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200.000 DEFINITIONS

1-1-18

Attributed beneficiaries	The Medicaid beneficiaries for whom primary care physicians and participating practices have accountability under the PCMH program. A primary care physician's attributed beneficiaries are determined by the ConnectCare Primary Care Case Management (PCCM) program. Attributed beneficiaries do not include dual eligible beneficiaries.
Attribution	The methodology by which Medicaid determines beneficiaries for whom a participating practice may receive practice support and shared savings incentive payments.
Benchmark cost	The projected cost of care for a specific shared savings entity against which savings are measured. Benchmark costs are expressed as an average amount per beneficiary.
Benchmark trend	The fixed percentage growth applied to PCMH practices' historical baseline fixed costs of care to project benchmark cost.
Care coordination	The ongoing work of engaging beneficiaries and organizing their care needs across providers and care settings.

Care coordination payment	Quarterly payments made to participating practices to support care coordination services. Payment amount is calculated per attributed beneficiary, per month.
Cost thresholds	Cost thresholds are the per beneficiary cost of care values (high and medium) against which a shared savings entity's per beneficiary cost is measured.
Default pool	A pool of beneficiaries who are attributed to participating practices that do not meet the requirements in Section 233.000, part A or part B.
Historical baseline cost of care	A multi-year weighted average of a shared savings entity's per beneficiary cost of care.
Medical neighborhood barriers	Obstacles to the delivery of coordinated care that exist in areas of the health system external to PCMH.
Minimum savings rate	A fixed percentage set by DMS. In order to receive shared savings incentive payments for performance improvement described in Section 237.000, part A, a shared savings entity must achieve a per beneficiary cost of care that is below its benchmark cost by at least the minimum savings rate.
Participating practice	A physician practice that is enrolled in the PCMH program, which must be one of the following: <ul style="list-style-type: none"> A. An individual primary care physician (Provider Type 01 or 03); B. A physician group of primary care providers who are affiliated, with a common group identification number (Provider Type 02, 04 or 81); C. A Rural Health Clinic (Provider Type 29) as defined in the Rural Health Clinic Provider Manual Section 201.000; or D. An Area Health Education Center (Provider type 69).
Patient-Centered Medical Home (PCMH)	A team-based care delivery model led by Primary Care Physicians (PCPs) who comprehensively manage beneficiaries' health needs with an emphasis on health care value.
Per beneficiary cost of care	The risk- and time-adjusted average of attributed beneficiaries' total Medicaid fee-for-service claims (based on the published reimbursement methodology) during the performance period, net of exclusions.
Per beneficiary cost of care floor	The lowest per beneficiary cost of care for which practices within a shared savings entity can receive shared savings incentive payments.
Per beneficiary savings	The difference between a shared savings entity's benchmark cost and its per beneficiary cost of care in a given performance period.
Performance period	The period of time over which performance is aggregated and assessed.

Petite pool	Pool reserved for practices with less than 300 attributed beneficiaries that do not wish to participate in a voluntary pool.
Pool	<p>A. The beneficiaries who are attributed to one or more participating practice(s) for the purpose of forming a shared savings entity; or</p> <p>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).</p>
Practice support	Support provided by Medicaid in the form of care coordination payments to a participating practice and practice transformation support provided by a DMS contracted vendor.
Practice transformation	The adoption, implementation and maintenance of approaches, activities, capabilities and tools that enable a participating practice to serve as a PCMH.
Primary Care Physician (PCP)	See Section 171.000 of the Arkansas Medicaid provider manual.
Provider portal	The website that participating practices use for purposes of enrollment, reporting to the Division of Medical Services (DMS) and receiving information from DMS.
Quality Improvement Plan (QIP)	QIP is a plan of improvement that practices must submit to PCMH Quality Assurance team after receiving notice of attestation failure or validation failure.
Recover	To deduct an amount from a participating practice's future Medicaid receivables, including without limitation, PCMH payments, or fee-for-service reimbursements, to recoup such amount through legal process, or both.
Remediation time	The period during which participating practices that fail to meet deadlines, targets or both on relevant activities and metrics tracked for practice support may continue to receive care coordination payments while improving performance.
Risk adjustment	An adjustment to the cost of beneficiary care to account for patient risk.
Same-day appointment request	A beneficiary request to be seen by a clinician within 24 hours.
Shared savings entity	A PCMH or pooled PCMHs that, contingent on performance, may receive shared savings incentive payments.
Shared savings incentive payment cap	The maximum shared savings incentive payment that DMS will pay to a shared savings entity, expressed as a percentage of that entity's benchmark cost for the performance period.
Shared savings incentive payments	Annual payments made to reward cost-efficient and quality care.
Shared savings percentage	The percentage of a shared savings entity's total savings

	that is paid to the PCMH in a shared savings entity.
State Health Alliance for Records Exchange (SHARE)	The Arkansas Health Information Exchange. For more information, go to http://ohit.arkansas.gov .

