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

Between _____

And

The Arkansas Department of Human Services

For the Service Delivery Period January 1, 2023 through December 31, 2026

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1. DEFINITIONS AND ACRONYMS

Actuarial Financial Data Request
A quarterly report submitted to DHS that contains specified financial activities of the PASSE.

Adverse Benefit Determination

The PASSE is required to comply with 42 CFR 431 Subpart E, "Fair Hearings for Applicants and Beneficiaries" and 42 CFR 438 Subpart F, "Grievance and Appeal System."
Based on the definition in 42 CFR § 438.400(b) that is applicable to the PASSE program, an adverse benefit determination means in the case of any of the following:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, requirements for health and safety, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service through prior authorization, concurrent or retrospective review. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) of this chapter is not an adverse benefit determination.
4. The failure to provide services in a timely manner, as defined by the State.
5. The failure of a PASSE to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
6. The denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.
7. The denial of an enrollee's request to dispute a financial liability.

Adverse Decision/Adverse Action

1. Any decision or action by the PASSE or DHS that adversely affects a Medicaid provider or member in regard to receipt of and payment for claims and services including but not limited to decisions or findings related to: Appropriate level of care or coding
2. Medical necessity
3. Prior authorizations
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 ACSC 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 Attorney General Office
The Office of the Attorney General serves as the lawyer for the state, the chief law enforcement officer, and chief consumer advocate.

Appeal
Per 42 CFR §438.400 (b), the procedure by which certain individuals ("Appellants") may request a review by the PASSE of an adverse benefit determination. The procedure by which certain individuals (known as "appellants") may challenge an adverse benefit determination Decision/Adverse Action by requesting PASSE review of the action.

Arkansas Department of Health (ADH)
The state agency with authority delegated by DHS 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 single state Medicaid agency for the state of Arkansas as defined by Section 1902(a)(5) of the Social Security Act and 42 CFR 431.

Arkansas Insurance Department (AID)
The Arkansas Insurance Department (AID) has the responsibility to license PASSEs as a Risk Based Provider Organization. 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.

Care Coordination
Is defined in Ark. Code Ann. § 20-77-2701 et seq to include the following activities: health education and coaching, coordination with other healthcare providers for diagnostics, ambulatory care and hospital services, assistance with social determinants of health, such as access to healthy food and exercise, promotion of activities focused on the health of the patient Requirements of Care Coordination are outlined in Section 5.2. and must meet the requirements outlined in 42 CFR § 438.208.

Care Coordinator Responsibilities
A care coordinator is the principal point of contact between the PASSE and the member. The responsibilities of a care coordinator are outlined in Section 5.3.

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 § 438.208 and 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 comply with the requirements of the administration of a Medicaid managed care organization as defined in 42 CFR 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 individual'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
In accordance with 42 CFR § 447.45 (b) a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a PASSE's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

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* 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.

Community and Employment Support Waiver
Services and supports authorized under the DDS 1915(c) Home and Community-Based Services (HCBS) Waiver.

Community Investments
A PASSE may choose to spend up to five percent (5%) of benefit expenditures on Community Investments. Community Investments must be allowable as "activities that improve health care quality" under 45 CFR § 158.150 as determined by DHS. Expenditures must be approved by DHS in advance and will be counted as benefit expenditures rather than administrative expenditures in calculating and reporting the Medical Loss Ratio in the year in which the expenditures were made.

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.

Continuation of Benefits
The right of the enrollee to have benefits continue pending resolution of an appeal of an adverse benefit determination.

Direct Service Provider
An organization or individual that delivers services to beneficiaries enrolled in a PASSE. PASSE Equity Owners can be Direct Service Providers.

Disenrollment
The process as a result of a determination by DHS that a member is no longer eligible to receive PASSE services.

Division of Aging, Adult and Behavioral Health Services (DAABHS) The Division within DHS responsible for the overall coordination of services for Arkansans with mental illness and substance use disorders.

Division of Children and Family Services (DCFS)
The Division within DHS responsible for child abuse prevention, protection, foster care, and adoption programs.

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

Division of Medical Services (DMS)
The Division within DHS responsible for the administration and supervision of the Medicaid program including the PASSE program.

Enhanced Care Coordination
Each member of a PASSE identified as a needing a Tier IV of care. Care coordination is overseen by a multidisciplinary team within the PASSE and maintains communication with appropriate DHS staff on 24 hours/7 days a week 365 days a year when needed to ensure health and safety of the member including appropriate residential setting.

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 the Open Enrollment Period.

