Medicare Physician Fee Schedule for routine office visits.

- **Federally Qualified Health Centers**
  FQHCs do not submit claims on a Medicare Physician/Supplier claim form and are not paid according to the Medicare Physician Fee Schedule for routine office visits.
Applications are being accepted NOW

APPLICATION DEADLINE: Thursday, September 15, 2016 @ 11:59 pm ET
All documents must be signed, scanned and uploaded to the application portal at https://app1.innovation.cms.gov/cpcplus
Download the CPC+ Application Checklist: https://innovation.cms.gov/Files/x/cpcplus-appchecklist.pdf

Comprehensive Primary Care Plus (CPC+)
A new model for primary care in America

CPC+ Practice Application Checklist

This checklist details the information that your practice will need to complete the CPC+ Application, as well as a comprehensive list of all documents that your practice is required to submit with your application.

Please note that not all documents are required from all applicants; some documents are specific to the Track for which an applicant is applying, and some are required only from practices with specific ownership organization. It is the responsibility of the applicant to ensure that you include all items that are required for your specific circumstances.

All documents must be signed, scanned, and uploaded to the application portal at https://app1.innovation.cms.gov/cpcplus. Please retain the original, signed letters. If you have any questions about what your practice is required to submit, please contact CMS at CPCplus@cms.hhs.gov.

Gather the following information for each practice site before beginning your application:

- **Contact information:**
  - Applicant Contact (individual completing the application)
  - Practice Contact (required if the Applicant Contact is not the primary contact in the practice or does not work in the practice)
  - Health Information Technology Contact (individual responsible for HIT in the practice)

- **Total number of individual physicians, nurse practitioners, physician assistants and clinical nurse specialists who provide patient care at your practice and practice under their own NPI.**

- **Primary care practitioners, including full-time and part-time staff in your practice:**
  - Number of physicians, NPs, PAs, CNs
  - For each primary care practitioner:
    - Name
    - NPI
    - Specialty
    - If practitioner works at the practice (or satellite office) and/or if the practitioner practices at another location

- **If your practice is owned by a larger health care organization, such as a group practice or health system:**
  - Name of organization (if other practices from your organization are applying to CPC+, please use identical text in this field)
  - Corporate address and phone number
  - Number of primary care practice sites, physicians, and Medicare Eligible Professionals that are part of this organization
  - Name and TIN of all other practices in your organization that are applying for CPC+

- **All TINs used by your practice to bill Medicare, including those used since January 1, 2013**

- **Medicare Shared Savings Program ACO name and TIN (if applicable)**

- **Information about each Health IT used:**
  - Vendor name
  - Product name
  - Version
  - CPC+ Function (if applicable; Track 2 only)

- **Meaningful Use attestation progress among the primary care practitioners in your practice who are Eligible Professionals:**
  - Total number of Medicare EPs, number of Medicare EPs who plan to attest to Meaningful Use Stage 2
  - Total number of Medicaid EPs, number of Medicaid EPs who plan to attest to Meaningful Use Stage 2

- **CMS EHR Certification ID**

- **Percentage of patients by race and preferred language**

- **Practice revenue and budget information:**
  - Total revenue in 2015
  - Total 2015 revenue by specified payer
  - Percentage of patients by insurance type (e.g., commercial, Medicare)

- **Care delivery information to answer application questions about care management, access, and quality improvement.**

- **Organizations through which your practice has received Medical Home recognition (if applicable)**

A completed application for CPC+ will also include the following additional documents:

- **Letter of support from your practice’s clinical leader:**
  - Each practice must submit a separate letter of support from leadership at the practice site

- **Letter from system leadership regarding segregation of CPC+ funds (if applicable)**

- **Health IT Cover Letter (Track 2 applicants only)**

- **Letter of support from Health Information Technology vendor (Track 2 applicants only), if vendor has not submitted a Global Letter of Support**
Many Opportunities for Learning, Collaboration, and Support

**CPC+ Practice Portal**
Online tool for reporting, feedback, and assessment on practice progress

**CPC+ Connect**
Web-based platform for CPC+ stakeholders to share ideas, resources, and strategies for practice transformation

**Aligned Data Feedback**
Actionable data reports on attribution and cost, utilization, and quality at the practice and patient level from multiple payers

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**Learning Opportunities**

**National Learning Communities**
- Cross-region collaboration
- National learning opportunities
- Annual Stakeholder Meeting

**Regional Learning Communities**
- Virtual and in-person learning sessions
- Outreach and support for practice leads
- Leadership engagement
- Alignment with regional reform
CPC+: Additional Help

