IN THE CIRCUIT COURT OF PULASKI COUNTY
_____ DIVISION

ARKANSAS RESIDENTIAL ASSISTED LIVING ASSOCIATION,
BY AND THROUGH ITS MEMBERS,
CLARKSVILLE RETIREMENT CENTER, SEBASTIAN
COUNTY RETIREMENT CENTER PHASE I, SEBASTIAN
COUNTY RETIREMENT CENTER PHASE II,
MULBERRY LODGE, SHORT MOUNTAIN LODGE,
RETIREMENT CENTER OF ARKANSAS, FORREST HILLS
RESIDENTIAL CARE FACILITY, FORREST MANOR, INC.,
GREENWOOD RETIREMENT CENTER,
MAGNOLIA RETIREMENT CENTER, OMEGA CARE, INC.,
SPLIT RAIL RESIDENTIAL CARE FACILITY, WILSON'S
RESIDENTIAL CARE, BAXTER RETIREMENT VILLAGE,
WEST MEMPHIS RESIDENTIAL CARE, INC., AND
JOHN DOE MEDICAID BENEFICIARIES 1-10 PLAINTIFFS

v. CASE NO. CV_____

ARKANSAS DEPARTMENT OF HUMAN SERVICES,
CINDY GILLESPIE, IN HER OFFICIAL CAPACITY
AS DIRECTOR OF THE ARKANSAS DEPARTMENT
OF HUMAN SERVICES;
AND PAULA STONE, IN HER OFFICIAL CAPACITY
AS DEPUTY DIRECTOR, INNOVATION AND
DELIVERY SYSTEM REFORM,
ARKANSAS DEPARTMENT OF HUMAN SERVICES DEFENDANTS

VERIFIED COMPLAINT FOR TEMPORARY RESTRAINING ORDER, PRELIMINARY AND PERMANENT INJUNCTION AND DECLARATORY JUDGMENT

COMES NOW the Plaintiffs by and through their attorneys, Kutak Rock LLP, and for their Verified Complaint for Temporary Restraining Order, Preliminary and Permanent Injunction and Declaratory Judgment states:

PARTIES

1. Plaintiff Arkansas Residential Assisted Living Association ("Association") is an Arkansas non-profit organization that was founded in 1983 to provide advocacy, communication, education, and other resources to the Residential Care and Assisted Living industry and residents. Each facility is licensed through the Department of Human Services Office of Long Term Care and offers, among other things, assistance with medication, an Administrator licensed by the state of Arkansas, balanced meals and snacks, scheduled activities and events, Perspectives Behavioral Health Management, beauty services, private and semiprivate rooms, laundry and housekeeping, certified Nursing Assistants, scheduled transportation to medical appointments, and trained professional staff on duty twenty-four (24) hours per day. The Association represents several Arkansas Residential and Assisted Living Facilities, including the following representative members who have joined together to bring this action:

a. Clarksville Retirement Center is a Residential Care Facility located in Clarksville, Arkansas, with seventy (70) beds.

b. Sebastian County Retirement Center Phase I ("Phase I") is a Residential Care Facility in Barling, Arkansas, with 104 beds.

c. Sebastian County Retirement Center Phase II ("Phase II") is a Residential Care Facility in Barling Arkansas, with 104 beds.

d. Greenwood Retirement Center is a Residential Care Facility located in Greenwood, Arkansas with sixty-four (64) beds.

e. Mulberry Lodge is a Residential Care Facility located in Mulberry, Arkansas, with sixty (60) beds.

f. Short Mountain Lodge is a Residential Care Facility located in Paris, Arkansas, with eighty (80) beds.

g. Retirement Centers of Arkansas is a Residential Care Facility located in Sherwood, Arkansas, with sixty-five (65) beds.

h. Forrest Hills is a Residential Care Facility located in Forrest City, Arkansas, with forty-five (45) beds.

i. Forrest Manor, Inc. is a Residential Care Facility located in Dewitt, Arkansas, with twenty (20) beds.

j. Magnolia Retirement Center is a Residential Care Facility located in Little Rock, Arkansas, with one hundred eighty-three (183) beds.

k. Omega Care, Inc. is a Residential Care Facility located in Helena, Arkansas, with forty-eight (48) beds.

l. Split Rail, Inc. is a Residential Care Facility located in Prescott, Arkansas, with one hundred and two (102) beds.

m. Wilson's Residential Care is a Residential Care Facility located in Marianna, Arkansas, with twelve (12) beds.

n. Baxter Retirement Village is a Residential Care Facility located in Mountain Home, Arkansas, with seventy (70) beds.

o. West Memphis Residential Care, Inc. is a Residential Care Facility located in West Memphis, Arkansas, with sixty (60) beds.

2. Plaintiffs John Doe Medicaid Beneficiaries 1-10 are Medicaid recipients and individuals who have been, or should be, assigned to one of the PASSES, as described in more detail below. They have also been, and will continue to be, affected by the systemic failures described in this Complaint, and have no adequate remedy at law or equity to ensure continued

access to vital Medicaid services based upon the actions and inactions of Defendants outlined elsewhere.

3. Defendant Arkansas Department of Human Services ("DHS") is Arkansas' largest state agency and serves more than 1.2 million Arkansans every year. The purpose of DHS is to ensure the citizens of Arkansas are healthy, safe, and enjoying a high quality life. To manage the services and programs it provides, DHS has nine divisions and seven (7) support offices headquartered in Little Rock, Arkansas, in addition to the eighty-five (85) county offices.

4. Defendant Cindy Gillespie ("Gillespie") is the Director of the Arkansas Department of Human Services and is sued in her official capacity. Defendant Gillespie has the responsibility for implementation and oversight of the Provider-Led Arkansas Shared Savings Entity, a managed care system created by Act 775 of 2017 (codified at Ark. Code Ann. § 20-77-2701).

5. Defendant Paula Stone ("Stone") is DHS Deputy Director, Innovation and Delivery System Reform and is sued in her official capacity. Stone has the responsibility for implementation and oversight of the PASSE system.

JURISIDICTION AND VENUE

6. This is an action for a temporary restraining order, declaratory and injunctive relief related to the imminent implementation of significant changes to the Arkansas Medicaid Program, as administered by DHS. Plaintiffs are not seeking monetary damages.

7. This Court has jurisdiction over the parties and subject matter of this case pursuant to Amendment 80, Sec. 6 of the Arkansas Constitution, Ark. Code Ann. § 16-13-201; and Arkansas Supreme Court Administrative Order 14.

8. Venue is proper in this Court under Ark. Code Ann. § 16-60-104(3)(A).

INTRODUCTION

5. This case challenges the efforts for Defendants to act unilaterally to comprehensively and haphazardly transform Medicaid, the cornerstone of the social safety net, and threatening irreparable harm to the health and welfare of the poorest and most vulnerable in the State.

6. The Medicaid program provides health insurance coverage to more than 75 million low-income people in the United States. Medicaid enables states to provide a range of federally specified preventative, acute, and long-term health care services to individuals who income and resources are insufficient to meet the costs of necessary medical services. The core populations covered by Medicaid include children; pregnant women; the aged, blind or disabled; and adults with household incomes of less than 133% of the federal poverty level (currently $12,140 for an individual). Just under one million Arkansas residents rely upon Medicaid coverage.

5. Here, when Arkansas chose to participate in the federal Medicaid program, Arkansas agreed to follow all of the federal Medicaid requirements, including those regarding the scope of coverage and eligibility for the program. The State of Arkansas may not impose additional eligibility requirements other than those set forth in the Medicaid Act, and Arkansas cannot pick and choose among individuals within a covered population group.

6. The Provider-led Arkansas Shared Savings Entity ("PASSE") system is a model of organized care created by Act 775 of 2017. The PASSE system is a fully funded Medicaid program that is set for full implementation (referred to as "Phase II") on March 1, 2019. However, as this Complaint demonstrates, DHS has entirely failed to ensure the PASSE system is ready for full implementation, in spite of delaying implementation from January 1, 2019 to March 1, 2019, ostensibly to ensure PASSE system stability.

7. Arkansas mental healthcare providers, including Plaintiff's members, and PASSE executives have voiced serious concerns about the issues with the PASSE system, the anticipated harm to Medicaid beneficiaries, and the need to postpone full implementation of the PASSE system until such time as the system is fully prepared and functional. These concerns have been so serious, that, upon information and belief, at least one PASSE opted to exit the system, rather than continue to participate in the flawed implementation.

8. Gillespie and DHS have refused to heed the warnings of various stakeholders, in spite of direct knowledge of the significant issues that have arisen around the Phase II implementation, which will have a direct and immediate effect on providers' and Medicaid beneficiaries' ability to provide and receives services.

9. Defendants' refusal to halt or delay implantation of the PASSE system, knowing the harm such implementation will have on Arkansas citizens, is an action beyond the agency's constitutional duties, *ultra vires*, arbitrary, capricious, and in bad faith.

10. Plaintiffs thus seek expedited interim relief by issuance of a temporary injunction enjoining Defendants from implementing Phase II of the PASSE system until such time as the system is determined to be fully prepared and functional as to avoid irreparable harm to Medicaid providers and beneficiaries.

FACTUAL ALLEGATIONS

I. Overview of PASSE System.

A. Purpose and General Structure.

11. DHS is implementing the PASSE system as a mechanism for service provision to certain Arkansans with qualifying developmental disabilities ("DDS"), behavioral health diagnoses ("BH"), or other "significant" needs.

12. Per DHS, the goals of the PASSE system are:

a. to improve the health of Arkansans who need specialized care for behavioral health issues or developmental/intellectual disabilities;

b. to link providers of physical health care with specialty providers of behavioral health and developmental/intellectual disabilities services;

c. to coordinate care for all community-based services for these individuals;

d. to allow flexibility in the types of services offered;

e. to increase the number of service providers available in the community to serve the PASSE members;

f. to reduce cost of care by coordinating and providing appropriate and preventative care.

13. Each PASSE is Medicaid-funded and acts like an insurance group. Each PASSE has members that are attributed to it by DHS or who voluntary enroll. Providers join with one or more PASSEs to be in its "network," and the PASSE pays providers for the healthcare services rendered to its members.

14. The PASSE is also responsible for overall care coordination for its members. Over 40,000 Arkansans are expected to receive services through the PASSEs, including: (i) 4,600 individuals on the DDS Waiver and 2,400 on the DDS Waiver Wait List; (ii) 38,000 individuals with a behavioral health diagnosis whose independent assessment determined he/she has significant needs; and (iii) 750 people in private Intermediate Care Facilities.

15. According to DHS, the PASSE system is not intended to change a person's eligibility for Medicaid, but change only the way services are paid for.

16. The PASSE entities did not exist before the passage of Act 775 of 2017 and have never before managed any health care services needed by the citizens of Arkansas, let alone crucial DD and BH needs. These entities have no prior coordination of care or reimbursement infrastructure on which to rely.

B. The Uncertainty of the PASSE Model.

8. Originally, there were five (5) PASSEs. However, one PASSE, Arkansas Advanced Care, pulled out from the PASSE model in 2018.

9. The remaining four (4) PASSEs – ForeverCare, Arkansas Total Care, Empower Healthcare Solutions, and Summit Community Care – provided care coordination for clients beginning early 2018. This was referred to as "Phase I" of the PASSE system implementation.

10. The PASSEs were set to enter "Phase II," which was full risk, care coordination, and reimbursement on January 1, 2019. However, upon information and belief, due to lack of system preparation, and concerns voiced by various providers, stakeholders, and representatives of the PASSE's themselves, Phase II was delayed until March 1, 2019.

11. DHS stated this would allow systems to be tested, billing systems to function seamlessly, additional enrollment opportunities for providers, and training of those providers.

12. DHS stated that during the delay it would conduct webinars and town halls, use client feedback to provide more information materials, educate and inform providers on the benefits of joining the PASSE model, and help providers enroll in one or more PASSEs.

13. On January 18, 2019, approximately six (6) weeks before Phase II was to begin, DHS made a public announcement that ForeverCare had made a "business decision" to pull out of the current PASSE model.

14. Mike McCabe, the president of the ForeverCare, told the members of ForeverCare in an e-mail on January 16, 2018: "Despite our best efforts we do not have the systems in place to assure members would be cared for in the way they deserve. In addition, the risks posed by the continuing questions around the program are too great for us to move forward at this time."

15. Further, in an email to Defendant Stone and others, McCabe wrote ForeverCare "reached this decision with much reluctance in light of the March 1, 2019 implementation date." McCabe continued: "As we have discussed, in addition to the fact that ForeverCare's internal requirements dictate that it cannot enter into Phase II Agreement unless the start date of Phase II is moved to July 1, 2019, we believe there are also program operational issues which need to be resolved before DHS implements Phase II." **Exhibit "A"**, KARK Article.

16. McCabe advised Defendants that ForeverCare could continue to participate in the PASSE model of its participation in full risk was moved to July 1, 2019.

17. Defendants have publically denied any operational issues with the PASSE model, while internally fielding concerns from providers, beneficiaries, and the PASSE's themselves. In spite of their awareness of these serious concerns, Defendants insist on moving forward with March 1, 2019 implementation, even though by all accounts, the PASSE system is unprepared to enter Phase II.

II. Areas of Instability within the PASSE System

A. Member Attribution and Reattribution

18. According to a Fact Sheet published by DHS and dated January 23, 2019, ForeverCare's 7,600 members will be reassigned to a new PASSE "about the second week in February," and their participation in the new PASSE will become effective March 1, 2019. (*See* PASSE Program: Reassignment of Clients Fact Sheet, **Exhibit "B"**.)

19. In short, this means that just *weeks* before the scheduled implementation of the PASSE model, 7,600 beneficiaries have become unassigned.

20. Assignment to a new PASSE will be "round robin" style. Because of this, beneficiaries and providers, including Plaintiffs, are unable to determine what PASSE the beneficiaries may be ultimately placed.

21. Following attribution to any PASSE, beneficiaries then have ninety (90) days to change to a new PASSE for any reason. *Id*.

22. There appears to be no procedure in place to direct this process, notify providers as to when a beneficiary transfers from one PASSE to another, or alert providers as to when (and how) to transition billing between PASSE's.

23. As of February 19, 2019, beneficiary membership cards have still not been mailed out. Upon information and belief, beneficiaries are told that such cards are not going to be mailed out until February 22, 2019. This means beneficiaries may not have a membership card necessary for services until just days before implementation on March 1, 2019, if at all.

24. Providers and beneficiaries who are unable to receive and provide needed services because there is a lack of clarity around member attribution and transfers as of March 1, 2019, will suffer irreparable and continuing injury for which there will be no adequate remedy at all.

B. Beneficiary Assessments

25. If a beneficiary receives Medicaid and has been identified as needing BH services, receiving DD services through a waiver, or is on a waiver waitlist, then DHS requires an independent assessment ("Assessment").

26. DHS has contracted with Optum to provide these Assessments.

27. While the prior Assessment process included a review of medical records by a registered nurse and significant time spent with the beneficiary to accurately evaluate the beneficiary's needs, the Optum Assessment includes none of these important aspects.

28. Although DHS states that Optum will perform the Assessments in-person at the facility where the beneficiary receives services, a school, or the beneficiary's home, Optum has been performing many Assessments by telephone, if at all.

29. Even those Assessments performed in-person by Optum consist only of asking the beneficiary questions that require a Yes or No or a few-word answer. Optum does not review the relevant medical records nor does Optum spend quality time with the beneficiary. This process is deficient and results in inaccurate Assessments.

30. For example, Optum may ask a beneficiary if he or she needs help showering or some other activity of daily living ("ADL"). The beneficiary may respond no. Optum does not follow-up with more specific inquiries as to the ADL in question, review additional records or talk with staff at the residential care facility to evaluate whether the beneficiary's response is accurate. Optum makes no inquiry as to whether the beneficiary can enter the shower without physical help but requires the prompt to shower, a prompt to use shampoo, a prompt to use body soap, a prompt to dry off fully, and a prompt to put on clean clothes.

31. At the end of Optum's Assessment, the beneficiary's answers are scored, which each answer being worth a certain number of points. Based on the total number of points, the beneficiary is assigned to the corresponding tier level ("Tier") – Tier 1, Tier 2, and Tier 3 – to which the beneficiary is assigned.

32. The Tier into which a beneficiary is placed determines what services the beneficiary can receive.

33. Tier 1 means that the beneficiary can receive counseling services and medication management. Beneficiaries categorized into Tier 1 are not assigned to a PASSE. Beneficiaries in a Tier 1 level are required to have their needs met through outpatient services.

34. Tier 2 means that a beneficiary is eligible for target services provided in home and community settings in addition to counseling. Beneficiaries categorized into Tier 2 are assigned to a PASSE.

35. Tier 3 means that a beneficiary is eligible for all of Tier 2 services and may need services provided in a residential setting. Only in this Tier 3 is a beneficiary eligible for inpatient residential care. Beneficiaries categorized into Tier 3 are assigned to a PASSE.

36. Once the assessment is completed by Optum, the beneficiary receives the results in a packet.

37. For those beneficiaries that score into a Tier 2 or Tier 3 and are thus assigned a PASSE, the beneficiary also receives a letter in the mail informing the beneficiary of the PASSE to which he or she has been assigned.

38. Upon information and belief, many beneficiaries who were previously identified as requiring Tier 2 or Tier 3 services are now suddenly being assessed as needing Tier 0 (not eligible for services) or Tier 1 (eligible for reduced services) based on Optum's deficient Assessments. Tier 0 and Tier 1 beneficiaries are not assigned to a PASSE.

39. Providers providing services and residential facilities to these beneficiaries previously identified as requiring Tier 2 or Tier 3 services, who have now been identified as non-Tiered or Tier-1 beneficiaries, are faced with having to remove beneficiaries in need of vital services from their programs, due to the inability to provide such care without any expectation of compensation for the services.

40. In addition, DHS extended the expiration date of certain Assessments that allow beneficiaries to receive personal care services so that they expire on February 28, 2019. Meaning, many beneficiaries will no longer qualify for the services they need as of March 1, 2019.

41. Neither DHS nor the PASSES have officially advised as to whether these beneficiaries will be able to continue receiving the services they need, and providers are receiving mixed messages as to who will be responsible for extending or renewing those Assessments as of March 1, 2019.

42. Providers have received differing messages from DHS and the PASSES on beneficiaries' prior authorizations for services. DHS has stated prior authorizations will be extended for sixty (60) days after March 1, 2019 implementation, after which providers will have to negotiate directly with the PASSES regarding rates and continuing services for their beneficiaries. Conversely, some PASSES have claimed prior authorizations will be extended for ninety (90) days after March 1, 2019 implementation, after which providers will have to negotiate directly with the PASSES regarding rates and continuing services for their beneficiaries. In spite of demand, neither DHS nor the PASSES will commit to a particular timeline in writing for how long the extended prior authorizations will be effectuated following the March 1, 2019 implementation date.

43. Pleading further, it is unclear as of the date of filing this Complaint, as to who – DHS or the PASSE's – will be responsible for the Optum Assessment process as a whole beginning March 1, 2019, including arranging and managing assessments, referrals, and renewals. Indeed, it is unclear whether beneficiaries will be reassessed by Optum following March 1, 2019 implementation.

44. Upon information and belief, Optum has been refusing to conduct prior authorization assessments of beneficiaries residing in Residential Care Facilities. Upon further information and belief, Optum has attempted to conduct some prior authorization assessments of beneficiaries via telephone.

45. According to Defendants' own documents, it was unable to answer this very question as of January 18, 2019. In a draft Fact Sheet, Defendant DHS poses the question: "Will I have to get approval to see a new doctor or specialist?" Defendant DHS's draft response reads: "Need this answer. Families have been asking how referrals will work, when, and how the communication line will work between them, the PASSE, and the PCP, etc." **Exhibit "C"**, Draft FAQ Sheet.

46. Providers and beneficiaries who are unable to receive and provide needed services because of the current deficient Assessment, referral, and renewal process and the lack of clarity around these processes as of March 1, 2019, will suffer irreparable and continuing injury for which there will be no adequate remedy at law.

C. Provider Contracts / Billing

47. According to DHS, each PASSE is responsible for contracting directly with providers. These contracts will provide the key terms applicable to the relationship between a provider and a PASSE, including billing requirements and reimbursement rates.

48. However, as of the filing of this Complaint, DHS nor the PASSEs have received executed contracts, nor have they been told what the reimbursement rates will be.

49. Plaintiff providers have been told by at least one PASSE that they will not receive an executed contract until "a couple weeks prior to the implementation of Phase 2."

50. In addition, the PASSEs are wholly unprepared with regards to billing. For example, one PASSE was unable to advise Plaintiffs as to how they were to bill for personal care services, which is a Medicaid covered service, beginning March 1.

51. Moreover, as of February 19, 2019, the PASSE provider portals are not even functioning yet. This means that, days before full implementation, providers are unaware and untrained regarding the mechanics of billing under each PASSE's unique billing system in order to receive payment for services rendered to each PASSE's members.

52. In addition, beneficiaries are unable to determine whether their provider is even in a PASSE. Defendant DHS stated in a draft Fact Sheet drafted on or around January 18, 2019, that: "Some people have said that their care coordinators can't answer this question, and it can't be found on the PASSE websites either. ATC does not have it listed." The posed question was: "How do I know if my provider is in a PASSE?"

53. When asked whether Arkansas Children's Hospital and UAMS were in-network members of a PASSE, DHS was unable to provide an answer. DHS inserted a placeholder reading: "Need this answer. Need to explain why families may not see their individual physician listed and what that means." *Id.*

54. As a result, providers such as Plaintiff are unable to determine whether it is cost efficient to accept a beneficiary into the Plaintiff's residential centers (or whether they will be paid at all) and beneficiaries are unable to determine the most cost effective providers for their care.

55. Providers and beneficiaries who are unable to receive and provide needed services because of the lack of clarity around billing and reimbursement as of March 1, 2019, will suffer irreparable and continuing injury for which there will be no adequate remedy at law.

D. Appeal Rights

56. In the current system, the rights of providers and beneficiaries to appeal various decisions regarding payment of Medicaid funds is memorialized in various places, include the Arkansas Medicaid Providers' Manual and the Arkansas Medicaid Fairness Act, Ark. Code Ann. § 20-77-1701, *et. seq*.

57. However, now, according to the PASSE agreement executed amongst the various member PASSE's and DHS, the current appeal process will transition to one in which the individual PASSE's have the ability to create and utilize their own, individual, internal appeal procedures, and to have "all appeals and grievances resolved by an independent review organization through an external review process." (PASSE Provider Agreement, 2.4.19, Section 4.9.4, Complaints, Grievances and Appeals, **Exhibit "D"**; PASSE Town Hall QA Log 12.6.2018, **Exhibit "E"**.)

58. Such an arrangement strips existing due process rights from providers and beneficiaries and create significant barriers to access to the judicial system in cases initiated within these new internal appeal processes. This arrangement also fosters confusion amongst providers and beneficiaries now charged with three distinct appeal procedures based on the preferences of the three individual PASSE's.

59. Upon information and belief, upon the filing of this Complaint, neither DHS nor the PASSEs have provided final guidelines with regard to beneficiary and provider appeal rights.

60. Providers and beneficiaries who are unable to receive and provide needed services because of the lack of clarity around the appeal process of March 1, 2019, will suffer irreparable and continuing injury for which there will be no adequate remedy at law.

STANDARD FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

61. Plaintiffs incorporate by reference into this paragraph all allegations set forth above in this Complaint.

62. Arkansas Rule of Civil Procedure 65(a)(1) states that a preliminary injunction may be granted where it appears by that irreparable harm may result to the plaintiff if the preliminary injunction is not granted.

63. Concurrent with the filing of this Complaint, copies have been provided to the Arkansas Department of Human Services Office of Chief Counsel, pursuant to Ark. R. Civ. P. 65(b)(1)(B).

64. It is within the Court's discretion whether to grant a preliminary injunction. *Custom Microsystems, Inc. v. Blake*, 344 Ark. 536, 540, 42 S.W.3d 453, 456 (2001); *Smith v. American Trucking Association, Inc.*, 300 Ark. 594, 781 S.W.2d 3 (1989). The Eighth Circuit's standard for issuance of a preliminary injunction consists of four elements that must be considered: (1) the probability of the movant's success on the merits; (2) the threat of irreparable harm to the movant in the absence of relief; (3) the balance between that harm and the harm that the relief would cause to the other litigants; and (4) the public interest. *Dataphase Systems, Inc. v. CL Systems, Inc.*, 640 F.2d 109, 112-114 (8th Cir. 1981). Arkansas courts, though, hold that the two critical factors are whether a plaintiff demonstrates a likelihood of success on the merits and whether the plaintiff demonstrates a likelihood that, absent the granting of preliminary relief, irreparable harm will occur. *Custom Microsystems*, 344 Ark. At 542, 42 S.W.3d at 456-57. The phrase "likelihood of success on the merits" has been interpreted by the Arkansas Supreme Court to mean a reasonable probability of success in the litigation on appeal. *Id.* at 542, 42 S.W.3d at 457.

65. If allowed to proceed, the PASSE Phase II implementation on March 1, 2019, will have a direct and immediate effect on providers' ability to provide DD and BH services to Medicaid beneficiaries and on Medicaid beneficiaries' ability to secure needed DD and BH services. Implementation on March 1, 2019 constitutes an arbitrary and capricious and an abuse of discretion.

66. This inability to provide and receive services will result in irreparable and continuing injury for Plaintiffs and the Medicaid beneficiaries they serve for which there will be no adequate remedy at law.

67. Defendants have a duty not only to Plaintiffs, but to Medicaid beneficiaries throughout the state, to ensure that this new PASSE system is implemented correctly. Failure at this juncture will result in immediate and grave harm to the most vulnerable citizens in Arkansas. This Court must act now to ensure these citizens are protected.

68. Plaintiffs thus seek:

a. That this Court enter a declaratory judgment finding that the PASSE system, as administered by DHS, is unprepared to adequately provide services to Medicaid beneficiaries in this State, and that forced implementation of this system by March 1, 2019 will result in grave and irreparable harm to Medicaid beneficiaries and their providers;

b. That Defendants be restrained and enjoined from implementation of Phase II of the PASSE system until further order of the Court finding that the system is fully prepared to function for its intended purpose, including evidence that a) Medicaid beneficiaries have received and understand how to use, their PASSE membership cards, (b) that PASSE operating systems, phone systems, and

billing platforms are functional, (c) that providers have received adequate training from each PASSE and DHS as to proper billing procedures, (d) that the PASSES have given the providers accurate reimbursement rate information, (e) that a consistent, fair, and timely assessment process for personal care services be established, (f) that provider appeal procedures consistent with established Arkansas law, the Administrative Procedures Act, and the Arkansas Medicaid Providers' Manual be clearly delineated, and (g) that all beneficiaries have been attributed to a PASSE and know which PASSE they have been attributed to, including those impacted by ForeverCare's exit from the PASSE system; and

c. For all other just and proper relief to which Plaintiffs may be entitled.

69. Plaintiffs should be awarded reasonable attorneys' fees and all costs of this action.

70. Plaintiffs request that the Court schedule an expedited hearing on this matter.

WHEREFORE, Plaintiffs respectfully request the Court declare that implementation of Phase II of the PASSE system constitutes irreparable harm to the citizens of Arkansas and violates the intent, purpose, and authorization contained in Act 775 of 2017; issue an injunction enjoining the Arkansas Department of Human Services from implementing Phase II of the PASSE system until such time as it can demonstrate sufficient infrastructure and functionality, including providing providers and beneficiaries with clear guidance as to reimbursement rates, billing procedures, appeal rights, and system functionality; and for all other just and proper relief.

Respectfully submitted,

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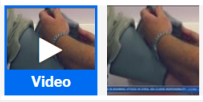
EXHIBIT “A”

Local News

ForeverCare Drops Out of Medicaid Organized Care Model

By: Jessi Turnure

Posted: Jan 16, 2019 07:12 PM CST
Updated: Jan 17, 2019 01:39 PM CST



- **Three PASSEs Sign, Move Forward in DHS PASSE Model**

LITTLE ROCK, Ark. - A company that offers services to high-needs Medicaid beneficiaries wants to partially stop doing business in Arkansas.

ForeverCare told its members Wednesday in an email that it will pull out of an organized care program operated by the Arkansas Department of Human Services (DHS).

"I apologize some of you may be finding out about our decision not to proceed with Phase II of the PASSE program this morning from anyone but me," wrote Mike McCabe, the plan president. "Over the last two years we have attempted to build a health plan focused on members care and providing the best of everything for those in Arkansas we serve. In the end, the decision we made was based on what is best for the members."

A state law passed in 2017 created Provider-led Arkansas Shared Savings Entities, known as PASSEs, that operate like managed care companies. Four companies are part of the program that serves a total of more than 40,000 Arkansans with significant behavioral health issues or developmental or intellectual disabilities.

Phase I of the program, which began in Feb. 2018, provided care coordination. ForeverCare dropped out of Phase II Wednesday, which would also make the PASSEs responsible for paying for members' Medicaid services.

McCabe continued in his email, "Despite our best efforts we do not have the systems in place to assure members would be cared for in the way they deserve. In addition, the risks posed by the continuing questions around the program are too great for us to move forward at this time."

"I believe we have three PASSEs that didn't have the same thoughts on this," said Paula Stone, the deputy director of the Division of Medical Services for DHS. "We meet with passes weekly, actually

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1. Passport fairs to be held in 3 Arkansas cities
2. Web Extra: AR couple drives homeless man, thought to be dead, 600 miles to his family in Illinois
3. Health Matters: New vein treatment helps pain in legs
4. Vaping THC at LR schools sparks concern among law enforcement
5. Mother: Son, 18, turned to 'nurse' on the street for medical help after being shot by LRPD

Latest News

Local

What Happened to Luky?

daily at this point. We had a really large meeting with the passes to address any outstanding questions or concerns they had."

Stone said ForeverCare's 7,600 beneficiaries will soon get a notice of their reassignment to one of the three remaining PASSEs well before the Phase II start date of March 1.

DHS pushed back the implementation of Phase II from Jan. 1 to March 1 "to allow systems to be tested, ensure that the billing systems are functioning seamlessly to allow timely payments to providers and allow more time for the training and enrolling of even more providers to the PASSE networks."

In an email to the DHS director and others involved in the program explaining his company's withdrawal, McCabe wrote ForeverCare "reached this decision with much reluctance in light of the March 1, 2019 implementation date."

McCabe continued, "As we have discussed, in addition to the fact that ForeverCare's internal requirements dictate that it cannot enter into the Phase II Agreement unless the state date of Phase II is moved to July 1, 2019, we believe there are also program operational issues which need to be resolved before DHS implements Phase II."

McCabe wrote the company could still be involved if DHS pushed back the deadline or delayed ForeverCare's participation in full risk until July 1.

"I think the reason ForeverCare has elected to walk away is because they see what's coming forward on March 1," said Loretta Cochran, a ForeverCare member. "They know the risk of the gaps that are still open, and they're not going to be a willing party to hurting their clients. I appreciate them being honest. The other three, I think, are sticking their heads in the sand."

Cochran, who is the guardian of a ForeverCare beneficiary, worries payments will not work correctly for smaller, more rural providers and beneficiaries will lose services.

"I won't be here forever," she said. "I have to have a system that I know is going to take care of and close that gap in support and leadership. If ForeverCare leaves and we don't get these problems fixed before we cut over, I don't know if we're going to have that. In fact, I fully doubt that we will have any kind of security like that."

Stone said DHS does not plan on extending the deadline, confident everything will be in place by March 1.

"We feel like we have a good plan in place where we've spent the morning making sure it will go smoothly for all of those beneficiaries," she said.

Once reassigned to one of the three remaining PASSEs, former ForeverCare beneficiaries will have 90 days to switch.

Beneficiaries can find more information by visiting the PASSE website or calling the PASSE ombudsman at 501-320-6006.

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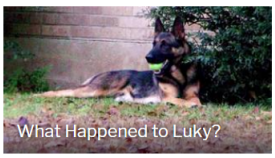
More Stories



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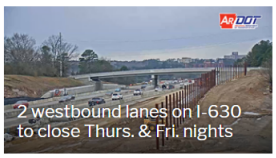

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KARK 4 News

EXHIBIT “B”

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Fact Sheet

PASSE Program: Reassignment of Clients

The Provider-led Arkansas Shared Savings Entity (PASSE) is a model of organized care created to manage the services of individuals with significant developmental disabilities or behavioral health needs.

Arkansas Total Care, Empower Healthcare Solutions, and Summit Community Care have chosen to progress to Phase II while ForeverCare Health Plan has notified DHS that the organization has made a business decision not to move into Phase II. As a result, its clients will be reassigned.

What will happen to ForeverCare's clients?

Four PASSEs have been providing care coordination for clients since early 2018. ForeverCare will continue to provide care coordination and assist in transitioning their members to the members' newly assigned PASSE through February 28. On March 1, the three remaining PASSEs will begin receiving monthly payments from DHS to manage the complete healthcare of their clients. Clients will be reassigned to their new PASSEs by the second week in February, effective March 1, 2019.

How many people will be reassigned?

ForeverCare had been assigned approximately 7,600 members. Those people will be given a new PASSE to manage their care.

How and when will ForeverCare's clients be reassigned?

ForeverCare's clients will be reassigned proportionally ("round-robin style"). Clients will receive a letter about the second week of February telling them what their new PASSE assignment is. Care coordinators with ForeverCare will also assist in the transition. After clients receive their letters, they can expect to be mailed a welcome packet and an identification card from their new PASSE, and to get a phone call from their new care coordinator.

After clients receive their assignment letters, they will be given a 90-day period in which they can choose a new PASSE, if they wish. Choice Counselors will be available to answer questions about the PASSEs and help members switch. Clients can call 1 (833) 402-0672 for choice counseling or information about the PASSEs.

Why can't clients choose their new PASSE?

The rules of the program require that DHS follow a procedure to reassign ForeverCare's clients evenly among the three remaining PASSEs. Then clients will have the choice to switch to a different PASSE if they wish.

Where can I find more information about these changes?

For more information on the PASSE program, visit www.passe.arkansas.gov. Those who need help may contact choice counselors at 1 (833) 402-0672.

EXHIBIT “C”

Fact Sheet

PASSEs Starting March 1: Frequently Asked Questions

Starting in March 2019, individuals' services will be managed by the Provider-led Arkansas Shared Savings Entity (PASSE) groups if individuals are on the Developmental Disabilities Waiver or Wait list, if they live in a private DD Institutional Care Facility, or if they have a Behavioral Health diagnosis and have received an Independent Assessment assigning them to tier 2 or tier 3.

Will I have coverage on March 1?

Yes, if you are a client assigned to a PASSE, you will have health ~~insurance~~ coverage on March 1, 2019. The PASSEs have signed an agreement to cover your current plan of care as it is now, including prior authorizations, for at least 60 days. They must meet with you to discuss your plan of care before any changes can be made. Even if you have just been reassigned from ForeverCare to one of the other PASSEs, you will get to have your same plan of care for at least the first 60 days.

Are the PASSEs ~~r~~ready for the March 1 deadline?

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The PASSEs have signed agreements to enter Phase II. The PASSEs have indicated they ~~r~~are ready for the March 1 start date because they have spent the past year hiring and training staff~~.~~; documenting their policies~~.~~; developing their billing systems~~.~~; and planning for any issues that could arise. They have spent the past three months further developing their networks and training providers on their systems. The transition plan that all PASSEs agreed to also protects clients and makes sure clients existing services will be covered for the first 60 days.

This new program is a partnership between ~~DHS~~the Arkansas Department of Human Services (DHS) and the PASSEs. Every new program requires a transition period and can have ~~has~~ some bumps when it begins, but ~~both~~ the PASSEs and DHS are committed to quickly responding to assist clients and address issues if they arise. PASSEs will continue to develop their networks and improve their care for clients.

What if my doctor or pharmacy claim gets denied~~s my insurance~~ when PASSEs take over?

~~The Department of Human Services~~DHS and ~~every~~ each PASSE is prepared to help providers to process claims. If your ~~insurance~~ coverage is denied on March 1, providers will be able to see that you are a ~~member~~ client of the PASSE program, and they will have phone numbers to contact people who will be ready to help solve your issue. DHS and the PASSEs will be open and taking calls through the weekend of March 1-3, 2019.

If your provider says ~~they~~ it can't fill your prescription or that Medicaid says you aren't covered for services, you can tell them to call the PASSE Assistance Center for more information: provide number.

DHS and each PASSE ~~will~~ also will be operating Internal Command Centers for providers and clients to address billing questions or concerns as they arise and to monitor any billing trends and address issues during the transition.

Will I have to get approval~~ed~~ to see a new doctor or specialist?

Fact Sheet

Need this answer. Families have been asking how referrals will work, when, and how the communication line will work between them, the PASSE, and the PCP, etc.

How will Medicaid caps on yearly visits work with the PASSE starting on March 1?

As clients transition from the current fee-for-service system to the PASSE system, each individual PASSE will determine how their programs will work. Through their handbooks available online, the PASSEs~~they~~ will communicate to their ~~members~~ clients their policies for caps on yearly visits. For example, your PASSE will let you know how many times a year you can see your primary care physician.

How will in-network and out-of-network visits work?

If your provider has signed a contract to be a participating member of your PASSE's network, that provider is considered "in network." They will be notified of how to process claims for your PASSE, and they will have guaranteed rates with your PASSE.

If a provider is not a participating member of your PASSE, they will be considered "out of network." The PASSE can still pay for your visit; however, you might have to get your services preapproved. Providers who are not "in network" with a PASSE will not have guaranteed rates with that PASSE. Each PASSE will handle out-of-network providers ~~differently~~according to each PASSE's internal practices and policies~~.~~

How do I know if my provider is in a PASSE?

To find out if your provider is in your PASSE's network, check your PASSE's network list on ~~their~~the PASSE's website or call to ask them: This is what we have been saying. Some people have said that their care coordinators can't answer this question, and it can't be found on the PASSE websites either. ATC does not have it listed. Empower and Summit both do.

- Arkansas Total Care www.arkansastotalcare.com | 1-866-282-6280
- Empower Healthcare Solutions www.getempowerhealth.com | 1-866-261-1286
- Summit Community Care www.summitcommunitycare.com | 1-844-405-4295

Are Arkansas Children's Hospital and UAMS in-network members of a PASSE?

Need this answer. Need to explain why families may not see their individual physician listed and what that means.

How will Pharmacy costs change with the PASSEs?

In this new system with the PASSEs, the Medicaid-approved list of medicines will be available, clients won't have any caps on medicines per year, and they won't have copays at pharmacies. CVS Caremark is the pharmacy benefits manager for all PASSEs.~~s~~

What if I want to switch my PASSE after March 1?

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Fact Sheet

Open enrollment will happen during the month of May 2019. During that time, ~~members~~ clients will have the opportunity to switch to a new PASSE, if they want to. If ~~members~~ clients do nothing, they will stay with their current PASSE.

ForeverCare clients who have been reassigned to a new PASSE will have 90 days to switch PASSEs which will extend from February to May.

I still have questions. Who can I call?

If you are a ~~member~~ client of a PASSE, and you have concerns or questions, you can call the PASSE Ombudsman office at 1-844-843-7351 or email PASSEOmbudsmanOffice@dhs.arkansas.gov. For more information on the PASSE, please visit www.passe.arkansas.gov.

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EXHIBIT “D”

Provider-Led Arkansas Shared Savings Entity (PASSE) Provider Agreement

Between

APC PASSE, LLC dba Summit Community Care

and

The Arkansas Department of Human Services

For the Service Delivery Period March 1, 2019 through December 31, 2021

February 4, 2019

TABLE OF CONTENTS

1. DEFINITIONS AND ACRONYMS

Adjusted Premium Revenue

Premium revenue as defined in 42 CFR § 438.8 minus the PASSE's Federal, State and local taxes, licensing and regulatory fees as defined in 42 CFR § 438.8.

Administrative Cost Ratio

Administrative Cost Percentage [42 CFR § 438.116 (a) and (b)] is the total administrative expenses, divided by total payments received from State of Arkansas less premium tax.

Adverse Decision/Adverse Action

Any decision or action by the PASSE or DHS that adversely affects a Medicaid provider or beneficiary in regard to receipt of and payment for claims and services including but not limited to decisions or findings related to:

1. Appropriate level of care or coding,
2. Medical necessity,
3. Prior authorization,
4. Concurrent reviews,
5. Retrospective reviews,
6. Least restrictive setting,
7. Desk audits,
8. Field audits and onsite audits
9. Inspections, and
10. Payment amounts due to or from a particular provider resulting from gain sharing, risk sharing, incentive payments or another reimbursement mechanism or methodology.