External Quality Review (EQR)
The analysis and evaluation by an External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that a managed care plan, or its contractors, furnish to Medicaid beneficiaries. The annual EQR results in the generation of an annual EQR technical report. Section 1932(c)(2) of the Social Security Act and 42 CFR §438.350-370 requires that each state that contracts with a managed care plan, including Medicaid and/or CHIP managed care organizations (MCO), (described in §438.310(c)(2)) must ensure that a qualified EQRO performs an annual EQR for each such contracting managed care plan. The 2016 Medicaid and CHIP Managed Care Final Rule applies all EQR and EQRO requirements to CHIP plans in 42 CFR § 457.1250.

Fair Hearing
The State's process and procedures, to be followed by the PASSE as applicable, for complying with 42 CFR 431 Subpart E, "Fair Hearings for Applicants and Beneficiaries" and 42 CFR Part 438 Subpart F, "Grievance and Appeal System."

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 (f) (3).

Fee for Service Medicaid (FFS)
A traditional type of Medicaid coverage in which the Medicaid will pay the medical provider directly for services rendered.

Fraud
An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Flexible Services
As defined in Act 775, means 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 the member of an enrollable Medicaid beneficiary population. These are outside of the benefit package that are delivered at the PASSE's discretion. The cost of these services cannot be used in the development of capitation rates but may be reported as costs in the numerator of the plan's MLR. Examples: additional non-medical transportation services not covered under Medicaid; supplemental Over-the-Counter (OTC) drugs or vitamins, nutritional assessment, home-delivered meals, services to "wrap around" an individual to enable successful discharge plan from a hospital to home; temporary supports to the family to avoid out-of-home placement; social activities to counter negative effects of isolation; 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.

Grievance
An expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the PASSE to make an authorization decision.

Home and Community Based Services (HCBS)
An array of services and supports that although are largely non-medical in nature, are necessary to protect the health and safety of an individual and to enable the individual to live safely in a home or community-based setting. To qualify for the PASSE program, an individual has been identified through the Independent Assessment to have one or more functional limitations that impact the individual's ability to care for oneself and is thus presumed to need some level of HCBS service or support. These services and supports enable individuals to live safely in the community regardless of whether provided under 1905, 1915(c), or 1915(i) authority. HCBS services and supports provide the individual with an alternative to receiving care in an institution. Therefore, the delivery of HCBS must be coordinated with the delivery of medical services. The actual services available to a member are based on the goals described in the member's PCSP. LTSS and NCSS are related to HCBS. HCBS services with a clinical component must use the medical necessity standard.

Incurred Claims
Incurred claims are as defined in 42 CFR § 438.8 (e) (2).

Independent Assessment (IA/ARIA)
Also known as the Arkansas Independent Assessment (ARIA). A functional assessment conducted by qualified individual who is not employed by DHS, a PASSE, or a provider of services using an assessment instrument approved by DHS. The IA is an objective assessment that identifies that the need for services exists. However, the types and levels of supports and services needed to achieve an individual's goals are beyond the scope of the IA and instead are developed by the PCSP process and are described in the individual's PCSP.

Information Systems Capabilities Assessment Tool (ISCAT)
An information collection tool provided to an MCO by the state or its EQRO to obtain the information needed to validate the capabilities of the MCO's information systems, processes, and data, to support annual EQR-related activities and associated EQR analysis and recommendations.

In Lieu Of Services
In general, these services are not covered by Medicaid and therefore are not a PASSE-covered benefit. However, the PASSE may determine it is more cost effective to provide a non-covered service in lieu of more expensive care which is covered under the PASSE program. The cost of the non-covered service may be reported in the numerator of the plan's MLR and the capitation rate development will include the cost of the covered service that was replaced by the non-covered "in lieu of" service. See IMD.

Inpatient Psychiatric Services for Individuals Under Age 21
Payments are generally allowable for inpatient psychiatric services for individuals under age 21 are described at 42 CFR Part 456 Subpart G.

Institution for Mental Diseases (IMD)
An IMD as defined at 42 CFR § 435.1010 (b) means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of person with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. A general hospital that provides psychiatric treatment is not an IMD.

"IMD Exclusion"
In general, federal financial participation (FFP) is not allowed to pay for services in an IMD for Medicaid beneficiaries aged 21-64. The exclusion does not apply for this adult population in a facility of 16 beds or less and is therefore allowable in a smaller facility and is not subject to a length of stay limit.

