Click below to view any of the materials in this quarter’s packets. Note: Some links will open a webpage.

NEW THIS QUARTER

ICD-10
humanservices.arkansas.gov/dms/Pages/ICD-10.aspx
  • Town Hall Meetings: Click here for dates and locations

ARKids B changes
Anticipated to begin August 1, 2015
  • Click here for more information.

Arkansas Health Care Payment Improvement Initiative (AHCPII)
paymentinitiative.org

Patient Centered Medical Home (PCMH)

- Enrollment/welcome letter
- Enrollment instructions
  • Samples
  • Blank forms
- 24/7 Best practices
- Guide to reading your PCMH quarterly report
  • Sample PCMH quarterly report
- PCMH FAQs
  paymentinitiative.org/medicalHomes/Pages/FAQs.aspx
- PCMH manual and supplemental manual
  • https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/pcmh.aspx
- PCMH QA
  afmc.org/qa
- Practice transformation
  • Qualis Health
  • Arkansas Foundation for Medical Care (AFMC)

Episodes of Care (Algorithms)
paymentinitiative.org/episodesofcare

Links

- Arkansas Medicaid Information Interchange (AMII)
  • User guide
- Dental update
  • Fluoride Varnish Initiative: “Paint a Smile”
  • Fluoride varnish policy statement
  • TFV training site
  • Visit https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/dental.aspx. Accept the copyright acknowledgement and click on “Section II.” You will find the added information in Section 217.100.
- EPSDT
  www.medicaid.state.ar.us/Provider/docs/epsdt.aspx
  • Billing sheet
  • Fee schedule
  • Foster care guidelines
  • Screenings and sick visits

CONTINUED, NEXT PAGE
Click below to view any of the materials in this quarter’s packets. Note: Some links will open a webpage.

- **MMCS Update newsletters**
  [mmcs.afmc.org/publications](mmcs.afmc.org/publications)

- **MMCS PCP packets, electronic edition**
  [mmcs.afmc.org/HealthCareProfessionals/PCPUpdatePackets.aspx](mmcs.afmc.org/HealthCareProfessionals/PCPUpdatePackets.aspx)

- **MMCS provider representative contact information**

- **PCP profile reports**
  Log in at the link below to view your report.
  [www.medicaid.state.ar.us/InternetSolution/Provider/Provider.aspx](www.medicaid.state.ar.us/InternetSolution/Provider/Provider.aspx)

- **Preferred drug list (PDL)**
  [www.medicaid.state.ar.us/download/provider/pharm/pdl.xls](www.medicaid.state.ar.us/download/provider/pharm/pdl.xls)

- **Psych TLC**
  [psychiatry.uams.edu/clinical-programs/psych-tlc/](psychiatry.uams.edu/clinical-programs/psych-tlc/)

- **Quality improvement project updates**
  - **Antibiotic resistance tip sheet update**: Visit the link below and click on “Medicaid quality improvement tools”
    [afmc.org/tools](afmc.org/tools)
  - **BreastCare**: Click on the following link for information on the BreastCare program and qualification guidelines.
    [http://www.healthy.arkansas.gov/programsServices/chronicDisease/ArBreastCare/Pages/default.aspx](http://www.healthy.arkansas.gov/programsServices/chronicDisease/ArBreastCare/Pages/default.aspx)
  - Breastfeeding
  - CT imaging in the emergency department
  - Opioids
  - Pap smear/cervical cancer screening

- **Smoking cessation codes update**

- **“What’s new” for providers**
  [www.medicaid.state.ar.us/InternetSolution/Provider/newprov.aspx](www.medicaid.state.ar.us/InternetSolution/Provider/newprov.aspx)
## 2015 Arkansas Medicaid ICD-10 Town Hall Meetings Schedule

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>CITY</th>
<th>MEETING SITE</th>
<th>ADDRESS</th>
<th>PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 7</td>
<td>Noon-1 p.m.</td>
<td>Camden</td>
<td>Camden Public Library</td>
<td>405 Cash Road</td>
<td>870-836-5083</td>
</tr>
<tr>
<td>July 7</td>
<td>6-7 p.m.</td>
<td>Hope</td>
<td>Wadley Regional Medical Center – Hope</td>
<td>2001 S. Main St.</td>
<td>903-798-8085</td>
</tr>
<tr>
<td>July 8</td>
<td>Noon-1 p.m.</td>
<td>Jonesboro</td>
<td>St. Bernards Health and Wellness Institute</td>
<td>1416 E. Matthews Ave.</td>
<td>870-207-7711</td>
</tr>
<tr>
<td>July 8</td>
<td>6-7 p.m.</td>
<td>West Memphis</td>
<td>West Memphis Public Library</td>
<td>213 N. Avalon</td>
<td>870-732-7590</td>
</tr>
<tr>
<td>July 9</td>
<td>Noon-1 p.m.</td>
<td>Searcy</td>
<td>ASU Campus, Room TE 127</td>
<td>1800 E. Moore Ave.</td>
<td>501-207-6249</td>
</tr>
<tr>
<td>July 21</td>
<td>Noon-1 p.m.</td>
<td>Fayetteville</td>
<td>Hilton Garden Inn Hotel</td>
<td>1325 N. Palek Drive</td>
<td>479-249-8804</td>
</tr>
<tr>
<td>July 21</td>
<td>6-7 p.m.</td>
<td>Ft. Smith</td>
<td>Chaffee Crossing Media Center</td>
<td>7801 Ellis</td>
<td>479-452-4554</td>
</tr>
<tr>
<td>July 22</td>
<td>6-7 p.m.</td>
<td>Little Rock</td>
<td>AFMC Offices, MPR A and B</td>
<td>1020 W. 4th St., Suite 300</td>
<td>501-212-8660</td>
</tr>
<tr>
<td>July 23</td>
<td>Noon-1 p.m.</td>
<td>Little Rock</td>
<td>AFMC Offices, MPR A and B</td>
<td>1020 W. 4th St., Suite 300</td>
<td>501-212-8660</td>
</tr>
<tr>
<td>July 28</td>
<td>Noon-1 p.m.</td>
<td>Warren</td>
<td>Warren Housing Authority</td>
<td>801 W. Central</td>
<td>870-226-2600</td>
</tr>
<tr>
<td>July 28</td>
<td>6-7 p.m.</td>
<td>Pine Bluff</td>
<td>Jefferson Regional Medical Center</td>
<td>1600 W. 40th St.</td>
<td>870-535-7271</td>
</tr>
<tr>
<td>Aug. 4</td>
<td>Noon-1 p.m.</td>
<td>Mena</td>
<td>Polk County Library</td>
<td>410 8th St.</td>
<td>479-394-2314</td>
</tr>
<tr>
<td>Aug. 4</td>
<td>6-7 p.m.</td>
<td>Hot Springs</td>
<td>National Park Community College, Lab Sciences Auditorium</td>
<td>101 College Drive</td>
<td>501-760-4223</td>
</tr>
<tr>
<td>Aug. 5</td>
<td>Noon-1 p.m.</td>
<td>Bull Shoals</td>
<td>James Gaston Visitors Center</td>
<td>153 Dam Overlook Lane</td>
<td>870-445-3629</td>
</tr>
<tr>
<td>Aug. 5</td>
<td>6-7 p.m.</td>
<td>Mountain View</td>
<td>Stone County Medical Center</td>
<td>2106 E. Main St.</td>
<td>870-269-4361</td>
</tr>
<tr>
<td>Aug. 6</td>
<td>Noon-1 p.m.</td>
<td>Russellville</td>
<td>Pope County Library, Heritage Hall</td>
<td>113 E. 3rd St.</td>
<td>479-968-4968</td>
</tr>
<tr>
<td>Aug. 6</td>
<td>6-7 p.m.</td>
<td>Conway</td>
<td>Conway Regional Medical Center</td>
<td>2302 College Ave.</td>
<td>501-450-2111</td>
</tr>
</tbody>
</table>
July 14, 2015

Dear Provider,

You recently received communication regarding vaccine program changes for ARKids-B beneficiaries. This letter is to provide additional information and clarify requirements for vaccine storage.

As previously announced, it is anticipated that on Aug. 1, ARKids-B beneficiaries will no longer be eligible for the VFC program. ARKids-B beneficiaries will still be eligible for vaccines through the ARKids-B SCHIP Vaccines Program. Vaccines for ARKids-B beneficiaries can be obtained by contacting Bill Ledford at the Arkansas Department of Health (ADH) by calling 501-661-2723 or emailing William.ledford@arkansas.gov.

Providers must differentiate between SCHIP and VFC vaccines for auditing purposes due to the funding source. In addition to clearly labeling the VFC and ARKids-B SCHIP vaccine vials, providers must separate the vaccines by one of the following ways:

- Placing the vaccines on separate shelves in the refrigeration unit
- Labeling a split box with a Sharpie or by utilizing stickers
- Placing the vaccines in separate refrigeration devices

Please note that while storage in separate refrigeration units is one option, it is not a requirement.

A tool kit has been provided by ADH that provides information on proper vaccine handling and storage, which can be accessed online at http://www.cdc.gov/vaccines/recs/storage/toolkit/storage-handling-toolkit.pdf.

Sincerely,

Department of Human Services
Division of Medical Services
July 1, 2015

As you begin this journey to become a patient centered medical home, we wanted to highlight the upcoming requirements and their due dates as well as the resources DHS is making available.

Shared Savings
You are eligible to participate in shared savings incentive payments based on your enrollment.

■ To receive shared savings incentive payments, your pooled entity must have a minimum of 5,000 beneficiaries attributed to you for a minimum of 6 months during the entire performance period.

■ To receive a shared savings incentive payment, the shared savings entity must meet at least two-thirds of the quality metrics on which the entity is assessed and must also be eligible for practice support.

Selecting high-priority beneficiaries and other practice support activities

■ You will be eligible to receive quarterly care coordination payments if you meet the program requirements for practice support.

■ In July, you should begin using the provider portal at https://secure.ahin-net.com/ahin/logon.jsp to complete activities and provide self-reported information.

■ The portal is the place for you to complete the first practice support activity: selecting the top 10% of high-priority beneficiaries. This activity is due by March 31, 2015.

■ The portal is also the place for you to complete all activities. Both the 6-month and 12-month activities will be due by December 31, 2015.

Payments for Care Coordination

■ The total attributed beneficiaries for each quarter will determine your payment amount. Payments will be processed quarterly, paid in the first month of the quarter.

■ If there are changes in the number of your practice’s beneficiaries, the next quarterly payment will contain adjustments.

Practice transformation support

■ As of January 1, 2015, your practice will be eligible to receive practice transformation support from DHS through our vendors, Qualis Health and Arkansas Foundation for Medical Care (AFMC).

■ Qualis Health and AFMC could be helpful partners if your practice is asking questions like the following: How have other practices transformed into a PCMH? What tools are available? What best practices exist? What should the roadmap look like for my practice?
For more information on the services Qualis Health can provide your practice, see http://www.qhmedicalhome.org/arkansas or contact the program manager, Stephen Tonguis stephent@qualishealth.org 501-517-3013

For more information on the services AFMC can provide your practice, contact Rhelinda McFadden at rmcfadden@afmc.org or 501-212-8762.

Quarterly reports on your practice performance

- Reports, containing data on your practice’s performance, will be available in mid-February 2015 on the provider portal (https://secure.ahin-net.com/ahin/logon.jsp).
- Samples of past reports, along with report guides that explains the content, are available on the APII website (www.paymentinitiative.org).

As you become familiar with your data, reports, and the PCMH initiative, please keep in mind that you should continue to submit and will receive reimbursement for claims as you do today.

For more information on PCMH, we encourage you to visit the visit the APII website at www.paymentinitiative.org to:
- Access the provider portal and download current/prior informational and performance reports.
- View current and upcoming performance periods.
- Obtain training (webinars), materials, and frequently asked questions.

If information on your enrollment application changes, please report the changes to the Patient-Centered Medical Home Enrollment Unit by fax 501-374-0549 or email to ARKPCMH@hp.com within 30 days.

