ARKANSAS MEDICAID PATIENT-CENTERED MEDICAL HOME PROGRAM
POOLING REQUEST FORM

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

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

First Practice

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

Second Practice

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

Pooling Request

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

____
(Please print, stamp or type second practice name)

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

___________________________ ______________________________ ______________
For the first practice Title Date

Practice name: _____________________

Phone number: _____________________

Email address: _____________________

___________________________ ______________________________ ______________
For the second practice Title Date

Practice name: _____________________

Phone number: _____________________

Email address: _____________________

For the performance period beginning in 2015:

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

___________________________ ______________________________ ______________
Division of Medical Services Signature Title Date

ARKANSAS MEDICAID PATIENT-CENTERED MEDICAL HOME PROGRAM
PRACTICE PARTICIPATION AGREEMENT

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

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

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

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

A. This agreement may be voluntarily terminated by either party by giving written notice as required by section 211.100 of the PCMH Provider Manual;

B. This agreement may be terminated immediately by the Department for the following reasons:
   1) Returned mail;
   2) Death of provider;
   3) Change of ownership; or
   4) Other reason for which a sanction may be issued as set forth under the applicable Medicaid Provider Manual; and

C. Should the Provider Enrollment Agreement be terminated, suspended, or otherwise nullified, this agreement shall be terminated on the same terms and at the same time as the Provider Enrollment Agreement.

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

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

Office lead for Practice
Transformation:____

Title:
____

Email:
____

Signature: ____

Office lead for Care Coordination:
____

Title:
____

Email:
____

Signature: ____

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

______________________________ .
Medicaid Billing ID Number

______________________________ ______________________________ ______________
For the practice Title Date

Phone number: ____________________

Email address: ____________________

______________________________ ______________________________ ______________
Division of Medical Services Signature Title Date

Please list the physicians who are part of your practice:

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

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

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

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

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