IMD "In Lieu of Services"
Under the April 21, 2016 Medicaid managed care rule, CMS permits a short-term stay in an IMD of 15 days or less as "in lieu of" other services available under the state plan. Thus, a PASSE may make payment for an enrollee aged 21-64 receiving inpatient treatment in an IMD for a qualified short term stay not to exceed 15 days within a month. The PASSE must reasonably

determine based on a clinical review of documentation submitted by the IMD that the member has an inpatient level of care need and can respond to those services and potentially be stabilized in less than 15 days prior to authorizing services. The capitation payment to the PASSE shall include a rate that is developed in accordance with 42 CFR § 438.6 (e) for an IMD and the cost will be reported in the numerator of the plan's MLR.

Inmate of a Public Institution
As defined at 42 CFR § 435.1010 (b) means a person who is living in a public institution. An individual is not considered an inmate if (a) is in a public educational or vocational training institution for purposes of securing education or vocational training or (b) is in a public institution for a temporary period pending other arrangements appropriate to his/her needs. The term "public institution" does not include a publicly operated community residence that serves no more than 16 residents.

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)
Services and supports provided to members of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the member to live or work in the setting of their choice, which may include the member's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting. The PASSE program provides LTSS as an alternative to living in an institutional setting.

Medicaid Fraud Control Unit (MFCU)
The state agency, which investigates and prosecutes violations of State and Federal laws involving Medicaid providers and the abuse or neglect of nursing home residents. Additionally, the MFCU accepts complaints regarding Medicaid fraud and abuse and neglect.

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.

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 CFR § 438.8 (d).

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 member requesting the service. For this

purpose, a "course of treatment" may include mere observation or (where appropriate) no treatment at all. 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, unless objective clinical evidence demonstrates circumstances making the service necessary.

Network Adequacy
The PASSE must maintain a network of providers of each service as described in Section 6 to ensure timely access to services.

Network Provider
Any provider, group of providers, or entity that has a network provider agreement with the PASSE and receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the state's agreement with the PASSE.

Nonmedical Community Supports and Services (NCSS)
Although these supports and services are nonmedical in nature, they are necessary to protect the health and safety of the recipient and enable the individual to live safely in the community. They are available under the federal authority of sections 1905, 1915(c), or 1915(i) or under state authority under Act 775 to provide such supports and services through an AR Medicaid enrolled provider as approved by a PASSE for an individual. NCSS are provided with the intention to prevent or delay entry into an institutional setting or to assist or prepare an individual to leave an institutional setting, meaning the service should assist the individual to live safely in his/her own home or in the community. The need for supports and services is established by the functional deficits identified on the Independent Assessment (IA). The actual services and supports are described in the PCSP. HCBS services with a clinical component must use the medical necessity standard.

Office of the Medicaid Inspector General (OMIG)
The state agency designated to prevent, detect, and investigate fraud, waste, and abuse within the Arkansas Medicaid Program, including the PASSE program.

Open Enrollment Period
Time period, offered on an annual basis by DHS, in which all the PASSEs' current members may choose a different PASSE for coverage beginning January 1 of the following year.

Out-of-Network Provider/
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 a Network Provider but must comply with any applicable Arkansas Medicaid consent decree.

PASSE Unit
The unit with the DHS Division of Medical Services which is the office that oversees all PASSE activities.

PCP
Primary Care Provider. This can include both a physician and an advanced practice registered nurse (APRN), as well as Federally Qualified Health Centers or Rural Health Centers

Person Centered Service Plan (PCSP)
The total plan of care made in accordance with the planning process as described in the 1915(c) waiver requirements for Home and Community-Based Services (42 CFR § 441.301 (c)) and 1915(i) State Plan Services (42 CFR § 441.725).

The PCSP is developed by the Care Coordinator with the member, family members, caregivers, and providers. It identifies the member's preferences, goals, and choices about living safely in a home and community-based setting. It must provide an appropriate level of supervision, identify potential risks and temporary measures to be used to reduce risks. Restricting independence or access to resources is appropriate only to reduce specific risks to the individual.

While the PCSP describes the services and reflects the services needed to achieve the individual's goal, it does not automatically authorize services. The individualized PCSP must be designed to prevent the provision of unnecessary or inappropriate services and supports for that individual. Particular services or the scope or frequency of them may be inherently inappropriate or unnecessary for a specific individual, especially as the individual's situation changes. There is no legitimate advantage to the individual or to Medicaid in providing unneeded services (see *Federal Register*, Vol. 79, No. 11, January 16, 2014, p. 3010).