210.000 ENROLLMENT AND CASELOAD MANAGEMENT

211.000 Enrollment Eligibility 1-1-18

To be eligible to enroll in the PCMH program:

- A. The entity must be a participating practice as defined in Section 200.000.
- B. The practice must include PCPs enrolled in the ConnectCare Primary Care Case Management (PCCM) Program.
- C. The practice may not participate in the PCCM shared savings pilot established under Act 1453 of 2013.
- D. Beginning in January 2018, practices participating in PCMH should work towards adopting an Electronic Health Record (EHR). The EHR adopted must be one that is certified by Office of the National Coordinator for Health Information Technology. Practices should adopt the certified health IT modules which meet the definition of CEHRT according to the timeline and requirements finalized for use in CMS programs supporting certified EHR use. DMS reserves the right to identify and implement EHR metrics in future performance periods.
- E. The practice must have at least 150 attributed beneficiaries at the time of enrollment.

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

212.000 Practice Enrollment 1-1-18

Enrollment in the PCMH program is voluntary and practices must re-enroll annually. To enroll, practices must access the Advanced Health Information Network (AHIN) provider portal and submit a complete and accurate Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement (DMS-844). The AHIN portal can be accessed at <http://www.paymentinitiative.org/enrollment>.

Once enrolled, a participating PCMH remains in the PCMH program until:

- A. The PCMH withdraws;
- B. The practice or provider changes ownership, becomes ineligible, is suspended or terminated from the Medicaid program or the PCMH program; or
- C. DMS terminates the PCMH program.

A physician may be affiliated with only one participating practice. A participating practice must update the Department of Human Services (DHS) on changes to the list of physicians who are part of the practice. Physicians who are no longer participating with a practice are required to update in writing via email at ARKPCMH@DXC.com within 30 days of the change.

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

To withdraw from the PCMH program, the participating practice must email a complete and accurate Arkansas Patient-Centered Medical Home Withdrawal Form (DMS-846) to ARKPCMH@DCX.com. View or print the Arkansas Patient-Centered Medical Home Withdrawal Form (DMS-846) on the APII website at <http://www.paymentinitiative.org/pcmh-manual-and-additional-resources> or download the form from the AHIN provider portal.

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

- A. Submitting a complete PCMH Program enrollment application during the designated enrollment period
- B. Successful implementation of the activity(s) which the practice failed and which resulted in suspension or termination from the program

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

213.000 Enrollment Schedule 1-1-16

Enrollment is open for approximately 3 months in Quarter 3 and Quarter 4 of the preceding calendar year.

DMS will not accept any enrollment documents received other than during an enrollment period.

214.000 Caseload Management 1-1-16

A participating practice must manage its caseload of attributed beneficiaries, including removal of a beneficiary from its panel. DMS retains the right to disallow beneficiary removals if it was determined it was done so to dismiss high costs and/or high-risk patients from the panel.

220.000 PRACTICE SUPPORT

221.000 Practice Support Scope 1-1-18

Practice support includes both care coordination payments made to a PCMH and practice transformation support provided by a Division of Medical Services (DMS) contracted vendor and is subject to funding limitations on the part of DMS.

Receipt and use of the care coordination payments is not conditioned on the PCMH engaging a care coordination vendor, as payment can be used to support participating practices' investments (e.g., time and energy) in enacting changes to achieve PCMH goals. Care coordination payments are risk-adjusted to account for the varying levels of care coordination services needed for beneficiaries with different risk profiles.

DMS will contract with a practice transformation vendor on behalf of PCMHs that require additional support to catalyze practice transformation and retain and use such vendor. PCMHs must maintain documentation of the months they have contracted with a practice transformation vendor. Practice transformation vendors must report to DMS the level and type of service delivered to each PCMH. Payments to a practice transformation vendor on behalf of a participating practice may continue for up to 24 months.

DMS may pay, recover or offset overpayment or underpayment of care coordination payments.

DMS will also support PCMHs through improved access to information through the reports described in Section 244.000.

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

222.000 Practice Support Eligibility 1-1-16

In addition to the enrollment eligibility requirements listed in Section 211.000, in order for PCMHs to receive practice support, DMS measures PCMH performance against activities tracked for practice support identified in Section 241.000. PCMHs must meet the requirements of this section to receive practice support.