Ambulatory Care Sensitive Condition (ACSC)

A medical condition that generally can be treated or prevented in a primary care setting. Hospitalization for an ASCS is potentially avoidable and may indicate the unavailability of services or less than optimal use of services in the community that are 1) physician-related; 2) system-related; 3) medical; 4) patient-related; or 5) lack of social support. The PASSE shall use each of the most recent Prevention Quality Indicators (Version 6.0 or later) for reporting avoidable ACSC purposes in its QAPI Strategic Plan for individuals with and without behavioral health needs.

Arkansas Department of Health (ADH)

The state agency with authority to hear Medicaid Provider Appeals under the Medicaid Fairness Act, Ark. Code Ann. § 20-77-1701 et seq.

Arkansas Department of Human Services (DHS)

The Arkansas Department of Human Services (DHS) is the designated single state agency with responsibilities to administer the Medicaid program, including to oversee the PASSE model of care delivery.

Arkansas Insurance Department (AID)

The Arkansas Insurance Department (AID) has the responsibility to license PASSEs. Among its responsibilities, AID establishes bonding and reserve requirements for solvency.

Assignment

The process by which DHS assigns a newly eligible member among the active PASSEs. The individual will have 90 days from the date coverage begins to switch to a different PASSE. If the individual does not choose to switch to a different PASSE within this time, he/she will remain a member of that PASSE until the end of the coverage year.

Avoidable Institutional Length of Stay

The excess time an individual stayed in any type of institutional setting due to administrative inefficiencies such as inadequate discharge planning, ineffective care coordination, and limited administrative staffing beyond the business day and on weekends. The PASSE must report on this measure on a quarterly basis by each facility type and implement appropriate strategies for reducing its occurrences as part of its QAPI Strategic Plan. The quarterly report must specifically identify any ambulatory sensitive condition related to the stay.

Avoidable Emergency Department Encounter

The use of a hospital Emergency Department that was likely avoidable if services in an effective primary care or HCBS setting had been provided. The PASSE must report on this measure on a quarterly basis and implement appropriate strategies for reducing its occurrences as part of its QAPI Strategic Plan. The quarterly report must specifically identify any ambulatory care sensitive condition related to the stay.

Benefit Expenditure Report (BER)

The Benefit Expenditure Report documents how much was paid during the performance year by the PASSE, in the aggregate, to direct service providers for services provided to its members. A PASSE may choose to spend up to five percent (5%) of benefit expenditures on community investments. Community investments will be counted as benefit expenditures rather than administrative expenditures in calculating and reporting the medical loss ratio.

Care Coordination

Care Coordination is a critical component of implementing an individual's PCSP. Activities involving a collaborative patient-centered engagement of the individual and their caregiver in service referral, follow up, and service navigation. The care coordination process includes assessing, collaborating on care planning, treatment plan follow-through, service coordination, monitoring the patient adherence, and reevaluating the patient for medically necessary care and service. These activities focus on ensuring the individual's healthcare and support service needs are met; through effective provider and patient communication, information sharing, follow up,

care transitions, and assurance of timely access to care that promotes quality, cost-effective outcomes. Requirements of care coordination are outlined in Section 5.2.

Case Management

A distinguishable subset of care coordination services, case management services assist individuals in gaining access to needed medical, social, educational, and other services, in accordance with 42 CFR § 440.169.

Centers for Medicare & Medicaid Services (CMS)

The Centers for Medicare & Medicaid Services (CMS) is the federal agency delegated by the Secretary of the US Department of Health and Human Services to administer the Medicaid program under Title XIX of the Social Security Act and thereby has federal oversight responsibilities for the state and the PASSEs. The state and the PASSEs must meet the requirements of a Medicaid managed care organization as defined in 42 C.F.R. Part 438.

Chemical Restraint

Any drug that is administered to manage a member's behavior in a way that reduces the safety risk to the member or others and has the temporary effect of restricting the resident's freedom of movement. Chemical restraints do not include drugs that are a standard treatment for the member's medical or psychiatric condition.

Clean Claim

A claim for payment of services that has no defect, impropriety or special circumstance, including incomplete documentation that delays timely payment.

Claims Payment

A claims payment is a payment made in full or in part to a service provider for the provision of medically necessary treatment and services to an eligible beneficiary that is a PASSE member (*see* enrolled member). Claims types include hospital inpatient, outpatient, professional payments, clinic, ancillary, pharmacy, support service, behavioral health services, services for intellectual and developmental disabilities and other institutional payments.

Claims Payment Process

A claims payment process involves all the business and operational processes, claims management information systems, and banking processes that are necessary to receive, validate, adjudicate, audit, and reimburse providers for services provided to eligible beneficiary. These business and operational activities, processes, and systems are performed and managed by the PASSE organization to meet the claims payment standards of the State.

Coordination of Benefits (COB)

The activities involved in determining Medicaid benefits when a member has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.

Direct Service Provider

An organization or individual that delivers services to beneficiaries attributed to a PASSE. PASSE Equity Owners can be direct service providers.

Disenrollment

A determination by DHS that a member is no longer eligible to receive PASSE services.

DDS

Division of Developmental Disabilities Services. The Division within DHS responsible for the overall coordination of services for Arkansans with intellectual or developmental disabilities.

Enrolled Member

A Medicaid beneficiary who is eligible to be enrolled in one of the PASSE entities and is either auto-assigned to the PASSE or chooses to enroll in the PASSE during open enrollment.

Global Payment/Per Member Per Month (PMPM)

See definition of Risk-Based Comprehensive Global Payment.

Fair Hearing

The State's process for reviewing the PASSE's adverse decisions of appeals and grievances, as required by 42 CFR § 438.400.

Family Planning Services

Services and medical supplies, including prescription drugs and devices, that are provided before pregnancy occurs.

Federal, State, and local taxes and licensing and regulatory fees

Federal, State, and local taxes and licensing and regulatory fees are as defined in 42 CFR § 438.8.

Flexible Services

Alternative services that are not included in the state plan or a waiver of the Arkansas Medicaid Program and that are appropriate and cost-effective services that improve the health or social determinants of a member of an enrollable Medicaid beneficiary population that affect the health of a member of an enrollable Medicaid beneficiary population.

Fraud

Knowingly making or causing to be made any false statement or representation of a material fact in any claim, request for payment, or application for any benefit or payment under the Arkansas Medicaid Program, or knowingly making or causing to be made any omission or false statement or representation of a material fact for use in determining rights to a benefit or payment under the Arkansas Medicaid Program.

Fraud Prevention Activities

Fraud Prevention Activities are as defined in 42 CFR § 438.8.

Home and Community Based Services (HCBS)

An array of services and supports that are largely non-medical in nature and that address the needs of individuals with functional limitations who need assistance with everyday activities. They are focused on functionally supporting individuals living in the community regardless of whether provided under 1905, 1915(c), or 1915(i) authority. HCBS services are generally an alternative to an institution. The actual services available to a member will be described in the member's PCSP.

IDSR

Office of Innovation and Delivery System Reform. This is the Office that oversees all PASSE activities.

Incurred Claims

Incurred claims are as defined in 42 CFR § 438.8.

Independent Assessment (IA/ARIA)

Also known as the Arkansas Independent Assessment (ARIA). A functional assessment conducted by qualified individual who does not work for DHS, a PASSE, or a provider of services using an assessment instrument approved by DHS.

In Lieu Of Services

Services that are provided in lieu of a required covered benefit. These services are not part of the PASSE covered benefit, but because of special circumstances, it is deemed more cost effective to provide a non-covered service in lieu of more expensive institutional care which is covered under the PASSE program. For services provided in an Institution for Mental Diseases, the PASSE must ensure compliance with 42 CFR § 438.6(e).

Limited Rehabilitation Stay

A stay in a facility-based care setting directly related to an acute medical need due to an injury or illness and of limited duration for rehabilitation purposes, including notwithstanding the limitation on skilled nursing services.

Long-Term Services and Supports (LTSS)

These services can be either institutional or non-institutional. When offered as an HCBS service, the LTSS service is an alternative to an institutional setting. These are an array of services are largely non-medical in nature that are provided to members who have functional limitations that have the primary purpose of supporting the ability of the member to live or work in the most appropriate, least restrictive, and most integrated setting that also protects their health and safety in a cost-effective manner. The actual services to a member will be described in the member's PCSP.

Mechanical Restraint

Any device attached or adjacent to the member's body that cannot be easily removed and that restricts freedom of movement or normal access to the body.

Medical/Quality Management Committee

A committee developed by the PASSE to oversee its QAPI Strategic Plan. The Committee must include clinicians that specialize in providing behavioral health services, HCBS, and LTSS services and at least one consumer advisor.

Medical Loss Ratio (MLR)

A basic financial measurement used to calculate and categorize costs, profits, and losses of a health insurance plan. Calculation of the MLR is defined at 42 C.F.R. § 438.8.

Medical Necessity

All Medicaid benefits are based upon medical necessity. A service is "medically necessary" if it is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap or cause physical deformity or malfunction and if there is no other equally effective (although more conservative or less costly) course of treatment available or suitable for the beneficiary requesting the service. For this purpose, a "course of treatment" may include mere observation or (where appropriate) no treatment at all. The determination of medical necessity may be made by the Medical Director or by the Medicaid Program Quality Improvement Organization (QIO). Coverage may be denied if a service is not medically necessary in accordance with the preceding criteria or is generally regarded by the medical profession as experimental inappropriate or ineffective using unless objective clinical evidence demonstrates circumstances making the service necessary.

MMIS

Medicaid Management Information System

Network Provider/Subcontractor

The provider who, under a contract with a PASSE, has agreed to provide services to PASSE members with an expectation of receiving payments directly or indirectly from the PASSE. While such provider is contracted as a network provider to the PASSE, the provider is considered a subcontractor by DHS. The PASSE remains accountable to DHS for any functions and responsibilities that it delegates to any subcontractor.

Open Enrollment Period

Time period, offered on an annual basis by DHS, in which all PASSEs' current members may choose a different PASSE for coverage beginning January 1 of the following year. (During contract year one - 2019, the first open enrollment period for current members of a PASSE will be from May 1, 2019 to May 30, 2019. Any changes made during the initial open enrollment period will take effect within 7 days of the change being processed. There will also be an

additional open enrollment period in the fall of 2019. Any changes made during the second open enrollment period of 2019 will take effect January 1st of the following year.)

Out-of-Network Provider/Subcontractor

A provider who is enrolled in the Arkansas Medicaid program but who did not join the network of the PASSE. Payment to an out-of-network provider may differ from an in-network provider but must comply with any applicable Arkansas Medicaid consent decree.

PCP

Primary care provider. This can include both a physician and an advanced practice registered nurse (APRN).

Person-Centered Service Plan (PCSP)

The total plan of care made in accordance with the member as described in 42 CFR 441.301(c)(1) that indicates the following:

1. Medical services in amount, duration, and scope sufficient to meet the needs of the member;
2. HCBS services including, if appropriate, LTSS services
3. The member's strengths, needs, and preferences and;
4. A crisis plan for the member.

Performing Provider

Individual who is the rendering provider of a particular service.

Physical Restraint

The application of physical force without the use of any device (manually holding all or part of the body), for the purpose of restraining the free movement of a member's body. This does not include briefly holding, without undue force, a member in order to calm them, or holding a member's hand to escort them safely from one area to another.

Potential Member

A Medicaid beneficiary who is eligible for the PASSE program but is not yet enrolled in a PASSE.

Premium Revenue

Premium revenue is as defined in 42 CFR § 438.8.

Preventable Hospitalization

An inpatient hospitalization linked to an ambulatory care-sensitive condition that was likely preventable if services in an effective primary care setting or with HCBS services had been provided. The PASSE must report on this measure for individuals with and without coexisting behavioral health needs as part of its QAPI Strategic Plan on a quarterly basis and implement appropriate strategies for reducing its occurrences.

Prohibited Relationships

A PASSE may not knowingly have a relationship with an individual or entity as described in Section 10.1 and shall comply with Section 10.1.

Provider-Led Arkansas Shared Savings Entity (PASSE)

A Risk Based Provider Organization (RBPO) in Arkansas that has enrolled in Medicaid and meets the following requirements:

1. Is 51% owned by PASSE Equity Partners; and
2. Has the following Members or Owners:
    a. An Arkansas licensed or certified direct service provider of Developmental Disabilities (DD) services;
    b. An Arkansas licensed or certified direct service provider of Behavioral Health (BH) services;
    c. An Arkansas licensed hospital or hospital services organizations;
    d. An Arkansas licensed physician's practice; and
    e. A Pharmacist who is licensed by the Arkansas State Board of Pharmacy.

Among other things, each PASSE must be licensed by AID, enrolled as a Medicaid provider, and enter into an annual PASSE agreement with DHS.

Provider Network

The group of direct service providers that are contracted to provide services to members of the PASSE.

Quality Assessment and Performance Improvement Strategic Plan

The PASSE's Quality Assessment and Performance Improvement Strategic Plan (QAPI) Strategic Plan is to the organization as the PCSP is to the individual. It describes its activities that improve the quality of care provided to its members as defined in 42 CFR § 438.330 and its improvement as an organization. These activities must be designed to:

1. Improve health quality;
2. Meet specified quality performance measures;
3. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and or producing verifiable results and achievements;
4. Be directed toward individual members incurred for the benefit of specified segments of members or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-members; and
5. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.
6. Specifically address the recommendations of the US Preventive Services Task Force recommendations on child cognitive and behavioral health.

Recoupment

A recovery of expenses or a reduction or withholding from future payments of part of or all of an owed amount.

Registered HCBS Provider

A HCBS provider that is registered with the MMIS through the PASSE. Registered providers are assigned a Medicaid provider identification number for encounter data purposes only as they do not bill through fee-for service claims submissions. The PASSE is responsible for credentialing and re-credentialing such providers. For such providers, the PASSE must describe the qualifications, standards, training, continuing education, and oversight to ensure member protections, quality, accountability, and program integrity.

Report Dates

Unless otherwise specified, a monthly report is due within fifteen (15) calendar days after the month ends, a quarterly report is due within thirty (30) calendar days after the quarter ends, and an annual report is due within sixty (60) calendar days after the year ends. If the report date falls on a Saturday or Sunday, the report is due the next immediate Monday. If the report date falls on a state recognized holiday, the report is due the following day unless that day is a Saturday or Sunday.

Risk-Based Comprehensive Global Payment (Global Payment)

A capitated payment that is made in monthly prorated payment to the PASSE for each enrolled PASSE member. Only a licensed Risk-Based Provider Organization/ Provider-Led Arkansas Shared Savings Entity (PASSE) in good standing in the State of Arkansas is eligible to receive a global payment under the program. *Comprehensive* means that the PASSE is at financial risk and obligated to pay for medically necessary inpatient hospital, outpatient, institutional, professional services, pharmacy, ancillary, long term care services and supports, and any other covered service, not excluded or carved out, for members as specified in the scope of services identified by DHS.

Risk-based Provider Organization (RBPO)

An entity that is licensed by the Commissioner of AID under Act 775 of 2017 and the risk-based provider organization rules promulgated by AID.

Seclusion

The involuntary confinement of a beneficiary alone in a room or an area from which the beneficiary is physically prevented from having contact with others or leaving.

Service Encounter

A standardized record of a health care-related service, procedure, treatment, or therapy rendered by a licensed provider or providers to an enrolled member of the PASSE. There are two types of service encounters, paid claim encounters and non-paid encounters (i.e., encounters that were performed but are not reimbursable).

Subcontract

A contract entered into by the PASSE with any of the following: a provider of medical, HCBS, or LTSS services who agrees to furnish covered services to a member; or with any other organization or person who agrees to perform any administrative function or service for the PASSE specifically related to fulfilling the PASSE's obligations to DHS under the terms of the Agreement.

Telemedicine

The use of electronic information and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient. It includes store-and-forward technology and remote patient monitoring. The following activities will not be considered a reportable encounter when delivered to a member of the PASSE:

1. Audio-only communication, including without-limitation, interactive audio;
2. A facsimile machine;
3. Text messaging; or
4. Electronic mail systems.

The Act

Title XIX of the Social Security Act.

Transition

The movement of a member from one PASSE to another, either during open enrollment or for cause as defined in section 213.000 of the PASSE Provider Manual.

Transition Plan

The PASSE must submit, as described in Exhibit I, not later than November 1, 2018.

Value-based Payments

Payments made by the PASSE to its providers to promote efficiency and effectiveness of services, improve quality of care, improve patient experience and access to care, and promote the most appropriate utilization in the most appropriate setting. Such payments may be made as part of a PASSE's QAPI Strategic Plan.

Virtual Home Visit Provider Services

Virtual services are telemedicine, telehealth, e-consulting, and provider home visits made via teleconference or video conferencing that are part of a patient care treatment plan and are provided at the individual's home or in a community setting. These services are provided using mobile secure telecommunication devices and electronic monitoring equipment, and includes clinical provider care, behavioral health therapies, and treatment provided to an individual at their residence. Virtual provider services may use various evidence-based and innovative independence at-home strategies. They may include the provision of on-going care management,

remote telehealth monitoring and consultation, face to face or through the use secure web-based communication and mobile telemonitoring technologies to remotely monitor and evaluate the patient's functional and health status. Virtual and telehealth services are provided in lieu of providing the same services at a practice site and are provided at the individual's place of residence. Therefore, these services must have patient consent, be documented in the patient integrated medical records, and submitted as a claims or encounter from a contracted provider as medically necessary service. The provision of virtual care can include an interdisciplinary care team or be provided by individual clinical service provider.

2. GENERAL OVERVIEW

2.1 PURPOSE

2.1.1 The purpose of the Provider-Led Arkansas Shared Savings Entity (PASSE) Provider Agreement (the "Agreement") between the Arkansas Department of Human Services (DHS) and _____ (the PASSE) is to operationalize Phase II of the Arkansas Medicaid Provider-Led Organized Care Program pursuant to Ark. Code Ann. § 20-77-2701 *et seq*. The program, as it is described in this Act is an innovative approach to organizing and managing the delivery of services for Medicaid beneficiaries with high medical needs, specifically those clients with a high level of needs due to a mental illness, substance abuse disorder, a developmental or intellectual disability.

2.1.2 In Phase II, which begins on March 1, 2019, the PASSE will begin providing all physical health, behavioral health, and specialized developmental disability services, as indicated in this agreement, for all beneficiaries enrolled as members in the PASSE. Additionally, the PASSE will provide care coordination to each enrolled member and develop a Person-Centered Service Plan (PCSP) for each client.

2.1.3 DHS will be responsible for oversight of the PASSE and for meeting all assurances under the individual Centers for Medicare and Medicaid Services (CMS) waivers that govern this program.

2.1.4 The parties to the Agreement are responsible for meeting all terms of the Agreement, including all exhibits and amendments hereto.

2.2 EFFECTIVE DATES

2.2.1 The Agreement is effective immediately upon all necessary signatures being affixed on the Signature Page.

2.2.2 The service delivery effective date is **MARCH 1, 2019**. The PASSE Provider Agreement, including all service delivery under this Agreement terminates at midnight on **DECEMBER 31, 2021**, subject to the terms and conditions herein and any subsequent amendments.

2.2.3 It will be within the sole discretion of DHS to extend this PASSE Provider Agreement after the expiration date. Extensions will be granted in increments no less than 30 days and not to exceed one year.

2.3 RESPONSIBILITIES OF THE DEPARTMENT OF HUMAN SERVICES

The Department of Human Services (DHS) is responsible for administering the Medicaid program. As such, DHS will administer the Agreements, monitor the performance of the PASSE, and provide oversight in all aspects of the PASSE's operations, including, but not limited to:

2.3.1 Determining a beneficiary's Medicaid eligibility and enrollment into the PASSE.

2.3.2 Sending an enrollment notice to each enrolled member stating the name of the PASSE to which they have been enrolled, the effective date of enrollment, and the enrolled member's right to transition to a different PASSE.

2.3.3 Conducting Fair Hearings in accordance with applicable laws, including, but not limited to, the Medicaid Fairness Act.

2.3.4 Monitoring the PASSE's compliance with the Agreement.

2.3.5 Establishing standards and requirements for the PASSE's provider network and monitoring the Provider Network.

2.3.7 Contracting with an external quality review organization (EQRO) and conducting other QI activities.

2.3.8 Setting quality metrics and the reporting requirements surrounding them and providing instructions to the PASSE on how to report those quality metrics.

2.3.9 Overseeing the operations of the Arkansas Medicaid Management Information System (MMIS) and contracting with the state's fiscal agent to exchange data with the PASSE, enrolling Medicaid providers, and establishing standards and requirements to ensure receipt of complete and accurate data for program administration.

2.3.10 Coordinating with the Office of Medicaid Inspector General (OMIG) to manage Medicaid overpayment and abuse prevention, detection, and recovery efforts.

2.3.11 Coordinating with OMIG to manage the Medicaid Integrity Program, with such monitoring as may be necessary.

2.3.12 Administering the Medicaid prescribed drug program, including negotiating supplemental rebates and favorable net pricing for drugs on the Medicaid Preferred Drug List (PDL) and maintaining the review of drug options to maintain an array of choices for prescribers within each therapeutic class.

2.3.13 Ensuring that no payment is made to a provider other than by the PASSE for services provided to an enrolled member and available under the Agreement. The State must ensure that no payment is made to a network provider other than by the PASSE for services covered under the contract between the State and the PASSE.

2.3.14 Determining needed policy or operational changes.

2.3.15 Determining and imposing sanctions for violations or noncompliance and requiring corrective actions for violations or noncompliance.

2.3.16 DHS must arrange for Medicaid services to be provided without delay to any member of a PASSE of which the PASSE Provider Agreement is terminated and for any member who is disenrolled from a PASSE for any other reason than ineligibility for Medicaid. Implementing a transition of care policy to ensure continued access to services during a members' transition from FFS to a PASSE, from one PASSE to another, or from a PASSE to FFS. DHS will make its

transition of care policy publicly available and provide instructions to members and potential members on how to access continued services upon transition.

2.4 RESPONSIBILITIES OF THE PASSE

2.4.1 The PASSE shall comply with all provisions of the Agreement, including all attachments, applicable exhibits, and any amendments, and shall act in good faith in the performance of the provisions.

2.4.2 The PASSE further agrees that failure to comply with any provision of this Agreement may result in the assessment of sanctions, up to and including termination of the Agreement.

2.4.3 Additionally, the PASSE shall:

a. Be located in and meet all requirements for doing business in the state of Arkansas.

b. Be responsible for the administration and management of all aspects of this Agreement, including but not limited to delivery of services, provider network, claims resolution and assistance, and all subcontracts, employees, agents, and services performed by anyone acting for or on behalf of the PASSE.

c. Maintain an effective executive administration and ensure adequate staffing and information systems capability to ensure that it can appropriately manage financial transactions, record keeping, data collection, and other administrative functions.

d. Cooperate with DHS, CMS, OMIG, or the Medicaid Fraud Control Unit (MFCU) in the Attorney General's Office in the discharge of their duties under state or federal law, including any investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect.

e. Comply with all reporting requirements, whether regular or ad hoc, in such form as specified by DHS, and verify that all data and information it submits is accurate, truthful, and complete. All responses to data requests must be submitted within thirty (30) days of the request, unless otherwise specified by DHS.

f. Develop and maintain written policies and procedures to implement and comply with all the provisions of this Agreement; and submit all such policies and procedures to DHS for approval, as directed.

g. Submit all subcontracts and proposed delegation of responsibility to DHS for approval.

h. Report to DHS any known violations of this agreement, including any state or federal laws or regulations incorporated herein or applicable to the PASSE.

2.5 APPLICABLE LAWS

2.5.1 In addition to any other state or federal laws or regulations referenced in the Agreement, the following are incorporated into the Agreement by reference:

- Title VI of the Civil Rights Act (CRA) of 1964
- The Age Discrimination Act of 1975
- The Rehabilitation Act of 1973
- Title IX of the Education Amendments of 1972
- The Americans with Disabilities Act
- Section 1557 of the Patient Protection and Affordable Care Act
- The Health Insurance Affordability and Accountability Act and pertinent regulations
- Act 775 of the 2017 Arkansas General Assembly, Ark. Code Ann. § 20-77-2701 et seq.
- CMS federal managed care regulations (42 CFR 438)
- Freedom of Information Act (ACA 25-19-101 et seq.)
- Arkansas Child Maltreatment Act (ACA 12-2-18 et seq.)
- Arkansas Adult Maltreatment Act (ACA 9-2-20 et seq.)

2.5.2 Both Parties must comply with any applicable Federal and State laws that pertain to member rights and ensure that its employees and contracted providers observe and protect those rights.

3. ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

3.1. ELIGIBILITY

3.1.1 Eligibility for a PASSE is determined regardless of Medicaid eligibility group (MEG). Instead, beneficiaries are eligible for a PASSE if they have been identified through the Arkansas Independent Assessment (ARIA) as being in need of behavioral health services or developmental disabilities services.

3.1.2 For individuals with behavioral health service needs, the tiers are as follows:

- Tier I: Counseling Level Services

  At this level, time-limited behavioral health services are provided by qualified licensed practitioners in an outpatient-based setting for the purpose of assessing and treating mental health and/or substance abuse conditions. Counseling services settings mean a behavioral health clinic/office, healthcare center, physician's office, and/or school.

- Tier II: Rehabilitative Level Services

  At this level of need, services are provided in a counseling services setting, but the level of need requires a broader array of services to address functional deficits.

- Tier III: Intensive Level Services

  Eligibility for this level of need will be identified by additional criteria, which could lead to placement in residential settings for more intensive delivery of services.

3.1.3 For individuals with Developmental Disabilities service needs, the tiers are as follows:

- Tier I: Community Clinic Level of Care

  At this level of need, the individual receives state plan services such as EIDT, ADDT, personal care, occupational therapy, physical therapy, or speech therapy due to their developmental or intellectual disability or delay.

- Tier II: Institutional Level of Care:

  The individual meets the institutional level of care criteria and is eligible to receive paid services and supports.

- Tier III: Institutional Level of Care (intensive):

  The individual meets the institutional level of care criteria and is eligible for the most intensive level of services, including up to 24 hours-a-day/7 days a week paid services and supports.

3.1.4 Tier 2 and Tier 3 behavioral health and developmental disability clients will be mandatorily enrolled in a PASSE through the auto-assignment process.

a. Clients who are eligible for Medicaid through the medically needy "spenddown" category will not be enrolled in the PASSE.

b. Clients who are seeking full admission to an HDC and tier at a Developmental Disability Tier 3 will be admitted to the HDC and not be assigned to a PASSE.

c. Clients who are eligible under eligibility category 06 (ARWorks) will not be assigned to a PASSE.

3.1.5 Tier 1 clients may voluntarily enroll beginning on or after July 1, 2019, as determined by DHS. DHS shall notify the PASSE's at least ninety (90) calendar days prior to the beginning of voluntary enrollment. This notification will include the information on the rate cells for the voluntary population.

3.1.6 Individuals who are dually-diagnosed as having both Behavioral Health and Developmental Disabilities service needs will be eligible to receive the dual diagnosis rate cell. DHS will make the determination of which members should receive the dual rate cell. To receive this, the member must:

a. Have a primary diagnosis that is behavioral health or intellectual/developmental disability and a secondary diagnosis that is behavioral health or intellectual/developmental disability (both diagnoses cannot be behavioral health or developmental disability);

b. Have met the institutional level of care for an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID); and

c. Have received the appropriate ARIA assessment and determined to meet the Tier II or Tier III level of need; and

d. Been reviewed and approved for the dual diagnosis rate cell by the DHS Dual Diagnosis Evaluation Committee.

3.2. ASSIGNMENT

3.2.1 Beginning January 16, 2019, a newly identified member that meets the criteria for mandatory enrollment will be assigned into the PASSE based upon the following rules:

a. Members will be assigned to the PASSE based upon proportional assignment. Under *proportional assignment,* the first member is assigned to PASSE A, the next to PASSE B, the next to PASSE C, etc.

b. The proportional assignment methodology will be utilized to assign members to the PASSE, unless at least one of the following conditions exists:

i. The PASSE has fifty-three percent (53%) or more of the market share of existing mandatorily assigned members;

ii. The PASSE fails to meet specified quality metrics as defined in the PASSE Provider Agreement, Section 8.2; or

iii. The PASSE is subject to a sanction, including a moratorium on having members assigned to it.

3.2.2 A member may voluntarily transition from their assigned PASSE and choose another PASSE within ninety (90) days of initial assignment. A member will not be permitted to change their PASSE more than once within a twelve (12) month period, unless:

a. The change occurs during the open enrollment period; or

b. There is cause for transition, as described in 42 CFR § 438.56.

3.2.3 Tier 1 beneficiaries that voluntarily enrolled will not be auto-assigned to a PASSE. Instead they will choose which PASSE they would like to join when they voluntarily enroll. Tier 1 beneficiaries will have ninety (90) days after enrollment to change their PASSE enrollment.

3.3 ENROLLMENT

3.3.1 The effective date of PASSE enrollment will be seven (7) calendar days after the date of auto-assignment or voluntary enrollment. The execution of enrollments will occur on a nightly basis, and the results of the daily enrollment will be sent the next morning in the daily 834 file.

3.3.2 DHS will pay the PASSE a prorated global payment for individuals beginning coverage the same month as auto-assignment or voluntary enrollment. Payments will be prorated for the number of days in the month in which the member is effective with the PASSE.

3.3.3 DHS reserves the right to cap enrollment of additional members to the PASSE for any of the following reasons, as determined by DHS in its sole discretion:

a. Consistently poor-quality performance;

b. Inadequate provider network capacity;

c. High number of member complaints about the PASSE's services or about access to care; or

d. Financial solvency concerns.

3.3.4 Anti-Discrimination Policy:

a. The PASSE must accept new enrollment from individuals in the order in which they apply without restriction, unless enrollment is capped by DHS, up to the limits set under the contract.

b. The PASSE is prohibited from discriminating against individuals eligible to enroll on the basis of health status or need for health care services.

c. The PASSE is prohibited from discriminating against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect

of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability.

3.4 DISENROLLMENT

3.4.1 Disenrollment from the PASSE shall be based solely upon a determination by DHS that a member is no longer eligible to receive PASSE services. Disenrollment will occur because of the following:

a. The enrolled member loses Medicaid eligibility.

b. The enrolled member is placed in a setting or receives services excluded from the PASSE, which include:

i. Full admission to a Human Development Center (HDC),

ii. Placement at a skilled nursing or assisted living facility, or

iii. Approval for waiver services provided through the ARChoices in Homecare or Independent Choices programs or a successor waiver for the frail, elderly, or physically disabled.

3.4.2 The PASSE may not request that a member be disenrolled, except in circumstances which involve fraud or other gross misuse of coverage. All requests for disenrollment must be submitted to DHS Beneficiary Support.

3.5 RE-ENROLLMENT

3.5.1 A member who was previously disenrolled will be assigned to the same PASSE if re-enrollment occurs within one-hundred and eighty (180) days of previous disenrollment.

3.5.2 After one-hundred and eighty (180) days, the member who was previously disenrolled in be required to undergo a new ARIA and auto-assignment into a PASSE. That member will have ninety (90) days to voluntarily transition to a different PASSE, including the PASSE the member was previously enrolled in.

3.6 TRANSITION

3.6.1 DHS shall complete a transition of an enrolled member, as follows:

a. For cause, at any time, and in accordance with 42 CFR § 438.56. For cause reasons for transition include:

i. The PASSE is sanctioned pursuant to the Agreement, the PASSE Provider Manual, or any state or federal regulations and laws;

ii. The PASSE does not, because of moral or religious objections, cover the service the member seeks; or

iii. Any other reason, including poor quality of care, lack of access to services covered under the Agreement, or lack of access to providers experienced in dealing with the member's care needs. Other just cause reasons will be determined by DHS, in its sole discretion.

b. Without cause, within the first 90 days of enrollment, within the first 90 days of re-enrollment, or during the annual open enrollment.

3.6.2 There will be a yearly open enrollment period when an enrolled member may voluntarily transition to a different PASSE. The annual open enrollment period when a member can transition their PASSE will be established by DHS and will last at least thirty (30) days. Open enrollment will occur on a yearly basis. If no action is taken by the member during open enrollment, they will remain in the PASSE and will not be permitted to change their PASSE, unless for cause, during the next year.

3.6.3 The first open enrollment period for current members of a PASSE will be from May 1, 2019 to May 30, 2019. Any changes made during the initial open enrollment period will take effect within 7 days of the change being processed. There will also be an additional open enrollment period in the fall of 2019. Any changes made during the second open enrollment period of 2019 will take effect January 1st of the following year.

3.6.4 DHS shall process transitions with an effective date that is no later than the first day of the second month following the month in which the member requested transition.

a. A transition is effective at midnight on the date provided in the enrollment or disenrollment file.

b. If DHS fails to make a transition determination within the specified timeframe, the transition is considered approved for the effective date that would have been established had DHS made a determination in the specified timeframe.

3.6.5 The PASSE must implement transition policies and procedure, that at a minimum:

a. Ensures that it does not restrict the member's right to voluntarily transition to a different PASSE, in any way;

b. Requires the PASSE to provide timely notification to the receiving PASSE on the special needs of the transitioning member, and ensure timely receipt of medical records, PCSP, treatment plans, and care coordination files; and

c. When receiving a transitioning member, provides care coordination so that services are not interrupted, and provides required information on participating Network providers, assignment of a care coordinator, and all other new member information, in accordance with Section 4 of the Agreement;

d. During transition, coordinates services (including those services on the PCSP) with the receiving or relinquishing PASSE to ensure smooth transition and continuity of care for 90 days or until the transition is completed, whichever is longer; and

e. Is consistent with federal requirements outlined in 42 CFR § 438.62.

3.6.6 The PASSE or its subcontractors, providers, or vendors must assist in the transition of an enrolled member from its PASSE to another or vice versa.

3.7 REINSTATEMENT:

3.7.1 A member who was disenrolled from the PASSE may be reinstated for the following month with no lapse in coverage if the member reestablishes his or her eligibility and such eligibility is entered into MMIS by the last day of the month, which would generate notification to the PASSE that they will continue to be responsible for that member.

3.7.2 A lapse in eligibility that is not resolved in the above timeframe would lead to the member not being reinstated for the following month and that member would be disenrolled from the PASSE.

3.7.3 If a continuity of care issue arises and it is mutually agreed by all parties, then the member can be reinstated to the PASSE for the following month and the capitated payment will be reconciled with the PASSE.

4. MEMBER INFORMATION AND SERVICES

4.1 GENERAL INFORMATION REQUIREMENTS

4.1.1 The PASSE must ensure that enrolled members are notified of the following:

a. Their rights and responsibilities;
b. The roles of their PCP, care coordinator, and case manager;
c. The role of the member in developing and approving the PCSP;
d. How to obtain needed care and services;
e. What to do in an emergency or urgent medical situation;
f. How to pursue a complaint, a grievance, appeal or Fair Hearing;
g. How to report suspected Medicaid fraud, waste and abuse;
h. How to report abuse, neglect and exploitation of themselves or another; and
i. All other requirements and benefits of the PASSE.

4.1.2 The PASSE must provide information to both enrolled members and potential members in accordance with 42 CFR § 438.10. Additionally, and in accordance with the above-referenced CFR, the PASSE must notify enrolled members, on at least an annual basis, of their right to request and obtain information.

4.1.3 The PASSE must make all information provided to potential members and enrolled members, whether required by the Agreement or otherwise, accessible. Additionally, the PASSE must notify all potential or enrolled members of their right to accessible information at no additional cost and how to access information in an accessible format. Notification must be accessible, given in both English and Spanish and be provided in alternative formats when appropriate. At a minimum, "accessible" means that:

a. All member communications, including written materials, spoken scripts and websites must be at or below the sixth (6^{th}) grade comprehension level.
b. All written materials must be provided in a font size no smaller than 12 point.
c. All written materials must be made available in both English and Spanish.
d. For all individuals whose primary language is not English, an interpreter must be provided, free of charge, in accordance with the Federal Limited English Proficiency (LEP) regulations.
e. Interpretation, either oral or written, of any provided information must be made available in any language spoken by the enrolled member or potential member.
f. All written and oral information must be provided in alternative formats, when appropriate, and in a manner that takes into consideration a member's special needs, including are visual impairment, hearing impairment, limited reading proficiency, or limited English proficiency.
g. Auxiliary aids and services must be made available upon request for enrolled member and potential members with disabilities.

h. A Teletypewriter Telephone/Text Telephone (TTY/TDY) number must be provided for enrolled members and potential member.
i. All written materials must include taglines in Spanish, as well as large print, explaining the availability of written translation or oral interpretation to understand information provided and the toll-free and TTY/TDY telephone number of the PASSE's Member Support Services unit. Large print means printed in a font size no smaller than 18 point.

4.1.4 The PASSE must mail all enrolled member materials to the enrolled member's primary address provided by DHS on the enrollment file unless an updated alternate address has been obtained from the member, and in accordance with the following requirements:

a. The PASSE's name or logo must be included on the envelope or the front of every mailing so that it is easily distinguishable.
b. All information sent to enrolled members by mail must include instructions for how a member can change or update their address.
c. If material sent to enrolled members is returned to the PASSE as "undeliverable," the PASSE must notify IDSR within thirty (30) calendar days on a monthly undeliverable mail report.
d. The PASSE may send emails in lieu of mailing if the enrolled member has agreed, in writing, to receive information by email.
e. If an enrolled member agrees to receive information by email, the PASSE must provide an opt-out process for that enrolled member to elect to no longer receive information by email.

4.1.5 Information required to be provided by the PASSE may be sent to the member's parent/legal guardian or authorized responsible person, as appropriate.

4.2 REQUIRED MEMBER INFORMATION

4.2.1 Within five (5) business days following receipt of the enrollment file from DHS, the PASSE must mail to each newly enrolled member a welcome packet that contains a member identification (ID) card, a member handbook, and instructions for how to access the PASSE's provider directory, including language specific for how a member can request a paper form of the provider directory.

4.2.2 Member ID Card—The Member ID card must include, at a minimum:

a. The member's name, and member's unique identification number, as established by the PASSE;
b. The PASSE's name, address and member helpline number;
c. A telephone number that a provider may call for billing information; and
d. The DHS provided logo on the front of the member ID card.

Replacement Member ID cards must be made available at the enrolled member's request.