Pharmacy Benefits Manager (PBM)
A PBM is a company that manages prescription drug benefits on behalf of health insurers and other payers. A PBM operates in the middle of the distribution chain for prescription drugs and contracts directly with individual pharmacies to reimburse for drugs dispensed to beneficiaries of the PASSE.

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 (f) (2).

Preventable Hospitalization
An inpatient hospitalization linked to an ambulatory care-sensitive condition that was likely preventable if services in an effective primary care setting, outpatient or with HCBS had been provided.

Prohibited Affiliations
A relationship with an individual or entity as described in Section 10.1 and shall comply with Section 10.1 and 42 CFR § 438.610.

Provider Complaint
Communication to the PASSE by a provider that a situation is unsatisfactory or unacceptable. An expression of dissatisfaction about any matter other than an adverse decision governed by the Appeals System. Complaints may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a employee, or failure to conduct business with the provider in a professional manner.

Provider Contract
A contract entered into by the PASSE with any provider of medical, pharmacy, HCBS, LTSS or any other service or benefit authorized under the PASSE program who agrees to furnish covered services to a member.

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 at least 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 a PASSE agreement with DHS.

For purposes of meeting the 51% ownership interest by participating providers as required in Ark. Code Ann. § 20-77-2706(a)(3), a participating provider shall not be owned in whole or in part by an entity licensed by the Arkansas Insurance Department or by any state's insurance regulatory agency as an insurance carrier or health maintenance organization participating in the same PASSE. Monthly status reports must be submitted each month prior to the effective date.

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 activities that

improve the quality of care provided to PASSE 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;
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; and

Recoupment

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

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. Global Payment rates must be actuarially sound pursuant to 42 CFR § 438.4.

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 member alone in a room or an area from which the member 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 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 a subcontractor.

Subcontractor

An individual or entity that has a contract with the PASSE that relates directly to indirectly to the performances of the PASSE's obligations under its contract with DHS. A network provider is not a subcontractor by virtue of the network provider agreement with the PASSE.

Telemedicine
The use of electronic information and communication technology to deliver medical care and related services under the PASSE program, 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. Services delivered by a licensed professional or under the supervision of a licensed professional may be considered a reportable encounter including when delivered to a member of the PASSE under the modes of communication allowable under the Arkansas Medicaid program. Communications for administrative activities such as scheduling an appointment are not considered to be a reportable encounter.

The Act
Title XIX of the Social Security Act.

Timely Access to Care Standards
Through its Provider Network, and out-of-network providers, if necessary, the PASSE must ensure services are provided to meet or exceed the Timely Access to Care Standards described as described in the PASSE manual.

Any Home and Community Based Service identified as necessary to protect the health and safety of the member must be provided within 90 calendar days of completion or revision of the PCSP. The individual circumstances of the member must be taken into consideration in determining a delay in the provision of the HCBS service has an negative impact on the member under Section 6.1.4.

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

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, improve timely access to care, or promote the most appropriate utilization in the most appropriate setting. Such payments may be for a "bundle" of services and must be described in the PASSE's QAPI Strategic Plan. Example: Paying a daily or monthly rate to a Program for Active Community Treatment (PACT) that is all inclusive for its array of services and types of providers.

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 as an alternative 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 claim 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 an 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 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 use disorder (SUD) or a developmental or intellectual disability.

2.1.2 The PASSE will provide 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 Member and develop a Person-Centered Service Plan (PCSP) for each member.

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 attached hereto and incorporated herein.

2.2 EFFECTIVE DATES

2.2.1 Except for provisions outlined in Section 2.2.4, the Agreement is effective immediately upon all necessary signatures being affixed on the Signature Page.

2.2.2 The agreement effective date is **January 1, 2023 – December 31, 2026**. The PASSE Provider Agreement, including all service delivery under this Agreement terminates at midnight on **December 31, 2026,** 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.

2.2.4 The following provisions will be effective July 1, 2023, pursuant to Section 2.2.1:

- Section 4.1.3 & 4.1.4: Member materials in Marshallese
- Section 4.7: Restrictions in a Home and Community Based Setting
- Section 5.2.2: Enhanced Care Coordination
- Section 5.11.1: DCFS Liaison
- Section 9.1.5: Arkansas Based Fraud Investigator

- Section 12.1.5: Encounter Data Report Request

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 Member stating the name of the PASSE to which they have been enrolled, the effective date of enrollment, and the Member's right to transition to a different PASSE.