If you have questions regarding your Patient-Centered Medical Home enrollment or the program, please contact the HP Enterprise Services Arkansas Health Care Payment Improvement Unit at 1-866-322-4696 (in-state) or 1-501-301-8311 (local and out-of state) or email ARKPCMH@hp.com.
How to enroll: Accessing the forms

1. Go to: https://secure.ahin-net.com/ahin/logon.jsp and login
2. Choose “APII Portal”
3. Choose “Download PCMH enrollment form” under “Enroll”
   - If you plan to pool for shared savings, download the pooling form next
How to enroll: Completing the forms

5. Complete PCMH practice participation agreement

Office lead for practice transformation & for care coordination can be the same or different people

A provider can only register with one PCMH

6. If pooling, complete PCMH pooling form

Both practices choosing to pool must submit a completed PCMH pooling form listing their pooling partner practice

- Remember to answer EVERY question on the forms
- Do not leave any question blank
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**

<table>
<thead>
<tr>
<th></th>
<th>First Practice Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Practice name (must match name on PCMH enrollment contract): The Best Little Clinic in Arkansas</td>
</tr>
<tr>
<td></td>
<td>(Please print, stamp or type practice name)</td>
</tr>
<tr>
<td>2</td>
<td>Practice address: 111 Best St.</td>
</tr>
<tr>
<td></td>
<td>Best City, AR</td>
</tr>
<tr>
<td>3</td>
<td>Practice Medicaid Billing ID Number: 123456789</td>
</tr>
<tr>
<td>4</td>
<td>National Provider Identifier: 9876543212</td>
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</tbody>
</table>

**Second Practice**

<table>
<thead>
<tr>
<th></th>
<th>Second Practice Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Practice name (must match name on PCMH enrollment contract): Kids' Choice Arkansas Pediatrics</td>
</tr>
<tr>
<td></td>
<td>(Please print, stamp or type practice name)</td>
</tr>
<tr>
<td>7</td>
<td>Practice address: 123 Kids Rd</td>
</tr>
<tr>
<td></td>
<td>Children's Valley, AR 99999</td>
</tr>
<tr>
<td>8</td>
<td>Practice Medicaid Billing ID Number: 121212121</td>
</tr>
<tr>
<td>9</td>
<td>National Provider Identifier: 3333333334</td>
</tr>
</tbody>
</table>
Pooling Request

By signing this form, 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
Practice name: The Best Little Clinic in Arkansas
Phone number: 501-111-1212
Email address: Jchildrens@BLCA.COM

For the second practice
Practice name: Kids' Choice Arkansas Pediatrics
Phone number: 870-999-0202
Email address: Apeoples@ncap.com

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 ___________________________
This agreement is made and entered into between The Best Little Clinic in Arkansas (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: Jane Smith
Title: Office Manager
Email: jsmith@blca.com
Signature: Jane Smith

Office lead for Care Coordination: Jane Smith
Title: Office Manager
Email: jsmith@blca.com
Signature: Jane Smith

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

123456789
Medicaid Billing ID Number

DMS-TBD (Rev. TBD)
Please list the physicians who are part of your practice:

1. Physician Name: Dr. John Childrens  
   Individual Medicaid Provider ID: 1543298760  
   NPI: 1987654321  
   Signature:  

2. Physician Name: Dr. Louise Allages  
   Individual Medicaid Provider ID: 1876543291  
   NPI: 2345678912  
   Signature:  

3. Physician Name: Dr. Mary Toddlers  
   Individual Medicaid Provider ID: 1765432981  
   NPI: 3456789122  
   Signature:  

4. Physician Name: Dr. Tom Elders  
   Individual Medicaid Provider ID: 1654329871  
   NPI: 4567891222  
   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.
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**

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1</td>
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</tr>
<tr>
<td></td>
<td>(Please print, stamp or type practice name)</td>
</tr>
<tr>
<td>2</td>
<td>Practice address: _____________________________________________________________________</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Practice Medicaid Billing ID Number:</td>
</tr>
<tr>
<td>4</td>
<td>National Provider Identifier:</td>
</tr>
</tbody>
</table>

**Second Practice**

<p>| | |</p>
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</tr>
<tr>
<td>7</td>
<td>Practice address: _____________________________________________________________________</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Practice Medicaid Billing ID Number:</td>
</tr>
<tr>
<td>9</td>
<td>National Provider Identifier:</td>
</tr>
</tbody>
</table>
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
Practice name: ________________
Phone number: ________________
Email address: ________________

For the second practice
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
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
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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: _________________________________________________________________________

DMS-844 (1/14)
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.
Best Practices for Providing After-Hours Care

Providing full continuity of care for patients requires physicians to provide some sort of system to handle patient crises after hours and on weekends. When communication is not available, patients either seek more expensive ER care or deteriorate, leading to more serious complications. Providing 24/7 physician communications is evolving as a professional standard of care and is an integral part of the medical home. Where improved after-hours communications have been implemented, patient satisfaction has increased and ER utilization has declined.

**BEST PRACTICES**

- PCPs should have an after-hours system in place that ensures that patients can reach the PCP or another on-call medical professional with medical concerns or questions.
- This system should connect callers with a live voice — either an answering service or after-hours personnel — who should either forward patient calls directly to the on-call professional or instruct callers that the professional will return the call within 30 minutes.
- The answering service or after-hours personnel should ask the caller if the situation is an emergency. If so, the caller should be told to call 911 or go straight to the nearest ER.
- If staff or an answering service is not immediately available, the PCP/clinic may use an answering machine with a recorded message that directs callers to call 911 if they have an emergency, and to dial an alternate number (or system prompt) to reach an on-call professional.
- PCPs may provide access to an on-call professional through arranging with other PCPs to rotate call, or by contracting with a triage hotline service staffed by nurses or other clinical personnel.
- Records of after-hours calls should be made and entered into the patient’s chart.

**AFTER-HOURS CARE PRACTICE ASSESSMENT**

To gauge your practice’s performance in providing after-hours care, answer the following questions:

- Does your clinic provide access to a medical professional — either an on-call provider or a telephone triage service staffed by clinical personnel — to give callers voice-to-voice medical advice and guidance 24 hours, seven days a week?
- Does your clinic use an answering service or clinic staff to answer after-hours calls?
- If not, does your clinic use an answering machine that directs callers to dial an alternate number or system prompt to reach a live voice?
- If your clinic uses an answering machine, do you check it regularly to make sure it’s working properly and the recorded message is current?
- Are non-emergency calls returned by a medical professional within 30 minutes?
- Are after-hours calls and their results documented and entered into patient records?
Example answering machine greeting

1. “You have reached [clinic name].”

2. “If this is an emergency, please hang up and dial 911 or go to the nearest hospital emergency room.”

3. “If this is not an emergency and you would like to speak to an on-call doctor or nurse, please dial [answering service, on-call pager number, triage hotline number, etc].”

4. If the alternate number is to an on-call pager, add: “A medical professional will return your call within 30 minutes.”

PROCESS FOR RECORDING AFTER-HOURS CALLS INTO A PATIENT’S CHART

- Check answering machine
- Retrieve messages
- Retrieve patient’s chart
- Document call in chart

FOLLOW UP:
- Contact patient and set appointment
- Contact patient and give referral
- Contact patient and counsel

For more information, contact your MMCS provider representative.
This guide explains how to read your Q1 report and can help you:
- Find specific information in the report
- Understand the connection between sections of the report and program requirements

Things to know about your Q1 PCMH report
- The report provides information based on historical data
  - Data is displayed in rolling one-year time periods; exact timeframes are noted on each page
  - The timeframes in the Q1 report do not intersect with the performance period and thus are not tied to continuation of practice support
- The report shows information about your PCMH practice
  - For pooled practices, the information for your shared savings entity will be provided in the Q2 PCMH report
  - All PCMHs will receive a shared savings report, even though not all PCMHs are eligible for shared savings

The PCMH program seeks to reward primary care physicians for high-quality care that drives system-wide quality and efficiency. The PCMH program is part of the Arkansas Health Care Payment Improvement Initiative, a multi-payer collaboration between Arkansas Medicaid, Arkansas Blue Cross Blue Shield, and QualChoice of Arkansas.

Visit us online to login to the portal and access PCMH resources
Our website www.paymentinitiative.org has details on:
- PCMH details, methodology, and links to resources
- Where to direct your questions and how to share feedback
- Upcoming and archived events such as Town Halls
- Upcoming and archived WebEx informational sessions

The website also has a link to the online portal. Use a secure username and password to:
- View your full report
- Submit required program data
Your report provides information on four areas

Summary data (page 2 of report)
The summary page gives basic data for your PCMH, as well as a summary of the requirements for practice support and shared savings payments once the performance period begins.

Practice support data (page 3 and 4 of report)
The practice support report includes both a progress report on activities and a historical view on practice support metrics. These two elements will be tied to practice support payments (PMPM) during the performance period.

Shared savings data (page 5 and 6 of report)
The shared savings report shows a historical view of costs and of the quality metrics that will be tied to shared savings incentive payments during the performance period.

Additional data (page 7 of report)
The additional data page provides a historical view on utilization metrics. These metrics will not be tied to either practice support or shared savings payments, and they are only for your planning purposes.
How to interpret your summary data (part 1 of 2)

Summary page

PCMH overview

The overview gives basic facts about your practice as of the time periods specified

- "Attributed beneficiaries" shows the number of beneficiaries that were attributed to your PCMH as of December 1, 2013
- "Beneficiaries attributed to you for at least 6 months" counts only beneficiaries assigned to primary care physicians in your PCMH for at least 6 months in the report period
- The "Risk score" is based on an average across all beneficiaries attributed to your PCMH for at least 6 months. Additional description of the risk score is available in section D on the next page of this guide.

Practice support progress report summary

This section provides two main data points: estimated care coordination payments and requirements to sustain practice support

- Care coordination estimates are based on historical numbers and the risk profile of patients
- Practice support has two requirements, both of which must be met in order to sustain practice support

Requirements to sustain practice support

Meet all Practice Support Activities - 6 of 6 activities due by June 30th, 2014 (p. 3)

Meet majority of Practice Support metrics - at least 3 of 4 metrics by Dec 31, 2014 (p. 4)

Note: CPC practices will be held accountable to different requirements as outlined in the CPC program requirements

Shared savings eligibility summary

This section displays pre-defined requirements to receive shared savings incentive payments

- PCMH must meet all practice support requirements, as indicated by the second box
- The PCMH total cost of care is compared to both the medium cost threshold as well as the PCMH-specific benchmark; both of these parameters are pathways to shared savings
Additional utilization metrics summary for informational purposes only

This section introduces risk cohorts, which will be used in the Q2 report to enable you to compare data against similar practices (for informational purposes only):

- Risk cohorts are based on the PCMH’s average risk score
- Only practices enrolled in PCMH are included
- A cohort of practices with similar risk scores will be used in your Q2 report to allow comparisons to these practices. The comparison will be informational only and not tied to payments.
- Your Q1 report displays your utilization metrics, but not in comparison to other practices.
Understanding the status of your practice support activities

Activities progress report

| Practice support activities status based on provider portal entries as of 12/31/2013 |
| Legend: 🔺 Submitted subject to verification | ✗ Not submitted | N/A Not due yet |

Enrollment effective: 1/1/14

<table>
<thead>
<tr>
<th>Practice support activity</th>
<th>Due date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identify top 10% of high priority beneficiaries (to be reviewed annually)</td>
<td>3/31/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>2...</td>
<td>...</td>
<td>...</td>
</tr>
</tbody>
</table>

Pre-defined activities come from the provider manual

- The provider portal at https://secure.ahin-net.com/ahin/logon.jsp should be used to submit materials for completed activities. You can also link to the provider portal on www.paymentinitiative.org.
- For the baseline report, the status of all activities will be marked as “N/A”—not due yet. For future reports, the status will show a green check whenever the activities have been completed.
How to interpret the legend for metrics charts

Legend for metrics charts

The legend applies to the following sections of the report: practice support (page 4), shared savings (pages 5 and 6), and additional utilization data (page 7)
- These symbols indicate whether historical data meets qualifying levels
- In instances where there are less than 25 beneficiaries, that metric will not be evaluated
  - For example, if two out of the nine quality metrics cannot be evaluated, the PCMH would have to meet two-thirds of the seven evaluated quality metrics

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Legend description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔</td>
<td>Meeting qualifying level</td>
<td>The historical data in this report (7/1/2012 – 6/30/2013) meets qualifying levels for the metric</td>
</tr>
<tr>
<td>✗</td>
<td>Not meeting qualifying level</td>
<td>The historical data in this report (7/1/2012 – 6/30/2013) does not meet qualifying levels for the metric</td>
</tr>
<tr>
<td>⏳</td>
<td>To be reported pending provider portal data</td>
<td>Metric data relies on data reported in the provider portal that is not yet due</td>
</tr>
<tr>
<td>○</td>
<td>Not enough beneficiaries to be evaluated</td>
<td>The data for the metric must be based on at least 25 applicable beneficiaries in order for the metric to be evaluated. Metrics not evaluated will be omitted for the purposes of meeting program requirements</td>
</tr>
</tbody>
</table>

1 Relevant to charts and metrics for practice support (page 4), shared savings (pages 5 and 6), and additional utilization data (page 7) sections of the report
How to read metrics charts

Metrics charts

The format of metrics charts are consistent across practice support metrics (page 4), shared savings metrics (pages 5 and 6), and additional utilization metrics (page 7)

- Utilization metrics do not show qualifying levels because metrics are not evaluated as part of the PCMH program requirements
- Refer to the provider manual and provider manual attachments for details on exclusions for each metric

The methodology for calculating each metric is shown in the definition

This report’s time period is labeled here in the header

Metrics chart

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
<th>You (7/1/12-5/30/13)</th>
<th>Rolling 12 month performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of 1-15 month beneficiaries with at least four wellness visits</td>
<td>40</td>
<td></td>
<td>80</td>
</tr>
<tr>
<td>Qualifying level: 257</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pre-published qualifying levels from the provider manual

The numbers reflect the patients in your PCMH who are included in this measure

Each point on the chart represents a rolling 12 months' worth of data for the time period labeled on the x-axis

The result for this report’s time period is shown in green font if qualifying levels are met, red font if qualifying levels are not met and black font if there are not enough beneficiaries to evaluate this metric

---

1 Relevant to charts and metrics for practice support (page 4), shared savings (pages 5 and 6), and additional utilization data (page 7) sections of the report
Understanding your cost data

Cost data

Performance relative to thresholds

Risk adjusted average beneficiary cost per year

- Dollars

- Your 2010-2012 weighted average costs
  - $2,032
  - $2,718

- Low cost
- Medium cost
- High cost

Cost data is displayed in the shared savings section of the report (page 5)

- Though costs are shown for every PCMH, only those with at least 5,000 beneficiaries that are attributed for at least 6 months will be eligible for shared savings incentive payments.
- All costs are in per beneficiary per year numbers that have been adjusted by both risk score and member months of the patient.

A. Your baseline total cost of care based on a weighted average of 2010-2012 costs

B. 2014 medium cost threshold

C. 2014 high cost threshold

Current cost information shows comparison of baseline cost to statewide thresholds

A. Your 2010-2012 weighted average cost is your baseline cost.

B. $2,032 is the medium cost threshold. A total cost of care below the medium cost threshold is in the low cost range. This is the threshold you will be measured against in the 2014 performance period.

C. $2,718 is the high cost threshold. A total cost of care between the medium and high cost thresholds is in the medium cost range, while a total cost of care above the high cost threshold is in the high cost range.