4.2.3 Member Handbook—The Member Handbook must meet the requirements set forth in 42 CFR § 438.10 and include, at a minimum:

a. A Table of Contents;

b. The terms, conditions, and procedures for enrollment, including reinstatement;

c. The member's rights and responsibilities, as describe in Section 4.6;

d. How to access information in accessible formats as described in Section 4.1.3;

e. The toll-free telephone numbers for member services, medical management and care coordination, and for any other unit that provides services directly to enrolled members;

f. The member's rights to transition to a different PASSE, the procedures for filing a request for transition, and the following language verbatim, in bold or large font:

To request a transition to another PASSE, you should contact the Arkansas Department of Human Services, Beneficiary Support Center, Phone Number: 1-833-402-0672.

g. A description of services provided by the PASSE in sufficient detail to ensure that enrolled members understand the services that may be available to them, including:

i. Care coordination and the development of the PCSP;

ii. Home and Community Based Services (HCBS); and

iii. The availability of emergency services under the PASSE, including (1) how emergency services are provided, (2) the definition of what constitutes an emergency medical condition and the definition of what constitutes an emergency medical service, (3) that prior authorizations are not required for emergency medical services, and (4) that an enrolled member may use *any* hospital or other setting for emergency care, regardless of whether it is a participating or out-of-network provider.

h. The process for selected and changing the member's PCP;

i. Any limitations and general restrictions on provider access, exclusions, and use of out-of-network providers, including how to access those providers;

j. Procedures for obtaining required services, including second opinions at no expense to the member (in accordance with 42 CFR § 438.206(b)(3) and s.641.51, F.S.) and authorization requirements, including service authorization documentation requirements, any services available without prior authorization, and information about the extent to which, and how, after-hours care is provided;

k. How and where to access any benefits that are available under the Medicaid State plan, but are not covered under the Agreement;

m. Procedure for reporting Medicaid fraud, waste, abuse and overpayment;

n. Information on the right to file a grievance or appeal an adverse decision/adverse action, and the procedure by which a grievance or appeal may be filed, including: the address, toll-free telephone number, and hours of the

Appeals and Grievance staff and the availability of assistance with filing a grievance or appeal;

o. Information on the right to a Fair Hearing through DHS and the procedures for filing a request for a Fair Hearing, including: DHS-approved timeframes, the address for filing a request for Fair Hearing, and the availability of assistance with requesting a Fair Hearing;

p. Notice that an enrolled member has the right to continue services upon appeal of a denial of services, but that the enrolled member may have to pay for the denied services if there is an adverse ruling;

q. Notice of Privacy Practices for Protected Health Information, as required by the HIPAA Privacy Rule, 45 CFR § 164.520;

r. Procedures for reporting abuse, neglect, or exploitation of the enrolled member by the PASSE or PASSE representatives;

s. Information regarding health care advance directives and the PASSE's policy regarding these, pursuant to 42 CFR § 438.3(j)(1)-(4) and 42 CFR § 422.128. The PASSE must provide this information to all enrolled members age eighteen (18) years and older. The information provided must, at a minimum, describe:
   i. State law governing advance directives. Any changes in state law must be reflected in the Member Handbook, as soon as possible, but no later than ninety (90) days after the effective change;
   ii. The enrolled member's rights under state law, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
   iii. The PASSE's written policies respecting the implementation of the enrolled member's rights and the state law, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;
   iv. Statement that complaints about non-compliance with advance directive laws and regulations may be filed with the state's complaint hotline; and
   v. Information on how enrolled members may direct their care using advance directives; and
   vi. Designation of staff and/or participating providers, with contact information, who are responsible for providing information on advance directives to interested enrolled members;

t. Notice of the right to file a complaint against the PASSE or any of its representatives, including participating providers, and information on the procedure for filing a complaint;

u. Notice that the PASSE cannot require the enrolled member to obtain a referral for a specific family planning provider, regardless of whether that provider is a participating provider or an out-of-network provider;

v. Directions for how to obtain the following information about the PASSE, upon request:
   i. The Structure, governance, and operation of the PASSE;

ii. How the PASSE rates on quality metrics and performance measures tracked by DHS or CMS;

iii. The PASSE's non-discrimination policies and the individual responsible for overseeing those policies, as well as responding to accessibility and discrimination claims made against the PASSE (*See* Section 3.3.4); and

iv. A list of any counseling or referral services not provided by the PASSE because of moral or religious objections, and how the enrolled member may obtain information on those services and how to access them through DHS.

w. Contact information for the Consumer Advisory Council (CAC).

x. The Member Handbook must be reviewed and approved by DHS in order to ensure compliance with the Agreement and 42 CFR § 438.10; and for content, before it is distributed to enrolled members.

y. Any changes to the Member Handbook must be submitted to DHS, through IDSR, for review and approval prior to distribution to enrolled members. The PASSE is required to provide each enrolled member notice of any significant change, as defined by DHS, of the information specified in the Member Handbook at least thirty (30) days before the intended effective date of the change.

z. The PASSE may choose not to distribute a printed version of the member handbook via surface mail. In lieu of providing the printed version, the PASSE must submit a written notification to the member that explains how to obtain the member handbook from the PASSE's website in a manner approved by DHS. This notification must also detail how the member can request a hard copy of the member handbook from the PASSE by toll-free phone, mail, or email, at no charge.

4.2.4 Provider Directory—The PASSE must maintain a Provider Directory that, at a minimum, does the following:

a. Provides information on each participating provider, including:

i. Name;

ii. Group affiliations, if any;

iii. Street address(es);

iv. Telephone number(s);

v. Website URLs, if any;

vi. Specialties, as appropriate;

vii. If the provider is accepting new Medicaid clients;

viii. Cultural and linguistic capabilities, including the languages offered by the provider or skilled medical interpreter at the provider's office; and

ix. Whether the provider's office/facility has accommodations for individuals with physical disabilities, including offices, exam rooms, and equipment.

b. Clearly explains the difference between a participating provider and an out-of-network provider;

c. States that some providers may choose not to perform certain services based on religious or moral beliefs, as required by the Act; and

d. Contains an attestation from the PASSE that its Provider Network meets DHS's required network adequacy standards, set out in the PASSE Medicaid Provider Manual.

e. The PASSE must submit to DHS an electronic file of the PASSE provider network directory and network services on a monthly basis. The PASSE provider network directory or a link to the PASSE provider network directory will be posted on the Arkansas Medicaid website. If no Provider Network changes occurs during the month, the PASSE must file an attestation to that affect with DHS.

f. The Provider Directory must be updated within thirty (30) calendar days of the PASSE's receipt of updated provider information.

g. The PASSE must ensure the Provider Directory being distributed to enrolled members and potential members, either through mail, email or the website, matches the most recent Provider Network file submitted to DHS.

h. The PASSE must make its Provider Directory available online, and in print form upon request. The online version must be in a machine-readable file and format, and must include the information listed in Section 4.2.4 above.

i. The online version of the Provider Directory must be searchable according to:
   i. Provider Name;
   ii. Provider Type;
   iii. Distance from the member's address;
   iv. Zip code; and
   v. Whether the provider is accepting new patients.

j. The PASSE must furnish each newly enrolled member the most recent version of the Provider Directory and may choose to distribute a printed version of the Provider Directory via surface mail or provide written notification to the enrolled member that explains how to obtain the Provider Directory from the PASSE's website. This notification must also detail how the member can request a hard copy of the printed Provider Directory from the PASSE, at no charge.

k. When distributing printed Provider Directories, the PASSE must append to the Provider Directory a list of the providers who have left the network and those who have been added since the Provider Directory was printed or, in lieu of the appendix to the Provider Directory, enclose a letter stating that the most current listing of providers is available by calling the PASSE at its toll-free telephone number, or at the PASSE's website. The letter must include the toll-free telephone number and the Internet address that will take the enrolled member or potential member directly to the online Provider Directory.

l. The PASSE must mail a Welcome Packet to a member who was disenrolled due to loss of Medicaid eligibility, and is subsequently re-enrolled in the PASSE, if:
   i. It has been more than 180 days since the disenrollment; or

ii. It has been less than 180 days and there was a significant change in the member materials during the time they were disenrolled.

4.2.5 Distribution/provision of the materials contained in the Welcome Packet must be documented in the PASSE's record for each enrolled member.

4.2.6 If the PASSE chooses to provide required information electronically to potential members and enrolled members, the PASSE must:

a. Comply with the electronic and information technology accessibility requirements under the federal civil rights laws including Section 504 and Section 508 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA);
b. Provide the material in a format that is accessible as defined in Section 4.1.3;
c. Place the information on the PASSE's website in a location that is prominent and easy to access;
d. Provide the information in an electronic format which can be electronically retained and printed;
e. Follow the content and language requirements of set forth in Section 4 of the Agreement;
f. Notify the member that the information is available in paper form without charge upon request; and
g. Provide, upon request, information in paper form within five (5) business days.

4.3 PASSE WEBSITE

4.3.1 The PASSE must maintain a website that contains up-to-date information regarding the PASSE.

4.3.2 The website must be concise, informational, user-friendly, functional, and subject to the marketing material limitations described in Section 4.4.

4.3.3 The website must be accessible 24 hours a day, seven days a week except for maintenance to be performed during non-peak hours.

4.3.4 The website must be approved by DHS prior to being accessible by the public. If documentation has previously been approved by DHS, the PASSE may post that information on its website as long as it adheres to the marketing guidelines in Section 4.4 of this Agreement.

4.3.5 The PASSE must make certain member information, including the Provider Directory and Member Handbook(s), available on PASSE's website, without requiring a member log-in.

4.3.6 The PASSE must post the Arkansas PDL on their website, in addition to the PASSE Drug Formulary that has been reviewed in accordance with Section 5.5. All pharmacy information must be current and searchable, and must include, in addition to the above:

a. The PASSE maximum allowable cost (MAC) pricing;
b. Instructions on how and whom to contact for questions regarding filling a prescription;
c. A provider guideline for pharmacy claims submission that includes, at a minimum:
    i. A payer sheet;
    ii. A toll-free call center number and the call center hours;
    iii. Paper claim submission requirements;
    iv. Compound prescription requirements; and
    v. Prospective DUR response requirements.

4.3.7 The PASSE must make available on its website, all contact information for the PASSE, including the Member Support Services, Grievances and Appeals, Complaints, and Compliance.

4.3.8 The PASSE may use the website to receive requests or questions from enrolled member and/or potential members. If it chooses to do so, the PASSE must demonstrate to DHS prior to implementation, how all requests or questions will be processed and responded to in a timely manner.

4.4 MARKETING

4.4.1 The PASSE may only market to potential members through its website or printed material distributed by DHS's beneficiary support staff.
a. Marketing materials produced by the PASSE must be made available to be distributed to the entire State.
b. All marketing materials produced by the PASSE must be approved by DHS prior to distribution.

4.4.2 Marketing materials, written and oral, produced by the PASSE must NOT:
a. Contain any assertion or statement that the potential member must enroll in the PASSE to obtain benefits or to not lose benefits;
b. Contain any assertion or statement that the PASSE is endorsed by CMS, the Federal or State government, or a similar entity; or
c. Mislead, confuse or defraud any potential member who receives the marketing material.

4.4.3 The PASSE is prohibited from directly or indirectly engaging in door to door, telephone, e-mail, texting, or other cold call marketing activities.

4.4.4 The PASSE is prohibited from seeking to influence enrollment in the PASSE in conjunction with the sale or offering of any private insurance or any other economic gain.

4.4.5 Other than the welcome information if a member transitions to their PASSE, a PASSE shall not provide any information to a potential member that is a member of another PASSE.

4.4.6 Participating providers and direct service providers shall not distribute information to a potential member about enrolling in a specific PASSE.

4.5 MEMBER SUPPORT SERVICES

4.5.1 The PASSE must have a Member Support Services unit that has the capability to answer inquiries from potential members and enrolled members through writing, telephone, email, web-based transmission, or face-to-face communication.

4.5.2 The PASSE must develop and implement operational policies and procedures for Member Support Services that address, at a minimum, staff development and training, operations, use of technology and privacy concerns, and performance measures related to Member Support Services.

4.5.3 Member Support Services must include a toll-free Member Helpline for potential and enrolled members and participating and out-of-network providers. The Requirements for the Member Helpline include:

a. HIPAA-compliance;
b. Ability to accommodate all calls, including those requiring the use of interpreter services for the hearing impaired or for callers that have limited English proficiency, free of charge;
c. A call pick-up system that places the call in a queue;
d. If a hold time message is used while members are in the call queue, the message cannot include information about non-health related items (e.g., health insurance products, disability benefits, etc.), nor can it be used for marketing purposes. All hold time messages must be submitted to DHS for prior approval.
e. A sufficient number of adequately trained staff to operate the Call Center on Business Days from 8:00 am to 5:00 pm Central time, at a minimum;
f. Responsive, courteous staff that responds to calls and inquires accurately;
g. Call scripts to process common inquiries;
h. Performance standards, including:
    i. 95% of all calls must be answered within 3 rings or 15 seconds;
    ii. Number of blocked calls/busy signals cannot exceed 5% of the total incoming calls;
    iii. The wait time in queue should not be longer than two (2) minutes for 95% of the incoming calls;
    iv. All calls requiring a call back to the attributed or potential PASSE Member or Provider should be returned within one (1) Business Day of receipt;

v. The abandoned call rate should not exceed 5% for any month. (A call is considered abandoned if the customer hangs up after 30 seconds in the initial queue.)

i. A DHS approved method for handling calls received after normal Business hours and during state-approved holidays on the next business day;

j. The technological capability to allow for monitoring and auditing of calls, both by the PASSE and designated DHS personnel, for quality, accuracy, and professionalism;

k. An electronic system that allows Call Center staff to document calls in sufficient detail for reference, tracking, and analysis. The documentation system must contain sufficient flexibility and reportable data fields to accommodate regularly required and ad-hoc reports. The system must also have reportable fields to accurately capture the type (inquiry, request for assistance, request for paper documentation, Grievance, or other topic), date, and subject of each call;

l. A DHS approved plan for providing Call Center services in the event the primary Call Center facilities are unable to function in their normal capacity; and

m. A clause relinquishing ownership of the toll-free numbers upon termination of the Agreement, at which time DHS must take title to these telephone numbers.

4.5.4 DHS must approve the plan for Member Support Services, including the Member Support Services Hotline, prior to implementation. As part of this approval, DHS will review all procedures and policies, as well as all performance measures the PASSE will be tracking to ensure compliance with the Agreement.

4.5.5 Automated Phone Tree System

a. If the PASSE chooses to use an automated phone tree system for the Member Support Services Hotline, the phone tree system must include an option for members to bypass the automation and speak with a member helpline agent/operator at any time during the call.

b. The PASSE may use a voice mail option for callers to leave messages between the hours of 5:00 p.m. and 8:00 a.m., central time, Monday through Friday and on weekends and holidays. If used, the voice mail option must have adequate capacity to receive all messages. All messages must be responded to on the next business.

4.5.6 The PASSE must track the number of requests for assistance with obtaining an appointment, including the county in which the potential or enrolled member making the request resides or required assistance and provide to DHS on a monthly basis.

4.5.7 The PASSE Member Hotline must maintain a quarterly call log that must be made available to DHS upon request, that includes the following information:

a. Total call volume;

b. Percentage of calls answered;
c. Percentage of calls answered that were on hold in 30 second increments;
d. Percentage of calls abandoned;
e. Average speed of answer;
f. Average hold time before answer;
g. Average time before abandonment;
h. Average length of call;
i. Type and subject of call by volume;
j. Average number of business days to return calls from calls received during non-business hours;
k. Percentage of calls answered within 3 rings or 15 seconds;
l. Percentage of calls on hold for 2 minutes or less; and
m. Longest time to return a call.

4.6 MEMBER PROTECTIONS—RIGHTS AND RESPONSIBILITIES

4.6.1 The PASSE must develop and implement policies and procedures, in clear and understandable language, for member's rights and take reasonable action to inform members of their rights by providing copies of policies and procedures and making them available on their website.

4.6.2 The PASSE must inform each enrolled member of his or her rights and responsibilities as a member of the PASSE.

4.6.3 These rights and responsibilities must include, at a minimum, the right to:
a. Receive information on the PASSE;
b. To understand their PCSP and to receive the services contained within it;
c. Be treated with respect and with due consideration for the dignity and privacy;
d. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;
e. Participate in decisions regarding his or her health care, including the right to refuse treatment;
f. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
g. Choose a participating provider for any service the member is eligible and authorized to receive under his or her PCSP, including a PCP;
h. Execute an advance directive without discrimination in the provision of care or otherwise;
i. Request and receive a copy of his or her medical records and request that they be amended or corrected;
j. Obtain needed, available and accessible health care services covered under the PASSE;

k. Live in an integrated and supported setting in the community and have control over aspects of their lives; and

l. Be protected in the community.

4.6.4 The PASSE and its participating providers are prohibited from treating an enrolled member adversely for exercising his or her rights outlined, as outlined above.

4.7 RESTRICTIVE INTERVENTIONS IN AN HCBS SETTING

4.7.1 Members have a right to have safeguards in place to prevent restrictive interventions. The PASSE must implement safeguards concerning the use of restraints or seclusion:

a. Physical restraints, i.e., use of a staff member's body to prevent injury to the member or another person are allowed in cases of emergency. An emergency exists for any of the following conditions:

i. The member has not responded to de-escalation techniques and continues to escalate behavior

ii. The member is a danger to self or others

iii. The safety of the member and those nearby cannot be assured through positive reinforcement.

b. The member must be continuously under direct observation of staff members during any use of restraints.

c. If the use of personal restraints occurs more than three (3) times per month, use should be discussed by the interdisciplinary team (made up of the physician and both clinical and direct care staff) and addressed in the PCSP. When emergency procedures are implemented, PCSP revisions including, but not limited to, psychological counseling, review of medications with possible medication change or a change in environmental stressors that are noted to precede escalation of behavior may be implemented.

d. For members in an HCBS Setting, use of mechanical or chemical restraint or seclusion is not allowed.

e. PASSE providers must not allow maltreatment or corporal punishment (the application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior) of members. Providers' policies and procedures must state that corporal punishment is prohibited.

f. Safeguards concerning the use of restrictive intervention:

When the behavior plan is implemented, all use of restrictive interventions must be documented in the member's case record and should include the initiating behavior, length of time of restraint, name of authorizing personnel, names of all individuals involved and outcomes of the event.

g. Restrictive interventions cannot include:

i. Aversion techniques

ii. Restrictions to a member's rights, including the right to physically leave

iii. Mechanical or chemical restraints

iv. Seclusion

4.7.2 These interventions might be implemented to deal with aggressive or disruptive behaviors related to the activity or possession. Staff, families and the member are trained by the provider to recognize and report unauthorized use of restrictive interventions.

4.7.3 Before absence from a specific social activity or temporary loss of personal possession is implemented, the member must first be counseled about the consequences of the behavior and the choices they can make.

4.7.4 All personnel who are involved in the use of restrictive interventions must receive training in behavior management techniques as well as training in abuse and neglect laws, rules and regulations and policies. The personnel must be qualified to perform, develop, implement and monitor or provide direction intervention as applicable.

4.7.5 Use of restrictive interventions requires submission of an incident report that must be submitted no later than the end of the second business day following the incident.

4.7.6 Before use of restraints or restrictive interventions, the PASSE must develop a written behavior management plan to ensure the rights of members. The plan must include a provision for alternative methods to avoid the use of restraints and seclusions. The behavior management plan must:

a. Be written or supervised by qualified professional;
b. Be designed so that the rights of the member are protected; and
c. Preclude procedures that are punishing, physically painful, emotionally frightening involve deprivation, or put the member at medical risk

4.7.7 The behavior management plan must also specify the length of time the restraint or restrictive intervention is to be used, who will authorize the use of restraint or seclusion and the methods for monitoring the member.

4.7.8 Behavior management plans cannot include procedures that are punishing, physically painful, emotionally frightening, depriving, or that put the member at medical risk.

4.7.9 All use of restraint must be documented in the member's case record, including the initiating behavior, length of time of restraint, name of authorizing personnel, names of all individuals involved and outcomes of the event.

4.8 CULTURAL COMPETENCY PLAN

4.8.1 In accordance with 42 CFR § 438.206, the PASSE must have a written Cultural Competency Plan (CCP) to ensure that services are provided in a culturally competent manner to all enrolled members, including all services and settings and including those with limited English proficiency.

4.8.2 The evaluation must include:

a. Results from the CAHPS or other comparative member satisfaction surveys, outcomes for certain cultural groups, member grievances, member appeals, provider feedback and PASSE employee surveys; and

b. A trending of any issues identified in the evaluation and a plan to implement interventions to improve the provision of services.

c. A description of the evaluation, its results, the analysis of the results and interventions to be implemented.

4.8.3 The PASSE must complete an annual evaluation of the effectiveness of its CCP. The CCP and the annual evaluation must be combined into a single comprehensive document and must address the following:

a. How providers, PASSE employees, and systems will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms, and respects the worth of the enrolled members and protects and preserves the dignity of each.

b. A demographic description of the PASSE's members.

c. Information demonstrating a direct link between the CCP and the annual evaluation that includes an analysis of the successes and challenges of meeting the previous year's goals and objectives.

4.8.4 During contract year one, the PASSE must submit the comprehensive CCP to DHS by June 1, 2019. The approved comprehensive CCP must be implemented by September 1st, 2019. The evaluation for contract year one must be submitted to DHS by November 1, 2020. Ongoing, the comprehensive CCP must be submitted to DHS for approval by June 1st of each year. The comprehensive CCP as approved by DHS must be implemented by September 1st of each year. The annual evaluation of the previous year's comprehensive CCP is due to DHS by November 1st of each year.

4.8.5 The PASSE must distribute a summary of the CCP to participating providers that includes information about how the provider may access the full CCP on the website. This summary must also detail how the provider can request a hard copy of the CCP from the PASSE, at no charge to the provider.

4.9 COMPLAINTS, GRIEVANCES AND APPEALS

4.9.1 To the extent not covered below, the PASSE's grievance and appeal system must comply with the requirements set forth in §160.000 and §190.000 of the Medicaid Provider Manual, and with all applicable federal and state laws, rules, and

regulations, including 42 CFR Part 431, Subpart E (Fair Hearings for Applicants and Beneficiaries) and 42 CFR Part 438, Subpart F (Grievance and Appeal System), the Medicaid Fairness Act, and the Arkansas Administrative Procedures Act (Ark. Code Ann. § 25-15-201 et seq.).

4.9.2 The PASSE must ensure that all adverse decisions/adverse actions, grievance or complaint decisions, and appeal resolutions are made by qualified personnel. The decision maker must be a qualified health care professional with the appropriate clinical expertise in treating the member's condition or disease, if:

a. If the decision involves an appeal of a denial based on lack of medical necessity;
b. If the decision involves a grievance regarding denial of expedited resolution of an appeal; or
c. If the decision involves a grievance or appeal involving clinical issues.

4.9.3 The PASSE must ensure that the decision makers on adverse decisions/adverse actions, complaints, grievances, and appeals are not:

a. Involved in any previous level of review or decision-making; and
b. The subordinate of any individual who was involved in a previous level of review or decision-making.

4.9.4 If approved by DHS, the PASSE may elect to have all appeals and grievances resolved by an independent review organization through an external review process. The independent review organization is subject to all applicable provisions of the Agreement.

4.9.5 The PASSE shall not take any punitive action against an enrolled member or a provider for filing or participating in a compliant, grievance or appeal.

4.9.6 Appeals Procedure—The PASSE must have an internal appeal procedure by which certain individuals (known as "appellants") may challenge an adverse decision/adverse action. This procedure must be approved by DHS prior to implementation. The PASSE must send written notice of significant changes to the appeals process to all enrolled members at least thirty (30) days prior to implementation. At a minimum, the PASSE process must include the following provisions:

a. The following individuals may file an appeal, as the "appellant":
    i. The enrolled member;
    ii. The enrolled member's parent or legal guardian;
    iii. An attorney authorized to represent the enrolled member;
    iv. Another authorized representative of the enrolled member, including the representative of the enrolled member's estate if that member is deceased;
    v. A direct service provider that is the subject of the adverse action/adverse decision, or the direct service provider's legal representative or attorney.

b. The appellant may file an appeal with the PASSE, orally or in writing, at any time within sixty (60) calendar days from the date on the notice of the adverse action/adverse decision.
    i. Unless an expedited resolution is requested, the PASSE must require the oral filing of an appeal to be followed by a written, signed appeal.
    ii. The PASSE must ensure that oral requests to appeal are treated as appeals and confirmed in writing.

4.9.7 The PASSE must adhere to the following timeframes for receiving appeals:
a. An appeal must be filed within sixty (60) calendar days from the date on the notice of the adverse action/adverse decision. The date of oral filing constitutes the date of receipt of the appeal.
b. Unless it is an expedited appeal request, an oral appeal request must be followed with a written, signed appeal within ten (10) calendar days of the oral filing, unless the appellant requests an expedited resolution.
c. The PASSE must acknowledge each PASSE appeal in writing within five (5) business days of receipt of each PASSE appeal, unless the appellant requests an expedited resolution.
d. Unless the appellant requested expedited resolution, an appeal must be heard and notice of appeal resolution sent to the member no later than thirty (30) calendar days from the date of receipt of the appeal.
e. If the PASSE fails to adhere to the notice and timing requirements for resolution of the appeal, the appellant is deemed to have completed the PASSE's appeals process, and the appellant may initiate a fair hearing in accordance with Section 4.8, below.

4.9.8 The PASSE must provide, free of charge, to the appellant, all documents and records considered or relied upon by the PASSE to make the adverse decision/adverse action that is the subject of the appeal. This includes, without limitation, the member's case file, medical records, or any other applicable documents or records. These documents and records must be provided sufficiently in advance of the resolution of the matter to allow appellant to review the records and documentation in preparation of their appeal arguments.

4.9.9 The PASSE must provide appellant a reasonable opportunity to present evidence and testimony and make allegations of fact or law, either in person or in writing, as requested by the appellant.

4.9.10 The PASSE must ensure that the decision maker considers all comments, documents, records, and other information submitted by the appellant, without regard as to whether such information was submitted or considered in the initial adverse decision/adverse action.

4.9.11 Upon request by the member or his or her parent/legal guardian, the PASSE must continue the member's benefits during the appeal, if all of the following requirements are met:

a. The request for appeal is timely in accordance with 42 CFR Part 438.420.
b. The PASSE appeal involves the termination, suspension or reduction of previously authorized course of treatment;
c. The services were ordered by an authorized provider;
d. The period covered by the original authorization has not expired; and
e. The member or his or her parent/legal guardian timely files for continuation of benefits in accordance with the PASSE's policy.

4.9.12 If, at the member's request, the PASSE continues or reinstates the benefits while the appeal is pending, the benefits must continue until one of the following occurs:

a. The appellant withdraws the appeal;
b. The member or the member's parent/legal guardian withdraws the request for extension of benefits; or
c. The appellant fails to request a Fair Hearing and continuation of benefits within ten (10) calendar days after the PASSE sends the notice of PASSE appeal resolution that is not wholly in the member's favor.

4.9.13 If the final resolution of the appeal or Fair Hearing is adverse to the appellant, the PASSE may recover the cost of services furnished to the member while the appeal or Fair Hearing was pending to the extent they were furnished solely because of the requirements for continuation of benefits.

4.9.14 The timeframe for a resolution of an appeal may be extended up to fourteen (14) calendar days if the appellant asks for an extension, or the PASSE documents that additional information is needed and the delay is in the member's best interest.

a. If the timeframe is extended other than at the appellant's request, the PASSE must provide oral notice of the reason for the delay to the appellant by close of business on the day of the determination, and written notice of the reason for the delay to the appellant within two (2) calendar days of the determination. The PASSE must also inform the appellant of the right to file a grievance if he or she disagrees with that decision.
b. The PASSE must resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

4.9.15 The PASSE must have an expedited review process for appeals that must be used when taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

a. The PASSE must resolve each expedited appeal and provide notice to appellant, as quickly as the member's health condition requires, within PASSE established timeframes not to exceed seventy-two (72) hours after receipt of the appeal.

b. The PASSE must inform the appellant of the limited time available to present evidence and allegations of fact or law and ensure that the appellant understands any time limits that may apply.

c. If the PASSE denies the request for expedited PASSE appeal, it must immediately transfer the PASSE appeal to the timeframe for standard resolution (with a possible 14-day extension) and so notify the appellant. The receipt of appeal date does not change.

d. The PASSE may extend the timeframe for processing an expedited appeal by up to fourteen (14) calendar days if the appellant requests the extension or if the PASSE shows that there is need for additional information and that the delay is in the member's best interest. If the PASSE extends the timeline for processing an expedited appeal not at the request of the appellant, it must:
   i. Give the appellant oral notice of the delay by close of business on the day of the determination;
   ii. Give the appellant written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the appellant of the right to file a grievance if he or she disagrees with the decision; and
   iii. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

e. In the case of an expedited PASSE appeal denial, the PASSE must provide oral notice of the resolution to the appellant by close of business on the day of resolution, and written notice to the appellant within two (2) calendar days of the resolution.

4.9.16 The PASSE must provide appellant with written notice of the resolution in a format that has been approved by DHS that includes the following:

a. The resolution of the appeal and the date it was completed;

b. If not decided wholly in the appellant's favor, information on the right to request a Fair Hearing and how to do so;

c. A unique identifying number, corresponding to the number on the notice of adverse benefit determination that is the subject of the appeal;

d. The address, phone numbers, and e-mail for Fair Hearings: and

Beneficiary Appeals	Provider Appeals
DHS Office of Appeals and Hearings P.O. Box 1437, Slot N401 Little Rock, AR 72203-1437 Phone 501-682-8622 Fax 501-404-4628	ADH Office of Medicaid Provider Appeals 4815 West Markham Street, Slot 31 Little Rock, AR 72205 Phone 501-683-6626 Fax:501-661-2357

e. A statement on the right to request the continuation of benefits, how to request the continuation of benefits, and that the member may have to pay for the cost of those benefits if the Medicaid Fair Hearing upholds the PASSE's appeal resolution.

4.9.17 Complaints Procedure—The PASSE must have a process to take and resolve complaints made by members or direct service providers. This process must be approved by DHS prior to implementation and must, at a minimum, meet the following requirements:

a. All complaints must be followed-up by close of business on the business day following receipt of the complaint.

b. If the complaint is not resolved within ten (10) business days, the PASSE must reach out to the member the next business day and offer the option to enter the complaint as a grievance and complete the grievance process to resolve the matter.

4.9.18 Complaints may be filed by:

a. The enrolled member or the enrolled member's parent or legal guardian, or

b. A direct service provider, whether or not it is a participating provider.

4.9.19 Grievance Procedure—The PASSE must have an internal grievance procedure that is approved by DHS prior to implementation. Any changes must be approved by DHS and notification sent to all enrolled members and participating providers at least thirty (30) days prior to implementation. At a minimum, the grievance process must meet the following requirements:

a. The following must be allowed to file a grievance, and shall be referred to as the "grievant":

i. The member or his or her parent/legal guardian;

ii. A direct service provider, whether or not a participating provider; or

iii. An authorized representative on behalf of i. or ii.

b. A grievance may be filed either orally or in writing.

c. The following timeframes must be observed:

i. The PASSE must acknowledge receipt of the grievance within five (5) business days of receipt. If the grievance was received orally, the PASSE acknowledgement must include a written summary of the grievance.

ii. The grievance investigation process must be completed, and the grievance resolved within thirty (30) days of the date of receipt.

iii. The 30-day timeframe may be extended up to fourteen (14) days, if:

1) The grievant asks for an extension, or the PASSE documents that additional information is needed to resolve the grievance, the information cannot be obtained within the 30-day timeframe, and it is in the member's best interest to extend the timeframe.

2) If the timeframe is extended, the PASSE must:

a) Provide oral notice of the reason for extension to the grievant by close of business on the day of the determination to extend the grievance timeframe; and
b) Provide written notice of the reason for the extension to the grievant within two (2) calendar days of the determination.

4.9.20 If the PASSE fails to provide DHS with the outcome of the grievance within this timeframe, the member's request for transition is considered approved.

4.9.21 The PASSE must refer all members who are dissatisfied with the PASSE or its activities to the PASSE's grievance/appeal office for processing and documentation of the issue.

4.9.22 The PASSE grievance/appeal office, whether internal or an independent review organization must:

a. Provide the member with assistance in completing forms and following the procedures for filing a complaint, grievance or appeal or requesting a Fair Hearing. This includes interpreter services, toll-free calling, and TTY/TTD capability.
b. Address all complaints, grievances and appeals filed within a timely manner, as set forth by the Agreement and in accordance with the PASSE's approved policies.
c. Maintain a complete and accurate record of all complaints, grievances and appeals that is available upon request to DHS or CMS. Each record must be maintained in compliance with 42 CFR § 438.416 and HIPAA, and for a period of not less than ten (10) years. The log must contain, at a minimum:
    i. A description of the subject of the complaint, grievance or appeal;
    ii. The date of receipt;
    iii. The of date of review;
    iv. The resolution of the complaint, grievance or appeal;
    v. The date of notice of the resolution;
    vi. Name of the member who was subject of the complaint, grievance or appeal; and
    vii. Any other information required by 42 CFR 438.316, the PASSE provider Manual, or the PASSE's internal policies.
d. Track and trend complaints, grievances and appeals received, without regard to the degree of seriousness or ultimate resolution of the complaint, grievance or appeal.

4.9.23 Fair Hearings—The PASSE must participate in the Fair Hearing process and comply with the Arkansas Administrative Procedures Act, Ark. Code Ann. §§ 25-15-201 et seq.

4.9.24 The PASSE must designate an email address for use by the DHS Office of Appeals and Hearings and the ADH Office of Medicaid Provider Appeals for all Fair Hearing related communications.

4.9.25 After completing the PASSE's internal appeal process and when the resolution of the appeal is adverse to the appellant, the appellant may request a Fair Hearing.

4.9.26 If the PASSE fails to adhere to the notice and timing requirements applicable to the appeal process, the appeal is considered adverse and the appellant may request a Fair Hearing.

4.9.27 The PASSE must timely notify the appellant that a request for a Fair Hearing must be filed with the appropriate office within 120 calendar days of receipt of resolution of the appeal.

4.9.28 The PASSE is considered a party to the Fair Hearing, and as such must attend the Fair hearing with all necessary witnesses and evidentiary materials.

4.9.29 The PASSE shall not create undue delay or obstruct the appellant's right to a Fair Hearing of an adverse resolution.

4.9.30 The PASSE must provide the appellant access to the Fair Hearing. This may include providing access to the conference line for telephone hearings or transportation to the hearing, if in person.

4.9.31 The PASSE must adhere to the following timeframes after receipt of notice of request for a Fair Hearing:

a. Within two (2) business days, provide the Notice of Adverse Benefits Determination and Notice of Appeal Resolution that is the subject of the Fair Hearing.

b. Within ten (10) business days, provide an evidence packet to the Fair Hearing officer and the appellant. The evidence packet must include the entire record of the appeal, including the statement of matters (or, alternatively, the denial letter) and any medical records or other documents/records considered or relied upon by the decision maker of the appeal, supporting the PASSE's adverse benefit determination and PASSE appeal resolution.

4.9.32 If the enrolled member files for a continuation of benefits within ten (10) calendar days of receipt of the notice of appeal resolution, the PASSE must continue the member's benefits while the Fair Hearing is pending and until one of the following occurs:

a. The appellant withdraws the Fair Hearing request;

b. The member withdraws the request for continuation of benefits; or

c. The Fair Hearing officer issues a hearing decision adverse to the member.

4.9.33 To the extent the Fair Hearing officer upholds the PASSE's appeal resolution, the PASSE may recover the cost of services furnished to the member while the appeal and Fair Hearing were pending, to the extent they were furnished solely because of the request for continuation of benefits.

4.9.34 To the extent the Fair Hearing officer reverses the PASSE's appeal resolution or finds in favor of the appellant and the PASSE did not furnish services while the appeal and Fair Hearing were pending, the PASSE must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours from the date the PASSE receives the Fair Hearing decision.

4.9.35 Judicial Review—Should an appellant appeal a Medicaid Fair Hearing final order to the appropriate circuit court for judicial review under the Arkansas Administrative Procedures Act, the PASSE must fully participate in the judicial review process.

4.9.36 The PASSE must contact DHS within five (5) business days after receipt of notice of an appeal of a Medicaid Fair Hearing.

4.9.37 The PASSE is responsible all costs associated with completing the record for appeal, including transcribing the audio recording of the Fair Hearing proceedings and providing a copy of the record to the appellant, the appropriate circuit court, and DHS.

4.9.38 For judicial reviews of Fair Hearings, the PASSE must provide the DHS with a copy of its draft brief(s) for review no later than ten (10) business days in advance of the filing deadline.

4.9.39 When the adverse action denies a claim for previously authorized, covered medical assistance, the PASSE must send the notice of the adverse action no less than 10 days before the action will be taken in accordance with 42 CFR 431.211. In all other cases, notice must be sent immediately after the adverse decision is made.

4.9.40 The PASSE may shorten the period of advance notice to 5 days before the date of action if the PASSE has facts indicating that the actions should be taken because of probable fraud by the member and the facts have been verified, if possible, through secondary sources.

4.9.41 The PASSE may send a notice not later than the date of action if:

a. The member has died;
b. The PASSE receives a clear written statement signed by the member that:
    i. Requests service termination;
    ii. Has information that requires service termination or reduction and indicates that the member understands that services termination or reduction will result.

c. The member has been admitted to an institution where he or she is ineligible under the PASSE program for further services;
d. The member's address is determined unknown based on returned mail with no forwarding address;
e. The member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth;
f. A change in the level of medical care is prescribed by the member's physician;
g. The notice involved an adverse determination with regard to preadmission screening requirements of Section 1919(e)(7) of the Act; or
h. In accordance with 42 CFR § 483.12(a)(5).

4.9.42 The PASSE must report on all complaints, grievances and appeals to DHS as specified in Section 8.6.

5. SERVICES

5.1 GENERAL REQUIREMENTS

5.1.1 All medical services provided by the PASSE to enrolled members must be medically necessary for each member and all HCBS and LTSS must be documented on their PCSP, unless it is an emergency or crisis stabilization service.

5.1.2 The PASSE must ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

5.1.3 The PASSE shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member. However, the PASSE may place appropriate limits on a service for utilization control, provided the services furnished:

a. Reasonably achieve their purpose for the member as outlined in the PCSP;

b. Are authorized in a manner that reflects the member's ongoing need for services and supports to treat his or her chronic conditions or support long-term service needs.

c. If for family planning, are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR § 441.20.

5.1.4 The PASSE shall not provide an incentive, monetary or otherwise, to providers for withholding medically necessary services in violation of the PCSP or otherwise to the detriment of the member.

5.1.5 If the PASSE elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must:

a. Furnish information about services it elects not to provide prior to signing the Agreement or immediately upon the adoption of such policy during the contract term; and

b. Furnish information about how those services may be accessed by enrolled members outside of the PASSE.

5.1.6 Emergency Management Plan—The PASSE must have a DHS approved Emergency Management Plan specifying what actions the PASSE will take to ensure the ongoing provision of required services to enrolled members in the event of an emergency or disaster, whether natural or man-made. The PASSE must recertify the Emergency Management Plan annually, and if updated, must re-submit the Emergency Management Plan for approval by DHS. Examples of emergencies and disasters include, but are not limited to localized acts of nature, accidents, technological emergencies, and attack related emergencies.

5.1.7 When the adverse action denies a claim for previously authorized, covered medical assistance, the PASSE must send the notice of the adverse action no less than 10 days before the action will be taken in accordance with 42 CFR 431.211. In all other cases, notice must be sent immediately after the adverse decision is made.

a. The notice must contain the following, in accordance with Ark. Code Ann. § 20-77-121:
   i. The type and amount of services requested;
   ii. The adverse action/adverse decision taken by the PASSE; and
   iii. A statement of the basis of the adverse action/adverse decision, including the facts that support the action/decision and the source of those facts.

b. The PASSE must not terminate or reduce the services until a decision is rendered on the appeal and the notice of resolution is sent in accordance with Section 4.9.16, unless:
   i. It is determined at the hearing that the sole issue is one of federal or state law or policy; and
   ii. The PASSE promptly informs the enrolled member and provider in writing that services are to be reduced or terminated pending the hearing decision.
   iii. If the PASSE's action is sustained by the resolution of the appeal and the enrolled member does not request a Fair Hearing, the PASSE may institute recovery procedures against the member to recoup the cost of any services furnished to the enrolled member that were furnished solely as a result of this provision of the Agreement.

5.2 CARE COORDINATION

5.2.1 The PASSE must provide care coordination, inclusive of case management, to all enrolled members. Unless a member expressly, and in writing, refuses care coordination.

a. Care coordination is defined under Act 775 (Ark. Code Ann. § 20-77-2701 et seq.) to include the following activities:
   i. Health education and coaching;
   ii. Coordination with other healthcare providers for diagnostics, ambulatory care, and hospital services;
   iii. Assistance with social determinants of health, such as access to healthy food and exercise;
   iv. Promotion of activities focused on the health of a patient and their community, including without limitation, outreach, quality improvement, and patient panel management; and
   v. Coordination of Community-based management of medication therapy.

b. The PASSE must have sufficient care coordination staff to provide care coordination to all enrolled members and to meet the required care coordination ratios as set forth in the PASSE Medicaid Manual.

c. Care coordination services must be available to enrolled members 24 hours a day, 7 days a week (24/7), through a telephone hotline or web-based application service.

d. All care coordination staff must meet the minimum qualifications to provide care coordination under the PASSE and be trained in accordance with the PASSE's care coordination training policy.

5.2.2 Each enrolled member must be assigned a care coordinator.

a. Prior to the first care coordinator visit, the enrolled member must be provided information on how to contact the designated care coordinator and how to access the 24/7 care coordination services.

b. If the member's designated care coordinator is changed, for any reason, the member must be notified of the new care coordinator within seven (7) business days of the change taking effect. This notice must include information on how to contact the new care coordinator.

5.2.3 The assigned care coordinator must make initial contact with each enrolled member within fifteen (15) business days of PASSE enrollment. If a new care coordinator is assigned to the enrolled member, the PASSE must provide written notification

5.2.4 The PASSE, through care coordination activities, must ensure that all services are coordinated and appropriately delivered by providers.

a. The PASSE must implement care coordination policies that ensure each enrolled member has an ongoing source of care appropriate to their needs.

b. The PASSE must have care coordinators who will work with the enrolled member's providers and care givers to ensure continuity of care across all services.