2.3.3 Conducting Fair Hearings in accordance with applicable laws and regulations, including, but not limited to, the Medicaid Fairness Act. (Ark. Code Ann. 20-77-1701 et seq.) and the Arkansas Administrative Procedure Act (Ark Code Ann. 25-15-201 et seq).

2.3.4 Monitoring the PASSE's compliance with the Agreement. including, but not limited to, inspection and audit of subcontracts, systems, records and access to facilities at any time.

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

2.3.6 Contracting with an external quality review organization (EQRO) for completion of the external quality review (EQR) and conducting other Quality Improvement (QI) activities.

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

2.3.8 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 including enrollment of members, paying the PASSEs, receiving encounters for analysis as appropriate and necessary, enrolling Medicaid providers, and establishing standards and requirements to ensure receipt of complete and accurate data for program administration.

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

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

2.3.10 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.

2.3.11 Ensuring that no payment is made to a provider other than by the PASSE for services provided to an 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.

2.3.12 Determining needed policy or operational changes.

2.3.13 Determining and imposing damages and/or sanctions for violations or noncompliance and requiring corrective actions for violations or noncompliance in accordance with 42 CFR § 438.700 et seq. and other applicable federal and state laws and regulations.

2.3.14 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 applicable federal and state laws and regulations and 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 or federal or state laws and regulations 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 and conducting nonemergency operations including provider and member y call centers, during Arkansas state business days and hours.

b. Provide 24 hour/7days a week/365 days per year access for its members to emergency care in a hospital emergency department and to a care coordinator.

c. 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.

d. 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.
e. At any time, allow the State, CMS, the Arkansas Attorney General's office, OMIG, the Office of the Inspector General, Medicaid inspector General, the Comptroller General, and their designees to inspect and audit any records or documents of the PASSE, or its subcontractors, and at any time, allow the State, CMS, the Office of the Inspector General, the Arkansas Attorney General's Office, OMIG, the Comptroller General, and their designees to inspect the premises, physical facilities, systems and equipment where Medicaid-related activities or work is conducted. The right to audit under 42 CFR § 438.3 (h) exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
f. 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.
g. 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 ad hoc data requests must be submitted within thirty (30) days of the request, unless otherwise specified by DHS.
h. 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.
i. Submit all changes to current provider contract template and subcontracts and proposed delegations of responsibility to DHS for review thirty (30) days in advance of being effective. All submissions shall be unredacted but may indicate where proprietary information is contained in said submission. DHS reserves the right to request any individual provider contract of subcontract at any time.
j. Timely report to DHS any known violations of this agreement, including any state or federal laws or regulations incorporated herein or applicable to the PASSE.

2.4.4 The PASSE must comply with all of the following federal and state authorities at all times as applicable to the PASSE program:

a. The Arkansas PASSE Provider Manual

b. Regulations for the administration of 1915(c) Home and Community-based Services and the Arkansas Community and Employment Supports Waiver (42 CFR Part 441 Subpart G)
c. Regulations for the administration of 1915(i) Services (42 CFR Part 441 Subpart M)
d. Regulations for the administration of 1915(b) managed care organizations under 42 CFR Part 438 and the Arkansas PASSE Waiver (42 CFR Part 431 Subpart B)
e. Regulations for the administration of Medicaid state plan services and the Arkansas state plan for Medicaid (42 CFR Part 447 Subpart B)

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
- Administrative Procedure Act Ark. Code Ann. § 25-15-201 et seq.
- Act 775 of the 2017 Arkansas General Assembly, Ark. Code Ann. § 20-77-2701 et seq.
- Medicaid Fraud Act Ark. Code Ann.§ 5-55-102 et seq.
- Arkansas Fraud False Claims Act Ark. Code Ann.§ 20-77-901 et seq.
- Medicaid Fairness Act Ark. Code Ann. 20-77-1701 et seq.
- Arkansas Freedom of Information Act Ark. Code Ann.et seq.
- Arkansas Child Maltreatment Act Ark. Code Ann.12-2-18 et seq.
- Arkansas Adult Maltreatment Act Ark. Code Ann.9-2-20 et seq.
- 42 U.S.C. § 1396b(r)(1)(F)
- 42 C.F.R. § 438.818 (2016)
- Section 6504 of the Patient Protection and Affordable Care Act

2.5.2 Both Parties must comply with any applicable federal and state laws and regulations.

2.5.3 Both Parties must comply with any applicable federal and state laws and regulations that pertain to member rights and ensure that its employees and contracted providers observe and protect those rights.