Note: See Section 237 of the provider manual for a detailed calculation of the shared savings incentive payment and how it relates to the medium and high cost thresholds shown here.

Note: Your Q2 reports will show a more recent historical total cost of care.

Contact our knowledgeable provider support teams with questions and feedback

- Arkansas Medicaid: 1-866-322-4696 (in-state) or 1-501-301-8311 (local and out-of-state) or ARKPII@hp.com.
Building a healthier future for all Arkansans

Arkansas Health Care Payment Improvement Initiative
Your Practice Baseline Report

Medicaid
Little Rock Clinic
Report date: TBD
Historical performance: 07/01/12 – 06/30/13

DISCLAIMER: The information contained in these reports is intended solely for use in the administration of the Medicaid program. The data in the reports is neither intended nor suitable for other uses, including the selection of a health care provider. For more information, please visit www.paymentinitiative.org
Dear Medicaid Provider,

Through the Arkansas Healthcare Payment Improvement Initiative (APII), the State aims to create a sustainable multi-payer patient-centered health care system that embraces the Triple Aim of improving (1) population health, (2) patients' experience of care, and (3) cost effectiveness of care. We are accomplishing this by transforming from a fragmented, fee-for-service model to a model that rewards and supports providers who consistently deliver high-quality, coordinated, and cost-effective care. In particular, the Patient Centered Medical Home (PCMH) initiative rewards primary care physicians through practice support and upside-only shared savings for managing patient health needs.

Practice support includes both care coordination payments and practice transformation support. To maintain eligibility for practice support, an enrolled PCMH must meet practice support metrics and successfully complete pre-defined activities. In addition, a PCMH with at least 5,000 beneficiaries attributed during the majority of the performance period may qualify for shared savings by meeting the quality metrics and managing costs.

As an enrolled PCMH, you are receiving this informational report that shows a historical view on practice support metrics and quality metrics to help you plan for the performance period. Since the performance period begins on January 1, 2014, payment will not be affected by whether qualifying levels are met in this report. Furthermore, the data for some metrics may not be included because the metrics depend on activities that are not yet required. Nevertheless, to aid you in your role as a PCMH, the previously announced qualifying levels and the available historical data are provided here.

In addition to the report, you should begin using the provider portal at www.paymentinitiative.org to complete activities and provide self-reported information. As you become familiar with your data, reports, and the PCMH initiative, please keep in mind that you should continue to submit and will receive reimbursement for claims as you do today.

We encourage you to visit the APII website at www.paymentinitiative.org to:
- Access the provider portal and download current/prior informational and performance reports.
- View current and upcoming performance periods.
- Obtain training (webinars), materials, and frequently asked questions.

We have been working diligently to solicit feedback from the provider community. You can contact us with questions at 1-866-322-4696, locally at 501-301-8311, or via email ARKPII@hp.com.

Additionally, be sure to check the website regularly for updates or to sign up for alerts.

Sincerely,

Andy Allison, PhD
Medicaid Director

DISCLAIMER: The information contained in these reports is intended solely for use in the administration of the Medicaid program. The data in the reports is neither intended nor suitable for other uses, including the selection of a health care provider. These figures are preliminary and are subject to revision. For more information, please visit www.paymentinitiative.org.
PCMH report overview
State Fiscal Year 2013 services paid through September 30, 2013

Practice overview

Attributed beneficiaries, Dec 2013

<table>
<thead>
<tr>
<th>Your practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>6,000</td>
</tr>
</tbody>
</table>

Beneficiaries attributed to you for at least 6 months, 07/01/12 – 06/30/13
(5,000 required during performance period for shared savings eligibility)

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5,200</td>
</tr>
</tbody>
</table>

Risk score, 07/01/12-06/30/13

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.11</td>
</tr>
</tbody>
</table>

Practice support progress report (pages 3-4)

Practice support payment description

- Risk adjusted payment for care coordination
- Your estimated per beneficiary per month payment is $3.22

Requirements to sustain practice support

Meet all Practice Support Activities – 6 of 6 activities due by June 30th, 2014 (p. 3)

Meet majority of Practice Support metrics – at least 3 of 4 metrics by Dec 31, 2014 (p. 4)

Shared savings eligibility (pages 5-6)

Shared savings description

- Calculated based on risk adjusted average cost per beneficiary
- Reward that is greater of
  - Performance relative to thresholds or
  - Performance relative to your benchmark

Requirements to receive incentive payments

5,000 or more beneficiaries attributed to your practice for at least 6 months (p. 2)

Meet requirements for practice support (p. 3, 4)

Meet two-thirds of assessed quality metrics (p. 5,6)

Risk-adjusted average cost per beneficiary less than the medium cost threshold (p. 5)

Risk-adjusted average cost per beneficiary less than your benchmark cost for performance period (p. 6)

Additional utilization metrics for informational purposes only (page 7)

- Additional utilization metrics are not tied to payment
- Metrics are intended to inform improvement efforts
- Risk cohorts – practices with similar risk scores – will be used in future reports to provide comparison

<table>
<thead>
<tr>
<th>Risk Cohort</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
<th>VI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range of risk scores*</td>
<td>0–0.4</td>
<td>0.4–0.8</td>
<td>0.8–1.2</td>
<td>1.2–1.6</td>
<td>1.6–2</td>
<td>&gt; 2</td>
</tr>
<tr>
<td>Practices</td>
<td>30</td>
<td>131</td>
<td>278</td>
<td>149</td>
<td>85</td>
<td>139</td>
</tr>
<tr>
<td>Your practice risk score</td>
<td>1.11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Cohorts include the high-end of the range but not the low-end of the range
# Practice support progress report

**Practice support activities status based on provider portal entries as of 12/31/2013**

**Legend:** ✓ Submitted subject to verification ✗ Not submitted N/A Not due yet

**Enrollment effective: 1/1/14**

<table>
<thead>
<tr>
<th>Practice support activity</th>
<th>Due date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identify top 10% of high priority beneficiaries (to be reviewed annually)</td>
<td>3/31/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Assess operations of practice and opportunities to improve</td>
<td>6/30/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>3. Develop and record strategies to implement care coordination &amp; practice transformation</td>
<td>6/30/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Identify and reduce medical neighborhood barriers to coordinated care at the practice level.</td>
<td>6/30/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>5. Provide 24/7 access to care. Provide telephone access to a live voice or to an answering machine that immediately pages an on-call professional</td>
<td>6/30/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>6. Document approach to tracking access to same-day appointments</td>
<td>6/30/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>7. Document approach to contacting beneficiaries who have not received preventive care</td>
<td>12/31/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>8. Complete survey related to timeliness of patients’ access to specialists</td>
<td>12/31/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>9. Document investment in healthcare technology or tools that support practice transformation</td>
<td>12/31/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>10. Join SHARE to get inpatient discharge information from hospitals. Document compliance.</td>
<td>12/31/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>11. Review/adjust top 10% of high priority beneficiaries</td>
<td>3/31/2015</td>
<td>N/A</td>
</tr>
<tr>
<td>12. Incorporate e-prescribing into practice workflows</td>
<td>6/30/2015</td>
<td>N/A</td>
</tr>
<tr>
<td>13. Integrate EHR into practice workflows</td>
<td>12/31/2015</td>
<td>N/A</td>
</tr>
<tr>
<td>14. Re-assess operations of practice and opportunities to improve</td>
<td>12/31/2015</td>
<td>N/A</td>
</tr>
<tr>
<td>15. Refine strategy to implement care coordination &amp; practice transformation improvements</td>
<td>12/31/2015</td>
<td>N/A</td>
</tr>
</tbody>
</table>
# Practice support progress report

State Fiscal Year 2013 services paid through September 30, 2013

## Practice support metrics

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
<th>You (7/1/12-6/30/13)</th>
<th>Rolling 12 month performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of high priority beneficiaries that have a care plan in medical record</td>
<td># with a care plan</td>
<td>Pending provider portal data</td>
<td>High priority beneficiaries must be selected through the provider portal. Once that information is entered and processed, this metric will be displayed.</td>
</tr>
<tr>
<td>Qualifying level: ≥70</td>
<td># high-priority beneficiaries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of high priority beneficiaries seen by PCP at least twice in past 12 months</td>
<td># seen by PCP at least 2x in past 12 months</td>
<td>Pending provider portal data</td>
<td>High priority beneficiaries must be selected through the provider portal. Once that information is entered and processed, this metric will be displayed.</td>
</tr>
<tr>
<td>Qualifying level: ≥67</td>
<td># high-priority beneficiaries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of beneficiaries who had an inpatient stay that saw a health provider within 10 days of discharge</td>
<td># seen by a health provider</td>
<td>20 / 100 = 20%</td>
<td></td>
</tr>
<tr>
<td>Qualifying level: ≥33</td>
<td># discharges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of time ED visits can be classified as non-emergent</td>
<td>% of ED visits expected to be non-emergent (NYU algorithm)</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Qualifying level: ≤50</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Shared savings progress report
State Fiscal Year 2013 services paid through September 30, 2013

Cost performance summary
Data is practice-level. Participating practices in a shared savings entity will receive a pool-level report at a later date.

Performance relative to thresholds
Risk adjusted average beneficiary cost per year
Dollars

- Your 2010-2012 weighted average costs
  - Low cost: $2,032
  - Medium cost: $2,718
  - High cost: $TBD

Performance relative to benchmark
Risk adjusted average beneficiary cost per year
Dollars

N/A will be calculated during performance period for practices eligible for shared savings based on volume of attributed beneficiaries

- Your benchmark cost this year
- You this year (adjusted)

Shared Savings quality metrics (1 of 2)

- Your rolling 12-month performance

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
<th>You (7/1/12-6/30/13)</th>
<th>Rolling 12 month performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of 1-15 month beneficiaries with at least four wellness visits*</td>
<td># 1-15 month old beneficiaries with at least four wellness visits / # beneficiaries 1-15 months</td>
<td>40 / 50 = 80%</td>
<td><img src="image1" alt="Graph" /></td>
</tr>
<tr>
<td>% of 3-6 year beneficiaries with wellness visits*</td>
<td># 3-6 year old beneficiaries with wellness visits / # beneficiaries 3-6 years</td>
<td>40 / 50 = 80%</td>
<td><img src="image2" alt="Graph" /></td>
</tr>
<tr>
<td>% of 12-21 year beneficiaries with wellness visits*</td>
<td># 12-21 year old beneficiaries with wellness visits / # beneficiaries 12-21 years</td>
<td>16 / 20 = 80%</td>
<td><img src="image3" alt="Graph" /></td>
</tr>
</tbody>
</table>

Qualifying level:
- % of 1-15 month beneficiaries with at least four wellness visits*: ≥67
- % of 3-6 year beneficiaries with wellness visits*: ≥67
- % of 12-21 year beneficiaries with wellness visits*: ≥40

*Age ranges are from HEDIS metrics and not meant to cover all ages
## Shared savings quality metrics (2 of 2)

### % of diabetes beneficiaries who receive annual HbA1C testing

**Qualifying level:** ≥75

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
<th>You (7/1/12-6/30/13)</th>
<th>Rolling 12 month performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of diabetes beneficiaries who receive annual HbA1C testing</td>
<td># with HbA1C testing / # diabetic beneficiaries</td>
<td>40 / 50 = 80%</td>
<td><img src="image1.png" alt="Graph" /></td>
</tr>
</tbody>
</table>

### % of beneficiaries on appropriate asthma medications

**Qualifying level:** ≥70

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
<th>You (7/1/12-6/30/13)</th>
<th>Rolling 12 month performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of beneficiaries on appropriate asthma medications</td>
<td># with appropriate Rx / # beneficiaries with asthma</td>
<td>40 / 50 = 80%</td>
<td><img src="image2.png" alt="Graph" /></td>
</tr>
</tbody>
</table>

### % of CHF beneficiaries on beta-blockers

**Qualifying level:** ≥40

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
<th>You (7/1/12-6/30/13)</th>
<th>Rolling 12 month performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of CHF beneficiaries on beta-blockers</td>
<td># on beta-blockers / # CHF beneficiaries</td>
<td>40 / 50 = 80%</td>
<td><img src="image3.png" alt="Graph" /></td>
</tr>
</tbody>
</table>

### % of women ages 50 – 69 screened for breast cancer in the past 24 months

**Qualifying level:** ≥50

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
<th>You (7/1/12-6/30/13)</th>
<th>Rolling 12 month performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of women ages 50 – 69 screened for breast cancer in the past 24 months</td>
<td># with follow-up visits / # women ages 50 - 69</td>
<td>40 / 50 = 80%</td>
<td><img src="image4.png" alt="Graph" /></td>
</tr>
</tbody>
</table>

### % of beneficiaries on thyroid drugs with a TSH test in the past 24 months

**Qualifying level:** ≥80

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
<th>You (7/1/12-6/30/13)</th>
<th>Rolling 12 month performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of beneficiaries on thyroid drugs with a TSH test in the past 24 months</td>
<td># with a TSH test in past 18 months / # beneficiaries on thyroid drugs</td>
<td>40 / 50 = 80%</td>
<td><img src="image5.png" alt="Graph" /></td>
</tr>
</tbody>
</table>

### % of 6-12 yr. olds who had a follow-up visit within 30 days of ADHD prescription initiation

**Qualifying level:** ≥25

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
<th>You (7/1/12-6/30/13)</th>
<th>Rolling 12 month performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of 6-12 yr. olds who had a follow-up visit within 30 days of ADHD prescription initiation</td>
<td># with follow-up visit within 30 days / # beneficiaries 6 – 12 with a dispensed ambulatory ADHD prescription</td>
<td>40 / 50 = 80%</td>
<td><img src="image6.png" alt="Graph" /></td>
</tr>
</tbody>
</table>
## Additional utilization data