CMS CPC+ Website:
https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

Contact CMS
Call the CPC+ Help Desk from 8:30a.m. – 7:30p.m. EDT at 1-844-442-2672
Email at CPCplus@cms.hhs.gov

Practice Materials
CPC+ Practice FAQs (PDF)       CPC+ Request for Applications (PDF)
CPC+ Practice Slide Presentation (PDF)   CPC+ In Brief (PDF)
CPC+ Payment Innovations Brief and Case Studies (PDF)
CPC+ Payment Innovations Video
CPC+ Care Delivery Transformation Brief (PDF)
CPC+ Care Delivery Transformation Video
Reflections from Original CPC Initiative Participants
CPC+ Health IT Vendor List (PDF)
CPC+ Health IT Vendor Letter of Support Cover Sheet (PDF)
CPC+ Health IT Vendor Global Letter of Support (PDF)
CPC+ Practice Care Delivery Requirements (PDF)
CPC+ Quality Reporting Overview PY 2017 (PDF)
CPC+: More Help

Health IT Vendor Materials
- CPC+ Health IT Vendor Memorandum of Understanding (PDF)
- CPC+ Health IT Vendor Letter of Support Submission Instructions (PDF)
- CPC+ Health IT Vendor Global Letter of Support Template (PDF)
- CPC+ Health IT Vendor Letter of Support Template (PDF)
- CPC+ Health IT and Track 2 Requirements (PDF)

Additional Information
- CPC+ Payer and Region List (PDF)
- CPC+ Press Release | CPC+ Regions Announcement Press Release
- CPC+ Fact Sheet | CPC+ Regions Announcement Fact Sheet
- JAMA article: "Medicare's Vision for Advanced Primary Care: New Directions for Care Delivery and Payment" (April 11, 2016)
- CPC+ Archived Materials
Quality Payment Program

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- **Provides incentive payments** for participation in Advanced Alternative Payment Models (APMs)

The Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (APMs)

- **First step to a fresh start**
- **We’re listening and help is available**
- **A better, smarter Medicare for healthier people**
- **Pay for what works to create a Medicare that is enduring**
- **Health information needs to be open, flexible, and user-centric**
How MACRA’s initial impact breaks down

The first performance year begins Jan. 1 for payments in 2019

761,342
Number of clinicians eligible for the Merit-based Incentive Payment System (MIPS)

30,658-90,000
Number that could be exempt from MIPS and get a bonus for participating in an advanced Alternative Payment Model (APM)

Components of MIPS

10%
Cost

15%
Clinical practice improvement

50%
Quality (replaces Physician Quality Reporting System and Value-based Payment Modifier)

25%
Advancing Care Information (replaces EHR meaningful use)

Maximum bonus or penalty under MIPS in 2019: +4% -4%
Medicare bonus in 2019 for participating in an advanced APM: 5%

Source: CMS
How much can MIPS adjust payments?

Note: MIPS will be a budget-neutral program. Total upward and downward adjustments will be balanced so that the average change is 0%.

Merit-Based Incentive Payment System (MIPS)

2019 2020 2021 2022 onward

*Potential for 3X adjustment

Maximum Adjustments
MACRA provides additional rewards for participating in APMs.

Potential financial rewards

<table>
<thead>
<tr>
<th>Not in APM</th>
<th>In APM</th>
<th>In eligible APM</th>
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</thead>
<tbody>
<tr>
<td>MIPS adjustments</td>
<td>MIPS adjustments</td>
<td>APM-specific rewards</td>
</tr>
<tr>
<td>+</td>
<td>+</td>
<td>+</td>
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<tr>
<td>APM-specific rewards</td>
<td></td>
<td>5% lump sum bonus</td>
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If you are a qualifying APM participant (QP)
How do I become a qualifying APM participant (QP)?

Eligible APM → QP

You must have a certain % of your patients or payments through an eligible APM.

QPs will:

- Be excluded from MIPS
- Receive a 5% lump sum bonus

Bonus applies in 2019-2024; then will receive higher fee schedule update starting in 2026

25% in 2019 and 2020
What about private payer or Medicaid APMs? Can they help me qualify to be a QP?

Yes, starting in **2021**, participation in some of these APMs with other non-Medicare payers can count toward criteria to be a QP.