5.2.5 The PASSE is responsible for assisting the enrolled member with moving between service settings to ensure that the member is placed in or remains at the most appropriate, least restrictive setting that meets the member's needs. For example, the care coordinator would help with the transition from a residential service setting to a HCBS setting.

a. The PASSE must implement procedures to coordinate the services between care settings.

b. The PASSE care coordinators must conduct appropriate discharge planning for short-term and long-term hospital and institutional stays in accordance with 42 CFR § 438.208(b)(2)(i).

5.2.6 The PASSE must comply with Conflict Free Case Management rules pursuant to 42 CFR § 440.169, as a critical protection for enrolled member and as a matter of program integrity.

a. Care coordinators may be either hired or contracted.

b. Care coordinators must provide "case management" activities. As such, the care coordinators must be independent of any direct service providers that provide any services to any enrolled members. Case management activities are:
   i. Assessment of an eligible member;
   ii. Development of a Person-Centered Service Plan;
   iii. Referral to services; and
   iv. Monitoring activities.
c. Care Coordinators or case managers who are employed or subcontracted by an organization that has responsibility for the development and delivery of a service plan for an enrollee must not fulfill the responsibility of the PASSE to provide case management for that individual.
d. Care Coordinators or case managers must not be related by consanguinity (3rd degree or less) or marriage to the individual enrollee, his or her paid caregivers, or anyone financially responsible for the individual.

5.2.7 The PASSE must have procedures to coordinate PASSE furnished services with services furnished by:
   a. Any other insurance provider, including Medicare or Third-Party insurance;
   b. Any other Medicaid MCO, PAHP, or PIHP (as those are defined by CMS and DHS);
   c. Medicaid in the FFS environment;
   d. Any community or social support providers not participating in the PASSE model.

5.2.8 The PASSE care coordinator must conduct an initial services assessment, including the required health questionnaire, of each enrolled member within thirty (30) days of enrollment of the member.
   a. This initial services assessment must be used in the creation of the enrolled member's PCSP, *see* Section 5.3.
   b. The PASSE must share component parts of the services assessment as appropriate with any other MCO, PIHP, or PAHP serving the member on behalf of Medicaid to prevent duplication of activities between these entities.

5.2.9 The PASSE care coordinator is responsible for creating the PCSP, *see* Section 5.3.

5.3 PERSON CENTERED SERVICE PLAN (PCSP)

5.3.1 The PASSE is responsible for the creation, monitoring, and updating of the PCSP for all enrolled members of the PASSE. The PCSP must adhere to content requirements as found at 42 CFR § 441.540 in a standardized format for the specific PASSE. The PCSP must include, without limitation:
   a. The enrolled member's health information, including:
      i. Relevant medical and mental health diagnoses;

ii. Relevant medical and social history;
iii. PCP and primary provider of Behavioral Health or Developmental Disability services;
iv. The individual who has legal authority to make decisions on behalf of the enrolled member; and
v. Indication of whether or not an advance directive or living will has been created for or by the enrolled member.

b. The enrolled member's outlined treatment goals and objectives;
c. All services necessary for the enrolled member, including amount and duration of service;
d. the provider who will provide each service listed in the PCSP;
e. Any specific needs the enrolled member has;
f. The enrolled member's strengths and preferences; and
g. A crisis plan for the enrolled member.

5.3.2 The PCSP must ensure that the enrolled member's needs are being met in a way that is individualized and specific to that member's needs. Specifically, the PCSP must address any needs identified for the enrolled member from the following sources:

a. ARIA assessment;
b. Health questionnaire;
c. Any psychological testing results;
d. Any adaptive behavior assessments;
e. Any social, medical, physical, or mental health histories;
f. Risk assessments;
g. Case plans for court-involved enrolled members;
h. Individualized Education Plans (IEP); or
i. Any other assessment or evaluation used by the PASSE prior to or at the time of PCSP development.

5.3.3 When developing the PCSP, the PASSE care coordinator should give special attention to the following circumstances that an enrolled member may have or experience:

a. Living in their own home with significant conditions or treatments such as pain control, hypertension, enteral feedings, oxygen, wound care, and ventilators;
b. Receiving ongoing services such as daily in-home care, crisis behavioral health care, dialysis, home health, specialized pharmacy prescriptions, medical supplies, chemotherapy and/or radiation therapy, or who are hospitalized at the time of enrollment;
c. Recently received prior authorization for services such as scheduled surgeries, post- surgical follow up visits, therapies to be provided after enrollment or out-of-area specialty services; or

d. Having significant medical conditions requiring ongoing monitoring or screening.

5.3.4 All enrolled members who have an existing PCSP or Master Treatment Plan (MTP) will carry that care plan with them when they are enrolled into the PASSE. The PASSE must honor the existing PCSP or MTP, including any authorizations for services under the PCSP or MTP that are verified, until the new PCSP is developed in accordance with the Agreement. See Exhibit I- Transition Plan for more information.

5.3.5 For any enrolled member without an existing PCSP or MTP, the PASSE will have sixty (60) days from date of enrollment to conduct the health questionnaire describe in Section 5.2.8, above and develop the PCSP.

5.3.6 The Care Coordinator is responsible for coordinating and scheduling the PCSP Development meeting.

a. The PCSP development meeting must be attended in person by:
   i. The member and his or her parent/legal guardian;
   ii. The member's primary caregivers;
   iii. The care coordinator;
b. The meeting should include other individuals who may attend in person, by telephone, or video conferencing such as:
   i. HCBS service providers;
   ii. Professionals who have conducted evaluations or assessment;
   iii. Anyone else the member desires to attend, including friends and family who support member.
c. If the member objects to anyone's participation in the PCSP development meeting, the care coordinator must ensure that they are not allowed to participate.
d. When developing the PCSP, those present must consider the member's preferences in regards to treatment goals, objectives, and services.
e. The PASSE care coordinator is responsible for engaging the member in the process and documenting member engagement, or efforts to do so, in the PCSP.

5.3.7 The PCSP must be updated at least annually for each enrolled member.

5.3.8 The PASSE must adhere to the PCSP reporting requirements so that DHS can conduct monitoring and oversight of the PCSP in accordance with CMS regulations and the terms of the applicable Waiver assurances. Additionally, the PASSE must grant DHS or its agents, including the EQRO, access to any files and facilities needed to determine compliance with the PCSP development requirements set forth in the Agreement, the PASSE Provider Manual, the 1915(c) Community and Employment Supports Waiver, the 1915(i) Home and Community Based Services State Plan Amendment, and the 1915(b) PASSE Waiver. The purpose of the

monitoring and oversight is to ensure that all enrolled members have a PCSP that meets the member's needs and that all services are being provided in accordance with the member's PCSP.

5.3.9 DHS or its agent will conduct random sampling of each PASSE care coordinator caseload annually. Sampling will be pulled in accordance with CMS recommended sample guide "A Practical Guide for Quality Management in Home and Community-based Waiver Programs." The sample size is based on a 95% confidence interval with a margin of error of +/- 8%. The DHS Department of Research and Statistics pulls the appropriate sample size from enrolled beneficiaries of the PASSE. DHS or its agent will then require the PASSE to submit the PCSP for all individuals in the sample.

5.3.10 DHS or its agent will conduct a retrospective review of provided PCSP's based on critical elements for quality review inclusive of programmatic, financial and administrative review. DHS or its agent will review plans to ensure they have been developed in accordance with applicable policies, that plans ensure the health and welfare of the beneficiary and implemented in accordance with plan. DHS or its agents will communicate findings to the PASSE including identification of areas requiring remediation or systemic changes. Patterns of non-compliance for a PASSE may result in sanctions under the PASSE Provider Manual or Provider agreement. Service plans must be maintained for a period of three years as required by 45 CFR 92.42. A minimum of ten percent (10%) of beneficiaries from each PASSE will be randomly selected as part of focused monitoring. This focused monitoring will include any combination of face to face interviews, attendance/observation of PCSP development process, health and welfare visit, and/or observation of PCSP implementation/activities.

5.3.11 In addition, DDS participates in the National Core Indicators (NCI) Project. Quality indicators that will be measured and used as part of the QIP for the program include assurance of beneficiary's rights, freedom choice of providers within PASSE networks, beneficiary assessment of service meeting their needs and risk mitigation. Focused monitoring of care coordination will be included as part of the core measures.

5.4 STATE PLAN SERVICES

5.4.1 The PASSE is required to ensure that all enrolled members have access to all mandatory and optional Medicaid State Plan Services including services available through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program for children that are medically necessary and HCBS described in Exhibit V, and LTSS in Section 5.7.

5.4.2 The PASSE must comply with Sections 1902(a)(43) and 1905(a)(4)(B) and 1905(r) of the Social Security Act and Federal regulations at 42 C.F.R. Part 441 Subpart B that require EPSDT services to include outreach and informing, screening, tracking, and, diagnostic and treatment services.

5.4.3 The PASSE must cover and pay for emergency services and post-stabilization services provided to an enrolled member regardless of whether the provider that furnishes the services is a participating provider. In accordance with Section 1932(b)(2)(D) of the Act and State Medicaid Director Letter (SMDL) 06-010, the PASSE may not pay a non-contracted provider for emergency services more than the amount that would have been paid if the service had been provided under the Arkansas Medicaid Fee for Service program.

a. The PASSE is responsible for coverage and payment of services until the attending emergency physician, or the provider actually treating the member, determines that the member is sufficiently stabilized for transfer or discharge.

b. The determination of the attending emergency physician, or the provider actually treating the member, of when the member is sufficiently stabilized for transfer or discharge is binding on the PASSE.

5.4.4 When processing claims, the PASSE shall not:

a. Deny payment for treatment obtained when an enrolled member had an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part;

b. Deny payment for treatment obtained when the a PASSE representative instructs the member to seek emergency services;

c. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms;

d. Refuse to cover emergency services based on the emergency services provider not notifying the member's PCP or care coordinator of the member's screening and treatment within ten (10) calendar days of presentation for emergency services; or

e. Hold a member liable for payment of subsequent screening or treatment needed to diagnosis or stabilize the specific emergency medical condition.

5.4.5 The PASSE must cover post-stabilization care services, regardless of whether they are obtained from participating providers, if:

a. They are pre-approved by the PASSE;

b. They are not pre-approved under sub-section 5.4.5.a, but are administered to maintain the enrolled member's stabilized condition within one (1) hour of a request to the PASSE for pre-approval;

c. Are administered to maintain, improve, or resolve the member's stabilized condition without pre-approval, when the PASSE did not respond to the request for pre-approval within one (1) hour of the request or the PASSE could not be contacted; or

d. The PASSE and the treating physician could not reach an agreement concerning the member's care and a PASSE physician was not available for consultation.

5.4.6 The PASSE is financially obligated to cover post-stabilization services when:

a. They are pre-approved by the PASSE;

b. Until one of the following occurs:

i. A PASSE physician with privileges at the treating hospital assumes responsibility for the enrolled member's care;

ii. A PASSE physician assumes responsibility for the member's care through transfer;

iii. A PASSE representative and the treating physician reach an agreement concerning the member's care; or

iv. The member is discharged.

5.5 PHARMACY

5.5.1 The PASSE must cover all federal Food and Drug Administration (FDA) approved drugs for enrolled members, as set forth in the SSA. However, drugs for which Federal Financial Participation is not available, pursuant to the SSA, shall not be covered.

a. The PASSE must cover all therapeutic classes of drugs covered by the Arkansas Medicaid pharmacy benefit and must follow the Arkansas Medicaid Preferred Drug List (PDL). The PDL is subject to change on an ongoing basis. The PASSE has an obligation to stay abreast of the changes and may do so by referring to the following link:

https://arkansas.magellanrx.com/provider/docs/rxinfo/PDL.pdf

i. Drugs on the PDL must be covered without prior authorization unless they are subject to clinical or utilization edits.

ii. DHS will provide the PASSE a weekly Custom Drug file, delegating the preferred or non-preferred status of each NDC.

a) The PASSE must update their pharmacy claims system within one (1) business day of receipt of the Custom Drug file. Failing to update in a timely manner, may be more restrictive than the State Fee-For-Service plan.

b) For off-cycle updates to the Custom Drug file, the PASSE must still update within one (1) business day of notification by DHS.

b. The PASSE is required to maintain a drug formulary to meet the unique needs of its enrolled members.

i. The formulary must be developed and reviewed at least annually by an appropriate Pharmacy and Therapeutics (P&T) or Drug Utilization Review (DUR) Committee.

ii. The reviewed formulary must be submitted to DHS for input at least thirty (30) days prior to implementation. Any changes to the formulary, including

changes to prior authorizations and quantity limits must also be submitted to DHS for input within the 30-day timeframe.

c. For those drugs not on the Arkansas PDL but that are covered by the SSA, the PASSE may require prior authorization.

d. Drugs not defined by the SSA may be excluded, consistent with the Medicaid State Plan.

e. The PASSE must, at a minimum, cover the OTC drugs listed in the Medicaid State Plan Amendment.

5.5.2 The PASSE is not authorized to, and must not, negotiate rebates with manufacturers for pharmaceutical products listed on the PDL. Arkansas Medicaid or its designee will negotiate rebate agreements. Regardless if the PASSE or its PBM has an existing rebate agreement with a manufacturer, all Arkansas Medicaid Supplemental rebate agreements on PDL drug claims, including provider administered drugs, must be rebatable exclusively to Arkansas Medicaid.

5.5.3 Pursuant to the SSA 1927, the PASSE must develop and maintain a Drug Utilization Review (DUR) program that complies with the DUR program standards as described in the Act including prospective DUR, retrospective DUR, educational program, and the DUR Board.

a. The PASSE's DUR committee will be responsible for fulfilling the DUR requirements defined in the SSA 1927.

b. The DUR Committee is responsible for ensuring safe, appropriate, and cost-effective use of pharmaceuticals for enrolled members in the PASSE.

c. The PASSE's DUR Committee will meet at least biannually. The DUR Committee must include a voting representative from DHS. The PASSE must provide DHS with the minutes from each DUR Committee meeting within thirty (30) calendar days of the date of the meeting.

d. The PASSE must provide DHS with a detailed description of its DUR program activities annually and it must complete and submit the annual Drug Utilization Review (DUR) Annual Report, as required by CMS. The PASSE must submit the CMS DUR Annual report to DHS at least forty-five (45) days prior to the due date established by CMS. DHS will share with the PASSE all reporting requirements including the web link for the submission of the DUR Report to CMS.

e. The PASSE must require all individuals participating on the DUR Committee to complete a financial disclosure form annually which is reviewable by DHS upon request.

5.5.4 Any outpatient drugs dispensed to enrolled members covered by the PASSE (including where the PASSE paid as the primary and/or secondary payer under the Agreement) must be subject to the same rebate requirements as DHS is subject to under the SSA 1927 and DHS must collect such rebates from pharmaceutical manufacturers.

5.5.5 For all covered outpatient drug authorization decisions, each Provider contract must provide notice as described in section 1927(d)(5)(A) of the Act. Under this section, the PASSE may require as a condition of coverage or payment for a covered outpatient drug for which Federal Financial Participation (FFP) is available the approval of the drug before its dispensing for any medically accepted indication only if the system providing for such approval provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization.

5.5.6 Drug utilization encounter data must include all claims including paid, denied, voided, and rejected.

a. Drug utilization encounter data entry is required for all drugs 1) dispensed at point-of-sale pharmacy (POS), 2) administered in a provider's office (physician administered drugs) or 3) other administered in an outpatient setting including outpatient hospitals (physician administered drugs).

b. Pursuant to the SSA 1927, DHS requires encounters to include the actual NDC on the package or container from which the drug was administered and the appropriate drug-related HCPCS drug code. Unless otherwise specified by DHS in supporting documentation, the quantity of each NDC submitted, including strength and package size, and the unit of measurement qualifier is also required. Each HCPCS drug code must be submitted with a valid NDC and NDC units on the corresponding claim line. If the drug administered is comprised of more than one ingredient (i.e., compound or same drug different strength, etc.), each NDC must be represented on a separate claim line. For the purpose of this contract the term "administer" is defined to include the terms "provide" and "dispense."

c. Drug utilization data for the PASSE must be reported based upon the date dispensed (date of service) within the quarter, as opposed to the claim paid date. A set forth in the SSA 1927, the PASSE must report drug utilization encounter data that is necessary for DHS to bill manufacturers for rebates no later than forty-five (45) calendar days after the end of each quarterly rebate period. The PASSE must provide encounter data for physician administered drugs and pharmacy claims in an extract, format, and timeframe as defined by DHS.

d. Pursuant to SSA 1927, the PASSE must develop a process and procedure to identify drugs administered under Section 340B of the Public Health Service Act as codified in 42 USC, as drugs dispensed pursuant to this authority are not eligible for the Medicaid Drug Rebate program. Failure to identify aforementioned 340B drugs on submissions to DHS or its rebate vendor must be treated as a compliance violation. The PASSE must identify encounter claims administered under Section 340B in a manner, mutually agreed upon between DHS and the PASSE, that supports an automated solution to identify and remove those encounter claims from Medicaid Drug Rebate processing. If a PASSE engages a Pharmacy Benefit Manager (PBM) to provide outpatient drug services to Medicaid Members, the PASSE must ensure that the PBM complies with the identification of 340B drugs on encounter claim data in a manner consistent with the NCPDP standards. This must include the use of a unique

BIN/PCN combination to distinguish Medicaid managed care claims from commercial or other lines of business. Drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies are not covered as part of the FFS pharmacy benefit. The PASSE may cover 340B Drugs but will exclude contract pharmacies from the 340B program.

e. The PASSE (and/or its Pharmacy Benefits Manager) must make available two (2) pharmacy representatives (one primary and one secondary) to work directly with DHS and its drug rebate vendor to assist in all rebate disputes and appeals. This representative must have pharmacy knowledge and/or experience in working with pharmacists and/or prescription drugs.

5.5.7 The PASSE must have in place policies and procedures to ensure the continuity of care for enrolled members with established pharmacological treatment regimens.

5.5.8 The PASSE must have authorization procedures in place that allow providers to access drugs outside of the PASSE formulary, if medically necessary.

5.5.9 The PASSE may require prior authorization as a condition of coverage or payment for a covered outpatient drug. The PASSE must follow internal prior authorization procedures and comply with the requirements for prior authorization for covered outpatient drugs in accordance with the SSA 1927. The PASSE must incorporate the requirements into its pharmacy provider contracts. Prior authorization criteria cannot be more restrictive than the Arkansas Medicaid Fee For Service Program.

a. The PASSE must respond to a prior authorization within 24 hours of receipt of request.

b. The PASSE must accept telephonic, facsimile, or electronic submissions of prior authorization requests.

c. The PASSE must submit all pharmacy prior authorization and step therapy policies, procedures, and any associated criteria to DHS Arkansas Medicaid for review.

d. If the PASSE denies a request for prior authorization, the PASSE must issue a Notice of Action within twenty-four (24) hours of the denial to the prescriber and the enrolled member. The Notice of Action must include appeal rights and instructions for submitting an appeal. DHS reserves the right to conduct random reviews to ensure that members are being notified in a timely manner in accordance with the SSA 1927.

5.5.10 The PASSE must nominate a non-voting member to attend the Arkansas Drug Utilization Review and Preferred Drug List Committees' meetings during the term of the Agreement. DHS will give written approval of the PASSE's selected nominee.

5.5.11 Pharmacy services for children must be reviewed in accordance with EPSDT requirements to cover drugs when medically necessary based upon a case-by-case review of the individual child's needs, such as for off-label use.

5.5.12 The PASSE must submit any proposed pharmacy program changes, such as pill-splitting programs, quality limits, etc. to DHS for review prior to implementation.

5.5.13 If needed, a seventy-two (72) hour emergency supply of a prescribed covered pharmacy service must be dispensed if the prescriber cannot readily provide authorization and the pharmacist, in his/her professional judgement consistent with the current standards of practice, determines that the enrolled member's health would be compromised without the benefit of the drug.

5.5.14 The PASSE must have policies and procedures for general notifications to participating providers and enrolled members of revisions to the formulary and prior authorization requirements. Notification for changes to the formulary and prior authorization requirements and revisions must be provided to all affected participating providers and enrolled members at least thirty (30) calendar days prior to the effective date of the change.

5.5.15 Contracted health plans must report to DHS for all pharmacy claims:

a. The actual amount paid to the pharmacy provider per claim, including but not limited to cost of drug reimbursement; dispensing fees; copayments; and the amount charged to the plan sponsor for each claim by its pharmacy benefit manager.

b. In the event DHS identifies a difference per claim between the amount paid to the pharmacy provider and the amount charged to the plan sponsor by its pharmacy benefit manager, the health plan must report an itemization of all administrative fees, rebates, or processing charges associated with the claim. On a monthly basis, DHS will notify the health plan when this report is required. Health plans are required to provide such reports by the 15th of each month or the next business day.

5.5.16 The PASSE must submit an annual report that describes its interventions targeted to prevent controlled substance abuse. The report must describe actions taken by the PASSE to prevent the inappropriate use of controlled substances, including but not limited to, any clinical treatment protocols, a detailed definition of what, if any substances the PASSE targets that are not scheduled substances but may place an individual at higher risk for abuse, prior authorization requirements, quantity limits, poly-pharmacy considerations, and related clinical edits.

5.5.17 Pharmacy Exclusions

a. Pharmacy claims extract: NCPDP 1.2/D.0 format at weekly intervals.

b. Physician administered drugs: J-code extract format at monthly intervals.

5.6 HOME AND COMMUNITY BASED SERVICES (HCBS)

For a description of Home and Community Based Services, *see* Exhibit V.

5.7 LONG-TERM SERVICES AND SUPPORTS (LTSS)

All long-term services and supports provided to PASSE members, whether provided through the State Plan or through the CES Waiver, must be provided in a setting which complies with 42 CFR § 441.301(c)(4) requirements for home and community-based settings. *See* Exhibit V for service descriptions.

5.8 EXCLUDED SERVICES

5.8.1 The following services are excluded from payment by the PASSE:

a. Nonemergency medical transportation (NET) provided through the PAHP;

b. Transportation to and from an EIDT and ADDT;

c. Dental benefits in a capitated program;

d. School-based services provided by school employees;

e. Skilled nursing facility services;

Limited Rehabilitation Stay is not considered an excluded skilled nursing facility service.

f. Assisted living facility services;

g. Human Development Center (HDC) services;

i. This means full admission to a HDC.

ii. Respite stays and conditional admission at HDCs are not excluded services.

h. Waiver services provided to the elderly and adults with physical disabilities through the ARChoices in Homecare program or the Arkansas Independent Choices program, or a successor waiver for the elderly and adults with physical disabilities; and

i. Abortions, unless:

i. The pregnancy is the result of incest or rape; or

ii. The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition that manifests during pregnancy, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

5.9 IN LIEU OF SERVICES

5.9.1 The PASSE may provide in lieu of services to an enrolled member in an Institution for Mental Diseases for fifteen (15) days per month in accordance with 42 CFR § 438.6(e) when the PASSE determines that the in lieu of services will reduce cost and avoid institutional placement or enhance the enrolled member's ability to move from an institutional or residential setting to a HCBS setting. DHS will periodically review any stays in an IMD.

5.9.2 The benefit to the PASSE is that the service will reduce expenditures for institutional care. For example, if providing a mobile phone or paying for a WIFI connection allows the PASSE to avoid residential or ICF placement by monitoring a member's

health and vitals remotely, the cost of the mobile phone service or WIFI service would be an in lieu of cost.

5.9.3 The PASSE may cover in lieu of services for members if the following conditions are met:

a. The member is not required by the PASSE to use the alternative service or setting; and

b. The approved in lieu of services are offered to members at the option of the PASSE, and only if the member agrees to the in lieu of service.

6. NETWORK AND PROVIDER REQUIREMENTS

6.1 NETWORK ADEQUACY STANDARDS

6.1.1 The PASSE must maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all services covered under the Agreement for all enrolled members. The network must be supported by written Provider Contracts as described in Section 6.2. The PASSE must submit documentation to DHS, in a format specified by DHS, to demonstrate:

a. That it offers an appropriate range of acute care, preventative, primary care, specialty services, rehabilitative services, LTSS, and HCBS that is adequate for the anticipated number of enrolled members;

b. That it has the capacity to serve the expected enrollment in accordance with DHS's standards for access and timeliness of care found in the PASSE Manual Section 226.000;

c. That it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrolled members; and

d. Meets the standards for each provider type.

e. That it has included at least one Federally Qualified Health Center (FQHC) and at least one Rural Health Clinic (RHC) in its Provider Network.

6.1.2 The PASSE must submit documentation of network adequacy as specified by DHS, but no less frequently than the following: 1) at the time it enters into the Agreement; 2) on an annual basis; 3) at any time there has been a significant change (as defined by DHS) in the PASSE's operations that would affect the adequacy of capacity and services, including changes in PASSE services, benefits, geographic service area, composition of or payments to its provider network, or at the enrollment of a new population in the PASSE.

6.1.3 If the PASSE's provider network is unable to provide necessary medical services covered under the Agreement to a particular enrolled member, the PASSE must adequately and timely cover the services out of network, for as long as the PASSE's provider network is unable to provide them. This must be provided at no cost to the member.

6.1.4 If a female enrolled member's designated PCP is not a women's health specialist, the PASSE must provide the enrolled member with direct access to a women's health specialist within the provider network for covered routine and preventative women's health care services.

6.1.5 The PASSE must provide for a second opinion of a medical treatment, if requested by an enrolled member, from a network provider or arrange for the member to obtain a second opinion outside the network.

6.1.6 Network adequacy maximum distance requirements are measured using the following standards:

a. A provider type listed must be within the specified mileage of anywhere within the State of Arkansas (geographic access standard). Out of state providers that are enrolled in Arkansas Medicaid can be used for purposes of this measurement. Some examples follow:

   i. If the requirement is that a specific provider must be within 40 miles in an urban county and within 90 miles of a rural county, that means that for purposes of evaluating distance requirements, DHS will be looking to ensure that there is at least one provider of the required type within 40 miles of an urban county location or within 90 miles of a rural county location.

   ii. According to the geographic access Network Adequacy standards, a PASSE must have at least one Provider Type 05 (Acute Inpatient Hospital) within 30 miles of an urban county location and within 60 miles of a rural county location.

   iii. The geographic access standard does not look at the total amount of providers as that is accounted for in the Provider Ratio Network Adequacy Check. The geographic access Network Adequacy Check is to ensure that members have adequate access to specific provider types.

b. Meet, along with its network providers, the State standards for timely access to care and services, taking into account the urgency of need for services. The PASSE must comply with all network adequacy requirements pursuant to Section 226.000 in the PASSE Medicaid Provider Manual.

c. Ensure that Network providers offer hours of operation that are no less than the hours offered to commercial members or are comparable to Medicaid FFS, if the provider serves only Medicaid members.

d. Make emergency services and care coordination available 24/7 when medically necessary

e. Establish mechanisms to ensure that its network providers comply with the timely access requirements.

f. Monitor network providers regularly to determine compliance with the timely access requirements.

6.1.7 The PASSE must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.

6.1.8 DHS has the discretion to allow a variance of any of the network adequacy standards set forth in the PASSE Manual. The PASSE may request a variance of these standards. Network adequacy variance requests will be handled on a case-by-case basis. If there is a situation when the geographic access standards for a given provider type cannot be met, access to the specified provider type may be provided via the use of telemedicine if specifically allowed by DHS. As specified in Section 241.000 of the PASSE Medicaid Provider Manual, if the PASSE is utilizing

telemedicine, the PASSE must document what services they allow the usage of telemedicine for, the settings allowed to utilize telemedicine at, and the qualifications for individuals to perform services via telemedicine.

6.2 PROVIDER CREDENTIALING AND CONTRACTING

6.2.1 The PASSE must enter into Provider Contracts with providers to ensure network adequacy under the Agreement. The PASSE may execute Provider Contracts, pending the outcome of screening, enrollment, and revalidation, of up to 120 days. All contracted providers must be enrolled in Medicaid.

6.2.2 The PASSE must notify members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, and helps them select a new practitioner. The PASSE must notify members affected by the termination of a practitioner or practice group which provides Behavioral Health or Developmental Disability Services specialty care at least 30 calendar days prior to the effective termination date, and helps the member select a new Behavioral Health or Developmental Disability Services specialty provider.

6.2.3 The State will screen and enroll, and periodically revalidate all PASSE network providers as Medicaid providers.

6.2.4 The PASSE may not prohibit or restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrolled member who is his or her patient regarding:

a. The enrolled member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
b. Any information the enrolled member needs to decide among all relevant treatment options.
c. The risks, benefits, and consequences of treatment or non-treatment.
d. The enrolled member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

6.2.5 The PASSE must give written notice of the reason for its decision when it declines to include individual or groups of providers in its provider network.

6.2.6 The PASSE must implement written policies and procedures for selection and retention of network providers.

6.2.7 The PASSE must prepare, submit to DHS for approval, and follow a documented process for credentialing and re-credentialing of providers who have signed Provider Contracts with the PASSE. The PASSE must utilize a universal application, credentialing, and contracting process for providers.

6.2.8 The PASSE is responsible for the credentialing of PASSE home and community-based service (HCBS) providers. All HCBS providers must be enrolled in Arkansas Medicaid as an HCBS provider. In order to enroll in Arkansas Medicaid as a PASSE Home and Community Based Service provider, the HCBS provider must be credentialed as such by the PASSE.

a. The PASSE must submit to DHS for approval the method by which the PASSE will credential HCBS providers.

b. The PASSE is required to submit a yearly attestation that all PASSE HCBS providers have been certified on an annual basis. DHS will audit the PASSE's records to ensure compliance with the annual certification requirement. Any PASSE HCBS provider discovered not to have been certified annually will be disenrolled as a Medicaid provider. Failing to annually certify HCBS providers that are enrolled with Medicaid may lead to sanctions by DHS in accordance with Section 14.1.

c. The PASSE's credentialing process must be approved by DHS and include the following, at a minimum, for HCBS providers:

i. Audit requirements;

ii. Inspection requirements;

iii. Complaint resolution process;

iv. Performing provider requirements; and

v. Any other information required for the PASSE to credential an HCBS provider as such.

6.2.9 Consistent with 42 CFR § 438.12, the PASSE's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

6.2.10 The PASSE must comply with the Arkansas Any Willing Provider laws, Ark. Code Ann. § 23-99-801 et seq.

6.2.11 The PASSE is not precluded from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrolled members.

6.2.12 The PASSE must demonstrate that its network providers are credentialed as required under 42 CFR § 438.214.

a. The PASSE must maintain a credentialing committee and the PASSE's Medical Director must have overall responsibility for the committee's activities.

b. The PASSE must prepare, submit to DHS for approval, and follow a documented process for credentialing and recredentialing of providers who have signed contracts/agreements with the PASSE. Credentialing must be completed before final execution of the contract with the provider.

c. The following providers must be credentialed:

i. Medical Doctor (MD)

ii. Doctor of Osteopathic Medicine (DOM)

iii. Doctor or Podiatric Medicine (DPM)

iv. Psychologists

v. Optometrists

vi. Nurse practitioners (NP)

vii. Physician Assistants (PA)

viii. Certified Nurse Midwives

ix. Occupational Therapists

x. Speech and Language Pathologists

xi. Physical Therapists

xii. Independent behavioral health professionals who contract directly with the PASSE including Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), Licensed Marriage/Family Therapist (LMFT), Licensed Independent Substance Abuse Counselor (LISAC)

xiii. Home and Community Based Providers who provide services under the CES Waiver or the 1915(i) authority

xiv. Board Certified Behavioral Analysts (BCBAs) and

xv. Any non-contracted provider that is rendering services and sees 50 or more of the contractor's members per contract year.

6.2.13 The PASSE may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act or providers listed on the Arkansas Medicaid Excluded Providers List.

6.2.14 The PASSE must have a credential review committee that approves or denies the final credentialing of its providers. The PASSE must demonstrate that it verifies primary source qualification data including:

a. The training and education through the applicable regulatory and accreditation organizations;

b. Current state medical licensure;

c. Specialty licensure or credentialing;

d. Employment history;

e. The Medicare and Medicaid exclusion list;

f. To ensure providers in its network are in good standing, including that no federal or state sanctions that have been imposed against them;

g. The National Practitioner Data Back on closed and settled claims history; and
h. The status of the provider applicant's privileges at hospitals and other health care facilities listed on the application.

6.2.15 The PASSE may approve temporary provider credentials for up to six (6) months pending completion of the full credential review and approval by the credential review committee. DHS may grant a variance for extending the temporary period following a demonstration of good cause.

6.2.16 The PASSE may deem the credential for providers who have already been approved and credentialed by another PASSE for up to six (6) months pending completion of the full credential review and approval by the credential review committee. DHS may grant a variance for extending the temporary period following a demonstration of good cause.

6.2.17 The PASSE must submit to DHS on a quarterly basis an electronic status file of providers who have submitted a credential application, are in a pended status, have received temporary credential approval and if credentialing was denied, the reason for denial of credentials.

6.2.18 HCBS providers must be re-credentialed annually. All other providers must be re-credentialed not less than every three years unless more frequently due to a change in the clinical scope of services of a provider.

6.2.19 No later than January 1, 2020, the PASSEs shall use a uniform standard credential application that must be submitted on-line and electronically and jointly select a single Contracted Credentialing Vendor Organization (CVO) according to specifications established by DHS. The costs of a CVO will be equally shared by the PASSEs. DHS shall establish a credentialing work group among the PASSEs for the purpose of setting credentialing process requirements. All current Medicaid providers will be deemed as credentialed during calendar year 2019. Starting January 1, 2020, the PASSE must credential all network providers.

6.2.20 The PASSE must inform providers and subcontractors, at the time they enter into a Provider Contract, about:

a. Member and provider grievance, appeal, and fair hearing procedures and timeframes as specified in 42 CFR § 438.400 through 42 CFR § 438.424 and described in Section 4.9 of the Agreement.
b. The member's and provider's right to file grievances and appeals and the requirements and timeframes for filing.
c. The availability of assistance to the member or provider with filing grievances and appeals.
d. The member's and provider's right to request a state fair hearing after the PASSE has made a determination on an appeal which is adverse to the member or provider.

e. The member's right to request continuation of benefits that the PASSE seeks to reduce or terminate during an appeal or state fair hearing filing, if filed within the allowable timeframes, although the member may be liable for the cost of any continued benefits while the appeal or state fair hearing is pending if the final decision is adverse to the member.

6.2.21 The PASSE must disseminate practice guidelines to all affected providers.

6.3 AUTHORIZATIONS OF SERVICES

6.3.1 The PASSE and its subcontractors must have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services.

6.3.2 The PASSE must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

6.3.3 The PASSE must consult with the requesting provider for medical services when appropriate.

6.3.4 The PASSE must authorize all services, including HCBS, based on a member's current needs assessment, and consistent with the member's PCSP.

6.3.5 Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by an individual who has appropriate expertise in addressing the enrolled member's medical, behavioral health, or long-term services and supports needs.

6.3.6 The PASSE's prior authorization requirements must comply with the requirements for parity in mental health and substance use disorder benefits. *See* Section 7.1.29.

6.3.7 For standard authorization decisions, the PASSE must provide notice as expeditiously as the enrolled member's condition requires, but within five (5) business days after receipt of request for service, with a possible extension of fourteen (14) business days if the member or provider requests an extension or the PASSE justifies the need for additional information and how the extension is in the enrolled member's interest.

6.3.8 When a provider indicates, or the PASSE determines, that following the standard timeframe could seriously jeopardize the enrolled member's life or health or ability to attain, maintain, or regain maximum function, the PASSE must make an expedited authorization decision and provide notice as expeditiously as the enrolled member's health condition requires and no later than 72 hours after receipt of the request for service.

6.3.9 Compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for denying, limiting, or discontinuing medically necessary services to any enrolled member.

6.3.10 After authorization of the PCSP, the PASSE have a mechanism in place to allow enrolled members to directly access services listed in the plan and emergency services.

6.3.11 For service authorization decisions not reached within defined timeframes specified in 42 CFR § 438.211(d), which constitutes a denial and is thus an adverse benefit determination, the PASSE must provide notice on the date that the timeframe expires.

6.4 PROVIDER SUPPORT SERVICES

The PASSE must have a process for handling and addressing the resolution of provider complaints, including those concerning claims and payment of claims.

6.5 MEDICAL/CASE RECORDS

6.5.1 The PASSE must ensure that each provider furnishing services to enrolled members, including the PASSE care coordinators, maintains and shares a member health record in accordance with professional standards.

6.5.2 The PASSE must use and disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular member, in accordance with the confidentiality requirements in 45 CFR parts 160 and 164. 42 CFR § 438.208(b)(6); and 42 CFR § 438.224. And, the PASSE must report to DHS the discovery of any use or disclosure of Personal Health Information (PHI) that is not in compliance with the Agreement or state or federal law in a manner and format prescribed by DHS.

6.6 THE SETTINGS RULE

6.6.1 The PASSE must ensure compliance with the Home and Community-Based Services (HCBS) Settings regulations as established by CMS. The federal regulation for the new rule is 42 CFR § 441.301(c) (4)-(5).

6.6.2 Settings that are HCBS must be integrated in and support full access of enrolled members receiving HCBS in the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as members not receiving HCBS.

6.6.3 HCBS settings must have the following characteristics:

a. Chosen by the individual member from among setting options including non-disability-specific settings (as well as an independent setting) and an option for a private unit in a residential setting.
   i. Choice must be included in the PCSP.
   ii. Choice must be based on the member's needs, preferences and, for residential settings, resources available for room and board.
b. Ensures the member's rights of privacy, dignity and respect and freedom from coercion and restraint.
c. Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
d. Facilitates individual choice regarding services and supports and who provides them.
e. In a provider-owned or -controlled residential setting (e.g., Group Homes), in addition to the qualities specified above, the following conditions must be met:
   i. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual member receiving services, and the member has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord/tenant laws do not apply, the PASSE must ensure that a lease, residency agreement or other form of written agreement will be in place for each member and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord/tenant law.
   ii. Each member has privacy in their sleeping or living unit:
      - Units have entrance doors lockable by the member, with only appropriate staff having keys to doors.
      - Members sharing units have a choice of roommates in that setting.
      - Members have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
   iii. Members have the freedom and support to control their own schedules and activities and have access to food at any time.
f. Members are able to have visitors of their choosing at any time.
g. The setting is physically accessible to the member.
h. Any modification of the additional conditions specified in items 1 through 4 above must be supported by a specific assessed need and justified in the PCSP. The following requirements must be documented in the PCSP:
   i. Identify a specific and individualized assessed need.
   ii. Document the positive interventions and supports used prior to any modifications to the PCSP.

iii. Document less intrusive methods of meeting the need that have been tried but did not work.
iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.
v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
vii. Include the informed consent of the member.
viii. Include an assurance that interventions and supports will cause no harm to the member.

7. PAYMENT TO PROVIDERS

7.1 CLAIMS AND PROVIDER PAYMENTS

7.1.1 The PASSE must reimburse providers for the delivery of authorized services as described in Section 6.3.

7.1.2 The PASSE must ensure that claims are timely processed and comply with all applicable federal and state requirements. The following standards regarding timely claims processing for all providers, regardless of whether they are filed by a participating provider or an out-of-network provider:

a. Process 70% of all clean claims submitted within seven (7) days of receipt;
b. Process 95% of all clean claims submitted within thirty (30) days of receipt;
c. Process 99% of all clean claims submitted within sixty (60) days of receipt.

7.1.3 For purposes of this Section, the date of receipt of the claim is the day it is received by the PASSE as indicated by the date stamp on the claim. The date of payment is the date on the check or other form of payment.

7.1.4 The clean claim must be submitted for payment by the provider, either by mail or electronic submission, within 365 days of:

a. The date of service;
b. The date of discharge from an inpatient setting; or
c. The date the provider was furnished with the correct name and address of the PASSE.

7.1.5 Claims not submitted within 365 days of the above date may be denied by the PASSE.

7.1.6 The PASSE must be able to accept electronically transmitted claims from providers in HIPAA compliant formats. HIPAA complaint electronic transmission of claims, transactions, notices, documents, forms and payments must be used to the greatest extent possible by the PASSE. For all electronically submitted claims for service, the PASSE must:

a. Within 24 hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgment of the receipt of the claim to the electronic source submitting the claim.
b. For contested, or "unclean" claims, the PASSE must include in the notice a list of additional information or documents necessary to process the claim.
c. Pay or deny the claim within ninety (90) calendar days after receipt, whether contested or not.
d. Failure to pay or deny the claim within one-hundred twenty (120) calendar days after receipt of the claim creates an uncontestable obligation of the PASSE to pay the claim.