State Fiscal Year 2013 services paid through September 30, 2013

### Utilization metrics*

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
<th>You (7/1/12-6/30/13)</th>
<th>Rolling 12 month performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient admissions/1000 attributed beneficiaries</td>
<td>Inpatient admissions [\frac{70}{700} \times 1000 = 100]</td>
<td>130</td>
<td>01/01/12-12/31/12 04/01/13-03/31/13 07/01/12-06/30/13</td>
</tr>
<tr>
<td>30 day readmission rate</td>
<td>[\frac{# \text{ readmission within 30 days}}{# \text{ IP admissions}} = \frac{20}{50} = 40%]</td>
<td>50</td>
<td>01/01/12-12/31/12 04/01/13-03/31/13 07/01/12-06/30/13</td>
</tr>
<tr>
<td>Billed Emergency department visits/1000 attributed beneficiaries</td>
<td>[\frac{ED \text{ visits}}{1000 \text{ attributed beneficiaries}} \times 1000 = 500]</td>
<td>450</td>
<td>01/01/12-12/31/12 04/01/13-03/31/13 07/01/12-06/30/13</td>
</tr>
</tbody>
</table>

*Your rolling 12 month performance

**X of your attributed beneficiaries went to the emergency room 12 or more times this year

### Cost metrics will be added in quarterly report

*Utilization metrics are intended to inform your practice improvement efforts. These metrics are not tied to payment.
Dynamic mockups for CPCi practices - replace appropriate pages with the following pages for CPCi practices
PCMH report overview

State Fiscal Year 2013 services paid through September 30, 2013

Practice overview

Attributed beneficiaries, Dec 2013

Your practice

6,000

Beneficiaries attributed to you for at least 6 months, 07/01/12 – 06/30/13
(5,000 required during performance period for shared savings eligibility)

Your practice

5,200

Risk score, 07/01/12-06/30/13

Your practice

1.11

Practice support progress report (pages 3-4)

Practice support payment description

- Risk adjusted payment for care coordination

- Your estimated per beneficiary per month payment is $0

Requirements to sustain practice support

Meet all Practice Support Activities – 6 of 6 activities due by June 30th, 2014 (p. 3)

Meet majority of Practice Support metrics – at least 3 of 4 metrics by Dec 31, 2014 (p. 4)

Shared savings eligibility (pages 5-6)

Shared savings description

- Calculated based on risk adjusted average cost per beneficiary

- Reward that is greater of
  - Performance relative to thresholds
  - Performance relative to your benchmark

Requirements to receive incentive payments

5,000 or more beneficiaries attributed to your practice for at least 6 months (p. 2)

Meet requirements for practice support (p. 3, 4)**

Meet two-thirds of assessed quality metrics (p. 5,6)

Risk-adjusted average cost per beneficiary less than the medium cost threshold (p. 5)

AND/OR

Risk-adjusted average cost per beneficiary less than your benchmark cost for performance period (p. 6)

Additional utilization metrics for informational purposes only (page 7)

- Additional utilization metrics are not tied to payment
- Metrics are intended to inform improvement efforts
- Risk cohorts – practices with similar risk scores – will be used in future reports to provide comparison

<table>
<thead>
<tr>
<th>Risk Cohort</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
<th>VI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range of risk scores*</td>
<td>0–0.4</td>
<td>0.4–0.8</td>
<td>0.8–1.2</td>
<td>1.2–1.6</td>
<td>1.6–2</td>
<td>&gt; 2</td>
</tr>
<tr>
<td>Practices</td>
<td>30</td>
<td>131</td>
<td>278</td>
<td>149</td>
<td>85</td>
<td>139</td>
</tr>
</tbody>
</table>

* Cohorts include the high-end of the range but not the low-end of the range
** CPCi practices must meet CPCi care management standards to receive shared savings
# Practice support progress report*

*Practice support activities status based on provider portal entries as of 12/31/2013*

<table>
<thead>
<tr>
<th>Practice support activity</th>
<th>Due date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identify top 10% of high priority beneficiaries (to be reviewed annually)</td>
<td>3/31/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Assess operations of practice and opportunities to improve</td>
<td>6/30/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>3. Develop and record strategies to implement care coordination &amp; practice transformation</td>
<td>6/30/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Identify and reduce medical neighborhood barriers to coordinated care at the practice level</td>
<td>6/30/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>5. Provide 24/7 access to care. Provide telephone access to a live voice or to an answering machine that immediately pages an on-call professional</td>
<td>6/30/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>6. Document approach to tracking access to same-day appointments</td>
<td>6/30/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>7. Document approach to contacting beneficiaries who have not received preventive care</td>
<td>12/31/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>8. Complete survey related to timeliness of patients’ access to specialists</td>
<td>12/31/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>9. Document investment in healthcare technology or tools that support practice transformation</td>
<td>12/31/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>10. Join SHARE to get inpatient discharge information from hospitals. Document compliance.</td>
<td>12/31/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>11. Review/adjust top 10% of high priority beneficiaries</td>
<td>3/31/2015</td>
<td>N/A</td>
</tr>
<tr>
<td>12. Incorporate e-prescribing into practice workflows</td>
<td>6/30/2015</td>
<td>N/A</td>
</tr>
<tr>
<td>13. Integrate EHR into practice workflows</td>
<td>12/31/2015</td>
<td>N/A</td>
</tr>
<tr>
<td>14. Re-assess operations of practice and opportunities to improve</td>
<td>12/31/2015</td>
<td>N/A</td>
</tr>
<tr>
<td>15. Refine strategy to implement care coordination &amp; practice transformation improvements</td>
<td>12/31/2015</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Practice support metrics are provided for reference only, and do not affect CPCi PBPM payments*
## Practice support progress report*

State Fiscal Year 2013 services paid through September 30, 2013

### Practice support metrics

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
<th>You (7/1/12-6/30/13)</th>
<th>Rolling 12 month performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of high priority beneficiaries that have a care plan in medical record</td>
<td># with a care plan / # high-priority beneficiaries</td>
<td>Pending provider portal data</td>
<td>High priority beneficiaries must be selected through the provider portal. Once that information is entered and processed, this metric will be displayed.</td>
</tr>
<tr>
<td>Qualifying level: ≥70</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of high priority beneficiaries seen by PCP at least twice in past 12 months</td>
<td># seen by PCP at least 2x in past 12 months / # high-priority beneficiaries</td>
<td>Pending provider portal data</td>
<td>High priority beneficiaries must be selected through the provider portal. Once that information is entered and processed, this metric will be displayed.</td>
</tr>
<tr>
<td>Qualifying level: ≥67</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of beneficiaries who had an inpatient stay that saw a health provider within 10 days of discharge</td>
<td># seen by a health provider / # discharges</td>
<td>20 / 100 = 20%</td>
<td></td>
</tr>
<tr>
<td>Qualifying level: ≥33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of time ED visits can be classified as non-emergent</td>
<td>% of ED visits expected to be non-emergent (NYU algorithm)</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Qualifying level: ≤50</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Practice support metrics are provided for reference only, and do not affect CPCI PBPM payments.
200.000 DEFINITIONS

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
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care coordination</td>
<td>The ongoing work of engaging beneficiaries and organizing their care needs across providers and care settings.</td>
</tr>
<tr>
<td>Care coordination payment</td>
<td>Quarterly payments made to participating practices to support care coordination services. Payment amount is calculated per attributed beneficiary, per month.</td>
</tr>
<tr>
<td>Cost thresholds</td>
<td>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.</td>
</tr>
<tr>
<td>Default pool</td>
<td>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.</td>
</tr>
<tr>
<td>Historical baseline cost of care</td>
<td>A multi-year weighted average of a shared savings entity’s per beneficiary cost of care.</td>
</tr>
<tr>
<td>Medical neighborhood barriers</td>
<td>Obstacles to the delivery of coordinated care that exist in areas of the health system external to PCMH.</td>
</tr>
<tr>
<td>Minimum savings rate</td>
<td>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.</td>
</tr>
<tr>
<td>Participating practice</td>
<td>A physician practice that is enrolled in the PCMH program, which must be one of the following:</td>
</tr>
<tr>
<td></td>
<td>A. An individual primary care physician (Provider Type 01 or 03);</td>
</tr>
<tr>
<td></td>
<td>B. A physician group of primary care providers who are affiliated, with a common group identification number (Provider Type 02, 04, or 81);</td>
</tr>
<tr>
<td></td>
<td>C. A Rural Health Clinic (Provider Type 29) as defined in the Rural Health Clinic Provider Manual Section 201.000; or</td>
</tr>
<tr>
<td></td>
<td>D. An Area Health Education Center (Provider type 69).</td>
</tr>
<tr>
<td>Patient-Centered Medical Home (PCMH)</td>
<td>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.</td>
</tr>
<tr>
<td>Per beneficiary cost of care</td>
<td>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.</td>
</tr>
<tr>
<td>Per beneficiary cost of care floor</td>
<td>The lowest per beneficiary cost of care for which practices within a shared savings entity can receive shared savings incentive payments.</td>
</tr>
<tr>
<td>Per beneficiary savings</td>
<td>The difference between a shared savings entity’s benchmark cost and its per beneficiary cost of care in a given performance period.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Performance period</td>
<td>The period of time over which performance is aggregated and assessed.</td>
</tr>
<tr>
<td>Pool</td>
<td>A. The beneficiaries who are attributed to one or more participating practice(s) for the purpose of forming a shared savings entity; or</td>
</tr>
<tr>
<td></td>
<td>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).</td>
</tr>
<tr>
<td>Practice support</td>
<td>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.</td>
</tr>
<tr>
<td>Practice transformation</td>
<td>The adoption, implementation and maintenance of approaches, activities, capabilities and tools that enable a participating practice to serve as a PCMH.</td>
</tr>
<tr>
<td>Provider portal</td>
<td>The website that participating practices use for purposes of enrollment, reporting to the Division of Medical Services (DMS) and receiving information from DMS.</td>
</tr>
<tr>
<td>Recover</td>
<td>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.</td>
</tr>
<tr>
<td>Remediation time</td>
<td>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.</td>
</tr>
<tr>
<td>Risk adjustment</td>
<td>An adjustment to the cost of beneficiary care to account for patient risk.</td>
</tr>
<tr>
<td>Same-day appointment request</td>
<td>A beneficiary request to be seen by a clinician within 24 hours.</td>
</tr>
<tr>
<td>Shared savings entity</td>
<td>A participating practice or participating practices that, contingent on performance, may receive shared savings incentive payments.</td>
</tr>
<tr>
<td>Shared savings incentive payment cap</td>
<td>The maximum shared savings incentive payment that DMS will pay to practices in a shared savings entity, expressed as a percentage of that entity’s benchmark cost for the performance period.</td>
</tr>
<tr>
<td>Shared savings incentive payments</td>
<td>Annual payments made to reward cost-efficient and quality care.</td>
</tr>
<tr>
<td>Shared savings percentage</td>
<td>The percentage of a shared savings entity’s total savings that is paid to practice(s) in a shared savings entity as a shared savings incentive payment for performance improvement.</td>
</tr>
</tbody>
</table>
To be eligible to enroll in the PCMH Program initially:

A. The entity must be a participating practice as defined in Section 200.000.

B. The practice must include PCPs enrolled in the ConnectCare Primary Care Case Management (PCCM) Program.

C. The practice may not participate in the PCCM shared savings pilot established under Act 1453 of 2013.

D. The practice must have at least 300 attributed beneficiaries at the time of enrollment.

DMS may modify the number of attributed beneficiaries required for enrollment based on provider experience and will publish at www.paymentinitiative.org any such modification.

Enrollment in the PCMH program is voluntary and practices must re-enroll annually. To enroll, practices must access the provider portal and submit a complete and accurate Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement (DMS-844) available at www.paymentinitiative.org. Once enrolled, a participating practice remains in the PCMH program until:

A. The practice withdraws;

B. The practice or provider 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. This update must be submitted in writing within 30 days and emailed to ARKPCMH@hp.com.

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

Initial enrollment periods are October 1, 2013 through December 15, 2013 and January 1, 2014 through May 15, 2014.

Beginning with the 2015 calendar year, enrollment is open for approximately 3 months in Q3 and Q4 of the preceding year.

DMS will return any enrollment documents received other than during an enrollment period.

A participating practice must manage its caseload of attributed beneficiaries, including removal of a beneficiary from its panel, according to the rules described in Section 171.200 of this manual. Additionally, a participating practice must submit, in writing at the end of every calendar
quarter, an explanation of each beneficiary removal during such quarter. DMS retains the right to disallow these beneficiary removals. If a participating practice removes a beneficiary from its PCMH panel, then that beneficiary is also removed from its ConnectCare panel.

### 220.000 PRACTICE SUPPORT

#### 221.000 Practice Support Scope 1-1-14

Practice support includes both care coordination payments made to a participating practice and practice transformation support provided by a DMS contracted vendor.

Receipt and use of the care coordination payments is not conditioned on the practice 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 participating practices that require additional support to catalyze practice transformation and retain and use such vendor. Practices 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 practice. 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 practices through improved access to information through the reports described in Section 245.000.

#### 222.000 Practice Support Eligibility 1-1-14

In addition to the enrollment eligibility requirements listed in Section 211.000, in order for practices to receive practice support, DMS measures participating practice performance against activities tracked for practice support identified in Section 241.000 and the metrics tracked for practice support identified in 242.000. Participating practices must meet the requirements of these sections to receive practice support.

Each participating practice that has pooled its attributed beneficiaries with other participating practices in a shared savings entity:

A. Has its performance individually compared to activities tracked for practice support and metrics tracked for practice support.

B. Will, if qualified, receive practice support even if other practices in a shared savings entity do not qualify for practice support.