Each PCMH in a shared entity will, if individually qualified, receive practice support even if another PCMH in a shared savings entity does not qualify for practice support.

223.000 Care Coordination Payment Amount 1-1-18

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

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

If a PCMH withdraws from the PCMH program, then the PCMH is only eligible for care coordination payments based on a complete quarter's participation in the PCMH program.

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 1-1-18

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

- A. The following beneficiaries shall not be counted toward the 5,000 attributed beneficiary requirements.
1. Beneficiaries that have been attributed to that entity's PCMH(s) for less than half of the performance period.
 2. Beneficiaries that a PCMH prospectively designates for exclusion from per beneficiary cost of care (also known as physician-selected exclusions) on or before the 90th day of the performance period. Once a beneficiary is designated for exclusion, a PCMH may not update selection for the duration of the performance period. The total number of physician-selected exclusions will be directly proportional to the PCMH's total number of attributed beneficiaries (e.g., up to one exclusion for every 1,000 attributed beneficiaries).
 3. Beneficiaries for whom DMS has identified another payer that is legally liable for all or part of the cost of Medicaid care and services provided to the beneficiary.

DMS may add, remove or adjust these exclusions based on new research, empirical evidence, provider experience with select beneficiary populations or inclusion of new payers. DMS will publish such an addition, removal or modification on the APII website at <http://www.paymentinitiative.org/pcmh-manual-and-additional-resources>.

- B. Shared savings incentive payments are conditioned upon a shared savings entity:
1. Enrolling during the enrollment period prior to the beginning of the performance period;
 2. Meeting Section 241.000 requirements for activities tracked for practice support;
 3. Meeting requirements for metrics tracked for shared savings incentive payments in Section 243.000 based on the performance for beneficiaries attributed to the shared savings entity for the majority of the performance period; and
 4. Maintaining eligibility for practice support as described in Section 222.000.

Shared savings payments are made to the individual PCMHs which are part of a shared savings entity. These payments are risk- and time- adjusted and prorated based on the number of beneficiaries of each PCMH. These payments are predicated on each PCMH maintaining eligibility for practice support as described in Section 222.000.

233.000 Pools of Attributed Beneficiaries

1-1-18

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

- A. Meet minimum pool size independently;
- B. Pool attributed beneficiaries voluntarily with other participating PCMHs as described in Section 234.000. In this method, practices voluntarily agree to have their performance measured together by aggregating both per beneficiary cost of care and quality metrics tracked for shared savings incentive payments across the practices; or
- C. Be assigned to the default pool as described in Section 234.000. Practices with beneficiaries in this pool will have their performance measured together by aggregating performance of the per beneficiary cost of care however the Quality metrics are tracked for shared savings incentive payments are measured at the individual PCMH; or
- D. Be assigned to the petite pool as described in Section 234.000. In this method, practices will have their performance measured together by aggregating both per beneficiary cost of care and quality metrics tracked for shared savings incentive payments across all practices in the pool. For the 2018 performance year, all practices with less than 300 beneficiaries will be assigned to the petite pool. In subsequent years, practices with less than 300 beneficiaries may be able to voluntarily pool with other PCMHs to reach the 5,000 minimum requirement.

A shared savings entity's **pool** configuration (A, B, C, or D) is established during the enrollment period and cannot be changed after the end of the enrollment period.

234.000 Requirements for Joining and Leaving Pools

1-1-18

PCMHs may voluntarily pool for purposes described in Section 233.000 before the end of the enrollment period that precedes the start of the performance period. To pool, the participating practice must email a complete and accurate Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form (DMS-845) to ARKPCMH@DXC.com. View or print the Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form on the APII website at <http://www.paymentinitiative.org/pcmh-manual-and-additional-resources>. You can also download the form from the AHIN provider portal.

The DMS-845 Pooling form must be executed by all PCMHs participating in the pool. Before the end of the enrollment period, PCMHs that are on their own or through pooling do not reach a minimum of 5,000 attributed beneficiaries will be assigned to the default pool. Practices with less than 300 attributed beneficiaries that do not wish to participate in a voluntary pool will be placed in the petite pool. Individual PCMHs whose attribution changes during the performance period will be classified as standalone, default, or petite pool members according to their attribution count at the end of the performance period.

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

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

235.000 Per Beneficiary Cost of Care Calculation

1-1-18

Each year, the per beneficiary cost of care performance is aggregated and assessed across a shared savings entity. Per beneficiary cost of care is calculated as the risk- and time-adjusted average of such entity's attributed beneficiaries' total fee-for-service claims (based on the published reimbursement methodology) during the annual performance period, with adjustments and exclusions as defined below.