7.1.7 For all non-electronically submitted claims for payment of services, the PASSE must:

a. Within 24 hours after the beginning of the next business day after receipt of the claim, provide electronic notice of receipt of the claim. Or, within fifteen (15) calendar days after receipt of the claim, provide acknowledgement of receipt of the claim to the provider or designee by mail and with information on how to electronically access the status of the claim.

b. The notification to the provider of a contested claim or "unclean" claim must include a list of additional information or documents necessary to process the claim.

c. Pay or deny the claim within 120 calendar days after receipt, whether contested or not.

d. Failure to pay or deny the claim within 140 calendar days after receipt of the claim creates an uncontestable obligation of the PASSE to pay the claim.

7.1.8 Any claim submitted to a PASSE for payment must be accompanied by an itemized accounting of the individual that is presented in a standardized format. The itemized accounting must include, at a minimum:

a. the enrolled member's name,

b. the date of service,

c. the procedure code,

e. service units,

f. the amount of reimbursement,

g. and the identification of the PASSE.

7.1.9 The PASSE and its providers must develop and maintain sufficient written documentation to support each service for which billing is made. This documentation, at a minimum, must consist of:

a. If applicable, a copy of the member's PCSP, including any amendments thereto.

b. The specific services rendered.

c. The date and actual time the services were rendered.

d. Updates describing the member's progress or lack thereof. Updates should be maintained on a daily basis or at each contact with or on behalf of the member. Progress notes must be signed and dated by the provider of the service.

7.1.10 The PASSE must screen the claim for completeness, logic, and consistency prior to payment.

7.1.11 The PASSE is responsible for Medicare co-insurance and deductibles for covered services that would otherwise be covered by Medicaid pursuant to the General Medicaid Provider Manual.

a. The PASSE must reimburse providers or enrolled members for Medicare deductibles and co-insurance payments made by the providers or members, according to Medicaid guidelines referenced in the Arkansas Medicaid Provider General Handbook.

b. If the enrolled member is a full-benefit dual eligible and has an existing Medicare PCP authorized through Medicare:

   i. The PASSE must not require a member's assigned Medicare PCP to enter into a Provider Contract to receive payment for copayments, co-insurance, or deductibles.

   ii. The Medicare PCP must either be fully enrolled in or registered with the Arkansas Medicaid program in order to be reimbursed for any copayments, co-insurance, or deductibles by the PASSE.

c. The PASSE must not deny Medicare crossover claims solely based on the period between the date of service and the date of clean claim submission. The claim must be submitted so that the PASSE can pay the claim within six months of notice of the disposition of the Medicare claim.

7.1.12 The PASSE must not pay for an item or service (other than an emergency item or service, including items or services furnished in an emergency room of a hospital) for the following:

a. Home health care services provided by DHS or another organization, unless DHS provides the state with a surety bond as specified in Section 1861(o)(7) of the Act.

b. Items or services furnished by an individual or entity during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless DHS determines that there is good cause not to suspend payments; and

c. Any expenditures related to items or services for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

7.1.13 The PASSE must incorporate the NCCI editing programs for the Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes to promote correct coding and control coding errors, except for allowable NCCI edits exclusions in accordance with 42 CFR § 433.116 and 45 CFR § 95.

7.1.14 The PASSE must prohibit balance billing by participating and out-of-network providers for covered services. This means that the provider may not bill the enrolled member directly for any amount not paid by the PASSE for the services provided.

7.1.15 The PASSE is responsible for Third Party Liability (TPL). Medicaid is the payor of last resort unless specifically prohibited by applicable State or Federal law. This means the PASSE must pay for covered services only after all other sources of payment have been exhausted, e.g. the insurance carrier of a tortfeasor. The PASSE

must take reasonable measures to identify potentially legally liable third-party sources.

a. If the PASSE discovers the probable existence of a liable third party that is not known to DHS, or identifies any change in coverage, the PASSE must report the information within thirty (30) days of discovery via the TPL File. Failure to report these cases may result in a sanction.

b. The PASSE must coordinate benefits in accordance with 42 CFR § 433.135, so that costs for services otherwise payable by the PASSE are cost avoided or recovered from a liable third party [42 CFR § 434.6(a)(9)]. The term "State" must be interpreted to mean "PASSE" for purposes of complying with the Federal regulations referenced above. The PASSE may require subcontractors to be responsible for coordination of benefits for services provided pursuant to the PASSE Provider Agreement. The two methods used for coordination of benefits are Cost Avoidance and Post-Payment Recovery. The PASSE must use these methods as described in Federal and State policies.

c. The PASSE must cost avoid a claim if it has established the probable existence of a liable party at the time the claim is filed. There may be limited circumstances when cost avoidance is prohibited, and the PASSE must apply post-payment recovery processes.

d. For purposes of cost avoidance, establishing liability takes place when the PASSE receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or service delivered to a PASSE member. If the probable existence of a party's liability cannot be established, the PASSE must adjudicate the claim, and then utilize post-payment recovery if necessary. If DHS determines that the PASSE is not actively engaged in cost avoidance activities, the PASSE may be subject to sanctions in accordance with Section 14.1.

e. If a third-party insurer other than Medicare requires the member to pay any copayment, coinsurance or deductible, the PASSE is responsible for making these payments for Medicaid covered services.

f. The PASSE is delegated the responsibility for coordination of benefits payment activities with legally liable third parties, including Medicare. For dual eligible members, the PASSE must coordinate Medicare fee-for-service (FFS) crossover claims payment activities with the Medicare Benefits Coordination and Recovery Center (BCRC) in accordance with 42 CFR § 438.3(t).

g. Post-payment recovery is necessary in cases where the PASSE has not established the probable existence of a liable third-party at the time services were rendered or paid for, was unable to cost-avoid, or post-payment recovery is required. In these instances, the PASSE must adjudicate the claim and then utilize post-payment recovery processes which include: Pay and Chase, Retroactive Recoveries Involving Commercial Insurance Payor Sources, and other third- party liability recoveries.

7.1.16 The PASSE must be registered with the BCRC as a trading partner to electronically process Medicare FFS crossover claims. An Attachment to the existing DHS

Medicare FFS Coordination of Benefits Agreement (COBA) must be executed by PASSE to register as a BCRC trading partner. Upon completion of the registration process, the BCRC must issue each PASSE a unique COB ID number. The PASSE will electronically receive data from the BCRC to coordinate payment of Medicare FFS crossover claims only. The PASSE must be exempt from BCRC crossover processing fees to the same extent as DHS.

a. Upon completion of trading partner registration, PASSE must coordinate with the BCRC regarding the sending, receipt and transmission of necessary BCRC-provided data files and file layouts, including eligibility and claim data files. PASSE must begin adjudicating Medicare FFS crossover claims upon completion of BCRC readiness review activities and receipt of BCRC approval.
b. Further information and resources for PASSE regarding the Medicare FFS COBA process and BCRC requirements are available at:
    i. Medicare Benefits Coordination and Recovery Center (BCRC) webpage: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of- Benefits-and-Recovery-Overview/Overview.html
    ii. COBA Implementation User Guide: https://www.cms.gov/Medicare/Coordination-of-Benefits- and-Recovery/COBA-Trading-Partners/Downloads/COBA-Implementation-Guide-January- 2017.pdf
    iii. Electronic File Layouts: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/COBA-Trading-Partners/Downloads/

7.1.17 The PASSE must not deny a claim for timeliness if the untimely claim submission results from a provider's reasonable efforts to determine the extent of liability.

7.1.18 The PASSE must pay the full amount of the claim according to the DHS Fee-For-Service Schedule or the negotiated contracted rate and then seek reimbursement from any third party if the claim is for the following:

a. Prenatal care for pregnant women, including services which are part of a global OB Package
b. Preventive pediatric services, including Early and Periodic Screening Diagnosis and Treatment (EPSDT) and administration of vaccines to children under the Vaccines for Children (VFC) program, or
c. Services covered by third party liability that are derived from an absent parent whose obligation to pay support is being enforced by Child Support Enforcement.

7.1.19 For a period of two years from the date of service, the PASSE must engage in retroactive third-party recovery efforts for claims paid to determine, if there are commercial insurance payor sources that were not known at the time of payment. In the event a commercial insurance payor source is

identified, the PASSE must seek recovery from the commercial insurance. The PASSE is prohibited from recouping related payments from providers, requiring providers to take action, or requiring the involvement of providers in any way, unless the provider was paid in full from both the PASSE and the commercial insurance.

7.1.20 Other Third- Party Liability Recoveries: The PASSE must identify the existence of potentially liable parties using a variety of methods, including referrals, and data mining. The PASSE must not pursue recovery in the following circumstances, unless the case has been referred to the DHS or DHS' authorized representative:

a. Motor Vehicle Cases
b. Other Casualty Cases
c. Tortfeasors
d. Restitution Recoveries
e. Worker's Compensation Cases

7.1.21 Upon identification of a potentially liable third party for any of the above situations, the PASSE must, within 10 business days, report the potentially liable third party to DHS for determination of a mass tort, total plan case, or joint case. Failure to report these cases may result in sanctions or other administrative remedy, pursuant to Section 13 of the Agreement. A mass tort case is a case where multiple plaintiffs or a class of plaintiffs have filed a lawsuit against the same tortfeasor(s) to recover damages arising from the same or similar set of circumstances (e.g. class action lawsuits) regardless of whether any reinsurance or Fee-For-Service payments are involved. A total plan case is a case where payments for services rendered to the member are exclusively the responsibility of the PASSE; no reinsurance or Fee-For-Service payments are involved. By contrast, a "joint" case is one where Fee-For-Service payments and/or reinsurance payments are involved. The PASSE must cooperate with DHS's authorized representative in all collection efforts.

7.1.22 In "total plan" cases, the PASSE is responsible for performing all research, investigation, the mandatory filing of initial liens on cases that exceed $250, lien amendments, lien releases, and payment of other related costs in accordance with DHS guidelines. The PASSE must use the DHS-approved casualty recovery correspondence when filing liens and when corresponding to others in regard to casualty recovery. The PASSE may retain up to 100% of its recovery collections if all of the following conditions exist:

a. Total collections received do not exceed the total amount of the PASSE's financial liability for the enrolled member,
b. There are no payments made by DHS related to Fee-For-Service, or applied DHS administrative costs (i.e., lien filing fee, etc.), and,
c. Such recovery is not prohibited by State or Federal law.

7.1.23 Prior to negotiating a settlement on a total plan case, the PASSE must notify DHS to ensure that there is no reinsurance or Fee-For-Service payment that has been made by DHS. Failure to report these cases prior to negotiating a settlement amount may result in sanction or other administrative remedy.

7.1.24 The PASSE must report settlement information to DHS using a format specified by DHS, within ten (10) business days from the settlement date. Failure to report these cases may result in sanctions or other administrative remedy determined by DHS.

a. Joint and Mass Tort Cases: DHS is responsible for performing all research, investigation and payment of lien-related costs, subsequent to the referral of any and all relevant case information to DHS by the PASSE. In joint and mass tort cases, DHS is also responsible for negotiating and acting in the best interest of all parties to obtain a reasonable settlement and may compromise a settlement in order to maximize overall reimbursement, net of legal and other costs. The PASSE is responsible for responding to requests from DHS to provide a list of claims related to the joint or mass tort case within 10 business days of the request. The PASSE will be responsible for their prorated share of the contingency fee. The PASSE's share of the contingency fee will be deducted from the settlement proceeds prior to DHS remitting the settlement to the PASSE organization.

7.1.25 All TPL reporting requirements are subject to validation through periodic audits and/or operational reviews which may include the PASSE submission of an electronic extract of the casualty cases, including open and closed cases. Data elements may include but are not limited to: the enrolled member's first and last name; Medicaid ID; date of incident; claimed amount; paid/recovered amount; and case status. DHS must provide the format and reporting schedule for this information to PASSE.

a. The PASSE must specify the retention policies for the treatment of recoveries of all overpayments from the PASSE to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.

b. The PASSE must specify the process, timeframes, and documentation required for reporting the recovery of all overpayments to DHS and OMIG.

c. The PASSE must specify the process, timeframes, and documentation required for payment of recoveries of overpayments to DHS in situations where the PASSE is not permitted to retain some or all of the recoveries of overpayments.

d. The PASSE must make use of, a mechanism for a network provider to report to the PASSE when it has received an overpayment, to return the overpayment to the PASSE within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the PASSE in writing of the reason for the overpayment.

e. The PASSE must submit the annual report of overpayment recoveries to DHS and OMIG.

7.1.26 The PASSE must honor any authorizations for services issued by DHS or its contractors for newly assigned members. If a provider can submit verification of an authorization issued by DHS or its contractors prior to the effective date of PASSE assignment, the PASSE must provide payment for that service at their negotiated rate.

7.1.27 The PASSE must not pay for organ transplants unless the Medicaid State Plan provides, and the PASSE follows, written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to members.

7.1.28 The PASSE must not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital), in one of the following categories:

a. Furnished under the PASSE by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act.

b. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or pursuant to sections 1128, 1228A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

c. Furnished by an individual or entity to whom DHS has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless DHS determines there is good cause not to suspend such payments.

d. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

7.1.29 Mental Health and Substance Abuse Parity Requirements

a. The PASSE must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same PASSE).

b. If a PASSE member is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the MCO member in every classification in which medical/surgical benefits are provided.

c. The PASSE may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient,

outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification.

d. The PASSE may not impose NQTLs for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the PASSE as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

7.1.30 The PASSE must require all providers to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made.

a. The PASSE cannot make payments for any provider-preventable conditions in accordance with 42 CFR § 438.3(g). The PASSE must track data and submit a report quarterly that identifies all provider-preventable conditions.

b. The report must include, at a minimum:

i. wrong surgical or other invasive procedure performed on an enrolled member; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

ii. Has a negative consequence for the enrolled member.

7.1.31 The PASSE may not pay an FQHC or RHC less than the amount of payments that would be provided if those services were furnished by a provider that is not an FQHC or RHC.

8. QAPI STRATEGIC PLAN AND UTILIZATION MANAGEMENT

8.1 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) STRATEGIC PLAN

8.1.1 The PASSE must establish and implement an ongoing Comprehensive Quality Assessment and Performance Improvement (QAPI) Strategic Plan for the services it furnishes to its enrolled members. The QAPI must include:

8.1.2 Performance Improvement Projects (PIP)—These are specific projects designed to increase the quality of services to enrolled members. Unless otherwise directed by DHS in its quality plan, the PIP must be designed to improve the results of a quarterly quality metric where the PASSE was deficient or lagging, including HEDIS® measures.

a. Each PIP must:
   i. Be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction.
   ii. Include measurement of performance using objective quality indicators.
   iii. Implement interventions to achieve improvement in the access to and quality of care.
   iv. Evaluate the effectiveness of the interventions based on the performance measures collected as part of the PIP.
   v. Include planning and initiation of activities for increasing or sustaining improvement.

b. The PIP must address:
   i. the collection and submission of performance measurement data, including any required by DHS or CMS.
   ii. Mechanisms to detect both underutilization and overutilization of services.
   iii. Mechanisms to assess the quality and appropriateness of care furnished to enrolled members with special health care needs, as defined by the state in the quality strategy.
   iv. Mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including:
      a) An assessment of care between care settings; and
      b) A comparison of services and supports received with those set forth in the enrolled member's PCSP.
   v. Participation in DHS's efforts to prevent, detect, and remediate critical incidents, consistent with assuring the health and welfare of the enrolled member, that are based on the requirements for home and community-based waiver programs.

8.1.3 The PASSE is encouraged to utilize Provider Incentive Plans to make incentive payments to providers under the Provider Contract that are based on value.

a. Incentive payments cannot be based on volume to increase inappropriate utilization (including denial of services) are not allowed.
b. The incentive payment may not condition provider participation in the PASSE network on the provider entering into or adhering to intergovernmental transfer agreements.
c. Provider Incentive Plans cannot allow for payments directly or indirectly through a subcontractor or delegate to induce a reduction or limit of medically necessary services to an enrolled member.
d. If the Provider Incentive Plan places the provider at substantial financial risk pursuant to 42 CFR § 422.208(a)(d)) for services that the provider does not furnish itself, the PASSE must ensure that all providers at substantial risk have either aggregate or per-patient stop-loss protection in accordance with 42 CFR § 422.208(f).
e. The PASSE must make available to DHS, CMS or their agents any provider incentive plans currently in use.

8.1.4 Withhold arrangements may be part of the Provider Contract. However, if the PASSE utilizes withholding arrangements, the following provisions apply:
a. The arrangement must be for a fixed period of time;
b. That performance is measured during the rating period under the contract in which the withhold arrangement is applied;
c. The arrangement is not renewed automatically;
d. The arrangement is made available to both public and private contractors under the same terms of performance;
e. The arrangement does not condition PASSE participation in the withhold arrangement on the PASSE entering into or adhering to intergovernmental transfer agreements; and
f. The arrangement must be necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the state's quality strategy.

8.2 QUALITY METRICS

8.2.1 The PASSE must report on the quality metrics outlined in this Section of the Agreement.

8.2.2 The PASSE must meet the quality metrics to avoid recoupment or other sanctions under the Agreement, as outlined in Section 14.1.

8.2.3 The quality metrics are as follows:
a. Care Coordinator caseload:

Metric	Target	Reporting to DHS (Frequency/Content)
The care coordinator's assigned caseload will be limited to a maximum of 50 enrolled members.	≥90% of care coordinators will have a caseload of ≤50 enrolled members	Quarterly/ Details of monthly caseload for each care coordinator employed, including the names of each enrolled member on the care coordinator's caseload

b. Initial Contact with Enrolled Member:

Metric	Target	Reporting to DHS (Frequency/Content)
Care coordinators must initiate contact with each enrolled member assigned to his or her caseload within 15 business days after effective date of enrollment.	≥75% of members are contacted within 15 business days of assignment by a care coordinator.	Quarterly/ Details of initial contact time frame with each enrolled member after their enrollment with the PASSE, including, but not limited to, date of enrollment, date of initial contact attempt, and date of completed initial contact

c. Monthly Contact with Enrolled Member:

Metric	Target	Reporting to DHS (Frequency/Content)
Care coordinators must maintain ongoing contact with each enrolled member assigned to his or her caseload, making at least one contact monthly.	≥75% of members are contacted monthly by a care coordinator.	Quarterly/ Details of monthly contact with each enrolled member including, but not limited to, date of enrollment, date of initial contact, date of monthly contact

d. Quarterly Contact with Enrolled Member:

Metric	Target	Reporting to DHS (Frequency/Content)
Care coordinators must maintain ongoing contact with each enrolled member assigned to his or her caseload, making at least one contact made in person quarterly.	≥75% of members are contacted quarterly in person by a care coordinator.	Quarterly/ Details of quarterly contact with each enrolled member including, but not limited to, date of enrollment, date of initial contact, date of in person contact

e. PCP Assignment

Metric	Target	Reporting to DHS (Frequency/Content)
Care coordinators must ensure that all enrolled members assigned to them have selected a Primary Care Physician (PCP), confirm that the member is seeing the PCP as needed, and if necessary, assist the member with selecting a PCP	≥80% of enrolled members will have selected a PCP and will be on the selected PCP's caseload	Quarterly/ Details on the number of enrolled members that have selected and have been assigned a PCP

f. Follow-up Care:

Metric	Target	Reporting to DHS (Frequency/Content)
Care coordinators must follow up with enrolled members assigned to their caseload within seven (7) business days of: 1) a visit to an Emergency Room or	≥50% of members with a visit to ER or discharge from Hospital or In-Patient Psychiatric Unit/Facility will have follow-up by a care coordinator ≤ 7	Quarterly/ Details of follow up visit with members after discharge from Emergency Room or urgent care or discharge from Hospital or In-Patient Psychiatric

2) Discharge from Hospital or In-Patient Psychiatric Unit/Facility	business days of visit.	Unit/Facility, including but not limited to the date of the visit, the date of the discharge, and action or treatment plan to prevent/avoid such visits in the future

g. Healthcare Effectiveness Data and Information Set (HEDIS®) measures
   i. The PASSE's first HEDIS® report will be due to DHS on June 15th of the first full contract year to coincide with the submission of HEDIS® measures to the National Committee for Quality Assurance (NCQA).
   ii. DHS may make any HEDIS® measures or performance results public.
   iii. The following, at a minimum are the HEDIS® measures that must be tracked and reported by the PASSE:

Measure	National Medicaid Health Plan Average (for reference) http://www.ncqa.org/hedis-quality-measurement/reports
Percentage of members with hospitalization for mental illness with a follow-up visit to behavioral health provider within 7 days of discharge *6-20 yr. old	2016 - 45.5%
Percentage of members with hospitalizations for mental illness with a follow-up visit to behavioral health provider within 30 days of discharge *6-20 yr. old	2016 – 63.8%
Percentage of members with hospitalizations for mental illness with a follow-up visit to behavioral health provider within 7 days of discharge *21+ yr. old	2016 - 45.5%
Percentage of members with hospitalizations for mental illness with a follow-up visit to behavioral health provider within 30 days of discharge	2016 – 63.8%

*21+ yr. old	
Percentage of members with newly prescribed ADHD medication with 1 follow-up visit during the 30-day initiation phase *6-12 yr. old	2016 – 44.5%
Percentage of members with newly prescribed ADHD medication with at least 2 follow-up visits during the 10-month continuation and maintenance phase *6-12 yr. old	2016 – 54.5%
Percentage of members on two or more concurrent antipsychotic medications (Lower rates are better) *1-17 yr. old	2016 – 2.4%
Percentage of members diagnosed with major depression who were treated with and remained on antidepressant medication for 12 weeks *18+ yr. old	New Measure
Percentage of members diagnosed with major depression who were treated with and remained on antidepressant medication for 6 months *18+ yr. old	New Measure
Percentage of members with Schizophrenia who were dispensed and remained on antipsychotic medication for at least 80 percent of their treatment period. *19+ yr. old	2016 – 59.2%
Percentage of members with Schizophrenia or Bipolar Disorder who were dispensed an antipsychotic medication and had a Diabetes screening test *18+ yr. old	2016 – 80.7%

h. PASSE created provider quality metrics

i. The PASSE must have quality metrics for quality, accuracy and timeliness that all providers who submit claims to the PASSE are held accountable for.

ii. The PASSE must verify the accuracy and timeliness of the data reports submitted by providers regarding these quality metrics, regardless of

whether they are participating or out-of-network providers or they are compensated through a capitation arrangement on or a by-service basis.

iii. This information must be compiled into a report and submitted to DHS with the quarterly metrics report. However, the raw data and information must be kept and made available for DHS or its agents to review.

8.3 ENCOUNTER DATA AND UTILIZATION MANAGEMENT

8.3.1 The PASSE is required to collect encounter data for all services provided to enrolled members, including in lieu of services and expanded benefits. The encounter data must include characteristics of the member and the provider as specified by the state and submit encounter data that meets established DHS data quality standards as defined herein. These standards are defined by DHS to ensure receipt of complete and accurate data for program administration and are closely monitored and enforced.

a. The PASSE must submit data on the basis of which the state certifies the actuarial soundness of capitation rates to a PASSE, including base data that is generated by the PASSE.

b. The PASSE must submit data on that basis of which the state determines the compliance of the PASSE with the MLR requirement.

c. The PASSE must submit data on the basis of which the state determines that the PASSE has made adequate provision against the risk of insolvency.

d. The PASSE must submit documentation on which the state bases its certification that the PASSE has complied with the state's requirements for availability and accessibility of services, including the adequacy of the provider network.

8.3.2 DHS will revise and amend these standards with sixty (60) days' advance notice to the PASSE to ensure continuous quality improvement. The PASSE must make changes or corrections to any systems, processes or data transmission formats as needed to comply with DHS data quality standards as originally defined or subsequently amended. The PASSE must be capable of sending and receiving any claims information directly to DHS in standards and timeframes specified by DHS within sixty (60) days' notice.

8.3.3 The PASSE must certify all data to the extent required in 42 CFR § 438.606. Such certification must be submitted to DHS with the certified data and must be based on the knowledge, information and belief of the Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Medical Officer (CMO) or an individual who has written delegated authority to sign for, and directly reports to the CEO or CFO that all data submitted in conjunction with the encounter data and all documents requested by DHS are accurate, truthful, and complete. The PASSE must provide the certification at the same time it submits the certified data in the format and within the timeframe required by DHS.

8.3.4 The PASSE must have the capacity to identify encounter data anomalies and must provide a description of that process to DHS for review and approval.

8.3.5 The PASSE must designate sufficient information technology (IT) and staffing resources to perform these encounter functions as determined by generally accepted best industry practices.

8.3.6 The PASSE must participate in DHS-sponsored workgroups directed at continuous improvements in encounter data quality and operations.

8.3.7 The PASSE must have a comprehensive automated and integrated encounter data system capable of meeting the requirements below:

a. All PASSE encounters must be submitted to DHS in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P — Professional; I — Institutional; D — Dental), and, for pharmacy services, in the National Council for Prescription Drug Programs (NCPDP) format. The PASSE's encounters must also follow the standards in DHS's 5010 Companion Guides, the Arkansas D.0 Payer Specification - Encounters and in this section. Encounters must include PASSE amounts paid to the providers and must be submitted for all providers (capitated and non-capitated).

b. The PASSE must follow the instructions in the User Guide and Report Guide regarding the reporting of pharmacy encounter data using the National Council for Prescription Drug Program (NCPDP) standard D. 0. format and field definitions. Additionally, the PASSE must submit all denied pharmacy claims data and the reason code(s) for denial.

c. The PASSE must convert all information that enters its claims system via hard copy paper claims or other proprietary formats to encounter data to be submitted in the appropriate HIPAA-compliant formats.

d. For any services in which a PASSE has entered into capitation reimbursement arrangements with providers, the PASSE must comply with all encounter data submission requirements in this section. The PASSE must require timely submissions from its providers as a condition of the capitation payment.

8.3.8 The PASSE must implement and maintain review procedures to validate encounter data submitted by providers.

8.3.9 The PASSE must submit complete, accurate and timely encounter data to DHS, as defined below.

a. For all services rendered to its enrolled members (excluding services paid directly by DHS on a fee-for-service basis), the PASSE must submit encounter claims monthly following the date on which the PASSE adjudicated the claims. At least ninety-five percent (95%) of all encounter data must be accurate.

b. Pharmacy Encounters (NCPDP)

i. Complete: The PASSE must submit pharmacy encounters for all of the covered services provided by participating and non-participating providers on a weekly basis.

ii. Accurate: For each encounter data submission, ninety-five percent (95%) of the PASSE's encounter lines submissions must pass NCPDP edits and the pharmacy benefits system edits as specified by DHS. The NCPDP edits are described in the National Council for Prescription Drug Programs Telecommunications Standard Guides. Pharmacy benefits system edits are defined on the following website: https://arkansas.magellanrx.com/provider/documents/

8.3.10 Complete. The PASSE must submit encounters for ninety-five percent (95%) of the covered services provided by participating and non-participating providers.

8.3.11 Accurate: No less than ninety-five percent (95%) of the PASSE's encounter lines submission must pass MMIS system edits as specified by DHS.

8.3.12 The PASSE must collect and submit encounter data to DHS's fiscal agent. The PASSE must be held responsible for errors or noncompliance resulting from their own actions or the actions of an agent authorized to act on its behalf.

a. The encounter data submission standards required to support encounter data collection and submission are defined by DHS in the Medicaid Companion Guides, Pharmacy Payer Specifications and this section.

b. The PASSE must adhere to the following requirements for the encounter data submission process:

i. Within thirty (30) days after notice by DHS or its fiscal agent of encounters getting a denied or rejected payment status (failing fiscal agent edits), the PASSE must accurately resubmit one hundred percent (100%) of all encounters for which errors can be remedied.

ii. The PASSE must retain submitted historical encounter data for a period not less than ten (10) years.

c. The PASSE must implement and maintain review procedures to validate the successful loading of encounter files by DHS fiscal agent's electronic data interface (EDI) clearinghouse. The PASSE must use the EDI response (acknowledgement) files to determine if files were successfully loaded. Within seven (7) days of the original submission attempt, the PASSE must correct and resubmit files that fail to load

d. If the PASSE fails to comply with the encounter data reporting requirements of this Agreement, DHS will impose sanctions pursuant to Section 14.1.

8.3.13 Encounter Resubmission - Adjustments, Reversals or Corrections

a. Within thirty (30) days after encounters fail NCPDP edits, X12 (EDI) edits or MMIS system edits, the PASSE must correct and resubmit all encounters for which errors can be remedied.
b. The PASSE must correct and resubmit one hundred percent (100%) of previously submitted X12 and NCPDP encounter data transactions to reflect the most current and accurate payment adjustments or reversals that resulted in a recoupment or additional payment within thirty (30) days of the respective action.
c. For encounter data acceptance purposes the PASSE must ensure the provider information it supplies to DHS is sufficient to ensure providers are recognized in MMIS as actively enrolled Medicaid providers. The PASSE is responsible for ensuring information is sufficient for accurate identification of participating network providers and non-participating providers who render services to PASSE members.

8.3.14 The PASSE has the option to conduct prepayment, concurrent and post-payment medical reviews of all claims including outlier claims;

8.3.15 Erroneously paid claims are subject to recoupment;

8.3.16 If the PASSE is unable to determine medical necessity for services through its inability to perform a concurrent medical review process, the lack of a medical necessity determination shall not constitute a basis for denial payment or recoupment of a paid claims;

8.3.17 If the PASSE validates the lack of medical necessity through a post-payment medical review of information provided that the PASSE could not have discovered during a prepayment or concurrent medical review or initial exercise of due diligence, the PASSE may recoup all or the appropriate portion of payment made to the provider;

8.4 EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO)

8.4.1 The PASSE must undergo annual, external independent reviews of the quality, timeliness, and access to the services covered under the Agreement.

8.4.2 DHS will contract with an independent vendor to perform the External Quality Review.

8.5 CONSUMER ADVISORY COUNCIL (CAC)

8.5.1 The PASSE must establish and maintain a Consumer Advisory Council (CAC) in accordance with Act 775 of 2017 and the PASSE Provider Manual.

8.5.2 The CAC will consist of at least one (1) consumer of developmental disabilities services, one (1) consumer of behavioral health services, and one (1) consumer of substance abuse treatment services.

8.5.3 At a minimum, the Consumer Advisory Council must:

a. Conduct meetings at least quarterly to discuss matters within the scope of Consumer Advisory Council business;
b. Review marketing materials for content and appropriateness;
c. Review other informational materials for content and appropriateness;
d. Review the results of the PASSE administered satisfaction survey; and
e. Monitor and provide quality assurance to grievances filed by PASSE members.

8.6 REPORTING REQUIREMENTS

8.6.1 The PASSE must extract and upload data sets, upon request, to a DHS-hosted secure FTP site to enable authorized DHS personnel, or agent, on a secure and read-only basis, to build and generate reports for management use. DHS and the PASSE must arrange technical specifications for each data set as required for completion of the request. These technical specifications will be communicated by DHS to the PASSEs and may be amended throughout the contract year.

8.6.2 During the PASSE Provider Agreement Term, the PASSE must:

a. Submit any reports, documentation, or information relating to the performance of the entity's obligations, on such basis, as required by DHS, OMIG, or CMS.
b. The individual who submits the data to DHS must provide a certification which attests, based on best information, knowledge and belief that the data, documentation and information are accurate, complete and truthful.
c. Data, documentation, or information submitted to DHS, OMIG, or CMS by the PASSE must be certified by one of the following:
    i. The PASSE's Chief Executive Officer (CEO);
    ii. The PASSE's Chief Financial Officer (CFO); or
    iii. An individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO of CFO so that the CEO or CFO is ultimately responsible for the certification.

8.6.3 The PASSE must submit certification concurrently with the submission of data, documentation, or information.

8.6.4 The PASSE must make any reports of transactions between the PASSE and parties in interest that are provided to DHS, OMIG, or other agencies available to PASSE members upon reasonable request.

8.6.5 DHS will collect the following information from the PASSE to improve the performance of its managed care program:

a. Enrollment and disenrollment data from the PASSE.
b. Member and provider grievance and appeal logs from the PASSE.
c. The results of any member satisfaction survey conducted by the PASSE.
d. The results of any provider satisfaction survey conducted by the PASSE.
e. Audited financial and encounter data from the PASSE.
f. The MLR summary reports from the PASSE.
g. Customer service performance data from the PASSE
h. Performance on required quality measures from the PASSE.
i. Medical management committee reports and minutes from the PASSE.
j. The PASSE's annual quality improvement PASSE.
k. HCBS data.

8.6.6 The PASSE, and any subcontractor that is involved in claims processing, medical reviews, claims audit, or who is required by law or regulation, shall prepare and provide to DHS and OMIG a quarterly Fraud, Waste, Abuse, and Overpayment Report on a template provided by the State. The Quarterly Report shall provide the following:

a. All internal and external tips regarding potential fraud, waste, abuse, or overpayment due to suspected fraud. Examples of internal tips include information such as identified patterns of data mining outliers or audit concerns. External tips include information from hotline calls or emails and other leads;
b. All audits conducted that quarter and the findings;
c. All referrals made to OMIG or other state or federal agencies regarding fraud, waste, or abuse;
d. Administrative actions taken against Providers;
e. Overpayments, including a determination on which were due to suspected fraud, waste, or abuse;
f. Involuntary terminations against Providers; and
g. The identification of providers who voluntarily terminate their contracts with the PASSE if the termination occurs upon a request for documents or an audit.

8.6.7 All suspected fraud by enrolled or potential members, providers, or by any other party involved in the Medicaid or PASSE program shall be reported within 15 business days of discovery to DHS and OMIG. Upon discovery of suspected fraud, absent written approval from OMIG, the PASSE shall not:

a. Contact the subject of the investigation about any matters related to the investigation; or
b. Enter into or attempt to negotiate any settlement or agreement regarding the incident.

8.7 INCIDENT REPORTS

8.7.1 The PASSE must submit incident reports upon the occurrence of any of the following events:

a. Death of a member;

**Requires Immediate Reporting within one hour of the PASSE becoming aware of the occurrence*

b. The use of restrictive interventions;

c. Suspected maltreatment or abuse of member;

d. Injury to a member that requires emergency room care, or a paramedic;

e. Injury to a member that may result in a substantial permanent impairment;

**Requires Immediate reporting within one hour of the PASSE becoming aware of the occurrence*

f. Injury to a member that requires hospitalization;

g. Threatening or attempting suicide;

h. Arrest;

i. Any situation where the member eloped from a service and cannot be located within 30 minutes;

j. Any event where a PASSE HCBS provider staff threatens, abuses, or neglects a member; and

k. Medication errors that cause serious injury to the member.

8.7.2 Other than Immediate Reporting, all other Incidents must be reported within 24 hours of the PASSE becoming aware of the occurrence. Incidents reports must contain the following information:

a. Date of Incident;

b. Member's Name and Date of Birth;

c. Time of Incident;

d. Location of Incident;

e. Persons involved;

f. Incident Description;

g. Any action taken by the Provider, staff, or PASSE; and

h. Name of Person that prepared the report with contact information.

9. PASSE ADMINISTRATION AND MANAGEMENT

9.1 ORGANIZATIONAL GOVERNANCE AND STAFFING

9.1.1 The PASSE must be located and operating in the State of Arkansas.

9.1.2 Each PASSE must inform DHS if it has been accredited by a private independent accrediting entity.

a. If a PASSE has been accredited by a private independent accrediting entity, the PASSE must authorize the private independent accrediting entity to provide DHS a copy of its most recent accreditation review, including:

i. The accreditation status, survey type and level (as applicable);

ii. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and

iii. Expiration of the accreditation.

b. DHS will make the accreditation status of each PASSE available to the general public on the Arkansas Medicaid PASSE website.

c. The contract requires that each PASSE inform the state as to whether it has been accredited by a private independent accrediting entity.

9.1.3 The PASSE must have a centralized executive administration that includes the following:

a. Administrator/Chief Executive Officer/Chief Operating Officer (CEO), who is located in Arkansas. The CEO oversees the entire operation of the PASSE, and has the authority to direct, implement and prioritize work, regardless of where performed to ensure compliance with Agreement requirements, and oversees all staff performing functions related to this Agreement.

b. Chief Financial Officer (CFO) who is located in Arkansas. The CFO oversees the budget, accounting systems, and financial reporting implemented by the PASSE.

c. Care Coordination Manager, who is located in Arkansas. The Care Coordination Manager is responsible for overseeing all Care Coordinators and ensuring that all aspects of Care Coordination Services outlined in Section 5.2 are being fulfilled.

d. IT/IS (Information Technology/Information Systems) Manager is responsible for all information systems management, including coordination of the technical aspects of application infrastructure, server and storage needs, reliability and survivability of all date and data exchange elements including Business Continuity/Disaster Recovery activities.

e. Compliance Officer must be qualified by knowledge, training, and experience in health care or risk management, to promote, implement, and oversee the compliance program. The compliance officer must exhibit knowledge of relevant regulations, provide expertise in compliance processes, and be qualified to design, implement, and oversee a fraud and abuse program designed

to ensure program integrity through fraud and abuse prevention and detection, which identifies and addresses emerging trends of fraud, abuse, and waste pursuant to this Agreement and state and federal law. The Compliance Officer is responsible for overseeing the activities of the Medical/Quality Management Committee, implementing the Fraud and Abuse Prevention Plan, and ensuring compliance with state and federal law.

i. The compliance officer must have unrestricted access to the PASSE's governing body for compliance reporting, including fraud and abuse and overpayment.

ii. The PASSE must have adequate Arkansas-based staff and resources to enable the compliance officer to investigate indicia of fraud and abuse and develop and implement corrective action plans relating to fraud, abuse and overpayment.

f. Medical Director who is an Arkansas licensed physician and located in Arkansas. The Medical Director is responsible for all clinical decisions of the PASSE and oversees the proper provision of covered services to enrolled members. The Medical Director is responsible for overseeing functions of the Credentialing Committee and is required to be the Chair of the Credentialing Committee. The Medical Director will also serve as a liaison between the PASSE and providers; be available to the PASSE's staff for consultation on referrals, denials, Complaints, Grievances, and Appeals; review potential quality of care problems, and participate in the development and implementation of corrective action plans.

9.1.4 The PASSE must also have the following staff members that may be located outside of Arkansas; however, the PASSE must designate and identify these staff to DHS and provide contact information for each:

a. Contract Manager;
b. Data Processing/Reporting Coordinator;
c. Medical/Case Records Review Coordinator;
d. Claims/Encounter Manager;
e. Quality Improvement Manager;
f. Utilization Management Manager;
g. Fraud Investigation Manager

9.1.5 The PASSE must have sufficient medical and professional staff to conduct daily business in an orderly manner.

a. Member Support Services staff must be available during business hours for consultation;
b. There must be sufficient full-time investigative staff to oversee all fraud, waste and abuse activities, including investigations and enforcement of the FAPP;
c. Care coordination staff must be available 24/7; and

d. The available staff must be capable of assisting members with emergency situations 24/7.

9.1.6 The PASSE must have sufficient additional staff and information systems capabilities (outlined in Section 9.9) to ensure the PASSE can appropriately manage financial transactions, record keeping, data collection, and other administrative functions outlined in the Agreement, including the ability to submit any financial, programmatic, encounter data or other information required by DHS.

9.1.7 The PASSE must submit an organizational chart to DHS that identifies members of key staff and management, as required by this Section of the Agreement. The PASSE must notify DHS of any changes to the organizational chart within five (5) business days.

9.1.8 The PASSE must designate members of the executive staff to serve as the main contact for DHS, unless otherwise specified in the Agreement.

9.1.9 The PASSE must establish a governing body that has overall responsibility for the organization and the development of PASSE policy. This governing body must include:

a. A representative from a member provider of developmental disabilities services;
b. A representative from a member provider of behavioral health services;
c. A representative from a member Arkansas licensed hospital or hospital services organization;
d. A representative from a member Arkansas licensed physician practice; and
e. A pharmacist who is licensed by the Arkansas State Board of Pharmacy.