**“Combination all-payer & Medicare threshold option”**

*IF the APMs meet criteria similar to those for eligible APMs run by CMS:*

- Certified EHR use
- Quality Measures
- Financial Risk
The Other Payer Advanced APM requires one or more of the following if actual expenditures exceed expected expenditures:

- Direct payment from the APM Entity
- Reduction in payment rates to the APM Entity or eligible clinicians
- Withhold of payment to the APM Entity or eligible clinicians
Other Payer Advanced APM Criterion 3: Medicaid Medical Home Model Financial Risk Criterion

The Medicaid Medical Home Model requires one or more of the following if actual expenditures exceed expected expenditures:

- Direct payment from the APM Entity
- Reduction in payment rates to the APM Entity or eligible clinicians
- Withhold of payment to the APM Entity or eligible clinicians
- Reduces an otherwise guaranteed payment or payments
Find additional information about the Quality Payment Program, including fact sheets, upcoming webinars and more at:
http://go.cms.gov/QualityPaymentProgram
Arkansas Health Care Payment Improvement Initiative (AHCPII)
Patient Centered Medical Homes (PCMH)

PCMH Enrollment
Presented by
Participating Practice

- A physician practice that is enrolled in the PCMH program, which must be one of the following:
  - An individual primary care physician (PCP) (provider type 01 or 03)
  - A physician group of primary care providers who are affiliated, with a common group identification number (provider type 02, 04 or 81)
  - A rural health clinic (provider type 29) as defined in the Rural Health Clinic Provider Manual Section 201.000
  - An Area Health Education Center (provider type 69)

- Enrollment in PCMH program is voluntary and practices must re-enroll annually
To be eligible to enroll in the PCMH program:

- The entity must be a participating practice as defined in Section 200.000
- The practice must include PCPs enrolled in the ConnectCare Primary Care Case Management (PCCM) program
- The practice may not participate in the PCCM shared savings pilot established under Act 1453 of 2013
- The practice must have at least 300 attributed beneficiaries at the time of enrollment. DMS may modify the number of attributed beneficiaries required for enrollment based on provider experience and will publish at [www.paymentinitiative.org](http://www.paymentinitiative.org) any such modification
- The practice must meet eligibility criteria as specified in the conditions for enrollment as indicated in the PCMH activities and metrics list. These criteria are published on the Arkansas Payment Improvement Initiative (APII) website at [www.paymentinitiative.org](http://www.paymentinitiative.org)
Enrollment Process

- Re-enrollment
- ARKPCMH@hpe.com
- AHIN
- Site location
Enrollment Form

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 MedicaidHRA@littlerock.gov. PCMHs 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.

<table>
<thead>
<tr>
<th>Patient-Centered Medical Home</th>
<th>National Provider Number (NPI)</th>
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</thead>
<tbody>
<tr>
<td>Practice Name:</td>
<td></td>
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<tr>
<td>Medical Billing ID:</td>
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<tr>
<td>Physical Address:</td>
<td></td>
</tr>
<tr>
<td>City/State:</td>
<td></td>
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<tr>
<td>Primary Lead Contact:</td>
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New Enrollment

PCP Enrollment

Update/Change Request

Section II - Satellite Location

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<tr>
<th>PGMH Satellite Location</th>
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<tbody>
<tr>
<td>Medicaid Billing Number:</td>
</tr>
<tr>
<td>National Provider Number (NPI):</td>
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New Enrollment

PCP Enrollment

Update/Change Request

Complete this section 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.

Practice Lead Signature: Date:

Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement

8/26/2016

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Unique Circumstances

- **Remediation**
  - Quality Improvement Plan (QIP)

- **Termination**
  - PBPM

- **Suspension**
  - Program
**SECTION IV: PROVIDER GROUP AFFILIATIONS**

(23) If the applicant is affiliated with a group practice or an organization that is authorized to submit Medicaid claims on their behalf, the applicant must complete this section and sign the Appointment of Billing Intermediary Statement. Add extra sheets if necessary.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M. I.</th>
<th>Title</th>
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<table>
<thead>
<tr>
<th>Group Organization Name</th>
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<table>
<thead>
<tr>
<th>Group Provider ID Number</th>
<th>Effective Date (Applicant Joined Group)</th>
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<tr>
<th>Group Taxonomy Code</th>
<th>Expiration Date (Applicant Left Group)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

The undersigned Provider authorizes the above-listed Group Practice Organization to submit claims to the Arkansas Division of Medical Services (hereinafter the Division) on his/her/its behalf, in accordance with the applicable Division regulations. The Provider also authorizes the Division to issue payment checks on his/her/its behalf to the above listed Group Practice Organization, in accordance with applicable Division requirements.