One hundred percent of the dollar value of care coordination payments is included in the per beneficiary cost of care calculation.

As described in Section 232.000, beneficiaries not counted toward the minimum number of attributed beneficiaries for shared savings incentive payments will be excluded from the calculation of per beneficiary cost of care.

Some costs are excluded from the calculation of per beneficiary cost of care. Each year DMS will announce which costs are excluded on the APII website at <http://www.paymentinitiative.org/pcmh-manual-and-additional-resources>.

236.000 Baseline and Benchmark Cost Calculations

1-1-18

DMS will calculate a historical baseline per beneficiary cost of care for each shared savings entity. This shared savings entity-specific historical baseline will be calculated as a multi-year blended average of each shared savings entity's per beneficiary cost of care.

DMS will calculate benchmark costs for each shared savings entity by applying a 2.6% benchmark trend to the entity's historical baseline per beneficiary cost of care. DMS may reevaluate the value of this benchmark trend if the annual, system-average per beneficiary cost of care growth rate differs significantly from a benchmark, to be specified by DMS. DMS will publish any modification to the benchmark trend on the APII website at <http://www.paymentinitiative.org/pcmh-manual-and-additional-resources>.

237.000 Shared Savings Incentive Payment Amounts

1-1-18

A shared savings entity is eligible to receive a shared savings incentive payment that is the greater of: (A) a shared savings incentive payment for performance improvement; or (B) a shared savings incentive payment for absolute performance.

- A. Shared savings incentive payments for performance improvement are calculated as follows:

1. During each performance period, each shared savings entity's per beneficiary savings is calculated as: [benchmark cost for that performance period] – [per beneficiary cost of care for that performance period].
 2. If the shared savings entity's per beneficiary cost of care falls below that entity's benchmark cost for that performance period by at least the minimum savings rate, only then may the shared savings entity be eligible for a shared savings incentive payment for performance improvement.
 3. The per beneficiary shared savings incentive payment for performance improvement for which the shared savings entity may be eligible is calculated as follows: [per beneficiary savings for that performance period] * [shared savings entity's shared savings percentage for that performance period].
 4. To establish shared savings percentages for performance improvement in a given performance period, DMS will compare the entity's previous year per beneficiary cost of care to the previous year's medium and high cost thresholds.
 5. If, in the previous performance period, a shared savings entity's per beneficiary cost of care was:
 - a. Below the medium cost threshold, then the shared savings entity may receive 50% of per beneficiary savings created in the current performance period (i.e., the entity's shared savings percentage will be 50%);
 - b. Between the medium and high cost thresholds, then the shared savings entity may receive 30% of per beneficiary savings created in the current performance period (i.e., the entity's shared savings percentage will be 30%);
 - c. Above the high cost threshold, the shared savings entity may receive 10% of per beneficiary savings created in the current performance period (i.e., the entity's shared savings percentage will be 10%) unless the shared savings entity's per beneficiary cost of care falls above the current performance period high cost incentive payment for that performance period.
- B. Shared savings incentive payments for absolute performance are calculated as follows:

If the shared savings entity's per beneficiary cost of care falls below the current performance period medium cost threshold, then the shared savings entity may be eligible for a shared savings incentive payment for absolute performance. The per beneficiary shared savings incentive payment for absolute performance for which the entity may be eligible is calculated as follows: ([medium cost threshold for that performance period] – [per beneficiary cost of care for that performance period]) * [50%].

Shared savings calculations under absolute performance and performance improvements are subject to the following criteria:

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

1. The minimum savings rate is 2%. DMS may adjust this rate based on new research, empirical evidence or experience from initial provider experience with shared savings incentive payments. DMS will publish any such modification of the minimum savings rate on the APII website at <http://www.paymentinitiative.org/pcmh-manual-and-additional-resources>.
2. If the per beneficiary shared savings incentive payment for which the shared savings entity is eligible exceeds the shared savings incentive payment cap, expressed as 10% of the shared savings entity's benchmark cost for that performance period, the shared savings entity will be eligible for a per beneficiary shared savings incentive payment equal to 10% of its benchmark cost for that performance period.