#### 223.000 Care Coordination Payment Amount 1-1-14

The care coordination payment is risk adjusted (e.g., ranging from $1 to $30 per attributed beneficiary per month) based on factors including demographics (age, sex), diagnoses and utilization.

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

If a practice withdraws from the PCMH program, then the practice is only eligible for care coordination payments based on a complete quarter’s participation in the PCMH program.
In order to begin receiving care coordination payments for the quarter starting January 1, 2014, a practice must submit a complete PCMH Practice Participation Agreement on or before December 15, 2013. In order to begin receiving care coordination payments for the quarter starting July 1, 2014, a practice must submit the PCMH Practice Participation Agreement on or before May 15, 2014. For all subsequent years, in order to participate in the PCMH program, a practice must submit the PCMH Practice Participation Agreement before the end of the enrollment period of the preceding year.

### 230.000 SHARED SAVINGS INCENTIVE PAYMENTS

#### 231.000 Shared Savings Incentive Payments Scope 1-1-14

Shared savings incentive payments are payments made to a shared savings entity for delivery of economic, efficient and quality care that meets the requirements in Section 232.000.

#### 232.000 Shared Savings Incentive Payments Eligibility 1-1-14

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

**A.** For purposes of calculating shared savings incentive payments only, the following beneficiaries shall not be counted toward the 5,000 attributed beneficiary requirement.

1. Beneficiaries that have been attributed to that entity’s practice(s) for less than half of the performance period.

2. Beneficiaries that a practice 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 practice may not update selection for the duration of the performance period. The total number of physician-selected exclusions will be directly proportional to the practice’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 or provider experience with select beneficiary populations. DMS will publish such addition, removal or modification on [www.paymentinitiative.org](http://www.paymentinitiative.org).

**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 requirements for metrics tracked for shared savings incentive payments in section 244.000 based on the aggregate performance for beneficiaries attributed to the shared savings entity for the majority of the performance period; and

3. Maintaining eligibility for practice support as described in Section 251.000.

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

#### 233.000 Pools of Attributed Beneficiaries 1-1-14

Section II-6
Participating practices will meet the minimum pool size of 5,000 attributed beneficiaries as described in 232.000 by forming a shared savings entity in one of three ways:

A. Meet minimum pool size independently;

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

C. Participate in a default pool if the practice does not meet the requirements for A or B of this section. Practices with beneficiaries in a default pool will have per beneficiary cost of care performance measured across the combined pool of all attributed beneficiaries in the default pool. There is no default pool in the first performance period beginning January 1, 2014.

234.000 Requirements for Joining and Leaving Pools 1-1-14

Practices may pool for purposes described in 233.000, part B, before the end of the enrollment period that precedes the start of the performance period. To pool, practices must submit to DMS a signed Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement with a completed and accurate Arkansas Medicaid Patient-Centered Medical Home Pooling Request Form, available at [www.paymentinitiative.org](http://www.paymentinitiative.org), executed by all practices participating in the pool.

In the first performance period beginning January 1, 2014, a maximum of two practices may agree to voluntarily pool their attributed beneficiaries.

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

When a practice has 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 practice that has pooled withdraws from the PCMH program, the other practice or practices in the shared savings entity will have performance measured as if the withdrawn practice had never participated in the pool.

235.000 Per Beneficiary Cost of Care Calculation 1-1-14

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, except for the performance period which begins January 1, 2014, for which fifty percent of the dollar value of care coordination payments is included.

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.

A. The following costs are excluded from the calculation of per beneficiary cost of care:

1. All costs in excess of $100,000 for any individual beneficiary.

2. Behavioral health costs for beneficiaries with the most complex behavioral health needs.

3. Select costs associated with developmental disabilities (DD) services, identified on the basis of DD provider types.
4. Select direct costs associated with Long-Term Support and Services (LTSS).
5. Select costs associated with nursing home fees, transportation fees, dental and vision.
6. Select neonatal costs.
7. Other costs as determined by DMS.

Detailed information on specific exclusions are at [www.paymentinitiative.org](http://www.paymentinitiative.org).

A. The following adjustments are made to costs for calculation of per beneficiary cost of care:

1. Inpatient hospital claims will be adjusted to reflect a standard per diem.
2. Pharmacy costs will be adjusted to reflect rebates.
3. The per beneficiary cost of care for a shared savings entity is adjusted by the amount of supplemental payment incentives, both positive and negative, made under Episodes of Care for the beneficiaries attributed to practice(s) as described in Section 232.000.
4. Technical adjustments may be made by DHS and will be posted at [www.paymentinitiative.org](http://www.paymentinitiative.org)

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 at the total cost of care floor, for purposes of calculating shared savings incentive payments. The 2014 cost of care floor is set at $1,400 and will increase by 1.5% each subsequent year.

### Baseline and Benchmark Cost Calculations

For the performance period that begins in January 2014, DMS will calculate a historical baseline per beneficiary cost of care for each shared savings entity. This shared savings entity-specific historical baseline will be calculated as a multi-year blended average of each shared savings entity’s per beneficiary cost of care.

DMS will calculate benchmark costs for each shared savings entity by applying a 2.6% benchmark trend to the entity’s historical baseline per beneficiary cost of care. DMS may reevaluate the value of this benchmark trend if the annual, system-average per beneficiary cost of care growth rate differs significantly from a benchmark, to be specified by DMS. DMS will publish any modification to the benchmark trend at [www.paymentinitiative.org](http://www.paymentinitiative.org).

### Shared Savings Incentive Payments Amounts

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 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. For the performance period beginning January 2014, DMS will compare the entity’s historical baseline cost to the base year thresholds to establish such entity’s shared savings percentage.

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, then the shared savings entity will not share in risk. Instead, 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%).

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: $\left(\text{medium cost threshold for that performance period} - \text{per beneficiary cost of care for that performance period}\right) \times \left[\frac{50}{100}\right].$

The medium and high cost thresholds for 2014 are:

   A. Medium cost threshold: $2,032
   B. High cost threshold: $2,718

These thresholds reflect an annual increase of 1.5% from the base year thresholds (base year medium cost threshold: $1,972; base year high cost threshold: $2,638) and will increase by 1.5% each subsequent year.

The minimum savings rate is 2%. DMS may adjust this rate based on new research, empirical evidence or experience from initial provider experience with shared savings incentive payments. DMS will publish any such modification of the minimum savings rate at www.paymentinitiative.org.

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.

If the shared savings entity’s per beneficiary cost of care falls above the current performance period high cost threshold, then the shared savings entity is not eligible for a shared savings incentive payment for that performance period.

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 entity’s practice(s) 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 in proportion to the number of attributed beneficiaries that each practice contributed to such pool.

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

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.

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 practice.

### 240.000 METRICS AND ACCOUNTABILITY FOR PAYMENT INCENTIVES

#### 241.000 Activities Tracked for Practice Support 6-5-14

Using the provider portal, participating practices must complete and document the activities as described in the table below by the deadline indicated in the table. The reference point for the deadlines is the first day of the first calendar year in which the participating practice is enrolled in the PCMH program.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Identify top 10% of high-priority beneficiaries using:</td>
<td>3 months and again 3 months after the start of each subsequent performance period (If such list is not submitted by this deadline, DMS will identify a default list of high-priority beneficiaries for the practice, based on risk scores).</td>
</tr>
<tr>
<td>1. DMS patient panel data that ranks beneficiaries by risk at beginning of performance period and/or</td>
<td></td>
</tr>
<tr>
<td>2. The practice’s patient-centered assessment to determine which beneficiaries on this list are high-priority.</td>
<td></td>
</tr>
<tr>
<td>Submit this list to DMS via the provider portal.</td>
<td></td>
</tr>
<tr>
<td>B. Assess operations of practice and opportunities to improve and submit the assessment to DMS via the provider portal.</td>
<td>6 months and again at 24 months</td>
</tr>
<tr>
<td>C. Develop and record strategies to implement care coordination and practice transformation. Submit the strategies to DMS via the provider portal.</td>
<td>6 months</td>
</tr>
<tr>
<td>D. Identify and reduce medical neighborhood barriers to coordinated care at the practice level. Describe barriers and approaches to overcome local challenges for coordinated care. Submit these descriptions of barriers and approaches to DMS via the provider portal.</td>
<td>6 months</td>
</tr>
<tr>
<td>E. Make available 24/7 access to care. Provide telephone access to a live voice (e.g., an employee of the primary care physician or an answering service) or to an answering machine that immediately pages an on-call medical professional 24 hours per day, 7 days per week. The on-call professional must:</td>
<td>6 months</td>
</tr>
<tr>
<td>1. Provide information and instructions for treating</td>
<td></td>
</tr>
</tbody>
</table>
emergency and non-emergency conditions,

2. Make appropriate referrals for non-emergency services and

3. Provide information regarding accessing other services and handling medical problems during hours the PCP’s office is closed.

Response to non-emergency after-hours calls must occur within 30 minutes. A call must be treated as an emergency if made under circumstances where a prudent layperson with an average knowledge of health care would reasonably believe that treatment is immediately necessary to prevent death or serious health impairment.

1. PCPs must make the after-hours telephone number known by all beneficiaries; posting the after-hours number on all public entries to each site; and including the after-hours number on answering machine greetings.

2. When employing an answering machine with recorded instructions for after-hours callers, PCPs should regularly check to ensure that the machine functions correctly and that the instructions are up to date.

Practices must document completion of this activity by written report to DMS via the provider portal.

F. Track same-day appointment requests by:

1. Using a tool to measure and monitor same-day appointment requests on a daily basis and

2. Recording fulfillment of same-day appointment requests.

Practices must document compliance by written report to DMS via the provider portal.

G. Establish processes that result in contact with beneficiaries who have not received preventive care. Practices must document compliance by written report to DMS via the provider portal.

H. Complete a short survey related to beneficiaries’ ability to receive timely care, appointments and information from specialists, including Behavioral Health (BH) specialists.

I. Invest in health care technology or tools that support practice transformation. Practices must document health care technology investments by written report to DMS via the provider portal.

J. Join SHARE and be able to access inpatient discharge and transfer information. Practices must document compliance by written report to DMS via the provider portal.
Activity | Deadline
--- | ---
K. Incorporate e-prescribing into practice workflows. Practices must document compliance by written report to DMS via the provider portal. | 18 months
L. Use Electronic Health Record (EHR) for care coordination. The EHR adopted must be one that is certified by Office of the National Coordinator for Health Information Technology and is used to store care plans. Practices are to document completion of this activity via the provider portal. | 24 months

DMS may add, remove, or adjust these metrics or deadlines, including additions beyond 24 months, based on new research, empirical evidence or experience from initial metrics. DMS will publish such extension, addition, removal or adjustment at [www.paymentinitiative.org](http://www.paymentinitiative.org).

### 242.000 Metrics Tracked for Practice Support

DMS assesses practices on the following metrics tracked for practice support starting on the first day of the first calendar year in which the participating practice is enrolled in the PCMH program and continuing through the full calendar year. To receive practice support, participating practices must meet a majority of targets listed below.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Target for Calendar Year Beginning January 1, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Percentage of high-priority beneficiaries (identified in Section 241.000) whose care plan as contained in the medical record includes:</td>
<td></td>
</tr>
<tr>
<td>1. Documentation of a beneficiary’s current problems;</td>
<td></td>
</tr>
<tr>
<td>2. Plan of care integrating contributions from health care team (including behavioral health professionals) and from the beneficiary;</td>
<td></td>
</tr>
<tr>
<td>3. Instructions for follow-up and</td>
<td></td>
</tr>
<tr>
<td>4. Assessment of progress to date.</td>
<td></td>
</tr>
<tr>
<td>The care plan must be updated at least twice a year.</td>
<td>At least 70%</td>
</tr>
<tr>
<td>B. Percentage of a practice’s high priority beneficiaries seen by their attributed PCP at least twice in the past 12 months</td>
<td>At least 67%</td>
</tr>
<tr>
<td>C. Percentage of beneficiaries who had an acute inpatient hospital stay and were seen by health care provider within 10 days of discharge</td>
<td>At least 33%</td>
</tr>
<tr>
<td>D. Percentage of emergency visits categorized as non-emergent by the NYU ED algorithm</td>
<td>Less than or equal to 50%</td>
</tr>
</tbody>
</table>

DMS will publish targets for subsequent years, calibrated based on experience from targets initially set, at [www.paymentinitiative.org](http://www.paymentinitiative.org). Such targets will escalate over time.

DMS may add, remove, or adjust these metrics based on new research, empirical evidence or experience from initial metrics.
243.000 Accountability for Practice Support 1-1-14

If a practice does not meet deadlines and targets for A) activities tracked for practice support and B) metrics tracked for practice support as described in Sections 241.000 and 242.000, then the practice must remediate its performance to avoid suspension or termination of practice support. Practices must submit an improvement plan within 1 month of the date that a report provides notice that the practice failed to perform on the activities or metrics indicated above.

A. With respect to activities tracked for practice support, practices must remediate performance before the end of the first full calendar quarter after the date the practice receives notice via the provider report that target(s) have not been met, except for activity A in Section 241.000 where no such remediation time will be provided.

B. With respect to metrics tracked for practice support, practices must remediate performance before the end of the second full calendar quarter after the date the practice receives notice via the provider report that target(s) have not been met. For purposes of remediation, performance is measured on the most recent four calendar quarters.

If a practice fails to meet the deadlines or targets for activities and metrics tracked for practice support within this remediation time, then DMS will terminate practice support. DMS may resume practice support when the practice meets the deadlines or targets for activities and metrics tracked for practice support in effect for that quarter.

DMS retains the right to confirm practices’ performance against deadlines and targets for activities and metrics tracked for practice support.