9.1.10 The PASSE must report the following:

a. The name and address of any person (individual or corporation) with an ownership or control interest in the managed care entity and its subcontractors. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box.
b. The date of birth and Social Security Number (SSN) of any individual with an ownership or control interest in the PASSE and its subcontractors.
c. Other tax identification number of any corporation with an ownership or control interest in the PASSE and any subcontractor in which the PASSE has a five percent (5%) or more interest.
d. Information on whether an individual or corporation with an ownership or control interest in the PASSE is related to another person with ownership or control interest in the PASSE as a spouse, parent, child, or sibling.
e. Information on whether a person or corporation with an ownership or control interest in any subcontractor in which the PASSE has a five percent (5%) or more interest is related to another person with ownership or control interest in the PASSE as a spouse, parent, child, or sibling.

f. The name of any other disclosing entity in which an owner of the MCP has an ownership or control interest.

g. The name, address, date of birth, and SSN of any managing employee of the PASSE.

9.1.11 Required Disclosures

a. The PASSE and subcontractors must disclose to DHS, any persons or corporations with an ownership or control interest in the PASSE that:

i. Has direct, indirect, or combined direct/indirect ownership interest of five (5%) or more of the PASSE's equity;

ii. Owns five (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the PASSE if that interest equals at least five (5%) of the value of the PASSE's assets;

iii. Is an officer or director of a PASSE organized as a corporation; or

iv. Is a partner in a PASSE organized as a partnership.

b. The PASSE and subcontractors must disclose information on individuals or corporations with an ownership or control interest in the PASSE to DHS at the following times:

i. When the PASSE submits a proposal in accordance with DHS's procurement process.

ii. When the PASSE executes the Agreement with DHS.

iii. When DHS renews or extends the Agreement.

iv. Within thirty-five (35) days after any change in ownership of the PASSE.

9.1.12 The PASSE must report to DHS, OMIG, and, upon request, to the Secretary of the Department of Health and Human Services (DHHS), the Inspector General of the DHHS, and the Comptroller General a description of transactions between the PASSE and a party in interest (as defined in Section 1318(b) of such Act), including the following transactions:

a. Any sale or exchange, or leasing of any property between the PASSE and such a party;

b. Any furnishing for consideration of goods, services (including management services), or facilities between the PASSE and such a party, but not including salaries paid to employees for services provided in the normal course of their employment;

c. Any lending of money or other extension of credit between the PASSE and such a party.

9.1.13 The PASSE must annually: measure and report to DHS on its performance, using the standard measures required by DHS; submit to DHS specified data that enables DHS to calculate the PASSE's performance using the standard measures identified by DHS in Section 8 and Exhibit II; OR perform a combination of these activities. 42 CFR § 438.330(c)(1) and (2).

9.1.14 The PASSE must cooperate with DHS, OMIG, CMS, the DHHS Inspector General, the Comptroller General or the designee of any of these entities in any audit, evaluation, or inspection (from the beginning of the contract until 10 years from the end date of the contract or the last audit, whichever is later) of the PASSE's premises, physical facilities, equipment, books, records, contracts, computers, or other electronic systems relating to the PASSE's activities under this agreement.

9.1.15 The PASSE must retain, and require subcontractors to retain, as applicable, the following information: member grievance and appeal records in 42 CFR § 438.416, base data in 42 CFR § 438.5(c), MLR reports in 42 CFR § 438.8(k), and the data, information, and documentation specified in 42 CFR §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

9.2 SUBCONTRACTING AND DELEGATION OF PASSE RESPONSIBILITIES

9.2.1 The PASSE may delegate performance of work required under the Agreement with prior written approval from DHS.

a. Work must be delegated by a subcontract or delegation agreement that is submitted to DHS for approval prior to work under the subcontract or agreement beginning.
b. All subcontracts or agreements delegating requirements of the Agreement must comply with all applicable state and federal law, including without limitation, 42 CFR §§ 447.45—46, 42 CFR § 438.230, 42 CFR §§ 455.14—106, all other Medicaid laws and regulations, other sub-regulatory guidance and contract provisions.
c. No subcontract or delegation agreement executed under this provision shall relieve the PASSE of any responsibility for the performance of the duties under the Agreement.
d. The PASSE is responsible for ensuring that all tasks delegated under the subcontract or delegation agreement are performed in accordance with the terms of the Agreement. The PASSE must submit to DHS a monitoring plan for each subcontract or delegation agreement.

9.2.2 The subcontract or delegation agreement, and any amendments thereto, must be in writing, signed and dated prior to work under the subcontract or agreement beginning. The subcontract or delegation agreement must:

a. Name the parties to the subcontract or delegation agreement (the PASSE and the subcontractor or delegate);
b. Designate the population covered;
c. State the effective dates of the subcontract or delegation agreement;
d. Incorporate all appropriate and applicable terms of the Agreement;
e. Require the submission of reports and clinical information required by the PASSE's policies, OMIG, or DHS;
f. Require the subcontractor or delegate participate in any internal and external quality improvement, utilization review, peer review, grievance or appeal

procedure, or complaint resolution established by the PASSE as needed according to the duties delegated through the subcontract or delegation agreement;

g. Prohibit the subcontractor or delegate from seeking payment or damages from a potential or enrolled member or directly from the State Medicaid program, whether on its own behalf or behalf of the PASSE;

h. Identify the conditions and methods of payment, including the information needed to make payment and the process for submission of payment requests;

i. Fully disclose the method and amount of payment or other consideration to be received by the subcontractor or delegate from the PASSE;

j. Require the subcontractor or delegate to maintain an adequate record system for recording services, charges, dates, and all other commonly accepted information elements for services rendered to the PASSE or PASSE enrolled members by the subcontractor or delegate;

k. If the subcontractor or delegate makes any payments to a provider, require that those payments be accompanied by an itemized accounting of the individual claims included in the payment, including, but not limited to:

   i. the enrolled member's name;

   ii. the date of service;

   iii. the procedure code;

   iv. the service units;

   v. the amount of reimbursement; and

   vi. the PASSE identification;

l. Require the PASSE to assume responsibility for cost avoidance measures for third party collections in accordance with Section 7.1.15;

m. Require compliance with all privacy and security standards, including, but not limited to HIPAA and HITECH;

n. Require the subcontractor or delegate safeguard information about potential members and enrolled members in accordance with 42 CFR § 438.224;

o. The following clauses:

p. An *exculpatory clause* that survives the termination of the subcontract or delegation agreement, including a breach due to insolvency, and which assures that enrolled members, potential members, and DHS will not be held liable for any debts incurred under the subcontract or delegation agreement by either party;

q. An *indemnification clause* that indemnifies, defends and holds harmless DHS, its designees, enrolled members, or potential members from and against all claims, damages, causes of action, costs or expenses, including court costs and attorney fees, to the extent such were proximately caused by a negligent act or other wrongful conduct arising from the subcontract or delegation agreement. This indemnification clause must survive the termination of the agreement, including breach due to insolvency;

r. A *waiver and severability clause* that allows for the severing or waiving of any clause that is deemed to be in conflict with the provision of the Agreement or state or federal law;

s. A *revocation clause* that allows the PASSE or DHS to revoke the delegation of duties to the subcontractor or delegate, and impose other appropriate sanctions, if the subcontractor's performance is inadequate; and

t. A *termination clause* that contains the grounds for termination and the procedures to terminate the subcontract or delegation agreement by either party or DHS.

u. Require the subcontractor or delegate to fully cooperate in any investigation by DHS, Medicaid Program Integrity (MPI), the Medicaid Fraud Control Unit (MFCU), the Office of Medicaid Inspector General (OMIG), the Department of Elder Affairs, or any other state of federal entity and any subsequent legal action that may result from any such investigation;

v. Require the subcontractor or delegate to cooperate with DHS, OMIG, MFCU, CMS, the DHHS Inspector General, the Comptroller General or the designee of any of these entities in any audit, evaluation, or inspection (from the beginning of the subcontract or delegation agreement until 10 years from the end date of the subcontract or delegation agreement or the last audit, whichever is later) of the subcontractor's or delegate's premises, physical facilities, equipment, books, records, contracts, computers, or other electronic systems relating to the its activities under the subcontract or delegation agreement, and to the PASSE and the potential and enrolled PASSE members;

w. Require, at the request of DHS, MPI, MFCU, OMIG, CMS, or the DHHS Inspector General, that the subcontractor submit to an inspection, evaluation, or audit at any time; and

x. Detail information about the following, as required by Section 6032 of the Federal Deficit Reduction Act of 2005:

   i. The False Claim Act;

   ii. The penalties for submitted false claims and statements;

   iii. Whistleblower protections; and

   iv. The entity's role in preventing and detecting fraud, waste and abuse, and each person's responsibility relating to detection and prevention.

9.2.3 The PASSE must document compliance certification (business-to-business) testing of transaction compliance with HIPAA for any subcontractor that receives member data.

9.2.4 The PASSE may not use a subcontract or delegation agreement to make a specific payment directly or indirectly under a physician incentive payment plan, as described in Section 8.1.3, as an inducement to reduce or limit medically necessary services to a member.

9.2.5 The PASSE may not structure a subcontract or delegation agreement that delegates utilization management activities to provide incentives for the subcontractor or delegate to deny, limit or discontinue medically necessary services to any member.

9.2.6 All subcontractors or delegates must meet the following requirements:

a. Eligible for participation in the Medicaid program; however, Medicaid participation in Medicaid Fee-for-Service is not required;

b. Pass a background check based on the nature and scope of the work the subcontractor or delegate will perform;

c. Not debarred, suspended or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations or guidelines issued under Executive Order 12549; and

d. Not debarred, suspended, or otherwise excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act or listed on the Arkansas Medicaid Excluded Provider's List.

9.2.7 DHS encourages use of minority or female-owned business enterprise subcontractors or delegates.

9.3 GENERAL PASSE SUBCONTRACTING RESPONSIBILITIES

9.3.1 Notwithstanding any relationship(s) the PASSE may have with any subcontractor the PASSE maintains ultimate responsibility for fully complying with all PASSE agreement terms and conditions and requirements of the manual [42 CFR § 438.230(b)(1); 42 CFR § 438.3(k)];

9.3.2 The PASSE is accountable for and must oversee, any functions and responsibilities that it delegates to subcontractors [42 CFR § 438.230(a))]. All such subcontracts must be in writing [42 CFR § 438.6(l)] and clearly describe the functions and responsibilities delegated to the subcontractor and shall be subject to the requirements of Arkansas DHS;

9.3.3 The PASSE shall maintain a fully executed original or electronic copy of all subcontracts, which shall be available to Arkansas DHS within five (5) business days of a request. All requested subcontracts must have full disclosure of all terms and conditions including all financial payment or other relevant information;

9.3.4 Subcontractor contract terms, conditions and other information may be designated as confidential, but may not be withheld from Arkansas DHS review;

9.3.5 Arkansas DHS will not disclose information designated as confidential without the prior written consent of the PASSE, except as required by law.

9.3.6 All subcontracts shall comply with the applicable provisions of Federal and State laws, regulations, and policies.

9.3.7 Arkansas DHS may, at its discretion, communicate directly with the governing body or Parent Corporation of the PASSE contractor regarding the performance of a subcontractor or PASSE contractor respectively.

9.3.8 The PASSE shall develop and maintain a system for regular and periodic assessment of all subcontractors' compliance with its terms.

9.3.9 No subcontract shall operate to terminate the legal responsibility of the PASSE contractor to assure that all activities carried out by the subcontractor conform to the provisions of this Contract [42 CFR § 434.6(c)];

9.3.10 The PASSE shall not delegate responsibility for the quality of care investigations, compliance reviews, or onsite quality of care visits to Administrative Services Subcontractor site or health care provider site; and

9.3.11 The PASSE and its subcontractors may not employ or contract with providers excluded from participation in Federal health care programs, under either section 1128 or section 1128A of the Social Security Act [42 CFR § 438.214(d)] or listed on the Arkansas Medicaid Excluded Provider's List.

9.4 PROVISIONS IN SUBCONTRACTOR AGREEMENTS

9.4.1 All subcontracts must reference and require compliance with the Minimum Subcontract Provisions. Each subcontract must contain the following:

a. The subcontractor's activities and obligations, and related reporting responsibilities [42 CFR § 438.230(c)(1)(i); 42 CFR § 438.3(k)];
b. A provision requiring subcontractor agreement to perform the delegated activities and reporting responsibilities specified in compliance with contract obligations [42 CFR § 438.230(c)(1)(ii); 42 CFR § 438.3(k)];
c. A provision that requires the subcontractor to comply with all applicable Medicaid laws, state and federal regulations, including applicable sub-regulatory guidance and contract provisions [42 CFR § 438.230(c)(2); 42 CFR § 438.3(k)];
d. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor;
e. Subcontract shall identify of the name and address of the subcontractor;
f. Identification of the eligible Medicaid population including patient Tier Level or qualifying patient condition that is to be covered by the subcontractor;
g. The amount, duration and scope of services to be provided by the subcontractor, and for which compensation will be paid;
h. The term of the subcontract including beginning and ending dates, methods of extension, termination, and re-negotiation;

i. The specific duties of the subcontractor relating to the coordination of benefits and determination of third-party liability;
j. A provision that the subcontractor agrees to identify Medicare and other third-party liability coverage and to seek such Medicare or third-party liability payment before submitting claims to the PASSE contractor;
k. A description of the subcontractor's patient medical record and record keeping system;
l. A contract provision that the PASSE subcontractor shall cooperate with quality management programs, and comply with the utilization control and review procedures specified in 42 CFR Part 456;
m. A provision stating that should there be a significant "Change in Organization Structure" or ownership of an Administrative Services Subcontractor the PASSE organization shall require a Contract amendment to the subcontractor's contract;
n. A provision that indicates that Arkansas DHS is responsible for enrollment, re-enrollment, and disenrollment of the covered population;
o. A provision that the subcontractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations which arise under this subcontract, for itself and its employees, and that the State of Arkansas shall have no responsibility or liability for any such taxes or insurance coverage;
p. A provision that the subcontractor must obtain any necessary authorization from the PASSE for services provided directly or through a licensed health care provider to eligible and enrolled members;
q. A provision that the subcontractor must comply with encounter reporting and claims submission requirements, which should be based on Arkansas encounter and claims submission and reporting requirements and claims data dictionary;
r. Provision(s) that allow the PASSE to suspend, deny, refuse to renew or terminate any subcontractor by the terms of this Contract and applicable law and regulation;
s. A provision for revocation of the delegation of activities or obligations, or specifies other remedies in instances where Arkansas DHS or the Contractor determines that the subcontractor has not performed satisfactorily [42 CFR § 438.230(c)(1)(iii); 42 CFR § 438.3(k)];
t. A provision that the subcontractor is prohibited from recommending or steering a member in the member's selection of a PASSE, the subcontractor may provide Arkansas DHS approved information;
u. A provision that compensation to individuals or entities that conduct utilization management and concurrent review activities is not structured to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any member [42 CFR § 438.210(e)];
v. A provision that the State of Arkansas or its auditors, CMS, the HHS Inspector General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor;

w. Such audit, evaluations, or inspections may pertain to any aspect of services and activities performed, or determination of amounts payable under the PASSE Agreement with the State. [42 CFR § 438.230];
x. The right to audit, evaluate, or inspect as stated above shall include any of the subcontractor's contractors;
y. A provision that the subcontractor will make available, for purposes of an audit, evaluation, or inspection under paragraph (c)(3)(i) of 42 CFR § 438.230, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its enrolled Medicaid members. [42 CFR § 438.230]; and
z. A provision that the right to audit under paragraph (c)(3)(i) of 42 CFR § 438.230 will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. [42 CFR § 438.230].

9.4.2 In the event of a modification to the Arkansas DHS Minimum Subcontract Provisions or Provider Manual requirements, the PASSE shall issue a notification of the change to its affected subcontractors within thirty (30) days of the published change and ensure amendment of subcontracts.

9.4.3 Affected subcontracts shall be amended on their regular renewal schedule or within three calendar months after the publishing of Provider Manual updates or new Minimum Subcontractor Provisions, whichever come first.

9.5 ADDITIONAL SUBCONTRACTOR PROVISIONS

9.5.1 The PASSE Contractor shall not include provisions in any subcontracts that contain compensation terms that discourage providers from serving any specific eligibility category;

9.5.2 Subcontractor agreement shall include a provision requiring provider subcontractors to participate in patient satisfaction, access to care, and network adequacy surveys administered by the PASSE or Arkansas DHS;

9.5.3 The PASSE must include provisions that require the provider to notify the PASSE if the subcontractor is no longer or unable to continue to accept new PASSE members, even if the subcontracted provider is willing to continue to provide services to currently assigned PASSE patients;

9.5.4 In all subcontracts with network providers, the PASSE Contractor must comply with any additional provider certification, licensure, or selection requirements established by Arkansas DHS [42 CFR § 438.12(a)(2); 42 CFR § 438.214(e)].

9.6 SUBCONTRACTOR WITH CAPITATED OR RISK-SHARING ARRANGEMENTS

9.6.1 For all subcontracts in which the PASSE and subcontractor have agreed to a capitated arrangement risk-sharing arrangement, the subcontract shall include the following provisions:

a. A provision requiring the subcontractor to provide a "claim for payment" for the capitated amount or risk-sharing payment;
b. A provision requiring the submission of a claim or encounter which conform to the Arkansas DHS claim and encounter format, for each inpatient, outpatient, professional, ancillary, or clinic service provided to PASSE member regardless of whether the pre-paid capitated payment amount or shared risk/shared savings payment includes the claim or encounter amount;
c. Subcontractor claims, or encounters submitted to the PASSE shall be subject to review under federal or state fraud and abuse statutes, rules, and regulations.

9.7 ADMINISTRATIVE SERVICE SUBCONTRACTS AGREEMENTS

9.7.1 All subcontract agreements between the PASSE and Administrative Service contractors are to be submitted to Arkansas DHS for review that applicable provisions, terms, and conditions related to delegated PASSE Contractor's responsibilities incorporated incorporate appropriate Arkansas DHS requirements;

9.7.2 The PASSE is not be permitted to subcontract for administrative services from organizations owned or managed by another PASSE;

9.7.3 The PASSE Administrator/CEO must retain the authority to direct and prioritize any delegated administrative services functions or responsibilities performed by the subcontractor;

9.7.4 If the PASSE delegates duties or responsibilities, then the PASSE shall establish in the written agreement the activities and reporting responsibilities delegated to the Administrative Services Subcontractor;

9.7.5 Before executing and implementing an Administrative Services Subcontract, the PASSE Contractor must evaluate the prospective subcontractor's ability to perform the activities to be delegated.

9.7.6 The subcontractor agreement shall include language for revoking delegation or imposing other sanctions if the Administrative Services Subcontractor's performance is inadequate or below required service levels;

9.7.7 It shall be the PASSE responsibility to evaluate subcontractor performance and determine if service level performance meet requirements;

9.7.8 If the PASSE identifies performance or service level deficiencies, the PASSE Contractor must communicate identified deficiencies to the Administrative Services Subcontractor and establish a corrective action plan [42 CFR § 438.230(b)];

9.7.9 The PASSE shall notify Arkansas DHS of any deficiencies identified and corrective action plans developed as a result of ongoing monitoring or performance reviews;

9.7.10 In addition to monitoring the Administrative Services Subcontractor's performance on an ongoing basis, the PASSE shall perform an annual review of Administrative Service subcontractor's compliance, service levels, and overall performance and submit the results of the review to the Arkansas DHS;

9.7.11 Arkansas DHS may request the PASSE perform additional reviews, if necessary, to assure subcontractor maintains adequate service level and complies with state requirements;

9.7.12 If at any time during the contract period the subcontractor is found to be in significant non-compliance with Arkansas DHS provider manual or PASSE contractual requirements, the PASSE shall notify Arkansas DHS;

9.7.13 The PASSE shall require Administrative Services Subcontractors to adhere to screening and disclosure requirements as required by Arkansas DHS or the State of Arkansas.

9.8 SUBCONTRACTOR AGREEMENTS

9.8.1 NON-CONTRACTED PROVIDERS

9.8.1.1 The PASSE shall reimburse a non-contracted provider for a PASSE member, who receives medically necessary services with discharge dates on and after March 1, 2019, or the beginning date of the PASSE contract period;

9.8.1.2 There is a reimbursement floor for Out-of-network Providers (non-contracted provider) which are not covered by the Arkansas consent decree. The reimbursement floor is ninety percent (90%) of the published Medicaid fee schedule until September 1, 2019, unless a different amount of payment is agreed upon by the PASSE and the out-of-network provider.

9.8.1.3 The PASSE is responsible for obtaining contracts or agreements with physicians who have admitting and treating privileges at the non-contracted hospital and that meet the credentialing requirements of the PASSE; and

9.8.1.4 The PASSE whose enrolled member receives services at a non-contracted out-of-state provider shall either establish contractual agreements with the out-of-state provider or pay the non-contractor reimbursement rate;

9.8.1.5 Starting on January 1, 2020 and lasting until the end date of the Agreement, payments to out-of-network providers may not exceed twenty percent (20%) of the total payments for services by the PASSE

a. DHS allows special consideration for the PASSE if it exceeds any of the out-of-network thresholds, if the PASSE demonstrates substantial efforts to contract with out-of-network providers.
b. Special consideration is granted on a per-provider basis.
c. If granted a special consideration, the non-contracted provider would be removed from the PASSE's out-of-network calculation.

9.8.2 PASSE CONTRACTED PROVIDERS

9.8.2.1 The PASSE is required to obtain contracts with providers in all service areas of the State. A PASSE whose enrolled member receives services at an out-of-state provider shall either establish contractual agreements with those out-of-state providers or pay the non-contractor reimbursement rate;

9.8.2.2 The PASSE shall, upon request, make available to DHS, provider subcontracts, and amendments;

9.8.2.3 The PASSE may negotiate with its contracted providers a unit-based payment, per diem, performance incentive payment, a value-based payment an episode of care, bundle, or global payment arrangement for service provided to PASSE members; and

9.8.2.4 Regardless of the payment arrangement, PASSE is responsible for submitting hospital claims and encounters information in the claims and encounter format required by Arkansas DHS.

9.8.2.5 The PASSE shall provide medically necessary care as required by the scope of services that is deemed to be cost-effective;

9.8.2.6 The PASSE is only responsible for contracting with providers as well as negotiating reimbursement rates for care provided during the time the member is enrolled with the PASSE;

9.8.2.7 The PASSE is responsible for payment of claims for PASSE members during eligible service dates and coverage period for services as required by the PASSE Provider Agreement;

9.8.2.8 The PASSE may impose reasonable authorization requirements; and

9.8.2.9 The PASSE is responsible for establishing contracts with alternatives to residential or institutional care facilities, to provide the necessary support services as an alternative to institutional care.

9.9 INFORMATION MANAGEMENT AND SYSTEMS (IT SYSTEM)

9.9.1 The PASSE must have information management processes and information systems (IT Systems) that collects, analyzes, integrates, and reports data that allows the PASSE to meet DHS and federal reporting requirements, other Agreement requirements, and all applicable DHS policies, state and federal laws, rules and regulations, including HIPAA.

9.9.2 The IT Systems must have sufficient capacity to handle the projected workload as of the beginning date of PASSE operations (prior to March 1, 2019).

9.9.3 The IT Systems must be scalable and flexible so as to be adapted as needed, within negotiated timeframes, in response to amendments to the Agreement, increases in enrollment estimates, or changes in the governing law or policies.

9.9.4 The IT Systems must be capable of connecting to DHS's statewide area data communications network, and the relevant IT systems attached to that network, in accordance with all applicable DHS or state policies, standards, and guidelines.

9.9.5 The IT Systems must be able to transmit, receive and process data in the DHS-specific formats and/or methods that are in use on the Agreement execution date.

9.9.6 The IT Systems must comply with Section 6504(a) of the Affordable Care Act (ACA). This means that it must have a claims processing and retrieval system that is capable of collecting data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of Section 1903(r)(1)(F) of the Act.

9.9.7 The IT System must provide information and generate reports in the prescribed formats for upload into the DHS system on the following, at a minimum:

a. Utilization of services;
b. claims and claims payment;
c. grievances and appeals;
d. disenrollment for reasons other than loss of Medicaid eligibility; and
e. quality metrics, as listed in Section 8.2.

9.9.8 The IT Systems that are required to or otherwise contain the applicable data type, must conform to the following, HIPAA-based standard code sets:

a. Logical Observation Identifiers Names and Codes (LOINC);
b. Healthcare Common Procedure Coding System (HCPCS);
c. Home Infusion EDI Coalition (HEIC) Product Codes;
d. National Drug Code (NDC);
e. National Council for Prescription Drug Programs (NCPDP);
f. International Classification of Diseases (ICD);

g. Diagnosis Related Group (DRG);
h. Claim Adjustment Reason Codes (CARC); and
i. Remittance Advice Remarks Codes (RARC).

9.9.9 The processes through which the data are generated should conform to the same standards, as needed.

9.9.10 The IT Systems that are required to or otherwise contain the applicable data type, must conform to the following, non-HIPAA based standard code sets:

a. As described in all DHS Medicaid reimbursement handbooks, for all "covered entities," as defined under HIPAA, and which submit transactions in paper format (non-electronic format).
b. As described in all DHS Medicaid reimbursement handbooks for all "non-covered entities," as defined under HIPAA.

9.9.11 The PASSE must be responsible for ensuring its ability to transition from new codes upon DHS implementation and must modify its policies, procedures and operations to reflect the coding changes brought about by the transition to new codes as required by DHS.

9.9.12 The IT Systems must conform to HIPAA and HITECH standards for data and document management.

a. This includes the ability to transmit, receive and process data in HIPAA-compliant formats that are in use as of the Agreement execution date.
b. All HIPAA-conforming transactions between DHS and the PASSE must be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker application.

9.9.13 The IT Systems must be:

a. Structured query language (SQL);
b. Open database connectivity (ODBC) compliant; or
c. Employ a relational data model in the architecture of its databases in addition to a relational database management system (RDBMS) to operate and maintain them.

9.9.14 The IT Systems must possess mailing address standardization functionality in accordance with US Postal Service conventions.

9.9.15 The IT Systems must be approved by DHS prior to implementation. The PASSE must provide details of the test regions and environments of its core production IT systems, including a live demonstration to DHS representatives, to enable DHS to determine the readiness of the PASSE's IT systems.

9.9.16 The IT Systems must conform to the HIPAA-compliant standards for Electronic Data Interchange (EDI) of health care data. The PASSE must submit and receive

transactions, ASC X12N, or NCPDP (for certain pharmacy transactions), including claims and encounter information, payment and remittance advice, claims status, eligibility, enrollment and disenrollment, referrals and authorizations, coordination of benefits and premium payment. Arkansas specific companion guides may be obtained on the Arkansas Medicaid provider website at: https://medicaid.mmis.arkansas.gov/Provider/Hipaa/compan.aspx.

9.9.17 Transaction types include, but are not limited to:

a. ASC X12N 820 Payroll Deducted & Other Premium Payment
b. ASC X12N 834 Enrollment and Audit Transaction
c. ASC X12N 835 Claims Payment Remittance Advice Transaction
d. ASC X12N 837I Institutional Claim/Encounter Transaction
e. ASC X12N 837P Professional Claim/Encounter Transaction
f. ASC X12N 837D Dental Claim/Encounter Transaction
g. ASC X12N 270/271 Eligibility/Benefit Inquiry/Response
h. ASC X12N 276 Claims Status Inquiry
i. ASC X12N 277 Claims Status Response
j. ASC X12N 278/279 Utilization Review Inquiry/Response
k. NCPDP D.0 Pharmacy Claim/Encounter Transaction

9.9.18 The PASSE's IT Systems must be able to:

a. Establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of DHS information and to protect DHS information from unauthorized access, use, modification, or dissemination.
b. Prohibit the use of unsecured telecommunications to transmit individually identifiable, or deducible, information derived from DHS information;
c. DHS information will be transmitted via secure FTP communications protocol approved by the DHS Office of Information Technology (OIT).
d. Comply with all federal and state laws and regulations regarding the access to, use, modification, or dissemination of personally identifiable information.
e. Obtain prior written approval from DHS for the use of DHS information for a project other than the one described in the Agreement.
f. Prohibit the reuse or further disclosure of original or derivative data file(s) without prior written approval from DHS.
g. Report any unauthorized access, use, or disclosure of DHS information to the DHS Chief Information Security Officer, at DHSSecurity@dhs.arkansas.gov and to the PASSE Office within two (2) business days of discovery of such unauthorized access, use, or disclosure.
h. In the event that OIT or the Privacy Office determines or has a reasonable belief that the PASSE has or may have accessed, used, reused, or disclosed DHS information that is not authorized by the Agreement, or another written authorization from DHS, the DHS Privacy Office or OIT may require the

PASSE to perform one or more of the following actions or such other actions as the Privacy Office or OIT deems appropriate:

i. Promptly investigate and report to the Privacy Office determinations regarding any alleged or actual unauthorized access, use, reuse, or disclosure;
ii. Promptly resolve any issues or problems identified by the investigation;
iii. Submit any formal response to an allegation of unauthorized access, use, reuse, or disclosure;
iv. Submit a corrective action plan with steps designed to prevent any future unauthorized access, uses, reuses, or disclosures; and
v. Immediately cease any and all access to any DHS information and return or destroy all DHS information received under the Agreement.

i. The PASSE understands and agrees that as a result of a determination or reasonable belief that an unauthorized access, use, reuse, or disclosure has occurred, DHS may refuse to release further DHS information to the PASSE for a period of time to be determined by DHS, OIT, or the Privacy Office.

9.9.19 The PASSE's IT Systems must be able to transmit and receive transaction data to and from the MMIS, as required for the appropriate processing of claims and any other transaction that could be performed by either system. This includes the capability to receive data electronically from DHS via:

a. A daily ASC X12 Benefit Enrollment and Maintenance (834) transaction; and
    i. The PASSE must receive, process and update daily 834 file sent by DHS or its agent(s).
    ii. The PASSE must update its eligibility/enrollment databases within twenty-four (24) hours after receipt of the 834.
    iii. The PASSE must have the ability to uniquely identify a distinct Medicaid recipient across multiple systems within its span of control.
    iv. The PASSE must transmit back to DHS, or its agents, specific information regarding a member, including third party liability data. DHS will determine the format, schedule, and method of the data exchange.
b. ASC Payment Order/Remittance Advice (820) transaction.

9.9.20 The PASSE must coordinate as requested by DHS.

a. The PASSE must coordinate activities and develop cohesive systems strategies across vendors and agencies.
b. The PASSE must partner with DHS in the management of standard transaction code sets specific to the DHS.
c. The PASSE must partner with DHS in the development and implementation of future standard code sets not specific to HIPAA or other federal efforts and must conform to these standards as stipulated in the Agreement to implement the standards.

d. The PASSE must partner with DHS in the management of current and future data exchange formats and methods and in the development and implementation of future data exchange methods not specific to HIPAA or other federal effort. Furthermore, the PASSE must conform to these standards.

e. The PASSE must work with DHS as required for any testing initiative required by DHS.

f. The PASSE must cooperate with DHS to implement secure, web-accessible, community health records for members. The methods for accessing community health records and the format of the record itself must comply with all HIPAA and other privacy and security related regulations.

9.9.21 The PASSE must house indexed images of documents used by members and providers to transact with the PASSE in the appropriate database(s) and document management systems so as to maintain the logical relationships between certain documents and certain data.

9.9.22 Information in the PASSE's systems must be maintained in electronic form for three (3) years in live systems and for ten (10) years in live and/or archival systems, or longer for audits or litigation, as specified elsewhere in the Agreement.

9.9.23 The PASSE's systems must conform to future federal and DHS-specific standards for data exchange within one hundred twenty (120) calendar days of the future standard's effective date or, if earlier, the date stipulated by CMS or DHS.

9.9.24 The PASSE must institute a process to ensure the validity and completeness of the data and reports its submits to DHS. DHS shall conduct, at its discretion, general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include, but are not limited to: member ID, date of service, assigned Medicaid provider ID, category and subcategory (if applicable) of service, diagnosis codes, procedure codes, revenue codes, date of claim processing, and (if and when applicable) date of claim payment. Control totals must also be reviewed and verified.

9.9.25 The PASSE must ensure that critical systems functions are available to members and providers are available 24/7, except during periods of scheduled system unavailability agreed upon by DHS and the PASSE.

a. The PASSE must make DHS aware of the nature and availability of these functions prior to extending access to these functions to members and/or providers.

b. If at any point there is a problem with a critical systems function, the PASSE must provide to DHS full written documentation that includes a corrective action plan that describes how problems with critical systems functions will be restored and prevented from occurring again.

i. The CAP must be delivered to DHS within five (5) business days of the critical systems function problem or failure.

ii. Failure to submit a CAP or to show progress in implementing the CAP subject the PASSE to sanctions, in accordance with Section 14.1.

9.9.26 The PASSE must develop a Business Continuity-Disaster Recovery Plan (BC-DR) that is continually ready to be invoked.

a. The BC-DR must be reviewed and prior-approved by DHS.
   i. If the approved BC-DR is unchanged from the previous year, the PASSE must submit a certification to DHS that the prior year's plan is still in place annually by April 30th of each Agreement year.
   ii. Changes in the plan are due to DHS within ten (10) business days after the change and are subject to review and approval by DHS.

b. At a minimum, the PASSE's BC-DR must address the following scenarios:
   i. The central computer installation and resident software are destroyed or damaged;
   ii. System interruption or failure resulting from network, operating hardware, software or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage;
   iii. System interruption or failure resulting from network, operating hardware, software or operational errors that compromise the integrity of data maintained in a live or archival system;
   iv. Unavailability of critical functions caused by events outside of a PASSE's span of control; and
   v. System interruption or failure resulting from network, operating hardware, software or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system, but do prevent access to the system, i.e., cause unscheduled system unavailability; and malicious acts, including malware or manipulation.

c. The PASSE must periodically, but no less than annually, by April 30th of each Agreement year, perform comprehensive tests of its BC-DR through simulated disasters and lower level failures in order to demonstrate to DHS that it can restore system functions per the standards outlined in the Agreement. In the event that the PASSE fails to demonstrate in the tests of its BC-DR that it can restore system functions per the standards outlined in the Agreement, the PASSE must submit to DHS a corrective action plan that describes how the failure will be resolved. The corrective action plan must be delivered within ten (10) business days of the conclusion of the test.

9.9.27 The PASSE must ensure that IT systems and processes within its span of control or associated with its data exchanges with DHS or its agents are available and operational according to specifications and the data exchange schedule.

9.9.28 For all IT systems available to enrolled members or providers as system users, the PASSSE must ensure that the IT systems are available to those users at least

between the hours of 7:00 a.m. and 7:00 p.m. in the time zone where the user is located, Monday through Friday.

9.9.29 When there are unexpected or unscheduled IT systems outages that are caused by the failure of systems and technologies within the PASSE's control, these outages must be corrected, and the IT systems restored within forty-eight (48) hours of the official declaration of system unavailability. However, the PASSE will not be responsible for correcting systems and technologies failures that are outside of its control.

9.9.30 The PASSE must notify DHS of the following systems changes, provided they are within the PASSE's span of control, within ninety (90) days before the projected effective date of the change, and if so directed by DHS, must discuss the proposed changes with the applicable DHS staff:

a. Software release updates of core transaction systems: claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management; and

b. Conversions of core transaction management systems.

9.9.31 DHS will provide the PASSE with a Report of Systems Problems Not Resulting in Systems Unavailability.

a. The PASSE must respond in writing within seven (7) calendar days of receipt of the Report and state the actions that will be taken to correct the problems noted on the Report.

b. The PASSE must correct the problems or provide a requirements analysis and specifications document to DHS within twenty (20) calendar days of receipt of the Report.

c. For all problems not corrected within twenty (20) calendar days, the PASSE must correct the problem by a date to be determined by DHS upon receipt of the requirements analysis.

9.9.32 Unless otherwise agreed to in advance by DHS, scheduled system unavailability for the purpose of performing system maintenance, repair and/or upgrade activities must not take place during hours that could compromise or prevent critical business operations.

9.9.33 The PASSE must develop, prepare, print, maintain, produce and distribute distinct IT systems processes and procedures manuals, user manuals, and quick-reference guides.

a. The Process and Procedure Manual must document and describe all manual and automated system procedures for information management processes and information systems.

b. The User Manuals must contain information about and instructions for using applicable systems functions and accessing applicable systems data.

c. When a system change is subject to DHS's approval, the PASSE must draft revisions to the appropriate manuals prior submitting the change to DHS for approval.
   i. Updates to the electronic version of these manuals must occur in real time;
   i. Updates to the printed version of these manuals must occur within ten (10) business days of the update's taking effect.
d. These reference manuals and guides must be available in printed form and online.

9.9.34 The PASSE and DHS or its agent must make predominant use of secure file transfer protocol (SFTP) and electronic data interchange (EDI) in their exchanges of data. Additionally, the PASSE must encourage participating providers to participate in DHS's Direct Secure Messaging (DSM) service when it is implemented.

9.9.35 If the PASSE uses social networking or smartphone/tablet applications (apps), the PASSE must develop and maintain appropriate policies and procedures that are submitted to DHS for review and approval.
a. Any app must be approved by DHS prior to utilization by the PASSE.
b. If the PASSE uses apps to allow enrolled members direct access to DHS approved materials, the PASSE must comply with the following:
   i. The app must disclaim that use is not private and that no PHI or personally identifying information should be published on the app by the PASSE or the end user; and
   ii. The PASSE must ensure that software applications obtained, purchased, leased, or developed are based on secure coding guidelines; for example:
      • OWASP [Open Web Application Security Project] Secure Coding Principles — http://www.owasp.org/index.php/Secure_Coding_Principles;
      • CERT Security Coding –http://www.cert.org/secure-coding/; and
      • Top 10 Security Coding Practices — https://www.securecoding.cert.org/confluence/display/seccode/Top+10+Secure+Coding+Practices.
c. DHS will monitor all social networking activities and smartphone/tablet apps to ensure compliance with all PASSE provider manual and PASSE provider agreement terms. The PASSE may be subject to sanctions in accordance with Section 14.1 for any prohibited activity that is found.

9.10 STAFF TRAINING

9.10.1 The PASSE must educate staff concerning their policies and procedures on advance directives.

9.11 PRACTICE GUIDELINES

9.11.1 The contract requires the PASSE to adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field. 42 CFR § 438.236(b)(1).

9.11.2 The contract requires the PASSE to adopt practice guidelines that consider the needs of the members. 42 CFR § 438.236(b)(2).

9.11.3 The contract requires the PASSE to adopt practice guidelines in consultation with contracting health care professionals. 42 CFR § 438.236(b)(3).

9.11.4 The contract requires the PASSE to review and update practice guidelines periodically as appropriate. 42 CFR § 438.236(b)(4).

9.11.5 The contract requires that decisions regarding utilization management, member education, coverage of services, and other areas to which practice guidelines apply should be consistent with such practice guidelines. 42 CFR § 438.236(d).

9.11.6 The PASSE must disseminate practice guidelines to all affected providers and, upon request, enrollees and potential enrollees.

10. PROGRAM INTEGRITY

10.1 PROHIBITED RELATIONSHIPS

10.1.1 The PASSE must not have a relationship for the administration, management, or provision of medical services (or the establishment of policies or provisions of operation support for such services), either directly or indirectly, with any individual or entity that is:

a. Excluded from participation in any Federal health care program under section 1128 or 1128A of the Act;

b. Listed on the Arkansas Medicaid Excluded Providers List;

b. Convicted of crimes described in section 1128(b)(8)(B) of the Act;

c. Debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order 12549;

10.1.2 For purposes of this Section, "have a relationship" includes:

a. A director, officer, owner, or partner of the PASSE;

b. A subcontractor or delegate of the PASSE;

c. A person with beneficial ownership of five percent (5%) or more of the PASSE entity's equity;

d. A participating provider or person with an employment, consulting or other arrangement with the PASSE for the provision of items and services that are significant and material to the PASSE entity's obligations under the Agreement; and

e. An employee of the PASSE.

10.1.3 If the PASSE determines it has a relationship, as that is defined in Section 10.1.2 above, with someone who is excluded from PASSE participation according to Section 10.1.1, the PASSE must disclose such relationship immediately to DHS and OMIG, in writing, along with any remedial actions being taken by the PASSE.