3. If the shared savings entity's per beneficiary cost of care falls **below** the current performance period total cost of care floor, then the shared savings entity's per beneficiary cost of care will be set as the total cost of care floor, for purposes of calculating shared savings incentive payments. The **2018** cost of care floor is set at **\$1,481** and will increase by 1.5% each subsequent year, or as specified at www.paymentinitiative.org.
4. A shared savings entity's total shared savings incentive payment will be calculated as the per beneficiary shared savings incentive payment for which it is eligible multiplied by the number of attributed beneficiaries as described in Section 232.000, adjusted based on the amount of time beneficiaries were attributed to such PCMHs and the risk profile of the attributed beneficiaries.

If participating practices have pooled their attributed beneficiaries together, then shared savings incentive payments will be allocated to those practices based on risk- and time-adjustment and in proportion to the number of attributed beneficiaries that each PCMH contributed to such pool.

1. A shared savings entity will not receive shared savings incentive payments unless it meets all the conditions described in Section 232.000.
2. DMS pays shared savings incentive payments on an annual basis for the most recently completed performance period and may withhold a portion of shared savings incentive payments to allow for final payment adjustment after a year of claims data is available.
3. Final payment will include any adjustments required in order to account for all claims for dates of service within the performance period. If the final payment adjustment is negative, then DMS may recover the payment adjustment from the participating PCMH.

240.000 METRICS AND ACCOUNTABILITY FOR PAYMENT INCENTIVES

241.000 Activities Tracked for Practice Support 1-1-18

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

242.000 Accountability for Practice Support 1-1-16

If a PCMH does not meet deadlines and targets for activities tracked for practice support as described in Section 241.000, then the practice must remediate its performance to avoid suspension or termination of practice support.

DMS will verify whether attestation and required documentation was submitted as required by the PCMH program. Failure to comply with this requirement will result in a Notice of Attestation Failure.

DMS will also validate whether attested activities met the PCMH program requirements. Failure to pass validation will result in a Notice of Validation Failure.

PCMHs which received a Notice of Attestation Failure and/or PCMHs which received a Notice of Validation Failure will have 15 calendar days to submit sufficient QIP. Failure to submit sufficient QIP within 15 days of receiving a Notice of Attestation Failure and/or a Notice of Validation Failure will result in suspension or termination of practice support. PCMHs which receive a Notice of Attestation Failure will have 90 days to remediate their performance from the date of

the Notice of Attestation Failure. PCMHs which received a Notice of Validation Failure will have 45 days to remediate their performance from the date of the Notice of Validation Failure.

If a PCMH fails to meet the deadlines or targets for activities within the specified remediation time, then DMS will suspend or terminate practice support.

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

DMS assesses quality metrics tracked for shared savings incentive payments according to the targets announced by DMS at www.paymentinitiative.org. To receive a shared savings incentive payment, the shared savings entity or PCMH must meet the quality metrics on which the entity or PCMH is assessed and which are published on the APII website at <http://www.paymentinitiative.org/pcmh-manual-and-additional-resources>.

244.000 Provider Reports 1-1-18

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

Failing to submit any updated license, address changes or changes to the Provider Id number, may result in provider reports with no beneficiary attribution. Providers may update at any time their licenses, address changes, or changes to their Provider ID number by submitting documentation to the Provider Enrollment unit via fax at (501) 374-0746. Providers who have concerns about information included in their reports should send an email to PCMH@AFMC.org. The PCMH Quality Assurance Manager will respond to the provider/practice with a review of their inquiry. If the review leads to a discovery that the provider report is inaccurate or does not reflect actual performance, DMS will take the necessary steps to correct the inaccuracies including those that are a result of a systems and/or algorithm error. Providers can also call the APII help desk at 501-301-8311 or 866-322-4698 and by email at ARKPII@DXC.com.

Appeals

If you disagree with DMS' decision regarding program participation, payment or other adverse action, you have the right to request reconsideration and you have the right to request an administrative appeal. During the remediation period, and prior to the notice of adverse action, practices continue receiving practice support payments. However, DMS will not pay practice support payments after the notice of adverse action. If the practice prevails during the appeal, or reconsideration, the practice support payments will resume retroactively from the date of the adverse action notice.

A. Request Reconsideration

The Division of Medical Services must receive written request for reconsideration within (30) calendar days of the Date of the adverse action, notice. Send your request to the Arkansas Department of Human Services, Division of Medical Services, Health Care Innovation P.O. Box 1437, Slot S425, Little Rock, AR 72203.

B. Request an Administrative Appeal

The Arkansas Department of Health must receive a written appeals request within (30) calendar days of the date of the adverse action notice, or within (10) calendar days of receiving a reconsideration decision. Send your request to Arkansas Department of Health: Attention: Medicaid Provider Appeals Office, 4815 West Markham Street, Slot 31, Little Rock, AR 72205.