244.000 Quality Metrics Tracked for Shared Savings Incentive Payments 6-5-14

DMS assesses the following quality metrics tracked for shared savings incentive payments according to the targets below. The quality metrics are assessed at the level of shared savings entity, except for the default pool. The quality metrics are assessed only if the entity or practice has at least 25 attributed beneficiaries in the category described for the majority of the performance period. To receive a shared savings incentive payment, the shared savings entity or practice must meet at least two-thirds of the quality metrics on which the entity or practice is assessed.

<table>
<thead>
<tr>
<th>Quality Metric</th>
<th>Target for Calendar year Beginning January 1, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Percentage of beneficiaries who turned 15 months old during the measurement year and had at least 4 well-child visits during the first 15 months of life</td>
<td>At least 67%</td>
</tr>
<tr>
<td>B. Percentage of beneficiaries 3-6 years of age who had one or more well-child visits during the measurement year</td>
<td>At least 67%</td>
</tr>
<tr>
<td>C. Percentage of beneficiaries 12-21 years of age who had one or more well-care visits during the measurement year</td>
<td>At least 40%</td>
</tr>
<tr>
<td>D. Percentage of diabetes beneficiaries who complete annual HbA1C testing</td>
<td>At least 75%</td>
</tr>
<tr>
<td>E. Percentage of beneficiaries prescribed appropriate asthma medications</td>
<td>At least 70%</td>
</tr>
<tr>
<td>F. Percentage of CHF beneficiaries on beta blockers</td>
<td>At least 40%</td>
</tr>
</tbody>
</table>
## Quality Metric

### G. Percentage of women ages 50-69 who have had breast cancer screening in past 24 months
- **Target:** At least 50%

### H. Percentage of beneficiaries on thyroid drugs who had a TSH test in past 24 months
- **Target:** At least 80%

### I. Percentage of beneficiaries 6-12 years of age with an ambulatory prescription dispensed for ADHD medication that was prescribed by their PCMH, and who had one follow-up visit with their PCMH during the 30-day Initiation Phase.
- **Target:** At least 25%

DMS will publish targets for subsequent performance periods, calibrated based on experience from targets initially set, at [www.paymentinitiative.org](http://www.paymentinitiative.org).

DMS may add, remove or adjust these quality metrics based on new research, empirical evidence or experience from initial quality metrics.

### 245.000 Provider Reports 1-1-14

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

### 250.000 COMPREHENSIVE PRIMARY CARE (CPC) INITIATIVE PRACTICE PARTICIPATION IN THE PCMH PROGRAM 1-1-14

Practices and physicians participating in the CPC initiative are not eligible to receive PCMH program practice support.

Practices participating in the CPC initiative may receive PCMH program shared savings incentive payments if they:

A. Enroll in the PCMH program;

B. Meet the requirements for shared savings incentive payments, except that a practice participating in CPC need not maintain eligibility for practice support described in Section 222.000; and

C. Achieve all CPC milestones and measures on time.
1. Documentation of current problem
   a. Each visit-related encounter document should include a list of current problems.

2. Plan of care integrating contributions from health care team (including behavioral health professionals) and from the beneficiary
   a. A visit-related encounter (or dated entry into a plan of care flowsheet or template) should include an entry that clearly summarizes the plan of care for the patient. Ideally, this should be a problem-based detail of the plan of care occurring twice during the 12-month timeframe.
   b. The problem assessment of diagnosis from the current problems could be included in the visit note in the “plan” section or as stand-alone documentation in a separate care plan template.
   c. If using separate documentation, make sure to include the date the plan is updated.
   d. The “Plan” or the “Assessment and Plan” section of the visit documentation must include statements of specific, problem-related plan information.
      i. For example, “Plan: follow up on diabetes in four months with repeat A1C.”
   e. Statements should include an approximate or absolute time and a follow-up item (e.g., lab, visit, referral, etc.).
      i. Example: Assessment and Plan
         1. Type II Diabetes Mellitus: Improved after recent increase in insulin dosing. Continue current insulin and metformin doses. Refer to patient educator for help with diet. Follow up in the clinic in six months with Hgb A1C and microalbumin.
         2. Essential Hypertension: Stable blood pressure, at target, no change in medications. Continue home blood pressure checks. Target is systolic <130. Patient will report blood pressure via secure messaging.
3. Instructions for follow-up

   a. Documentation mentioned in the visit/encounter of an existing future visit linked to a problem under management.
      
      i. For example, noting the patient has a future visit scheduled with a patient educator for diabetes management.

   b. Documentation could be contained within a completed assessment and plan would be acceptable, as would evidence in the chart.
      
      i. Example: Follow up in six months, patient is doing well.

4. Assessment of progress to date

   a. The encounter document should contain a problem-based assessment for all problems that were addressed during the visit.

   b. Clear documentation in the plan of care (EHR activity [telephone encounter/care plan update] or in a progress/visit note) identifying the course of a specific problem being tracked.

   c. Documentation should include reference to the problem stability.
      
      i. For example, problem is “improving, deteriorating or stable.”

   d. If the patient’s problem is not clearly managed in a separate EHR activity (stand-alone care plan), then the “Plan” section of the encounter/visit documentation must clearly state or update the status of each problem.
      
      i. For example: Assessment

         1. Type II diabetes, improved control after changes in insulin dosing. Hypertension that is at the treatment target. No changes in medications. Will draw lipid, CMP, A1C and complete a microalbumin in three months.

         2. Type II diabetes mellitus: Improved after recent increase in insulin dosing. Will follow up in six months for A1C.

         3. Essential hypertension: Stable blood pressure, at target, no change in medications. K+ level drawn today and results will be reported to patient via patient portal.
NON-COMPLIANT PATIENTS:

- If a patient misses a follow-up appointment, the clinic can utilize outreach to follow up.
- A telephone note can be used to address and update the care plan, but it must contain a specific timeframe for followup to re-engage the patient.
- If the patient is non-compliant and the clinic is utilizing outreach to follow up, there should be documentation showing a good faith effort has been made to reach the patient and reschedule them.
Arkansas Medicaid Information Interchange (AMII) for Primary Care Physicians

AMII is a link on the Arkansas Medicaid website, https://www.medicaid.state.ar.us. Primary Care Physicians (PCP) will have to register and establish a new password.

Password Restrictions
- Must contain at least 8 characters with at least one uppercase letter and at least one lowercase letter

User Restrictions
- Must change password every 90 days
- Cannot reuse the 3 most recent passwords

Logon Restrictions
- Disable account after 3 failed attempts to log on
- Reset failed logon count after 5 minutes
- Disabled accounts will be systematically re-enabled after 30 minutes

Once a PCP logs in to the portal, their Individual Medicaid provider ID used to log in will be queried. If it indicates you are a PCP, then you will see a new link in the left margin under My Information to View AMII.

First time user:
Once that link is activated, the PCP will be prompted to create a password, confirm the password and enter their email address. If it is approved, you will get a message indicating you have successfully registered. You will then be directed to the portal page to select the link again and enter the new password.

Note: Your Individual Medicaid provider ID used upon logging in to the portal is used as your ID and it is system plugged.

Non-first time user:
Once the link is activated, the PCP will be prompted for their password.

If the PCP needs a password reset, they will be able to initiate a reset through the system by using their registered email address. Email address is a required field.

AMII Reports:
Once you have logged in to AMII, you will be taken to a screen to access your reports in InfoView.

On the left, you will select Public Folders and then AMII.

You will have a selection of the following reports:
1) Caseload
2) Case Load Listing
3) Recipient Cancer Screening
4) Recipient Diabetes Screening
5) Recipient Screening – this one is for EPSDT, etc.

After you select the report, it will automatically run with your Individual Medicaid provider ID.

You will then be able to view the data returned in a report format or you can download it into a PDF or Excel file using the buttons at the top.

For assistance with AMII, contact the HP Electronic Data Interchange Unit (EDI). In-state toll-free (800) 457-4454 or Local and out-of-state (501) 376-2211. Select Option 0 for “Other Inquiries”; then Option 1 for the EDI Unit.
AMII PCP Reports

Once a Medicaid Provider has logged into the portal successfully, if the provider is a PCP, they will have available 'VIEW AMII REPORTS' under Available Tools in the left hand box. Click this link to proceed to the AMII logon page.
The following is the AMII registration page. If this is the first time the PCP has accessed the AMII reports, it will ask them for the following information. Please read the disclaimer in the text box. They must check the box ‘I accept terms and conditions’ before the create account button is activated.
Upon successful registration, the PCP will receive the following page. Click ‘here’ to logon to AMII reports.
AMII Login Page

The PCP is then redirected to the logon page where the PCP will now enter their user name (Medicaid provider ID used to log into the portal with) and the password created from the registration. If the PCP is entering the logon page outside of initial registration, your Medicaid ID will be plugged.

Click ‘log on’ to continue.
Log On to InfoView

Enter your user information and click Log On.
(If you are unsure of your account information, contact your system administrator)

User Name: 
Password: 

Log On
After successful login, the PCP will be directed to the Infoview home page.

To access the AMII reports the PCP must navigate to the “Documents List” using either of the two red highlighted links.

Please note that the PCP may change their preferences so that every time they login, they will automatically be redirected to this page.

This can be accomplished by selecting either of the two blue highlighted links and follow the instructions on the next page.
Changing Preferences

To change the PCP’s preferences so that you are always taken to the AMII reports page after logging in:

After selecting Preferences on the Infoview home page, expand the General section. Select the radio button next to “Folder:” and then click “Browse Folder”. Select the AMII folder located under Public Folders and then click on OK.
AMII Report Retrieval

After selecting “Document List”, the PCP must navigate to the AMII folder located under Public Folders to gain access to the AMII reports. The five reports seen here are those that are available to the PCP. Simply double click the title to access the report for the Medicaid ID that is in the logon credentials.
Examples of Filtering

The PCP may filter on any field within the AMII report retrieved. The following instructions are using a dummy sample report.
The **Show/Hide Report Filter Toolbar** needs to be activated by clicking it. When activated, it will show as if it were a button that is depressed.
When you activate the *Show/Hide Report Filter Toolbar* an area above the reports appear. You can now drag the objects to this space on which to filter. In this example, we are dragging NUM EOB to the red circle area.
Here you now see that the EOB number is available on the *Show/Hide Report Filter Toolbar* and a dropdown box is available to filter the data.
Drop down box showing all the filter options for EOB.
<table>
<thead>
<tr>
<th>Num Eob</th>
<th>Dsc Eob</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>DETAIL FROM DATE OF SERVICE MISSING/INVALID</td>
</tr>
<tr>
<td>002</td>
<td>THE ADMITTING DATE OF SERVICE IS MISSING OR INVALID.</td>
</tr>
<tr>
<td>003</td>
<td>THE TO SERVICE DATE IS INVALID.</td>
</tr>
<tr>
<td>004</td>
<td>DATES OF SERVICE SPAN STATE FISCAL YEAR. PLEASE SUBMIT 2 SEPARATE BILLS.</td>
</tr>
<tr>
<td>005</td>
<td>DATE OF DELIVERY/SURGERY DOES NOT CORRESPOND WITH HOSPITAL STAY</td>
</tr>
<tr>
<td>006</td>
<td>THE DISCHARGE DATE OF SERVICE IS MISSING OR INVALID.</td>
</tr>
<tr>
<td>007</td>
<td>TOTAL DAYS NOT EQUAL TO THE DIFFERENCE BETWEEN THE &quot;FROM&quot; AND &quot;TO&quot; DATE</td>
</tr>
</tbody>
</table>
Query filtered for EOB 004.
### Examples of downloading to PDF or Excel

<table>
<thead>
<tr>
<th>Num Eob</th>
<th>Desc Eob</th>
</tr>
</thead>
<tbody>
<tr>
<td>004</td>
<td>DATES OF SERVICE SPAN STATE FISCAL YEAR. PLEASE SUBMIT 2 SEPARATE BILLS.</td>
</tr>
</tbody>
</table>
To export the PCP report results to an Excel Spreadsheet or PDF, click on the down arrow of the save icon which is the diskette picture. Choose *Save to my computer as* either an Excel or PDF document.

The PCP will then be prompted to *Open* or *Save*. 
If the PCP chooses *Save*, you will be prompted to choose a file location:

![Save As dialog box](image)

If the PCP chooses *Open*, the query results will open in the selected application i.e. Excel or PDF.
Fluoride Varnish Initiative “Paint a Smile”

**Background and Purpose:** Tooth decay, a disease known as cavities or caries, is the most common chronic infectious disease of children age two to five. In Arkansas, 61 percent of children under age nine have already experienced tooth decay. Among these children, untreated decay has been associated with difficulty eating, sleeping, learning, and proper nutrition. Much of this problem could be prevented by a timely application of fluoride varnish. One potential approach to increasing a timely application of fluoride varnish is to encourage primary health care providers to apply fluoride varnish during well-child visits at least 2-4 times per year. Primary health care providers see children at least 12 times during the first five years of their life for well-child visits.

In 2011, the Arkansas legislature passed ACT 90: An Act to authorize physicians and nurses to apply fluoride varnish to a child’s teeth after appropriate training. The goal of the program is to close the gaps that exist for children who do not have regular access to comprehensive dental care.

The potential benefits of primary health care providers and designated health care professionals that provide fluoride varnish are:

- A reduction in the risk of dental caries
- Initiation of a referral to a dental home
- Education for caregivers about dental caries etiology and prevention

**What is Fluoride Varnish?**

Fluoride varnish is a protective coating that is painted on teeth. Over a period, the varnish releases fluoride, which strengthens teeth and help, prevent tooth decay.

**What does the Fluoride Varnish Initiative mean for Arkansas?**

- Primary care physicians and their designated nurse or health care professional will receive a one hour training course
- Medicaid will reimburse primary health care providers $19.95 per application of fluoride varnish.