The Provider accepts full liability to the Division for all acts committed by each Group Practice Organization listed above which relate in any manner to said Group Practice Organization’s performance of duties in preparing and submitting claims on the Provider’s behalf within the scope of its actual or apparent authority. Should any such acts result in the violation of any of the laws, rules or regulations governing the Medical Assistance Program or the Provider’s agreement with the Division, the Provider shall be fully liable to the Division as if such acts were the Provider’s own acts.

The Provider agrees to notify the Division at least ten days prior to the effective date of the revocation of this Appointment of Billing Intermediary. In such event, the Provider’s liability for the acts of the Group Practice Organization shall continue until the tenth day after the Department’s receipt of such notification or the effective date of the revocation, whichever date is later.

An original or approved electronic signature of the individual provider is mandatory. (No stamped or copied signature is allowed; “approved electronic signature” is described at the Arkansas Medicaid website, [https://www.medicaid.state.ar.us/](https://www.medicaid.state.ar.us/))

<table>
<thead>
<tr>
<th>Signature</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Typed or Printed Name</th>
<th>Provider ID Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider Taxonomy Code</th>
</tr>
</thead>
</table>

Primary Care Physicians must complete the Primary Care Physician Agreement in order to have their managed care fees paid to a new group Provider ID Number. (See item 25)
Shared Savings

- **Incentive payments eligibility**
  - Section 232.000

- **Pools of attributed beneficiaries**
  - Section 233.000
  - Independent
  - Voluntary
  - Default
  - Form available at [www.paymentinitiative.org](http://www.paymentinitiative.org)

- **Requirements for joining and leaving pools**
  - Section 234.000
Updates and Changes During Performance

- **Section 212.000 — Practice enrollment**
  - A participating practice must update DHS on changes to the list of physicians who are part of the practice.
  - Physicians who are no longer participating within a practice are required to update in writing via email at ARKPCMH@hpe.com within 30 days of the change.

- **Update/change form**
  - Office lead contact change
  - Add physician
  - Withdraw physician

- **Available on AHIN portal**

- **Submit to** ARKPCMH@hpe.com
# Update/Change Form

**Section I - Primary Location**

This document must be completed for each practice or provider 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 PCMH.RM@ahs.com. PCMHs 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.payimprovementinitiative.org](http://www.payimprovementinitiative.org).

## Patient-Centered Medical Home

<table>
<thead>
<tr>
<th>Practice Name:</th>
<th>Effective Date:</th>
<th>Status: [ ] Active [ ] Withdrawn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Billing ID:</td>
<td>NPI:</td>
<td></td>
</tr>
<tr>
<td>Signature of Physician:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## PCP Enrollment

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.

<table>
<thead>
<tr>
<th>First/Last Name:</th>
<th>Effective Date:</th>
<th>Status: [ ] Active [ ] Withdrawn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Billing ID:</td>
<td>NPI:</td>
<td></td>
</tr>
<tr>
<td>Signature of Physician:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Update/Change Request

<table>
<thead>
<tr>
<th>First/Last Name:</th>
<th>Effective Date:</th>
<th>Status: [ ] Active [ ] Withdrawn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Billing ID:</td>
<td>NPI:</td>
<td></td>
</tr>
<tr>
<td>Signature of Physician:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Practice Lead Signature:** [ ] Date:

DNR 864 (7/16)
Withdraw From PCMH Program

- Section 212.000
- Withdrawal form (DMS-846)
  - Available at [www.paymentinitiative.org](http://www.paymentinitiative.org) and AHIN portal
- Complete and submit to [ARKPCMH@hpe.com](mailto:ARKPCMH@hpe.com)
Managed Care Fee (PCCM)

- DMS-2608
- Negative impact on reports
- Six-month attribution

This agreement is made and entered into between ____________________________________________ 
(Please print, stamp or type physician's name)
hereafter called provider, and the Arkansas Division of Medical Services, hereafter called Medicaid.
The provider in consideration of the material benefits to be derived, and the rules and regulations of the Medicaid Program 
agrees as follows:
A. To be a Medicaid enrolled Physician provider and comply with all pertinent Medicaid policies, regulations and State Plan standards.
B. To be a Medicaid enrolled Early Periodic Screening Diagnosis and Treatment (EPSDT) provider and to comply with all pertinent Medicaid policies, regulations and State Plan standards. (Internists, Obstetricians/Gynecologists are exempt from this requirement.)
C. To perform various services as a primary care physician under the guidelines of the Primary Care Physician Managed Care Program and to comply with all pertinent Medicaid policies, regulations and State Plan standards.
D. To authorize their name be listed as a primary care physician and consent to release their name to interested parties.