10.1.4 On at least a monthly basis and at the time that the PASSE engages the individual or during renewal of agreements, the PASSE must disclose individuals they have a relationship with, as defined above, against

a. The federal List of Excluded Individuals and Entities (LEIE) and the federal System for Award Management (SAM) (includes the former Excluded Parties List System (EPLS)) or their equivalent, to identify excluded parties; and

b. DHS listing of suspended and terminated providers at the DHS website below, to ensure the PASSE does not include any non-Medicaid eligible providers in its network: http://apps.ahca.myArkansas.com/dm_web

10.1.5 The PASSE must not be controlled by a sanctioned individual who is excluded under Section 10.1.1.

10.2 FRAUD AND ABUSE PREVENTION

10.2.1 The PASSE must have a written Fraud and Abuse Prevention Program (FAPP) designed to reduce the incidence of fraud, waste, and abuse and must comply with all state and federal program integrity requirements, including but not limited to the applicable provisions of the Act, ss. 1128, 1902, 1903, and 1932; 42 CFR §§ 431, 433, 434, 435, 438, 441, 447, 455; 45 CFR Part 74; Chapters 409, 414, 458, 459, 460, 461, 626, 641 and all applicable state laws.

a. The FAPP must have internal controls, policies and procedures in place to prevent, reduce, detect, investigate, correct and report known or suspected fraud, waste and abuse activities.

b. The FAPP must have a clear procedure and policy to report instances of fraud, waste and abuse.

c. In accordance with Section 6032 of the federal Deficit Reduction Act of 2005, the PASSE must make available to all PASSE employees a copy of the written fraud, waste and abuse policies. If the PASSE has an employee handbook, the PASSE must include specific information about Section 6032, the PASSE's policies, and the rights of employees to be protected as whistleblowers.

d. The FAPP must have a fraud investigation unit to investigate and report possible acts of fraud, waste, abuse or overpayment. All fraud, waste, abuse or overpayments due to suspected fraud must be compiled into a quarterly report to DHS and OMIG, or at the request of DHS or OMIG. Any suspected incidents of fraud must be reported within 15 business days of discovery to OMIG.

10.2.2 The PASSE must meet quarterly with, or at the request of, DHS and OMIG to discuss fraud, waste, abuse, neglect, exploitation, and overpayment issues.

10.2.3 The PASSE must have a written compliance and anti-fraud plan (compliance plan), including its fraud, waste, and abuse policies and procedures.

10.2.4 The compliance plan must be submitted to DHS and OMIG for written approval at least sixty (60) days before implementation, and annually for re-certification by September 1st of each year.

a. The compliance plan must be fully implemented within ninety (90) days of approval. Failure to implement an approved plan within ninety (90) days may result in liquidated damages in accordance with Section 14.1.

b. If the compliance plan is not fully implemented within ninety (90) days, DHS or OMIG may reassess the implementation of the compliance plan every ninety (90) days until DHS deems the PASSE to be in compliance.

c. The compliance plan is subject to inspection by DHS or OMIG upon request by that agency, and must be updated quarterly or more frequently if required by DHS or OMIG.

10.2.5 The compliance plan must comply with 42 CFR § 438.608 and include an organizational chart listing PASSE's personnel who are responsible for the investigation and reporting of possible overpayment, abuse, waste or fraud.

10.2.6 The compliance plan must have a description of the PASSE's procedures for:

a. Detecting and investigating and reporting possible acts of fraud, waste, abuse and overpayment;

b. Mandatory reporting of possible overpayment, abuse, waste or fraud to DHS and OMIG;

c. Educating and training personnel on how to detect, prevent, and report fraud, waste, abuse and overpayment, which is conducted within thirty (30) days of new hire and at least annually thereafter. The PASSE must have the following as it relates to staff training:

   i. A methodology to verify training occurs as required; and

   ii. The PASSE must also include Deficit Reduction Act of 2005 requirements in the training curriculum.

d. The name, address, telephone number, e-mail address and fax number of the Compliance Officer responsible for carrying out the compliance plan;

e. A summary of the results of the investigations of fraud, waste, abuse, or overpayment which were conducted during the previous fiscal year by the PASSE's fraud investigative unit;

f. Written policies, procedures and standards of conduct that articulate the PASSE's commitment to comply with all applicable federal and state standards;

g. A description of the lines of communication available between the Compliance Officer and the PASSE's employees, and how employees can access them;

h. Enforcement of standards through well-publicized statutory requirements, the Agreement requirements, and related disciplinary guidelines;

i. Provision for internal monitoring and auditing; and

j. Provisions for prompt response to detected offenses and for development of corrective action initiatives;

k. A description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including but not limited to:

   i. An effective pre-payment and post-payment review process, including but not limited to data analysis, claims and other system edits, and auditing of participating providers;

   ii. A description of the method(s), including detailed policies and procedures, for verifying enrolled members' identities and if services billed by providers were actually received. Such methods may be either the use of electronic verification or biometric technology but may also include sending member explanations of Medicaid benefits (EOMB), contacting members by telephone, mailing members a questionnaire, contacting a representative sample of members, or sampling members based on business analyses;

iii. Provider profiling, credentialing, and re-credentialing, and ongoing provider monitoring including a review process for claims and encounters that must include participating providers and out of network providers who:

- Demonstrate a pattern of submitting falsified encounter data or service reports;
- Demonstrate a pattern of overstated reports or up-coded levels of service;
- Alter, falsify or destroy clinical record documentation;
- Make false statements relating to credentials;
- Misrepresent medical information to justify member referrals;
- Fail to render medically necessary covered services they are obligated to provide according to their provider agreements with the PASSE;
- Charge members for covered services; or
- Bill for services not rendered

l. Prior authorization;
m. Utilization management;
n. Subcontract and Provider Contract provisions;
o. Provisions from the provider and the member handbooks;
p. Standards for a code of conduct;
q. Provisions pursuant to this section of the Agreement for the confidential reporting of PASSE violations to DHS, OMIG, and other agencies as required by law;
r. Provisions for the investigation and follow-up of any reports; and
s. Protection of the identities of individuals reporting in good faith alleged acts of fraud and abuse;

10.2.7 At a minimum, the PASSE must ensure that:

a. All officers, directors, managers and employees know and understand the provisions of the compliance plan and all anti-fraud and abuse policies;
b. All suspected fraud, waste and abuse by participating and out-of-network providers, as well as subcontractors or delegates is appropriately reported when detected; and
c. The FAPP's primary purpose is for the investigation (or supervision of the investigation) of suspected insurance/Medicaid fraud and fraudulent claims;
d. All suspected or confirmed instances of internal and external fraud, waste and abuse relating to the provision of, and payment for, Medicaid services including but not limited to PASSE employees/management, providers, subcontractors, vendors, delegated entities, or members under state and/or federal law be reported to DHS and OMIG within fifteen (15) business days of detection;
e. All Provider Contracts entered into by the PASSE with providers must, at a minimum, require that the provider comply with all applicable state and federal laws, as well as the requirements of this Section of the Agreement;

f. Any final resolution reached by the PASSE regarding a suspected case of waste, abuse, or fraud must include a written statement that provides notice to the provider or member that the resolution in no way binds the State of Arkansas nor precludes the State of Arkansas from taking further action for the circumstances that brought rise to the matter; and

g. The PASSE, its subcontractors, and all participating providers, upon request and as required by DHS, OMIG, other state agents, and/or federal law, must:

   i. Make available to all authorized federal and state oversight agencies and their agents, including but not limited to DHS, the Arkansas Attorney General, and OMIG any and all administrative, financial, and medical/case records and data relating to the delivery of items or services for which Medicaid monies are expended; and

   ii. Allow access to all authorized federal and state oversight agencies and their agents, including but not limited to DHS, the Arkansas Attorney General, and OMIG to any place of business and all medical/case records and data, as required by state and/or federal law. Access must be during Normal Business Hours, except under special circumstances when DHS, the Arkansas Attorney General, or OMIG must have After Hours admission. DHS, OMIG, or the Arkansas Attorney General must determine the need for special circumstances.

h. The PASSE, its subcontractors, and participating providers cooperate fully in any investigation by federal and state oversight agencies and any subsequent administrative, civil, or criminal action that may result from such an investigation. Such cooperation shall include providing, upon request, information, access to records, and access to employees, subcontractors, providers, and consultants for the purpose of interviewing; and

i. The PASSE does not retaliate against any individual who reports violations of the PASSE's fraud, waste and abuse policies and procedures or suspected fraud and abuse.

10.2.8 If the PASSE provides telemedicine, it must include procedures specific to prevention and detection of potential or suspected fraud, waste and abuse of telemedicine in its FAPP and compliance plan.

10.2.9 The PASSE or subcontractor must, to the extent that the subcontractor is delegated responsibility by the PASSE for coverage of services and payment of claims under the Agreement, implement and maintain a compliance program that must include:

a. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements.

b. A Compliance Officer (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the CEO and the Board of Directors (BoD).

c. A Regulatory Compliance Committee (RCC) on the BoD and at the senior management level charged with overseeing the organization's compliance with the requirements under the Agreement.

d. A system for training and education for the CO, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the Agreement.

e. Effective lines of communication between the CO and the organization's employees.

f. Enforcement of standards through well-publicized disciplinary guidelines.

g. The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Agreement.

10.3 PASSE AND SUBCONTRACTOR RESPONSIBLITIES

10.3.1 The PASSE or subcontractor, to the extent that the subcontractor is delegated responsibility by the PASSE for coverage of services and payment of claims under the Agreement, must implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to DHS and OMIG.

10.3.2 The PASSE or subcontractor, to the extent that the subcontractor is delegated responsibility by the PASSE for coverage of services and payments of claims under the Agreement, must implement and maintain arrangements or procedures for prompt notification to DHS when it receives information about changes in an enrolled member's circumstances that may affect the enrolled member's eligibility, including changes in the member's residence or the death of a member.

10.3.3 The PASSE or subcontractor, to the extent that the subcontractor is delegated responsibility by the PASSE for coverage of services and payments of claims under the Agreement, must implement and maintain arrangements or procedures for notification to DHS and OMIG when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the PASSE program, including the termination of the Provider Contract with the PASSE.

10.3.4 The PASSE or subcontractor, to the extent that the subcontractor is delegated responsibility by the PASSE for coverage of services and payments of claims under the Agreement, must implement and maintain arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received

by enrolled members and the application of such verification processes on a regular basis.

10.3.5 For PASSEs that make or receive annual payments under this contract of at least $5,000,000, the PASSE or subcontractor, to the extent that the subcontractor is delegated responsibility by the PASSE for coverage of services and payments of claims under the Agreement, must implement and maintain written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act (FCA) and other Federal and State laws, including information about rights of employees to be protected as whistleblowers.

10.3.6 The PASSE or subcontractor, to the extent that the subcontractor is delegated responsibility by the PASSE for coverage of services and payments of claims under the Agreement, must implement and maintain arrangements or procedures that include provision for the timely referral of any potential fraud, waste, or abuse the PASSE identifies to OMIG.

10.3.7 The PASSE or subcontractor, to the extent that the subcontractor is delegated responsibility by the PASSE for coverage of services and payments of claims under the Agreement, must implement and maintain arrangements or procedures that include provision for the PASSE's suspension of payments to a network provider for which DHS or OMIG determines there is a credible allegation of fraud, absent a law enforcement exception.

10.4 DHS RESPONSIBILITIES

10.4.1 If DHS learns that the PASSE has a prohibited relationship, as defined in Section 10.1.1, or if the PASSE has a relationship with an individual who is an affiliate of such an individual, DHS may continue the Agreement if the PASSE terminates the prohibited relationship within thirty (30) calendar days, unless the Secretary directs otherwise.

10.4.2 If DHS learns that the PASSE has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act, DHS may continue the Agreement if the PASSE terminates the prohibited relationship within thirty (30) calendar days, unless the Secretary directs otherwise.

10.4.3 If DHS learns that the PASSE has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act, DHS may not renew or extend the Agreement, unless the Secretary provides to DHS and to Congress a written statement describing compelling reasons that exist for renewing or extending the Agreement despite the prohibited affiliation.

10.5 PROGRAM INTEGRITY OVERPAYMENT RECOVERY

10.5.1 The PASSE shall have primary responsibility for the identification of all potential waste, fraud, and abuse associated with services and billings generated as a result of the Agreement.

10.5.2 If a fraud referral from the PASSE generates an investigation, and corresponding legal action results in a monetary recovery to DHS, the reporting PASSE will be entitled to share in such recovery following final resolution (settlement agreement/final court judgment). The State shall retain its costs of pursuing the action, including any costs associated with DHS, OMIG, or MFCU operations associated with the investigation and its actual documented loss (if any). The State shall pay to the PASSE the remainder of the recovery, not to exceed the PASSE's actual documented loss. Actual documented loss of the PASSE may be determined by paid false or fraudulent claims, canceled checks, or other similar documentation which objectively verifies the dollar amount of loss.

10.5.3 If the State makes a recovery from a fraud investigation in which the PASSE has sustained a documented loss but the case did not result from a referral made by the PASSE, the State shall not be obligated to repay any monies recovered to the PASSE, but may do so at its discretion.

10.5.4 In cases involving wasteful or abusive Provider billing or service practices (including overpayments) identified by DHS or OMIG, DHS shall have the right to recover any identified overpayments directly from the Provider or to require the PASSE to recover the identified overpayment and repatriate the funds to the State Medicaid program as directed by DHS.

10.5.5 If the State determines it is in its best interest to resolve a matter under this section with a settlement agreement, the State shall have final authority concerning the offer, acceptance, and terms of settlement. The State will exercise its best efforts to consult with the PASSE about potential settlement. The State may consider the PASSE's preferences or opinions about offer, acceptance, or the terms of settlement, but those opinions shall not be binding on the State.

10.5.6 If final resolution of a matter does not occur until after the Agreement has expired, the terms concerning disposition of any recovery and consultation with the PASSE shall survive expiration of the Agreement and remain in effect until final resolution of a matter referred to State or Federal law enforcement.

10.5.7 Funds recovered as a result of a multi-state fraud investigation or litigation will be shared with the PASSE as prescribed for funds recovered as a result of the PASSE's fraud referral absent extenuating circumstances.

10.5.8 The PASSE shall be prohibited from the repayment of State-, federally-, or PASSE-recovered funds to any provider when the issues, services, or claims upon which the repayment is based meets one or more of the following:

a. The funds from the issues, services, or claims have been obtained by the State or Federal governments, either by the State directly or as part of a resolution of a State or Federal audit, investigation, and/or lawsuit, including but not limited to false claims act cases; or

b. When the issue, services or claims that are the basis of the repayment have been or are currently being investigated by DHS, OMIG, a Federal Medicaid Integrity Contractor, the PASSE, MFCU, or the United States Attorney, are the subject of pending Federal or State litigation, or have been or are being audited by the State's Recovery Audit Contractor.

10.5.9 This prohibition shall be limited to a specific Provider(s), for specific dates, and for specific issues, services, or claims. The PASSE shall check with OMIG before initiating repayment of any program integrity-related funds to ensure that repayment is permissible.

10.5.10 If required, the PASSE shall correct Federal Financial Participation from MMIS in accordance with any overpayment recovery.

10.5.11 DHS or OMIG shall have the right to take disciplinary action against any Provider identified by the PASSE, DHS, or OMIG as engaging in inappropriate or abusive billing or service provision practice.

11. CALCULATING & REPORTING COSTS, PROFITS, LOSSES

11.1 MEDICAL LOSS RATIO

11.1.1 The PASSE must calculate, and report to DHS, a MLR for each reporting year of the Agreement. This MLR will not be used for risk-corridor calculations.

11.1.2 The MLR Report submitted to DHS must include:

a. Total incurred claims.
b. Expenditures on quality improving activities.
c. Expenditures related to activities compliant with program integrity requirements.
d. Non-claims costs.
e. Premium revenue.
f. Taxes.
g. Licensing fees.
h. Regulatory fees.
i. Methodologies for allocation of expenditures.
j. Any credibility adjustment applied.
k. The calculated MLR.
l. Any remittance owed to the state, if applicable.
m. A comparison of the information reported with the audited financial report.
n. A description of the aggregation method used to calculate total incurred claims.
o. The number of member months.

11.1.3 The MLR is ratio of the numerator to the denominator as defined in 42 CFR § 438.8.

11.1.4 Each PASSE expense must be included only under one type of expense (services/quality improvement or administrative), unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense may be prorated between expense types.

a. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.
b. Allocation between expense types must be based on a generally accepted accounting method that is expected to yield the most accurate results.
c. Share expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.
d. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be

borne solely by the reporting entity and may not be apportioned to any other entity.

11.1.5 The PASSE may add a credibility adjustment, based on the methodology in 42 CFR § 438.8(h)(4), to the calculated MLR, if the MLR reporting year experience is partially credible. If the PASSE's experience is non-credible, it is presumed to meet or exceed the MLR calculation standard.

a. The credibility adjustment cannot be added to the calculated MLR, if the MLR reporting year is fully credible.

11.1.6 The PASSE shall aggregate data for all Medicaid eligibility groups covered under the Agreement, unless separate reporting is otherwise required.

11.1.7 The PASSE must require any third-party vendor claims adjudication activities to provide all underlying data associated with MLR reporting to the PASSE within 180 calendar days of the end of the MLR reporting year or within thirty (30) calendar days of being requested by the PASSE, whichever comes sooner, regardless of current contractual limitations, to calculate the MLR and validate the accuracy of MLR reporting.

11.1.8 If the state makes a retroactive change to the capitation payment for a MLR reporting year and the MLR report has already been submitted to DHS, the PASSE must:

a. Re-calculate the MLR for all MLR reporting years affected by the change; and
b. Submit a new MLR report meeting the applicable.

11.1.9 The PASSE must submit audited financial reports specific to the Agreement on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

11.1.10 The PASSE must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports. The report for each MLR Reporting Year must be submitted to DHS by April 30th of the year following the end of an MLR Reporting Year, in a format and in the manner prescribed by DHS.

11.2 BENEFIT EXPENDITURE REPORT (BER)

11.2.1 The PASSE must submit a quarterly Benefit Expenditure Report (Exhibit III), which includes the BER ratio, to DHS that summarizes how much the PASSE paid to direct service providers for services provided to enrolled members.

11.2.2 Community Investments—For purposes of the BER ratio, the PASSE may count the expenditures for Community Investments, consistent with and going beyond standards as defined in 45 § 158.150 as "Activities that Improve Health Care

Quality" and approved by DHS, as benefit expenditures rather than administrative costs up to amounts equal to five percent (5%) of revenue in the BER ratio. "Community investments," however, may not be counted as "losses" in the risk corridors under Section 11.3 of the PASSE Agreement.

11.2.3 Any activity that will be considered a Community Investment must be submitted and approved by DHS prior to being included as a benefit expenditure for purposes of the BER ratio. Any community investment expenditure that is made prior to DHS approval must be excluded from a benefit expenditure in the BER ratio.

11.2.4 The BER must be submitted quarterly to DHS in the format and in the manner prescribed by DHS in Exhibit III.

11.3 RISK CORRIDORS

11.3.1 The PASSE program for Contract Year 2019 includes a risk corridor program to control the risk associated with a new program that services a high need population. The risk corridor program is based on the BER ratio as defined in § 11.2 of the PASSE Agreement.

11.3.2 The pricing assumptions create an average target BER ratio of 92.5% based upon an administrative allowance of 4.0%, margin of 1.0%, and an Arkansas state premium tax of 2.5%. PASSE specific BER ratios will be calculated based upon their rate cell mix.

11.3.3 The risk corridor settlement will occur after the PASSE CY 2019 agreement period has ended and enough time has passed to collect and validate CY 2019 PASSE encounter data and financial data. It is anticipated to perform an initial settlement using CY 2019 contract year data with three months of claim runout and a final settlement using data with fifteen months of claim runout.

11.3.4 Only medical, care coordination, community investment, and pharmacy services costs, as defined in this agreement, will be included in the numerator of the BER ratio calculation for the risk corridor program. Quality improvement not explicitly approved by DHS as part of the Community Investments provision, premium tax, and other administrative costs will not be included in the numerator of the BER ratio calculation, consistent with the development of the PASSE specific risk corridor target BER ratio. All capitation revenue will be included in the denominator of the BER ratio calculation for the risk corridor program.

11.3.5 DHS reserves the right to review encounters and other information associated with payment to providers and may adjust the risk corridor calculation as necessary to reflect market level reimbursement of providers.

11.3.6 The risk corridor program will be evaluated annually and will be renewed automatically.

12. PAYMENT UNDER THE AGREEMENT

12.1 CAPITATION PAYMENTS

12.1.1 DHS will make capitation payments to the PASSE for all Medicaid-eligible enrolled members.

12.1.2 Capitation payments will be determined as described in Exhibit VII.

12.1.3 IMD Exclusion—DHS will only make a monthly capitation payment to the PASSE for a member, aged 21–64, receiving inpatient treatment in an Institution for Mental Diseases (IMD), as defined in 42 CFR § 435.1010, if the following is met:

a. The facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and

b. The length of stay in the IMD is for a short term stay of no more than fifteen (15) days during the period of the monthly capitation payment.

12.1.4 The PASSE must report on and meet quality metrics as outlined in Section 8.2 of the Agreement to receive a capitated payment. The PASSE may be subject to recoupment for failure to report on or meet the quality metrics.

12.1.5 The PASSE may be subject to recoupment for the portion of the capitation payment attributed to an enrolled member who has not received care coordination in sixty (60) days when there are also no paid claims for the enrolled member during that time period, as reflected in encounter data.

12.1.6 The PASSE and its subcontractor, as appropriate, shall report to DHS when it has identified overpayment of the capitation payment, or any other amount specified in the contract, within sixty (60) calendar days of when the overpayment was identified.

12.1.7 The State, during contract year 1 from March 1, 2019 to December 31, 2019, will not make any incentive payments to the PASSE.

12.2 RISK SHARING MECHANISMS

Only those risk-sharing mechanisms described in the Agreement are to be implemented as payment arrangements between DHS and the PASSE.

13. FINANCIAL RESERVES AND REQUIREMENTS

13.1 FINANCIAL RESERVES

13.1.1 The PASSE must maintain financial reserves in accordance with requirements established by the Arkansas Insurance Department (AID).

13.1.2 The PASSE must meet solvency standards for prescribed by Act 775 of 2017 and AID.

13.2 INSOLVENCY

13.2.1 Enrolled members are not to be held liable for the PASSE's debts, in the event the PASSE becomes insolvent.

13.2.2 Enrolled members are not to be held liable for covered services provided to the member, for which DHS does not pay the PASSE, or for which DHS or PASSE does not pay the provider that furnished the services under a contractual, referral, or other arrangement.

13.2.3 Enrolled members are not to be held liable for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the member would owe if the PASSE covered services directly.

13.2.4 The PASSE must provide satisfactory assurances to DHS that its provision against the risk of insolvency is adequate to ensure that enrolled members will not be liable for the PASSE's debt if the PASSE becomes insolvent.

14. SANCTIONS AND DAMAGES

14.1 SANCTIONS

Notwithstanding any other provisions related to the imposition of sanctions or fines in the Agreement, including any attachments, exhibits, addendums or amendments hereto, the following sanctions will be applied:

14.1.1 If the PASSE fails to timely submit an acceptable FAPP or fails to timely submit the reports referenced in Section 8.6, and specified in the PASSE Report Guide, a sanction of up to $2,000 per day, from the date the report is due to DHS or OMIG, may be imposed under the Agreement until DHS or OMIG deems the PASSE to be in compliance.

14.1.2 If the PASSE fails to implement an FAPP or create an investigative unit, a sanction of up to $10,000 may be imposed under the Agreement.

14.1.3 If the PASSE fails to timely report or fully report to DHS and OMIG all required information for suspected or confirmed instances of provider, recipient, or internal fraud within fifteen (15) business days after detection or fails to timely file quarterly reports of fraud, abuse, waste or overpayments due to suspected fraud, a sanction of up to $1,000 per day may be imposed under the Agreement, until DHS and OMIG deems the PASSE to be in compliance.

14.1.4 If the PASSE fails to substantially provide medically necessary services to an enrolled member that the PASSE is required to provide under law or under the Agreement, DHS may impose a fine of up to $25,000 for each failure to provide services. DHS may also:

a. Appoint temporary management to the PASSE.
b. Grant members the right to dis-enroll.
c. Suspend all new enrollments to the PASSE after the date the Secretary or DHS notifies the PASSE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.
d. Suspend payments for new enrollments to the PASSE until CMS or DHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

14.1.5 If the PASSE imposes premiums or charges on enrolled members that are in excess of those permitted in the Medicaid program, DHS may impose a fine of up to $25,000 or double the amount of the excess charges (whichever is greater). DHS may also:

a. Appoint temporary management to the PASSE.
b. Grant members the right to dis-enroll.

c. Suspend all new enrollments to the PASSE after the date the Secretary or DHS notifies the PASSE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.

d. Suspend payments for new enrollments to the PASSE until CMS or DHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

14.1.6 If the PASSE discriminates among members on the basis of their health status or need for health services, DHS may impose a fine of up to $100,000 for each determination of discrimination. DHS may impose a fine of up to $15,000 for each potential member the PASSE did not enroll because of a discriminatory practice, up to the $100,000 maximum. DHS may also:

a. Appoint temporary management to the PASSE.

b. Grant members the right to dis-enroll.

c. Suspend all new enrollments to the PASSE after the date the Secretary or DHS notifies the PASSE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.

d. Suspend payments for new enrollments to the PASSE until CMS or DHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

14.1.7 If the PASSE misrepresents or falsifies information that it furnishes to CMS or to DHS, DHS may impose a fine of up to $100,000 for each instance of misrepresentation. DHS may also:

a. Appoint temporary management to the PASSE.

b. Grant members the right to dis-enroll.

c. Suspend all new enrollments to the PASSE after the date the Secretary or DHS notifies the PASSE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.

d. Suspend payments for new enrollments to the PASSE until CMS or DHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

14.1.8 If the PASSE misrepresents or falsifies information that it furnishes to an enrolled member, potential member, or health care provider, DHS may impose a fine of up to $25,000 for each instance of misrepresentation. DHS may also:

a. Appoint temporary management to the PASSE.

b. Grant members the right to dis-enroll.

c. Suspend all new enrollments to the PASSE after the date the Secretary or DHS notifies the PASSE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.

d. Suspend payments for new enrollments to the PASSE until CMS or DHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

14.1.9 If the PASSE fails to comply with the Medicare physician incentive plan requirements, DHS may impose a fine of up to $25,000 for each failure to comply. DHS may also:

a. Appoint temporary management to the PASSE.
b. Grant members the right to dis-enroll.
c. Suspend all new enrollments to the PASSE after the date the Secretary or DHS notifies the PASSE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.
d. Suspend payments for new enrollments to the PASSE until CMS or DHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

14.1.10 If the PASSE distributes marketing materials that have not been approved by DHS or that contain false or misleading information, either directly or indirectly through any agent or independent contractor, DHS may impose a fine of up to $25,000 for each distribution.

14.1.11 If the PASSE violates any other applicable requirements in section 1903(m) or 1932 of the Social Security Act or any implementing regulations, DHS may impose only the following sanctions:

a. Grant members the right to dis-enroll.
b. Suspend all new enrollments to the PASSE after the date the Secretary or DHS notifies the PASSE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.
c. Suspend payments for new enrollments to the PASSE until CMS or DHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

14.1.12 If the PASSE violates any other applicable requirements in sections 1932 or 1905(t) of the Social Security Act, DHS may impose only the following sanctions:

a. Grant members the right to dis-enroll.
b. Suspend all new enrollments to the PASSE after the date the Secretary or DHS notifies the PASSE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.
c. Suspend payments for new enrollments to the PASSE until CMS or DHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

14.1.13 DHS may impose additional sanctions provided for under State statutes or regulations to address noncompliance.

14.1.14 DHS will deny payments for new members, when, and for so long as, payment for those members is denied by CMS based on DHS's recommendation, when:

a. The PASSE fails substantially to provide medically necessary services that the PASSE is required to provide, under law or under the Agreement, to an enrolled member.
b. The PASSE imposes on enrolled members, premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
c. The PASSE acts to discriminate among enrolled or potential members on the basis of their health status or need for health care services.
d. The PASSE misrepresents or falsifies information that it furnishes to CMS or DHS.
e. The PASSE misrepresents or falsifies information that it furnishes to an enrolled member, potential member, or health care provider.
f. The PASSE fails to comply with the requirements for PIPs, as set forth (for Medicare) in 42 CFR § 422.208 and 42 CFR § 422.210.

14.1.15 DHS will deny payments for new members when, and for so long as, payment for those members is denied by CMS. CMS may deny payment to DHS for new members if its determination is not timely contested by the PASSE.

14.1.16 Temporary management may only be imposed when DHS finds, through onsite surveys, member or other complaints, financial status, or any other source:

a. There is continued egregious behavior by the PASSE;
b. There is substantial risk to enrolled members' health; or
c. The sanction is necessary to ensure the health of the PASSE's enrolled members in one of two circumstances:
    i. While improvements are made to remedy violations that require sanctions; or
    ii. Until there is an orderly termination or reorganization of the PASSE.

14.1.17 DHS may impose mandatory temporary management when the PASSE repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR § 438. DHS will not delay the imposition of temporary management to provide a hearing and will not terminate temporary management until it determines that the PASSE can ensure the sanctioned behavior will not reoccur.

14.1.18 DHS must grant members the right to terminate PASSE enrollment when a PASSE repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR § 438.

14.1.19 If DHS imposes a fine or sanction on the PASSE for charging premiums or charges in excess of the amounts permitted under Medicaid, DHS will deduct the amount of the overcharge from the penalty and will return it to the affected member.

14.1.20 If DHS imposes temporary management because a PASSE has repeatedly failed to meet substantive requirements in section 1903(m) or 1932 of the Social Security Act or 42 CFR § 438, DHS will notify affected members of their right to terminate enrollment.

14.1.21 DHS will provide the PASSE with timely written notice before imposing any intermediate sanction (other than required temporary management) that explains the basis and nature of the sanction.

14.1.22 DHS will provide the PASSE with timely written notice before imposing any intermediate sanction (other than required temporary management) that explains any appeal rights DHS provides.

14.1.23 DHS will adhere to the following:

a. DHS must provide the PASSE with a pre-termination hearing before terminating the Agreement.
b. DHS must provide the PASSE a written notice of its intent to terminate and the reason for termination.
c. DHS must provide the PASSE with the time and place of the pre-termination hearing.
d. DHS must provide the PASSE written notice of the decision affirming or reversing the proposed termination of the Agreement.
e. For an affirming decision, DHS must provide the effective date for Agreement termination.
f. For an affirming decision, DHS must give the members of the PASSE notice of the termination.
g. For an affirming decision, DHS must inform enrolled members of their options for receiving Medicaid services following the effective date of termination.

14.1.24 After the PASSE is notified that DHS intends to terminate the Agreement, DHS may:

a. Give the PASSE's enrolled members notice of DHS's intent to terminate the Agreement.
b. Allow the members to dis-enroll immediately without cause.

15. MISCELLANEOUS PROVISIONS

15.1 CHOICE OF LAW AND VENUE

15.1.1 The agreement will be governed by the laws of the State of Arkansas and all matters arising under it are subject to the requirements and remedies afforded under the Arkansas Administrative Procedure Act, Ark. Code Ann. §25-15-201 et seq.

15.1.2 The choice of venue shall be governed by Arkansas law.

15.2 SEVERABILITY

15.2.1 If any statute or regulation is enacted which requires a change in the Agreement or any attachment, then both parties will deem the Agreement and any attachment to be automatically amended to comply with the newly enacted statute or regulation as of its effective date.

15.2.2 If any provision of the Agreement (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both DHS and the PASSE will be relieved of all obligations arising under such provision. If the remainder of the Agreement is capable of performance, it will not be affected by such declaration or finding and will be fully performed.

15.3 SOVEREIGN IMMUNITY

The State and DHS in no way waives the protections of Sovereign Immunity by any language contained in the Agreement or by any action undertaken related to the Arkansas Medicaid Provider-Led Organized Care Program.

15.4 AMENDMENTS

The Agreement may be amended only in writing. All amendments are fully incorporated into this agreement and effective upon the date of signing by both parties.

15.5 TERMINATION OF AGREEMENT

15.5.1 DHS may terminate a PASSE Agreement, and place members into a different PASSE or provide Medicaid benefits through other State authority, if DHS determines that the PASSE has failed to carry out the substantive terms of its contracts or meet the applicable requirements of sections 1932, 1903(m) or 1905(t) of the Social Security Act.

15.5.2 This Agreement may be terminated by the PASSE upon giving one-hundred (120) calendar days advanced written notice to DHS. Termination of this Agreement shall not discharge the PASSE of obligations with respect to services or items furnished prior to termination, including retention of records and verification of overpayments or underpayments. The PASSE will be responsible for all necessary activities to close out the Agreement. In the event of such termination, the PASSE

shall be entitled to payment, determined on a pro rata basis, for work or services satisfactorily performed through the effective date of cancellation or termination of this Agreement.

15.5.3 A termination of Agreement by the PASSE will require prior notification to DHS and AID. The PASSE must submit notification and a detailed Transition Plan to DHS and AID in accordance with AID statutes, rules and regulations, but in any case, at least, but no later than, one-hundred (120) calendar days prior to the effective date. The name and title of the PASSE's designated Transition Coordinator must be included in the Transition Plan. The Transition Coordinator identified will be the individual responsible for ensuring ongoing communication with DHS during the transition as well as ensuring transition of members to a new PASSE. The purpose of the plan review is to ensure uninterrupted services to PASSE Members, that services to PASSE Members are not diminished, and that major components of the organization and DHS programs are not adversely affected by the Agreement termination.

15.5.4 In the event that this Agreement is terminated by the PASSE, the PASSE must notify all enrolled members of such termination at least forty-five (45) calendar days in advance of the effective date of termination of this Agreement. This notice must be made available in an accessible format in accordance with § 4.1.3 of this Agreement.

15.5.5 In the event that this Agreement is terminated (by the PASSE or by DHS), the PASSE must submit to DHS all outstanding Encounter Claims information.

15.5.6 Any dispute by the PASSE, with respect to termination or suspension of this Agreement by DHS, will be exclusively governed by the laws of the State of Arkansas, and any applicable terms and conditions.

15.6 INDEMNIFICATION

15.6.1 Under Arkansas law, DHS, as a state agency, may not enter into a covenant or agreement to hold a party harmless or to indemnify a party from prospective damages.

15.6.2 However, without waiving any sovereign immunities, with respect to loss, expense, damage, liability, claims or demands, either at law or in equity, for actual or alleged injuries to persons or property arising out of any negligent act or omission by DHS or its employees or agents in the performance of this agreement, DHS agrees that: (a) it will reasonably cooperate with the vendor in the defense of any action or claim brought against the vendor seeking the foregoing damages or relief; and (b) it will in good faith address with the vendor should the vendor present any claims of the foregoing nature against DHS to the Claims Commission of the State of Arkansas.

15.6.3 DHS reserves its right to assert in good faith all claims and defenses available to it in any proceedings in the Claims Commission or other appropriate forum.

15.6.4 The obligations of Section 15.6 shall survive the expiration or termination of the Agreement.

15.7 PUBLIC DISCLOSURE

All terms of the Agreement shall become available to the public, pursuant to the Arkansas Freedom of Information Act, under Ark. Code Ann., § 25-19-101 et seq., upon execution by both Parties.

Signature Page

The named parties to this Agreement have approved the terms and limitations of this Agreement, and all exhibits attached hereto, and on the dates below their signatures, have signed agreement to the terms and conditions set forth therein.

The Department of Human Services

By: Paula Stone

Name: Paula Stone

Title: AR DHS DMS Deputy

Date: 2/11/19

The PASSE

~~AR PASSE~~, LLC dba Summit Community Care

By: [signature]

Name: Jason Miller

Title: AVP, Plan President

Date: 2/11/19

Exhibit I
Transition Plan

I. PURPOSE

a. Credentialing Providers: To safely transition from the current system of siloed specialty service providers who perform Home and Community Based Services to either developmentally disabled or behavioral health clients to a system of PASSE Home and Community Based Service Providers (herein, HCBS Provider) to serve both populations attributed to a PASSE. This Exhibit is intended to begin such a transition while maintaining the health and safety of the members and ensure service delivery is uninterrupted.

b. Person Centered Service Plans (Prior Authorizations and Current Rates): To honor and adhere to a member's Person Centered Service Plan until such time the PCSP is amended. This applies to any applicable current rates and any applicable prior authorizations. Note that revisions to a PCSP must adhere to the requirements outlined in the PASSE agreement as well as 42 CFR § 441.725. Specifically, informed consent of the member and any legal guardian in writing.

c. Network Adequacy Full Compliance Schedule: To ensure the PASSE contracts with an adequate network of Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the members.

d. The PASSE should submit its Transition Plan for approval by DHS no later than January 15, 2019.

II. CREDENTIALING HOME AND COMMUNITY BASED PROVIDERS

a. Minimum Requirements

i. Beginning March 1, 2019, the PASSE will ensure that all of their network providers are in good standing and actively enrolled in Arkansas Medicaid.

ii. A Provider shall at all times be duly organized, validly existing and in good standing as a legal entity under the laws of the State of Arkansas, with the power and authority under the appropriate federal, state or local statutes to own and operate its business.

iii. Any change to the legal name of the Provider or the name under which the Provider conducts business in the State of Arkansas must be reported to the Department of Human Services (DHS) prior to any change.

iv. A Provider must obtain and verify each of the following from an applicant prior to employment:

1. A completed job application that contains any required credentials for the position
2. All required criminal background checks in accordance with Arkansas Code Annotated §20-38-101 et. seq. and §20-48-812, or any applicable successor statutes

3. A completed Adult Maltreatment Central Registry check in accordance with Arkansas Code Annotated §12-12-1716, or any successor statute
4. A completed Child Maltreatment Central Registry check in accordance with Arkansas Code Annotated §12-18-901
5. Completed reference checks
6. A successfully passed drug screen

b. A current and valid driver's license or a commercial driver's license when applicable

III. PERSON CENTERED SERVICE PLANS AND MASTER TREATMENT PLANS

a. The PASSE must honor current Person Center Service Plans (PCSP) and Master Treatment Plans (MTP), which includes any current authorizations, for a minimum of sixty (60) days and up to six (6) months.
b. A PASSE cannot amend or revise a PCSP or MTP, or authorization without informed consent from the member and a legal guardian, if applicable.
c. If a PCSP or MTP expires during the transition period, the PASSE will extend the PCSP, which includes current prior authorizations, until such time a PCSP or MTP meeting can be held and all parties agree to amend/revise the plan.

IV. GRADUATED NETWORK ADEQUACY COMPLIANCE

a. Until March 31, 2019, the PASSE must meet 80% of the network adequacy standard for Behavioral Health Service Providers. Provider Type 26, Provider Type 19 and new PASSE Home and Community Based Providers will be considered by DHS to determine if this standard is met. From April 1, 2019 until August 31, 2019, the PASSE must meet 90% of the network adequacy standard for Behavioral Health Service Providers.
b. Until March 31, 2019, the PASSE must meet 80% of the network adequacy for Developmental Disabilities Service Providers. Provider Type 67 and new PASSE Home and Community Based Providers will be considered by DHS to determine if this standard is met. From April 1, 2019 until August 31, 2019, the PASSE must meet 90% of the network adequacy standard for Developmental Disabilities Service Providers.
c. Until March 31, 2019, the PASSE must meet 80% of the network adequacy for Primary Care Physicians. Provider Type 01, 02, 03, 04, 58, and 62 will be considered by DHS to determine if this standard is met. From April 1, 2019 until August 31, 2019, the PASSE must meet 90% of the network adequacy standard for Primary Care Physicians.
d. Until March 31, 2019, the PASSE may meet 80% of the network adequacy for Hospitals. Provider Type 05 will be considered by DHS to determine if this

standard is met. From April 1, 2019 until August 31, 2019, the PASSE must meet 90% of the network adequacy standard for Hospitals.

e. Until March 31, 2019, the PASSE must meet 70% of the network adequacy standard for all other providers. From April 1, 2019 until August 31, 2019, the PASSE must meet 80% of the network adequacy standard for all other providers.

f. The PASSE must meet full network adequacy standards for all provider types by September 1, 2019. A variance allowance is outlined in the PASSE Provider Agreement and the PASSE Provider Manual, and is available, when appropriate, to the PASSE.