**What can you do to help?**

- Become an early adopter of the program
  - Contact the Office of Oral Health and complete the one hour online training
  - Inform other physicians of the program
  - Educate your staff and if needed designate a nurse or health professional to participate in the one hour online course and apply fluoride varnish.
Fluoride Varnish Policy Statement
Association of State and Territorial Dental Directors (ASTDD)
Adopted: April 25, 2010

Problem
Dental caries is a chronic, progressive, multi-factorial, infectious disease that can begin in early infancy and that, by the time children reach adulthood, will affect over 92 percent of the U.S. adult population. A smaller proportion of the U.S. population will develop more moderate or severe dental caries. Dental caries prevalence and severity varies by age, dentition and type of tooth surface. Historically, dental caries control has been addressed by daily brushing, modifying dietary practices, and improving the resistance of tooth enamel to acid attack. However, only fluorides and dental sealants demonstrate a high degree of scientific evidence for reducing dental caries in populations. Benefiting from fluoride in drinking water and fluoride toothpastes, the baby boomer generation will be the first in which the majority will maintain natural teeth over their entire lifetime, according to the Centers for Disease Control and Prevention (CDC).

Methods
Fluoride methods, systemic and topical, include: drinking water (natural and adjusted levels), milk, salt, toothpaste, mouthrinse, and the professional application of concentrated fluoride in gels, foams or varnishes. Caries protection, lifetime cost and appropriateness for use in populations will vary by the fluoride method or combination of fluoride methods selected. Fluorides are most effective when used in combination with other modalities to prevent, control and reverse early dental caries. Fluorides are more effective in preventing dental caries on the smooth surfaces of teeth than in the pits and fissures. However, for the majority of dental caries limited to the pits and fissures of permanent molar teeth, dental sealants, alone or combined with multiple fluoride applications, are more effective than fluoride alone. Fluoride varnish alone may be more effective on pit and fissure caries than other fluoride products.

Fluoride varnish like other highly concentrated fluoride products is available only by prescription by authorized health professionals. Fluoride varnish is a resin or synthetic base that contains a high concentration of fluoride. Fluoride varnish sets quickly on contact with teeth in the presence of saliva. Some fluoride remains on caries-free teeth as a temporary layer of calcium fluoride-like material on the enamel surface. The fluoride in the material releases when the pH drops in response to acid production and becomes available to remineralize enamel. This layer slowly disappears over the following months and needs repeated application of the varnish to maintain effectiveness as a primary prevention strategy. Fluoride varnish enhances enamel remineralization with the initial fluoride uptake in early carious lesions (white spots) until it is brushed or flaked off. The calcium fluoride formed in initial
caries is more resistant to future demineralization. Therefore the use of fluoride varnish and other highly concentrated fluorides, as a secondary prevention strategy, is most cost-effective when active, non-cavitated, smooth surface caries are detectable. 24,25

Caries reductions attributed to fluoride varnish varies significantly in studies, reflecting the predominance of non-comparable study designs and cross-sectional outcome comparisons. 26 Reductions are associated with the caries risk of the population studied and the number of fluoride methods used. 27 One study found the incidence of new caries was reduced with a single application in a very young at risk, but caries free population. 28 Most studies indicate four applications over two years as the interval that demonstrates overall reductions in caries prevalence of approximately 30 percent (0-69%) in at-risk populations. 29,30 When fluoride varnish applications are discontinued, the incidence of dental caries increases. 31,32 For those with active dental caries, three to four applications annually may be more effective, however the strength of evidence is limited to few studies and the recommendation is based largely on opinion or information extrapolated from related studies. 4 Using fluoride varnish based on selection of risk for dental caries, will lower costs and optimize caries prevention using fluoride varnishes. 33,34 The addition of fluoride varnish in caries prevention programs for low risk individuals and populations, especially those that use water fluoridation and fluoride toothpastes, is unlikely to be cost-effective. 35

While caries risk assessment is not yet precise, the American Dental Association (ADA), Centers for Disease Control (CDC), and American Academy of Pediatric Dentistry (AAPD) agree that the single greatest risk factor for future caries is dental caries experience. 31 Fluoride varnish may be more effective than other professionally applied fluorides to remineralize early dental caries. 36 The Canadian Dental Association recommends targeting programs to low income populations and selectively applying fluoride varnish only to those individuals who have increased risk of caries, as indicated by past or current caries. 37 However, the AAPD, the US DHHS Maternal and Child Health Bureau Expert Panel and the ADA also identify low socioeconomic status (SES) of individual children under age six as a high risk factor for dental caries as an indicator for fluoride varnish application in an attempt to reduce caries prior to onset. 38 Similarly, the emerging Caries Management by Risk Assessment (CAMBRA) model recognizes the association with low SES yet; individual patients are treated according to their individual oral health environment. 39 In either case, prevention programs utilizing fluoride varnish need to begin earlier than later, as even age two is too late for children at highest risk. 40,41

Fluoride varnish is the safest choice of professionally applied fluoride for young children, or others, who otherwise could over-ingest fluoride available in gel or foam applications. There have been a few reports of contact dermatitis to the resin base used in fluoride varnish. There have been no reports of acute affects from fluoride varnish application in infants and toddlers. 42 The fluoride release from fluoride varnish is time- and dose-dependent in plaque up to 7 post-treatment days, peaking in plasma in 24-72
hours. Evidence from blood, saliva, urine and plaque indicate low elevations of fluoride following application of a thin layer of fluoride varnish. Therefore, because of the low fluoride elevations following ingestion and relatively infrequent applications, generally at 3-12 month intervals, fluoride varnishes pose little risk for enamel fluorosis, even among patients aged ≤ six years.

Fluoride varnish has an advantage over APF gels or foams, particularly for use in settings outside the dental office since no special equipment is needed. Delegation of the simple application technique to trained individuals must follow the rules and regulations of state practice acts governing prescription, dispensing and application of legend drugs. The cost of personnel required for training, assessment, prescription, and evaluation increases the cost of fluoride varnish applications when used for population-based primary prevention. For earliest prevention, application of fluoride varnish can begin as soon as tooth eruption, dependent on the individual child’s caries risk. Data from the 2000-2005 Medical Expenditure Panel Survey revealed that 89 percent of infants and 1-year-olds had office-based physician visits annually, compared with only 1.5 percent who had dental visits. Consequently, personnel in public and private medical practices can be a significant contributor in early caries recognition and prevention, when and as allowed by state statute.

Fluoride varnish is effective in preventing dental caries in both permanent and primary teeth of children, adults and seniors.

Policy Statement
The Association of State and Territorial Dental Directors (ASTDD) supports the use of fluoride varnish, beginning with tooth eruption, for individuals at moderate to high risk for tooth decay as an effective adjunct in programs designed to reduce lifetime dental caries experience.


The importance of oral health must be understood; oral disease, primarily dental caries, is the most common pediatric disease and can lead to physical and psychological disabilities as well as significant morbidity in adulthood.

**BILLING CODE**

**D1206**

**REIMBURSEMENT**

$19.95

Medicaid requires a certificate on file to receive payment

**PAINT A SMILE FOR ARKANSAS**
**Fluoride Varnish**

**The Law**

1. A minimum of one hour of continuing medical education shall be completed for any professional applying fluoride varnish.
2. The physician will keep a certificate of completion on file for themselves and all those under their supervision. Medicaid requires a certificate on file for payment.
3. The Office of Oral Health shall approve training courses on dental caries risk assessment and fluoride varnish application. It shall maintain a list of approved programs and publish the list on the Department website.
4. The Office of Oral Health will keep appropriate records.

**Getting The Education Requirement**

1. Establish an A-Train Account: Go to https://ar.train.org/. For instructions on How to Create an A-Train Account, Click on “Create Account”. Follow directions. When asked for Aasis personnel number, put 0.
2. Log in to your new a-Train Account. Access the course page from the HOME page by entering the course ID 1040373 into the search box at the top right.
3. Click on the registration tab.
4. Type your Profession (for instance: physician), Arkansas license number, and expiration date. Click “Launch”.
5. Fill out second course registration page. You must register again to receive your completion certificate. Click on "submit".
7. Take assessment and score at least 80%.
8. After a successful assessment, click on "Download your certificate of completion" on the “Thank you” page under Options.
9. Save your “Smiles for Life” certificate to computer and print if desired.
10. After closing the course, click on “Home” in upper left hand corner of next page. Do not return to course page by clicking on here.
11. On the right hand side of the screen, click on box titled “My Learning”.
12. Click on subtitle “TRAIN Transcript”.
13. Locate the course and click the “Upload External Certificate” button.
14. Under “Title”, type the name of the course (Caries Risk Assessment, Fluoride Varnish and Counseling).
15. Click BROWSE and select the certificate you will be uploading.
16. Click UPLOAD to attach the certificate to your A-TRAIN account.
17. Exit A-Train by clicking on “Log Off” in upper right hand corner of page.
**ARKIDS Full Preventive Health Screen Billing Procedures**

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*Newborn procedure codes pay $108.16 while all other listed codes pay $56.41.*
**ARKANSAS MEDICAID CHILD HEALTH SERVICES (EPSDT) FEE SCHEDULE**

This fee schedule does not address the various coverage limitations routinely applied by Arkansas Medicaid before final payment is determined (e.g., beneficiary and provider eligibility, benefit limits, billing instructions, frequency of services, third party liability, age restrictions, prior authorization, co-payments/coinsurance where applicable, etc.). Procedure codes and/or fee schedule amounts listed do not guarantee payment, coverage or amount allowed.

Although every effort is made to ensure the accuracy of this information, discrepancies and time lag may occur. All information may be changed or updated at any time to correct a discrepancy and/or error. The reimbursement rates reflected in this fee schedule are in effect as of the date of this report. The reimbursement rate made on a claim will depend on the date of service since our reimbursement rates are date of service effective. The fee schedule reflects only procedure codes that are currently payable. Any procedure code reflecting a Medicaid maximum of $0.00 is manually priced.

This fee schedule only reflects the EPSDT screenings and the Vaccine for Children immunizations. You will need to access the applicable fee schedule for all other services covered for the EPSDT program.

Please note that Arkansas Medicaid will reimburse the lesser of the amount billed or the Medicaid maximum. For a full explanation of the procedure codes/modifiers, refer to the information in your provider manuals.

*Current Dental Terminology* (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright © 2009 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Run Date 5/18/12

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<td>EP</td>
<td>00</td>
<td>00</td>
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</tbody>
</table>
Arkansas Medicaid beneficiaries entering the Arkansas foster care system are required to receive an intake physical examination within the first seventy two (72) hours. If the EPSDT provider who performs the screening is not the beneficiary’s PCP, the intake physical examination should be billed with procedure codes 99381-99385 and modifiers EP and H9. Billing with these procedure codes and modifiers will allow the claim to be submitted for payment without a referral from the beneficiary’s PCP and will alert the system not to count the screen toward the beneficiary’s yearly EPSDT periodic complete medical screening limits.

If the EPSDT provider who performs the screen is the beneficiary’s PCP, the intake physical exam should be billed with procedure codes 99391-99395 and modifiers EP and H9. Billing with these procedure codes and modifiers will allow the claim to be submitted for payment and will not count toward the beneficiary’s yearly EPSDT periodic complete medical screening limits.

Procedure codes 99381-99385 and 99391-99395, in conjunction with the EP and H9 modifiers, are to be used only for the required intake physical examination for Medicaid beneficiaries in the Arkansas foster care system.
Screenings and Sick Visits

292.575 Child Health Services (EPSDT) Screenings and Sick Visits 1-15-11

Screenings performed on the same date of service as an office visit for treatment of an acute or chronic condition may be billed as a periodic Child Health Services (EPSDT) screening, electronically or on paper using the CMS-1500 claim form.

Effective for dates of service on and after May 1, 2006, a Child Health Services (EPSDT) screening performed during an office visit for treatment of an acute or chronic condition may be billed as a separate visit for the same date of service using a CPT evaluation and management procedure code. Do not use modifiers on the sick visit procedure code. The visit must be billed electronically, or on paper using a separate CMS-1500 form. View a CMS-1500 sample form.

242.310 Completion of the CMS-1500 Claim Form

Required Reason Code location: 24H

H. EPSDT/Family Plan

EPSDT Reason Codes are required for EPSDT services. Please enter the appropriate 2 byte reason code in the upper shaded part of the detail line.

AV – Available – Not Used (patient refused referral)
NU – Not Used (used when no EPSDT patient referral was given)
S2 – Under Treatment (patient is currently under treatment for referred diagnostic or corrective health problem)
ST – New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.)

Family Planning Indicator is not applicable for this claim type.

See Sections 241.000 – 243.310 of the EPSDT manual for specific EPSDT billing instructions.

PLEASE REFER TO OFFICIAL NOTICE DATED: December 1, 2010........CMS-1500 Replaces DMS-694 for EPSDT Screenings or Services
Refer to the map and the color key below to find your representative.