Please indicate the maximum number of Medicaid beneficiaries you are willing to accept for primary care services. (a maximum of 2500).

Please indicate the Provider ID Number and Taxonomy Code (individual or group) for payment of your management fee and inclusion on a Federal 1099 Tax Form: 
Provider ID Number  Taxonomy Code

Physicians without hospital admitting privileges, please list the name of the enrolled PCP with admitting privileges who has agreed to be responsible for your beneficiary inpatient admissions: ____________, An agreement signed by the PCP and the Admitting physician is required.

Primary Care Physician Provider ID Number Primary Care Physician Signature Date

Primary Care Physician Taxonomy Code

Division of Medical Services Signature Title Date

DMS-2608 (Rev. 5-16)
171.230 Managed Care Fee (PCCM)

A. In addition to reimbursing PCPs on a fee for service basis for physician services, Arkansas Medicaid pays them a monthly case management fee for each enrollee on their caseloads.

B. The amount due for each month is determined by multiplying the established case management fee by the number of enrollees on the PCP’s caseload on the last day of the month.
   1. Medicaid pays case management fees quarterly—in October, January, April and July.
   2. The accompanying Medicaid Remittance and Status Report (RA) itemizes the payments and lists the number of enrollees and each enrollment month.
   3. Enrollees are listed alphabetically by name, with their Medicaid identification numbers and addresses also displayed.

C. PCP case management fees are paid according to the PCP’s direction. The PCP may choose to have the case management fee paid to his or her individual provider ID number or to the group provider ID number with whom the PCP is affiliated.

D. If the PCP’s case management fees are paid to a group and the PCP changes his or her affiliation, the PCP must submit a new PCP Agreement Form to Provider Enrollment within thirty (30) calendar days of changing affiliation. The PCP must also notify the beneficiaries on his or her caseload of the change.

E. If a PCP fails to submit a new PCP Agreement Form, the case management fees will pay to the provider of record until a new PCP Agreement Form is received by Provider Enrollment.

F. If a Group Affiliation Form is received by Provider Enrollment to disassociate a PCP from a group but the PCP Agreement Form is not received, the case management fees will be paid to the individual PCP’s provider ID number.

G. If a PCP’s case management fees were paid to a group in which the PCP is no longer affiliated, it is the responsibility of that group to reimburse Medicaid the fees they were not entitled to receive.

H. No case management fees will be back paid to a PCP who has failed to follow the process described in Paragraph D of this Section.
Electronic Funds Transfer (EFT)

- Enrollment
- Delayed payment

Authorization for Automatic Deposit

Name of Medicaid Provider ________________________________

Provider ID # ____________________________ Taxonomy Code __________________

Provider Address ______________________________________ Telephone Number ________

City, State ____________________________ Zip Code __________________________

Type of Authorization

☐ New  ☐ Change  ☐ Cancel

☐ Checking  ☐ Savings

(if not indicated will be automatically entered as checking)

ABA Transit Number __________________ Bank Account Number __________________

A COPY OF A VOIDED CHECK OR A LETTER FROM THE BANK IS REQUIRED TO VERIFY THESE NUMBERS. THE NAME ON THE VOIDED CHECK OR LETTER FROM BANK MUST MATCH THE NAME OF THE MEDICAID PROVIDER STATED ABOVE. TEMPORARY CHECKS ARE INVAlID IF THEY DO NOT HAVE THE PROVIDER’S NAME AND ADDRESS PRINTED BY THE BANK.

Name of Bank __________________________

Bank Address __________________________

City, State ____________________________ Zip Code __________________

I hereby authorize the Arkansas Medicaid Program/Title XIX, to initiate credit entries to my bank account as indicated above and the depository named above to credit the same to such account. I understand I am responsible for the validity on this form.

I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws.

Provider’s Original Signature (required)

Please return this form to:
Medicaid Provider Enrollment Unit
Hawlett Packed Enterprise
P.O. Box 8185
Little Rock, AR 72203-8185

(Rev. 10/15/05)
Contacts

- **Hewlett Packard Enterprise – APII help desk**
  - Email for general inquiries: ARKPII@hpe.com
  - Email for PCMH enrollment applications only: ARKPCMH@hpe.com
  - 501-301-8311 or 866-322-4946

- **Arkansas Foundation for Medical Care (AFMC)**
  - 501-212-8686
  - PCMH@afmc.org