Exhibit II
Performance Standards

Component	Performance Standard	Damages
Out-of-Network Provider Payment	Starting on January 1, 2020, no greater than 20% percent of the total dollars paid to the PASSE for services billed by out-of-network providers.	$1000 for each percentage point over 20% dollars paid for services by out-of-network providers per quarter. The percentage point must be rounded up to the next whole number (e.g. 20.01% must be treated as 21%). In no event must the damages assessed for this performance metric exceed $20,000 per quarter.
Call Center Answer and Abandonment Rates	i. 95% of all calls answered within 3 rings or 15 seconds; ii. Number of busy signals not exceeding 5% of the total incoming calls; iii. The wait time in queue not longer than 2 minutes for 95% of the incoming calls; iv. The abandoned call rate not exceed 5% for any month.	$500.00 for each percentage point for each criteria (i, ii, iii, or iv) that falls below the standard during each one-month reporting period.
Call Center Return Calls	i. All calls requiring a call back to the Beneficiary or Provider returned within 1 Business Day of receipt; ii. For calls received	$500 per telephone call that the PASSE fails to return in accordance with standards (i or ii) during each one-month reporting period.

	during non-Business hours, return calls to Beneficiaries and Providers made on the next Business Day.	
Website and Portal Availability	Contractor's website online at least 99% of the time each month, except that Contractor may take the website and portals down from 1:00 am to 5:00 am each Saturday for necessary maintenance.	$250 for each tenth of a percentage point below 99% (excluding maintenance time during the specified window) during the month.
Investigation and Resolution of Grievances	Investigate and resolve all Grievances within the following time frames: i. Acknowledgement in writing within five (5) business days of receipt of each grievance. ii. All grievances must be completed and resolved within 30 days of the filing date, unless an extension is granted in accordance with 4.9.19.c.iii of the PASSE Provider Agreement. iii. The PASSE must submit a grievance log with their quarterly report.	$500 for each Grievance or report the Contractor fails to administer in accordance with the standards (i, ii or iii) during each reporting period.
Claims Processing Denial, Approval, and Submission of Claims	Process, which means deny or approve and submit for payment claims within the following time frames: i. The PASSE must process seventy percent (70%) of all clean claims submitted within seven (7) days. iii. The PASSE must process ninety-five percent	$250.00 for each percentage point for each criteria (I, ii, iii, or iv.) that falls below the standard during each one-month reporting period identified in each quarterly report.

	(95%) of all clean claims submitted within thirty (30) days. iv. The PASSE must process ninety-nine percent (99% of all clean claims submitted within sixty (60) days.)	
Accuracy of Encounter Data – Clean Claims	At least ninety-five (95%) of all encounter data must pass through as a clean encounter claim submission to DXC or Magellan (or future contractors responsible for the collection of encounter claims)	$1,000 for each percentage point below the standard during the reporting period.
Timeliness of encounter data	All encounter data submitted in accordance with the timeframes established in the Contract.	$1,000 per each day past the deadline.
Report submission	All required reports submitted in accordance with timelines established in the Contract.	$1,000 per day past the deadline.
Key Personnel Vacancy	In the event of a Key Personnel Vacancy, propose a suitable Replacement to the Contract Monitor within 30 calendar days of the vacancy occurrence or from when the Contractor first knew or should have known the vacancy would be occurring.	$750 per each day after the 30th day that a suitable replacement has not been submitted. The suitability of the Replacement is at the sole discretion of the State.
Care Coordinator to Client Caseload	≥90% of care coordinators will have a caseload of ≤50 members	$1,000 for each percentage point below the standard during the reporting period.

Initial Contact of Client	≥75% of members will be contacted by a care coordinator within 15 business days after assignment to PASSE	$1,000 for each percentage point below the standard during the reporting period.
Monthly Contact of Client	≥75% of members are contacted monthly and in person quarterly by a care coordinator.	$1,000 for each percentage point below the standard during the reporting period.
Follow-Up Care	≥50% of members with a visit to Emergency room or discharge from hospital or Inpatient Psychiatric Unit/Facility will have a follow up from a PASSE care coordinator within seven (7) business days.	$1,000 for each percentage point below the standard during the reporting period.
Primary Care Physician Assignment	≥80% of members will have selected a PCP and are on a PCP's caseload	$1,000 for each percentage point below the standard during the reporting period.
Appeals	1. Unless it is an expedited appeal request, an oral appeal request must be followed with a written, signed appeal within ten (10) calendar days of the oral filing, unless the appellant requests an expedited resolution. 2. The PASSE must acknowledge each PASSE appeal in writing within five (5) business days of receipt of each PASSE appeal, unless the appellant requests an expedited resolution. 3. Unless the appellant requested expedited resolution, an appeal must be heard and notice of	$1,000 per day past the deadline.

	appeal resolution sent to the member no later than thirty (30) calendar days from the date of receipt of the appeal.	

Exhibit III
Benefit Expenditure Report

<PASSE NAME> Benefit Expenditure Report

PASSE Medicaid ID: _____

<Quarter Number>, 2019

Benefit Category	Month 1	Month 2	Month 3	Quarter Total
Behavioral Health				
Behavioral Health (in total)				
Therapy				
Evaluation				
Residential/Inpatient Psychiatric				
Home and Community Based Services				
Emergency Services				
Developmental Disabilities Services				
Developmental Disabilities Services (in total)				
Home and Community Based Services				
ICF				
Evaluation				
Environmental Modifications				
Halo				
Halo Spend (in total)				
Physician				
Physician Services (in total)				
Preventative Services				
Office Visit Services				
Hospital-Based Services				
Hospital Services (in total)				
Inpatient Hospital Services				

Outpatient Hospital Services				
Emergency Room Services				
Pharmacy Services				
Pharmacy (in total)				
Pharmacy Expenditures (do not Physician-administered drugs)				
Physician-Administered Drugs				
Personal Care				
Personal Care (total)				
Vision				
Vision (total)				
Care Coordination				
Care Coordination (total)				
All other Halo Services				
All other Halo services (total)				
*PASSE MUST list any other expenditures of any category of service provided by Medicaid provider type that exceeds $500,000 in total for the quarter				

Numerator				
	Month 1	**Month 2**	**Month 3**	**Quarter Total**
Incurred Claims				
Community Investments				
Total Amount in Numerator for State BER Ratio Reporting				

Denominator				
	Month 1	**Month 2**	**Month 3**	**Quarter Total**
Total Premium Amount Received from DHS				

State BER Ratio Calculation				
	Month 1	**Month 2**	**Month 3**	**Quarter Total**
State BER Ratio Numerator				
State BER Ratio Denominator				
State MLR				

Exhibit IV
Monthly Utilization Report

Monthly PASSE Utilization Report

PASSE: _____ Month/Year: _____

PASSE Medicaid ID: _____

Utilization Report Deliverable	Members Receiving Deliverable *	Total Members **	Percentage of Total Members Receiving the Deliverable
Members receiving care coordination during the month			
Members who have received a well-check visit during the month			
Members who have been admitted for an inpatient hospital stay			
Members who have been admitted for an inpatient psychiatric stay – Under Age 21 +			
Members who have been admitted for an inpatient psychiatric stay – Age 21 and above +			
Members who have been transitioned from ICF to Community-Based Setting +			
Members who are currently residing in an ICF +			
Members receiving CES Waiver Services +			
Members receiving 1915(i) Services			
Members receiving "in lieu of services"			
Members receiving no services, including care coordination			
Members receiving no services, excluding care coordination			
Members who have an assigned PCP, including a Medicare assigned PCP			
Members who are Dual-Eligible (Medicare/Medicaid)			
Members who do not have an assigned PCP			

*Members – Members who have received the specified utilization report deliverable

** Total Members – All members who are eligible to receive the utilization report deliverable. For most deliverables, all members are required to receive the deliverable. However, certain deliverables (identified with a + at the end of the deliverable) have a defined number of individuals who are required to, or can, receive the deliverable.

Utilization Report Deliverable	**Number**
Authorization requests	
Authorization approvals	
Authorization denials	
Claims received	
Claims paid	
Claims denied	

Exhibit V
Required Services

I. All services must be medically necessary. The Arkansas Division of Medical Services defines medical necessity as "All Medicaid benefits are based upon medical necessity. A service is "medically necessary" if it is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap or cause physical deformity or malfunction and if there is no other equally effective (although more conservative or less costly) course of treatment available or suitable for the beneficiary requesting the service. For this purpose, a "course of treatment" may include mere observation or (where appropriate) no treatment at all. The determination of medical necessity may be made by the Medical Director or by the Medicaid Program Quality Improvement Organization (QIO). Coverage may be denied if a service is not medically necessary in accordance with the preceding criteria or is generally regarded by the medical profession as experimental inappropriate or ineffective using unless objective clinical evidence demonstrates circumstances making the service necessary."

MEDICAID STATE PLAN SERVICES, 1915 (i) AS DEFINED IN THE STATE PLAN, AND CES WAIVER SERVICES AS DEFINED IN THE WAIVER ARE REQUIRED TO BE PROVIDED BY THE PASSE, EXCEPT FOR THOSE SERVICES LISTED AS EXCLUDED IN SECTION 5.8 OF THIS AGREEMENT.

EXHIBIT VI
CONFLICT OF INTEREST ADDENDUM

I. Definitions.

(1)(A) "Conflict of Interest" means that:

(i) Because of other activities or relationships with other persons, the Contractor is unable or potentially unable to render impartial assistance or advice to the State;

(ii) The Contractor's objectivity in performing the contract work is or might be otherwise viewed as compromised;

(iii) The Contractor has or is perceived as having impaired objectivity; or

(iv) The Contractor has an unfair competitive advantage

(B) A conflict of interest may be organizational or personal, and may result when:

(i) Activities or relationships create an actual, apparent, or potential conflict of interest related to the performance of the contract; or

(ii) The nature of the contract creates an actual, apparent, or potential conflict of interest with respect to the Contractor in relation to future contracts with the State.

(2) "Contractor" includes the Contractor and its employees, affiliates, consultants, and subcontractors.

(3) "Impaired objectivity" includes without limitation the following situations that would cause a reasonable person with knowledge of the relevant facts to question a person's objectivity:

(A) Financial interests or reasonably foreseeable financial interests in or in connection with products, property, or services that may be currently utilized or utilized in the future by a person, organization, or institution in the course of implementing any program administered by the Department of Human Services ("the Department");

(B) Connections or access to program details, information, or methodologies that might require or encourage the use of specific products, property or services; or

(C) Significant identification with philosophical viewpoints or other non-public information which is property of the Department that might require or encourage the use of specific products, property or services.

II. The contractor shall certify that, to the best of their knowledge and belief, there are no relevant facts or circumstances which could give rise to an organizational or personal conflict of interest, be it actual, apparent, or potential, for the organization or the contractor, AND that the contractor has disclosed all relevant information if an actual, apparent, or potential conflict of interest appears to exist to a reasonable person with knowledge of the relevant facts or if such a person would question the impartiality of the contractor. Actual, apparent, or potential conflicts of interest may arise in the following situations:

(A) Unequal access to information – a potential contractor has access to non-public information which is the property of the Department, including without limitation, data, plans, policies, and other knowledge, through its performance on a government contract

and that the Department's non-public information could give the contractor an unfair competitive advantage in a future procurement if used;

(B) Biased ground rules – a potential contractor has worked, in one government contract or program, on the basic structure or ground rules of another government contract or future government contract. For example, the Contractor shall not use information gained from this contract to counsel current or future beneficiaries on the provision of services provided now or in the future by the Department; or

(C) Impaired objectivity.

(2) Contractors shall disclose as described above regarding any actual, apparent, or potential conflict of interest regardless of their own opinion that such actual, apparent, or potential conflict of interest would not result in impaired objectivity.

(3) If an actual, apparent, or potential conflict of interest is disclosed, the Department will take appropriate actions to eliminate or address the actual, apparent, or potential conflict, including without limitation mitigating or neutralizing the conflict or requiring the contractor to provide a satisfactory mitigation plan to the Department identifying specific methods which will be imposed by the offeror to eliminate, to the extent possible, the conflict of interest. The Department may restrict or modify the work to be performed by the contractor to avoid or reduce the actual, apparent, or potential conflict of interest.

(4) If a contractor anticipates working on more than one contract with the Department currently or in the future that is related in any way to this contract, the mitigation plan developed by the contractor shall provide, at a minimum, assurances that no staff, communication, or data will be shared within the organization regarding this contract and any future contract that relates to the scope of services provided under this contract. Information gained by the contractor from this contract shall not be used to benefit the contractor in gaining competitive advantage in future contracts with the State.

III. The contractor agrees that if impaired objectivity, or an actual, apparent, or potential conflict of interest is discovered after the award is made, it will make a full disclosure in writing to the Contracting Officer. This disclosure shall include a mitigation plan, which shall include a description of actions that the contractor has taken or proposes to take, after consultation with the Contracting Officer, to avoid, mitigate, or neutralize the actual, apparent, or potential conflict of interest.

IV. Remedies

(1) The State may terminate this contract for convenience, in whole or in part, if it determines that termination is necessary to avoid an actual, apparent, or potential conflict of interest or if the contractor fails to provide a mitigation plan for an actual, apparent, or potential conflict of interest that is satisfactory to the Department. The contractor may also be required to

reimburse the Department for costs the Department incurs arising from activities related to conflicts of interest.

(2) If the contractor was aware of an actual, apparent, or potential conflict of interest prior to award or discovered an actual, apparent, or potential conflict of interest after award and misrepresented or did not disclose relevant information to the Contracting Officer, the State may terminate the contract for default, debar or suspend the contractor, or pursue such other remedies as may be permitted by law or this contract.

(3) If the Department has accepted a mitigation plan from the contractor to minimize any actual, apparent, or potential conflict of interest and there is a violation of the mitigation plan, the contractor shall be liable to the Department for one hundred thousand ($100,000) for the first violation. Any subsequent violations to the mitigation plan shall be twice the amount of the immediately preceding violation (Example, second violation = $200,000, third violation = $400,000).

V. A contractor may request a waiver under this provision in writing to the Department. The request shall include a full description of the requested waiver and the reasons or justifications in support of the waiver. If it is determined by the Department to be in the best interest of the State, the Department may grant the waiver in writing.

VI. In cases where remedies short of termination have been applied, the contractor agrees to eliminate the conflict of interest, or mitigate it to the satisfaction of the Contracting Officer. This may include creating or revising a mitigation plan.

VII. The contractor further agrees to insert in any subcontract or consultant agreement hereunder, provisions which shall conform substantially to the language of this clause, including specific mention of potential remedies and this paragraph (g).

EXHIBIT VII
RATES

The PASSE is required to pay, to Developmental Disabilities Services specialty providers, their current rates as of November 1, 2018, until the end of the Transition Period, as defined in Exhibit I. Rates paid to providers by the PASSE are negotiated between the PASSE and the Provider. The PASSE must comply with any applicable consent decrees impacting Arkansas Medicaid providers.

Global Capitated Rates to be paid to the PASSE by DHS are contained in the attached document "CY 2019 PASSE Capitation Rates".

EXHIBIT VIII
REPORTS

PASSE Reports

Report Dates

Unless otherwise specified, a monthly report is due within fifteen (15) calendar days after the month ends, a quarterly report is due within thirty (30) calendar days after the quarter ends, and an annual report is due within sixty (60) calendar days after the year ends. If the report date falls on a Saturday or Sunday, the report is due the next immediate Monday. If the report date falls on a state recognized holiday, the report is due the following day unless that day is a Saturday or Sunday.

Monthly	Within fifteen (15) calendar days after the month ends.
Quarterly	Within thirty (30) calendar days after the quarter ends.
Bi-Annually	Due dates are specific to the report and are listed in the exhibit.
Annually	Within sixty (60) calendar days after the year ends.

EXHIBIT VIII
REPORTS

Monthly PASSE Reports

Report	Applicable Agreement/Manual Section	Expected Deliverables
Call Center	PA- Exhibit II/4.5.3 h.	Report to DHS via SFTP
Contracted Health Plans- Itemization of all administrative fees, rebates, or processing charges associated with a pharmacy claim, if DHS identifies a difference per claim between the amount paid to the pharmacy provider and the amount charged to the plan sponsor by its pharmacy benefit manager	PA- 5.5.15 b.	Report to DHS via SFTP
Cumulative Recoupment for provider TIN	PM-248.220	Report to DHS via SFTP
PASSE Online Provider Directory ATTESTATION	PA- 4.2.4(e) PM-231.400	Report to DHS via SFTP
Third Party Liability Activities	PA- 7.1.15 a. PM-243.000	Report to DHS via SFTP
Undeliverable Mail Report	PA-4.1.4.c	Report to DHS via SFTP
Utilization Report	PA- Exhibit IV	Report to DHS via SFTP

EXHIBIT VIII
REPORTS

Quarterly PASSE Reports

Report	Applicable Agreement/Manual Section	Expected Deliverables
Fraud, Waste, Abuse and Overpayment Report	PA- 8.6.6/14.1.3	Report to DHS via SFTP Report to OMIG
Appeals Log	PA- 4.9.22/4.9.40 PM-247.000	Report to DHS via SFTP
Benefit Expenditure Report (BER)	PA- 11.2.1/11.2.3/ Exhibit III	Report to DHS via SFTP
Claims Operation Performance Report	PA-7.1.2 PM-248.220	Report to DHS via SFTP
Consumer Advisory Committee	PA- 8.5 PM-236.000	Meeting Minutes/Reports Report to DHS via SFTP
Drug Utilization Data	PA- 5.5.6 c. PM-221.210	Report to DHS via SFTP
Electronic Status File of Providers	PA- 6.2.18 PM-248.300	Report to DHS via SFTP
Geographic and Demographic Info of Beneficiaries	PM- 248.210	Report to DHS via SFTP

Healthcare Effectiveness Data & Information Set (HEDIS)	PA- 8.2 3.e.	Report to DHS via SFTP
Medical Loss Ratio (MLR)	PM-214.000	Report to DHS via SFTP
Member Hotline Call Log	PA-4.5.7	Report to DHS via SFTP
Out of Network Provider Payment	PA-9.8.1.5	Report to DHS via SFTP ***First report due 4/30/2020***
PASSEs Complaint & Grievance Log	PA-4.9.19 PM-247.000	Report to DHS via SFTP
Provider-preventable conditions	PA- 7.1.30 PM-248.260	Report to DHS via SFTP
Quality Metrics (Care Coordination)	PA- 8.2.3 a-e PM -248.210/259.300 a-d	Report to DHS via interChange
Satisfaction Scores from Member Surveys	PM-248.210	Report to DHS via SFTP
Unique Identifiers of Beneficiaries	PM-248.210	Report to DHS via SFTP
Website and Portal Availability	PA-4.3.3/Exhibit II	Report to DHS via SFTP

EXHIBIT VIII
REPORTS

Bi- Annual PASSE Reports

Report	Applicable Agreement/Manual Section	Expected Deliverables	Due Date to DHS
Drug Utilization Review Committee Meeting Minutes	PA-5.5.3.c	Report to DHS via SFTP	Thirty (30) calendar days after the date of the meeting.
Network Adequacy	PA- 6.1.6 PM-226.000/226.300/241.100 a.	Report to DHS via SFTP	January 30 and July 30

EXHIBIT VIII
REPORTS

Annual PASSE Reports

Report	Applicable Agreement/Manual Section	Expected Deliverables	Due Date to DHS
Network Adequacy	PA- 6.1.2 PM-226.000/226.300/ 241.100 b.	Report to DHS via SFTP	July 30,2019
Compliance Plan & Anti-Fraud Plan	PA- 10.2.4	Report to DHS via SFTP Report to OMIG	September 1,2019
Audited Financial Reports	PA- 8.6.5 e. 11.1.9 PM-225.100	Report to DHS via SFTP	June 1, 2020
Emergency Management Plan-Recertify	PA- 5.1.6	Report to DHS via SFTP	February 29, 2020
Information Reports-Improvement for PASSE Performance	PA- 8.6.5	Report to DHS via SFTP	February 29, 2020
Interventions targeted to prevent controlled substance abuse	PA- 5.5.16	Report to DHS via SFTP	February 29, 2020
Medical Loss Ratio(MLR)	PA- 11.1 PM-214.000/ 229.000	Report to DHS via SFTP Report to AID	February 29, 2020
Overpayment Recoveries	PA-7.1.25 e. PM-248.210 g.	Report to DHS via SFTP Report to OMIG	February 29, 2020
Accreditation Review/ Medicare Review/	PM-257.100/257.300	Report to DHS via SFTP	April 30, 2020

External Quality Review (EQR) results			
BC-DR Comprehensive Tests	PA- 9.9.26 c.	Report to DHS via SFTP	April 30, 2020
Business Continuity-Disaster Recovery (BC-DR) Certification	PA-9.9.26 a. i.	Report to DHS via SFTP	April 30, 2020
Drug Utilization Review Program Activities/ DUR Annual Report	PA-5.5.3 d. PM-221.210	Report to DHS via SFTP	April 30, 2020
National Core Indicators (NCI)	PM-259.400	Report to DHS via SFTP	July 31, 2020 (each year for the previous 12 months)
Cultural Competency Plan Evaluation	PA-4.8.1/ 4.8.4	Report to DHS via SFTP	November 1, 2020

EXHIBIT VIII
REPORTS

PASSE Reports Upon Occurrence

Report	Applicable Agreement/Manual Section	Expected Deliverables	Due Date to DHS
Disclosure of PHI	PA-6.5.2	Report to DHS via SFTP	Upon discovery of any use or disclosure of Personal Health Info that is not compliant with the Provider Agreement or state/federal law
Incident Reporting	PA-4.7.5/8.7 PM-253.000	Report to DHS via SFTP	Upon occurrence, timelines are referenced in Section 8.7 of the Provider Agreement
Key Personnel Vacancy Report	PA-Exhibit II PM-241.000.a	Notification to DHS PASSE Office	Upon occurrence
Provider Sanctions	PM-248.250	Report to DHS via SFTP Report to OMIG	Upon occurrence
Settlement Information (Joint and Mass Tort Cases)	PA-7.1.24 PM-243.000	Report to DHS via SFTP	Upon occurrence, within 10 business days from settlement date

TPL (Third Party Liability) #1	PA-7.1.15 a.	Report to DHS via SFTP	Upon discovery, within 30 days
TPL (Third Party Liability) #2	PA-7.1.21	Report to DHS via SFTP	Upon identification within 10 business days
Unauthorized access, use, or disclosure of DHS info	PA- 9.9.18 g.	Email to DHS Chief Information Security Officer at DHSSecurity@dhs.arkansas.gov	Upon occurrence, within 2 business days of discovery
Incident of Suspected Fraud, Waste, or Abuse	PA – 8.6.7/14.1.3	Report to DHS via SFTP Report to OMIG	Within 15 business days of discovery

EXHIBIT “E”

Information for the Public

Where can we find all of the info from the Town Hall held on December 6, 2018?

The recording and Q&As of this town hall will be posted to the DHS PASSE website www.passe.arkansas.gov.

Is there a possibility that one or more of the PASSEs being suspended? What does that mean for these consumers?

DHS has the ability to sanction PASSEs in accordance to Section 271.000 of the PASSE Provider manual and the PASSE Provider Agreement. There are a variety of sanctions, up to and including termination of the PASSE contract. However, this is the most severe sanction DHS can impose. In the event a PASSE contract is terminated, DHS would require a transition plan to ensure uninterrupted services to PASSE beneficiaries.

The PASSEs and Networks

Is PASSE the same as Summit Health Care?

No, Summit Community Care is one of PASSEs. The four PASSEs are:

Arkansas Total Care
www.arkansastotalcare.com | 1-866-282-6280
John Ryan – jryan@centene.com
Care Coordination Contact: Amber Baker | (501) 478-2597
Amber.Baker@ArkansasTotalCare.com

Empower Healthcare Solutions
www.getempowerhealth.com | 1-866-261-1286
Nicole May – nicole.may@beaconhealthoptions.com
Care Coordination Contact: Jamie Ables | Office (501) 707-0961
Jamie.Ables@beaconhealthoptions.com

Forevercare
www.forevercare.com | 1-855-544-8744
Mike McCabe – mmccabe@forevercarehealthplan.com
Care Coordination Contact: Sherri McCourtney
smccourtney@forevercarehealthplan.com

Summit Community Care
www.summitcommunitycare.com | 1-844-405-4295
Jason Miller - jason.miller@summitcommunitycare.com
Care Coordination Contact: Tiffany Parkhurst | (501) 773-6273
Tiffany.parkhurst@summitcommunitycare.com

As a provider, who do I call if I have questions or concerns about contracting with the PASSEs?

Contact the specific PASSE you are trying to contact at the phone numbers below or contact the DHS PASSE Provider Relations Liaison, Tanya Giles at tanya.giles@arkansas.gov or 501-320-6189.

Arkansas Total Care
Providers@ArkansasTotalCare.com
1-844-631-6830 | www.arkansastotalcare.com

Forevercare
ProviderServices@forevercarehealthplan.com
1-855-544-8744 | www.forevercare.com

Empower Healthcare Solutions
EmpowerHealthcareSolutionsPR@Empowerhcs.com
1-866-261-1286 | www.getempowerhealth.com

Summit Community Care
Natasha.adams@summitcommunitycare.com
1-844-405-4295 | www.summitcommunitycare.com

Is there a timeline for the PASSE to notify the providers of what the billing method will be?

With the March 1, 2019 start date, this will allow more time for the training and enrolling of even more providers into the PASSE. The PASSEs are collectively coming together to host townhalls. This topic will be covered. Please see link for more information: https://humanservices.arkansas.gov/about-dhs/dms/passe-provider-info/passe-resources-for-providers

What would the protocol be if my child has multiple providers - but not all providers are in same PASSE/s? Is there a way to retain all service providers?

DHS encourages providers to join all PASSEs, however, PASSEs are permitted to pay "out-of-network" to providers who have not joined that PASSE.

So is a member now limited to only doctors in their PASSE's networks?

PASSEs have the ability to pay out of network providers. Please contact your specific PASSE for more details on their out of network policies.

It is stated that "Out of Network" payment is limited to 20%. Can you clarify this? Will out of network providers be reimbursed at 20%?

DHS requires the PASSEs to maintain an adequate network of providers in order to provide adequate access to all services for their enrolled members. DHS will look at payments submitted to all providers and evaluate payments made to providers that are in network or out of network. Payments to out of network providers cannot exceed 20% of the total payments for services by the PASSE.

Unless a different amount of payment is agreed upon by the PASSE and the out of network provider, the reimbursement floor for an out of network or non-contracted provider is 90% of the published Medicaid fee schedule until 9/1/19.

Can all Medicaid providers enroll with the PASSEs or can the PASSE decline based on the existing network?

Medicaid providers are encouraged to join all four PASSEs. The PASSEs must comply with the Arkansas Any Willing Provider laws.

You said that only Tier 3 and 2 members would be in a PASSE. We were told that next summer, Tier 1 would also be included?

We are working towards allowing clients that have been assessed as Tier 1 to voluntarily enroll in a PASSE. This will be implemented in Phase III of the PASSE model. We have not set a date at this time.

What is the process when a person has been assessed for both DD and BH services and has been attributed to two PASSEs?

This should not have happened. Please contact the PASSE Ombudsman at (501) 320-6006.

When are the PASSE identification cards going to be mailed to members?

Beginning in February, PASSE enrolled beneficiaries should begin to receive their Member ID card in the mail.

Is Arkansas Community Independence Services a different service with Medicaid that we have to have a provider number? Do we have to continue with our provider numbers because we will use them for billing with the PASSE except the Case management one, correct?

Currently, you can provide the services as a certified Outpatient Behavioral Health Agency or a CES Waiver provider when appropriate. Over the course of next year, DHS will provide a path for a new HCBS provider type. The new provider type will be able to provide services under the 1915 (c) and (i) waivers. The PASSEs are collectively coming together to host townhalls. This topic will be covered. Please see link for more information: https://humanservices.arkansas.gov/about-dhs/dms/passe-provider-info/passe-resources-for-providers

Populations Included in the PASSE

Which populations are included in the PASSE?

Behavioral Health clients who receive the Independent Assessment and are a Tier 2 or Tier 3 will be enrolled in a PASSE.

Developmental Disability clients who are residing in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID), clients who are receiving services under the Community and Employment Supports (CES) Waiver, and clients on the CES Waiver Waitlist will be assessed and enrolled in a PASSE.

Do you have to sign up for the PASSE and is each PASSE offer different benefits?

A Medicaid eligible individual who has received a tier 2 or tier 3 determination for BH or DD on their independent assessment will automatically be enrolled into a PASSE. Currently, the PASSE assignment is based on the individual's relationship with direct service providers who joined that PASSE's referral network. Beginning January 16, 2019, a newly identified member will be assigned into the PASSE based upon proportional assignment. A member may voluntarily change PASSEs within 90 days of initial assignment and during open enrollment periods. Each PASSE is required to provide tier 2 and tier 3 BH

and DD services, in addition to the services covered by the Medicaid state plan and all applicable waiver services.

Which populations are not included?

Clients who are eligible as "Medically Frail" or Medicaid Spenddown will be excluded from the PASSE. Additionally, clients who are fully admitted to a Human Development Center, an Assisted Living Facility, or a Skilled Nursing Facility will not be enrolled in a PASSE. Also, clients who are enrolled on the ARChoices or Independent Choices Waiver will not be enrolled in a PASSE.

Will there still be DDS Contracts available for individuals who do not receive Medicaid?

Yes, please contact DDS Intake and Referral at (501) 682-6355.

When will information be sent to those on waiting list about option to receive supportive living services?

Clients on the waiver waitlist who are enrolled in a PASSE currently receive care coordination. The PASSE will be responsible for providing all services to these members beginning on March 1, 2019. During Phase III, which is anticipated to begin on September 1, 2019, DHS anticipates utilizing at least half of the premium tax revenue to offer an interim service package to the waitlist clients and add an 500 additional fully funded CES waiver slots.

Can Medicare beneficiaries with Medicaid as a secondary be enrolled in and get services in a PASSE.

Yes, dual eligible clients can be referred for a BH Independent Assessment if the client's functional deficit is related to their BH issue.

<u>Payment and Services</u>

What is the "global payment"? Is there a maximum amount of money allotted per individual in a PASSE?

Each PASSE will receive a "global payment" from DHS monthly. The global payment is a lump sum payment paid prospectively to each PASSE to cover needed services for all members attributed to that PASSE. The global payment is calculated based on the PASSE's enrollment and member characteristics.

Much like a traditional health insurance plan, the PASSE is responsible for covering all service needs of its members and is at risk for the cost of those services. For example, Ann is attributed to PASSE X and the PASSE developed a PCSP and the total plan cost of Ann's services were only $4,500. In February and March, Ann did not utilize additional services. However, in April, Ann had an emergency surgery and her services cost $6,000. The PASSE is still responsible for the full amount of services in April even though the total cost exceeded Ann's PSCP budget.

I would like a more in-depth explanation as to how a client's global payment amount is being calculated?

DHS contracted with an actuarial firm to calculate and certify actuarially sound capitation rates for the PASSE program. The capitation rates were developed using detailed enrollment data and fee for service claims from SFY 2016 and 2017.

If a client has private insurance as primary does that affect their global payment amount?

The global payment amount is tied to the tier determination from the independent assessment. A Medicaid eligible individual who has received a tier 2 or tier 3 determination for BH or DD on their independent assessment will automatically be enrolled into a PASSE. If the beneficiary has other medical coverage, Medicaid and the PASSE will always be the last payer.

Is there a prompt payment clause with the insurance providers in the PASSE?

Yes, contractually the PASSE must pay all providers for submitted, clean claims within certain timeframes from date of receipt. Timeframes include clean claims submitted within 7 days, 30 day and 60 days of receipt.

Once phase II starts will beneficiaries have to contact the PASSE for all services such as well child exams and sick exams to get a prior approval for the appointment?

Each PASSE will establish their own referral process. Beneficiaries should work with their PASSE care coordinator for more information about how their PASSE's referral process will work. For more information on each PASSE, please go to the PASSE Website at https://humanservices.arkansas.gov/about-dhs/dms/passe/contact-us.

Will there be any rate changes for any services provided by the PASSE (such as EIDT or ADDT services)?

The PASSEs may negotiate rates with providers of these services to provide the services to members of the PASSE.

So will the minimum wage changes be incorporated into the DD waiver plans?

DHS will not be increasing plans based on the minimum wage changes. Plans would only be increased if the client's needs changed.

Why is Early Intervention Day Treatment (EIDT) not listed as a covered service?

Even though all state plan services were not specifically listed, the PASSEs are required to cover all state plan services. EIDT is a state plan service and must be covered by the PASSE for enrolled members.

Are Occupational Therapy (OT), Physical Therapy (PT), and Speech Therapy (ST) affected by the PASSE?

OT, PT, and ST are state plan services and must be covered by the PASSE for enrolled members.

How will this effect Rural Health clinics, who register their patients as rural?

Rural Health Clinics will continue to follow their current reporting requirements. PASSEs are required to have Rural Health Clinics in their Network.

Is one group going to be used for the mobile crisis unit? Who?

Each PASSE will make that decision for their PASSE and contract with providers to provide mobile crisis services.

What is the deadline to get adaptive equipment, environmental modifications, etc. approved? Will there be any approval on these items after 12/31/18?

DDS will continue to approve this services through 2/28/19.

So, Personal Care in public schools will be affected by the PASSE? And will I not be billing Medicaid monthly for services rendered?

If the beneficiary is a member of the PASSE, submit the personal care claim for reimbursement to the PASSE. However, if the beneficiary is not a member of PASSE, submit to Medicaid FFS for reimbursement via interChange.

Will a certification by a physician continue to be required for services?

Each PASSE will make a decision on the management of services, including what certifications are required.

How will billing work for a client with private insurance? Private first and then PASSE pays the rest if it's a covered service?

Yes, Medicaid and the PASSE will always be the last payer.

<u>Transition</u>

Will providers be able to see which clients are assigned to which PASSE prior to the "go live" date?

DHS is compiling client lists with assigned PASSE for BH and DD providers.

Additionally, all providers will be able to see which PASSE a member is enrolled in on the DXC eligibility panel beginning on February 15, 2019.

Why has DHS pushed back the ability to see PASSE enrollment to Feb 15?

With the original January 1, 2019 go live date, providers would have been able to access this information in MMIS on December 15, 2018. With the March 1, 2019 start date, the other MMIS changes have been pushed back to February 15, 2019.

Please clarify the requirements of the Transition Plan.

Starting on March 1, 2019, PASSEs will become responsible for providing care coordination and paying providers for services laid out in each member's Person Centered Service Plan (PCSP). DHS and the PASSE have a "Transition Plan" to smoothly move individuals from the current system to the new PASSE system. The transition plan will begin when the PASSE's become responsible for paying for members' services on March 1, 2019. Under that Transition Plan, the PASSEs will be required to honor a member's PCSSP, prior authorizations (PAs) and current rates until the PCSP can be discussed with the member and the care coordination team. Specifically,

a. The PASSE must honor current PCSPs, which includes any current PAs, for a minimum of 60 days up to six months.
b. A PASSE cannot change a PCSP without consent from the member or a guardian.

c. If a PCSP or PA expires during the transition period, the PASSE will extend the plan until a PCSP development meeting can be held.

Additionally, during the transition period, the PASSEs are required to make sure that all of their network providers are in good standing and actively enrolled in Arkansas Medicaid. The PASSE must meet full network standards for all provider types by October 1, 2019.

Once PASSEs take over personal care plans - what are services now approved and offered that will now not be available?

The PASSE is required to offer state plan personal care services. The transition plan applies to personal care services with PASSEs required to honor current authorizations for 60 days and up to 6 months. Needed personal care services will be captured in the member's PCSP.

Independent Assessment (IA)

If we have not received an Independent Assessment who should we contact?

If you are receiving Community and Employment Supports (CES) Waiver services, are on the waiver waitlist or living in an Institutional Care Facility for Individuals with Intellectual or Developmental Disabilities (ICF/IID) and have not received an IA you should contact Shelby Maldonado with DDS at Shelby.maldonado@dhs.arkansas.gov.

If you are a behavioral health client, please work with your behavioral health provider to make a referral for an IA.

If you have an open referral in the Optum system, you may call Optum to schedule the appointment at 844-809-9538.

For questions or concerns regarding the Independent Assessment, who should we call?

For Developmental Disability IAs, please contact at Shelby.Maldonado@dhs.arkansas.gov.

For Behavioral Health IAs, please contact Patricia Gann at Patricia.Gann@dhs.arkansas.gov.

Will Optum accommodate our schedules? We are working parents with busy schedules and cannot always get off during a work day with short notice.

Optum should work with the families to schedule the assessment, which would include an evening appointment for working parents.

How do I know what Tier I was assessed as by the IA?

Each client should have received a results packet from Optum that contains their Tier results and a comprehensive report of identified needs. If the client did not receive this, they can ask their PASSE care coordinator for the information or contact Optum at (844) 809-9538.

If a beneficiary that has been assessed as a Tier 3 on the DD Assessment, but has also been assessed as a Tier 1 for Personal Care, how does this impact this beneficiary on the PASSE?

The PASSE will receive the global payment related to the DD Tier 3. The Tier 1 personal care designation will not impact the payment to the PASSE. The PASSE will be responsible for providing personal care services to this beneficiary beginning on March 1, 2019, and this beneficiary will not need to receive another Personal Care IA.

It seems referrals for an IA get closed very quickly, what is required before Optum can close a referral? How do we reopen a referral after it has been closed?

Optum is required to call the beneficiary 3 times to schedule an appointment, then notify the provider that the client has not responded and call 3 additional times if the contact information is updated before closing the referral. DHS has asked Optum to offer an extension period of 20 (twenty) extra days to allow the beneficiary, guardian and/or provider to call and schedule. Please note Optum cannot set up an appointment with the provider without the beneficiary or family, and providers cannot request a referral to be reopened. If the referral has closed, submit another referral.

Will tier 2-3 clients need to be reassessed January 1?

All BH clients are required to have an annual reassessment. DD clients are required to be reassessed every three years. For PASSE members, the PASSEs will receive lists members and due dates for reassessment and will work with Optum to complete.

Is DHS extending the deadline for the BH population to receive a reassessment?

Yes, DHS is extending the end dates of BH assessments to try to accommodate the needs of the PASSE and the clients, as well as even out the assessments to allow Optum assessor more flexible scheduling. This decision was encouraged and welcomed by all PASSEs.

Can beneficiaries or their legal guardians decline the Independent Assessment and PASSE assignment? Could this affect their Medicaid coverage?

If you decline the IA and assignment to a PASSE, it would not affect your Medicaid coverage. However, it would affect your ability to receive behavioral health or developmental disability services contained in Tier 2 and Tier 3, including CES Waiver services. The only mechanism for receiving these services after March 1, 2019, will be through the IA and PASSE assignment process.

<u>Care Coordination</u>

If we have questions or concerns about the care coordinators or PASSE Providers, who should we call?

You may contact the PASSE directly or the DHS Ombudsman office at (501) 320-6006.

What are the minimum requirements for Care Coordinators?

The requirements to be a care coordinator are listed in the PASSE Provider Manual § 243.000. That section states that a care coordinator must:

A. Be a Registered Nurse (R.N.), a physician, or have a bachelor's degree in a social science or health-related field;

OR

Have at least one (1) year of experience working with developmentally or intellectually disabled clients or behavioral health clients;

B. Successfully complete the following background checks:
    1. Criminal background check;
    2. Child maltreatment registry check; and
    3. Adult maltreatment registry check.

    AND

C. Successfully pass an initial drug screen prior to providing care coordination and working directly with clients;
D. Successfully pass an annual drug screen to continue to be allowed to provide care coordination; and
E. Cannot be excluded or debarred under any state or federal law, regulation or rule or not eligible or prohibited to enroll as a Medicaid provider.

We understand that Face-to-Face visits must occur with the care coordinator. Is this correct?

The PASSE care coordinators are required to make monthly contacts with the PASSE members. Beginning in Phase II, the PASSE care coordinator will continue to make monthly contacts and they also will be required to make an in-person contact with the member at least once per quarter.

<u>Transportation</u>

Please explain the transportation options for Medicaid clients in 2019, specifically as it relates to Early Intervention Day Treatment and Adult Developmental Day Treatment services.

For 2019, people who receive services at an Early Intervention Day Treatment (EIDT) or Adult Developmental Day Treatment (ADDT) center will have access to transportation to and from these centers each day through one of the following options:

a. An EIDT or ADDT provider will operate their own vehicles or work with local transportation providers to transport their clients; or
b. Clients will have access to transportation to and from the centers through one-year contracts DHS has established with NET brokers specifically for these rides.