**Manager**
Amelia Elam .. 501-212-8674
aelam@afmc.org

**Senior Program Coordinator**
Tonyia Haynes .. 501-212-8686
thaynes@afmc.org

**Representatives**
- Becky Andrews .. 501-212-8738
  bandrews@afmc.org
- Shawna Branscum .. 501-212-8633
  sbranscum@afmc.org
- Kellie Cornelius .. 501-212-8673
  kcornelius@afmc.org
- Carla Hestir .. 501-212-8684
  chestir@afmc.org
- Sheryl Hurt .. 501-212-8688
  shurt@afmc.org
- Tabitha Kinggard .. 501-212-8681
tkinggard@afmc.org
- Connie Riley .. 501-212-8682
criley@afmc.org
- Jerry Wicker .. 501-212-8726
  jwicker@afmc.org

**Medicaid Managed Care Services (MMCS) Information Sheet**
1020 W. 4th St., Suite 200 • Little Rock, AR 72201 • 501-375-5700 • Toll free: 1-877-650-2362 • Transportation Helpline: 1-888-987-1200

**MMCS PROVIDER RELATIONS**

**STATE OF ARKANSAS**
ARKANSAS DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

**ARKIDS FIRST / MEDICAID MEDICAL ASSISTANCE**
P.O. Box 1437, Slot 1101
Little Rock, AR 72203
www.medicaid.state.ar.us

- ARKids First Enrollment Information .. 888-474-8275

**SPECIAL PROJECTS**
- Central Arkansas .. 501-682-8297
- Toll free .. 800-482-1141

**CONNECTCARE**
- Toll free .. 800-275-1131

**PROVIDER ENROLLMENT**
HP Enterprise Services, P.O. Box 8105
Little Rock, AR 72203-8105

- Central Arkansas .. 501-376-2211
- Fax .. 501-374-0746

**ARKANSAS MEDICAL SOCIETY REPRESENTATIVE**
PHYSICIAN OUTREACH SPECIALIST
Gloria Boone .. 870-918-0944
gboone@arkmed.org

**HP ENTERPRISE SERVICES PROVIDER RELATIONS (Claims Processing)**
500 President Clinton Avenue, Suite 400 • Little Rock, AR 72201

- Operator .. 501-374-6608
- Helpline
  - In state toll free .. 800-457-4454
  - Local/out of state .. 501-376-2211
- Voice Response System .. 1-800-805-1512
- Supervisor, Service Relations
  - Jessie Smith .. 501-374-6609, ext. 398
- Manager, Provider Relations
  - David Jarnagin .. 501-374-6608

**STATE OF ARKANSAS**
ARKANSAS DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

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**ARKANSAS MEDICAL SOCIETY REPRESENTATIVE**
PHYSICIAN OUTREACH SPECIALIST
Gloria Boone .. 870-918-0944
gboone@arkmed.org
DIAGNOSIS: Viral respiratory infection

☐ Other: ______________________________________________

GENERAL INSTRUCTIONS

☐ Get plenty of rest.
☐ Drink more fluids.
☐ Take acetaminophen or ibuprofen for fever or aches.
☐ Do not give aspirin to people under age 19.
☐ Avoid smoking, second-hand smoke and alcohol.
☐ Soothe throat with ice chips or throat spray (throat drops for adults).
☐ Ease congestion with a vaporizer or nasal spray.

OTHER TREATMENTS

☐ Congestion: ________________________________
☐ Cough: ____________________________________
☐ Ear ache: _________________________________

Use medicines as directed by your doctor. Always read the instructions for over the counter medications.

FOLLOW UP – Call or return to the clinic:

☐ If not improved in _______ days.
☐ If new or changed symptoms occur.
☐ If temperature is greater than ________.
☐ If you have other concerns.
☐ May return to work/school/day care when fever is gone or on ________________.

SIGNED ________________________________________
FAST FACTS ON ANTIBIOTICS

- Antibiotics don’t work for viruses that cause colds, bronchitis and most sore throats.
- Using antibiotics against a virus can be harmful.
- Overuse of antibiotics creates bacteria that are resistant to antibiotics and difficult to treat.

IF YOUR DOCTOR GIVES YOU AN ANTIBIOTIC

- Take your antibiotic exactly how your doctor says you should.
- Don’t share your antibiotic with friends or family.
- Take every dose. Don’t keep your antibiotic for the next time you are sick.

<table>
<thead>
<tr>
<th>ILLNESS</th>
<th>USUAL CAUSE</th>
<th>ANTIBIOTIC NEEDED?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>VIRUS</td>
<td>BACTERIA</td>
</tr>
<tr>
<td>Bronchitis (coughing illness)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Chest cold</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Cold</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Green/yellow runny nose</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Middle ear infection</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sinus infection</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sore throat</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Save the antibiotic. Don’t use it when you don’t need it.
NOMBRE ___________________________________ FECHA_________________

DIAGNÓSTICO: Infección respiratoria viral

□ Otros: ______________________________________________

INSTRUCCIONES GENERALES
□ Descanse lo suficiente.
□ Tome más líquidos.
□ Tome acetaminofeno o ibuprofeno para la fiebre o dolores.
□ No le dé aspirina a personas menores de 19 años.
□ Evite fumar, el humo de segunda mano y el alcohol.
□ Alivie el dolor de garganta con trocitos de hielo o aerosol para la garganta (pastillas para los adultos).
□ Alivie la congestión con un vaporizador o aerosol nasal.

OTROS TRATAMIENTOS
□ Congestión: ______________________
□ Tos: _____________________________
□ Dolor de oído: _____________________

Use los medicamentos tal como lo indique su médico. Siempre lea las instrucciones para tomar medicamentos de venta libre.

SEGUIMIENTO – Llame o regrese a la clínica:
□ Si no ha mejorado en _______ días.
□ Si se presentan síntomas nuevos o cambiados.
□ Si la temperatura es superior a _________.
□ Si usted tiene otras preocupaciones.
□ Puede volver al trabajo/escuela/guardería cuando la fiebre haya desaparecido o el _________________.

FIRMADO ________________________________________
Tome su antibiótico exactamente como su médico le dice que debe.

No comparta su antibiótico con amigos o familiares.

Tome todas las dosis. No guarde su antibiótico para la próxima vez que usted está enfermo.

### DATOS RÁPIDOS SOBRE ANTIBIÓTICOS

- Los antibióticos no actúan sobre los virus que causan los resfriados, bronquitis y la mayoría de los dolores de garganta.
- El tomar antibióticos contra un virus puede ser perjudicial.
- El tomar antibióticos en exceso crea bacterias que son resistentes a los antibióticos y difíciles de tratar.

### SI SU MÉDICO LE RECETA UN ANTIBIÓTICO

- Tome su antibiótico exactamente como su médico le dice que debe.
- No comparta su antibiótico con amigos o familiares.
- Tome todas las dosis. No guarde su antibiótico para la próxima vez que usted está enfermo.

#### ENFERMEDAD
<table>
<thead>
<tr>
<th>CAUSA USUAL</th>
<th>¿NECESITA ANTIBIÓTICOS?</th>
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<tbody>
<tr>
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<td>VIRUS</td>
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<tr>
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<tr>
<td>Congestión de pecho</td>
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<tr>
<td>Catarro</td>
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<tr>
<td>Nariz moquea verde/amarillo</td>
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</tr>
<tr>
<td>Infección del oído medio</td>
<td>X</td>
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<tr>
<td>Infección sinusal</td>
<td>X</td>
</tr>
<tr>
<td>Dolor de garganta</td>
<td>X</td>
</tr>
</tbody>
</table>

**Salva al antibiótico.**

No lo uses cuando no lo necesitas.
Breastfeeding is best for both of them.

**YOU can help make it easier.**

Fewer than one-third of infants born in Arkansas are breastfed six months after birth.\(^1\) The most recent state ranking by the CDC puts us at number 52 in promoting breastfeeding.

Breastfeeding is natural but is not always easy. Education and increased support can increase success. Success or failure of breastfeeding promotion efforts can often be traced to the level — or lack — of administrative support.\(^2\)

For more information, the CDC Guide to Breastfeeding Interventions and other resources can be found at [www.cdc.gov/breastfeeding](http://www.cdc.gov/breastfeeding/).

**Family Doctors and Pediatricians**

At any prenatal visits and in the hospital, educate mothers about the benefits of breastfeeding and what to expect. Ensure that the hospital staff offers skin-to-skin contact immediately after birth and appropriate support from nurses and/or lactation specialists.

**At the first post-partum visit:**

- Ask if the mother is still breastfeeding and how it is going.
- Prescribe vitamin D supplementation for all breastfeeding infants.
- Assess the infant’s weight and address any concerns about whether the baby is getting enough milk. (Any weight loss greater than 7% from birth could be a sign that breastfeeding is not going well.)
- Ask questions to keep communication open:
  - “How often is your baby feeding?”
  - “How is your milk flowing?”
  - “Does your baby seem to be latching on well?”
- Remind mothers to eat well and drink plenty of liquids to stay hydrated.
- If possible, observe the baby feeding to help identify any problems, such as improper or inadequate latch, no swallowing sound, no jaw movement or inability to latch both breasts.
At the hospital

Hospitals have a critical role in encouraging breastfeeding and increasing long-term success. Though nurses and lactation specialists provide most of the hands-on support, physicians and administrators must set policy and ensure that staff members have the training and resources needed.

The UNICEF/WHO Baby Friendly Hospital Initiative (www.babyfriendlyusa.org) is now being implemented at hospitals across the United States. The BFHI Ten Steps to Successful Breastfeeding for U.S. hospitals are:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give newborn infants no food or drink other than breastmilk, unless medically indicated.
7. Practice “rooming in” — allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

To be designated by Baby-Friendly USA, hospitals must comply with the International Code of Marketing of Breast Milk Substitutes (www.unicef.org/nutrition/index_24805.html). Hospitals should also ensure that HIV status is known at labor and that all maternal medications are compatible with breastfeeding.

During discharge, ensure that the baby is scheduled for routine pediatric care within the first week.


Make mothers aware of any resources available, such as the Arkansas Breastfeeding Helpline (1-800-445-6175).

---

At the hospital

Hospitals have a critical role in encouraging breastfeeding and increasing long-term success. Though nurses and lactation specialists provide most of the hands-on support, physicians and administrators must set policy and ensure that staff members have the training and resources needed.

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During discharge, ensure that the baby is scheduled for routine pediatric care within the first week.


Make mothers aware of any resources available, such as the Arkansas Breastfeeding Helpline (1-800-445-6175).
Cervical Cancer Screening Guidelines Summary

INITIAL SCREENING
All women should begin cervical cancer screening at age 21. Women under the age of 21 should NOT be screened regardless of their age of first sexual contact unless they have a high-risk condition, such as HIV.

WOMEN AGES 21-29
Women of this age should receive cervical cancer screening once every 3 years using either a conventional pap smear or a liquid-based cytology method. HPV testing should not be performed for the purpose of screening in this age range.

WOMEN AGES 30-65
Women of this age should receive co-testing for cervical cancer screening. Co-testing combines cytology (conventional or liquid based) with HPV testing. The recommended screening interval is every five years. Cytology (conventional or liquid based) without HPV testing is also acceptable for screening of women in this age group, but should be done every three years.

WOMEN AGES 65 YEARS AND OLDER
Women of this age should not be screened if they have had adequate prior screening and no history of CIN or cervical cancer within the last 20 years.

WHAT’S NEW

Hysterectomy: Women who have had a hysterectomy with removal of the cervix for benign reasons and with no history of abnormal or cancerous cell growth may discontinue routine cervical cancer screening. Women who have had a hysterectomy who have had previous cervical cancer or CIN should continue to receive individualized testing.

More frequent or earlier (under age 21) cervical cancer screening may be indicated for high-risk women, such as patients with HIV, patients who are immunosuppressed or patients who were exposed to DES in utero. Testing should be individualized.

HPV Vaccine: An HPV vaccine is recommended for all girls, ages 11-26. The CDC states that girls as young as nine years of age may receive the vaccine; however, the provider should be aware that insurance plans may not cover the vaccine in 9-11-year-old patients. Ideally, the vaccine should be administered to girls before they reach an age when they might be exposed to HPV. The HPV vaccine is not recommended for pregnant women. At this time, cervical cancer screening is the best approach to prevent cervical cancer. Recommendations for cervical cancer screening apply regardless of the patient’s HPV vaccination status.
PAP COLLECTION PROCEDURE
Cytology specimens should be collected using a “broom” or a “brush-spatula” technique. If using a broom device with a liquid-based method, follow the manufacturer’s specifications. If using a brush-spatula technique, an extended tip spatula is recommended. The brush should be inserted in to the endocervix first and rotated one-half turn. The cells should be applied to a glass slide and spray-fixed immediately. Repeat the procedure with the extended-tip spatula. Avoid excessive force as this may produce bleeding, which may obscure the specimen. A single slide may be used at the discretion of the clinician rather than using two slides. A Pap smear that is performed on a pregnant patient uses the same technique except that some clinicians may prefer to use a Dacron swab instead of an endocervical brush.

REMINDER
These recommendations apply only to screening situations; that is, for patients who have no current evidence or history of CIN or cervical cancer. Please refer to other guidelines for follow-up and testing of patients who have had abnormal cytologic screening, positive HPV testing or a diagnosis of CIN or cervical cancer.

PLEASE NOTE
Cervical cancer screening should not be used as a substitute test for other sexually transmitted diseases. However, specimens collected using liquid-based techniques may also be tested for HPV, gonorrhea and chlamydia by some laboratories.
Smoking Cessation:

Effective for dates of service on or after June 15, 2014, the following procedure codes will be payable for all ages for Tobacco Cessation counseling to Certified Nurse Midwife, Nurse Practitioner and Physician providers. No coverage criteria have changed. Existing procedure code 99406, modifier SE, must be used for one 15-minute unit of service and procedure code 99407, modifier SE, must be used for one 30-minute unit of service. These codes will be billable on paper or on electronic claims.

This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

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<thead>
<tr>
<th>Current Procedure Code</th>
<th>Current Modifier</th>
<th>Replacement Code</th>
<th>Replacement Modifier</th>
<th>Arkansas Medicaid Description</th>
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</thead>
<tbody>
<tr>
<td>99401</td>
<td>SE</td>
<td>99406</td>
<td>SE</td>
<td>(Smoking and tobacco use cessation counseling visit; intermediate, 15-minutes)</td>
</tr>
<tr>
<td>99402</td>
<td>SE</td>
<td>99407</td>
<td>SE</td>
<td>(Smoking and tobacco use cessation counseling visit; intensive, 30-minutes)</td>
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</tbody>
</table>