2.5.4 Noncompliance with any of these authorities may result in a sanction allowable under federal rules for a Medicaid Managed Care Organization described in 42 CFR Part 438 Subpart I.

3. ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

3.1 ELIGIBILITY

3.1.1 Eligibility for a PASSE is determined after a determination of eligibility for the Arkansas Medicaid program regardless of Medicaid eligibility group (MEG) including the new adult group under authority of the Affordable Care Act (ACA) and children eligible under Title XXI subject to the exceptions in 3.1.5. Beneficiaries are eligible for the PASSE program if they have been identified through the Arkansas Independent Assessment (ARIA) as in need of behavioral health services and/or intellectual/developmental disabilities services subject to a Tier II, Tier III, or Tier IV level of 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, child advocacy center, home, shelter, group home, and/or school.

- Tier II: Rehabilitative Level Services

  At this level of need, the individual's independent assessment score reflects difficulties with certain functional behaviors allowing eligibility for a full array of services to help the client function in home and community settings and move towards recovery.

- Tier III: Intensive Level Services

  At this level of need, the individual's independent assessment score reflects greater difficulties with certain functional behaviors allowing eligibility for a full array of services to help the member function in home and community settings and move towards recovery.

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's independent assessment score reflects difficulties with certain functional deficits allowing eligibility for a full array of services to help the member function in home and community settings.

- Tier III: Institutional Level of Care

  The individual's independent assessment score reflects greater difficulties with certain functional deficits allowing eligibility for a full array of services at higher levels (amount, frequency, or duration) to help the member function in home and community settings.

3.1.4 Tier IV is the designation for individuals with complex care needs due to mental illness or an Intellectual/ Developmental Disability who also have exhibited behaviors that cause a threat to community safety and have a history of with multi-system involvement, including law enforcement, and thereby need a high level of supervision. Eligibility for this level is determined by DHS based on review of an updated ARIA assessment. Within 60 days of a member receiving the Tier IV designation, the PASSE must:

a. Update the member's PCSP to reflect the array of services and supports necessary to transition to or maintain the member in home and community settings.
b. Ensure a positive behavior support plan is developed and appropriate to address behaviors that cause a threat to community safety in the future.
c. Participate in Quarterly Tier IV service analysis for sample of members identified by DHS.

3.1.5 Medicaid clients who have received a Behavioral Health or Developmental Disabilities Independent Assessment score of Tier II or above will be mandatorily enrolled in a PASSE through the auto-assignment process. Exceptions:

a. Beneficiaries who are eligible for Medicaid through the medically needy "spenddown" category will not be enrolled in the PASSE.
b. Beneficiaries who are seeking full admission to a Human Development Center (HDC) and tier at a Developmental Disability Tier III will be admitted to the HDC and not be assigned to a PASSE.
c. Beneficiaries who are eligible under eligibility Medicaid Spend Down will not be assigned to a PASSE.
d. Beneficiaries who are placed at a skilled nursing facility or assisted living facility, or
e. Beneficiaries who are approved for waiver services provided through the ARChoices in Homecare or Independent Choices programs or a successor waiver for the frail, elderly, or physically disabled, and the Autism Waiver.

3.1.6 Beneficiaries who no longer meet at least a Tier II level of care will be disenrolled by DHS.

3.1.7 On or after January 1, 2023, DHS may choose to allow Medicaid beneficiaries with a Tier I level of care to voluntarily enroll in the PASSE program. If DHS chooses to allow beneficiaries with a Tier I level of care, DHS will submit an amendment to the 1915(b) waiver to CMS for approval, provide public notice at least 180 days prior to the effective date, and in accordance with the Administrative Procedures Act.

3.2 ASSIGNMENT

3.2.1 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.

3.3 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.
e. Subject to sanctions under this agreement.

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 program shall be in accordance with 42 CFR § 438.56 and 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 Member loses Medicaid eligibility.
b. The Member is placed in a setting or receives services excluded from the PASSE, as defined in Section 3.1.5:

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 will 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 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. Poor quality of care that resulted in a documented threat to the member's health or safety, 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 Period.

3.6.2 There will be a yearly Open Enrollment Period when an 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 calendar year.

3.6.3 The Open Enrollment Period for PASSE members will be from October 1 to October 31 each year of this agreement. Any changes made during the Open Enrollment Period 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 notification to the receiving PASSE no more than one (1) business day prior to eligibility start date on the special needs of the transitioning member, and provide receipt of medical records, PCSP, treatment plans, and Care Coordination files to the receiving PASSE within twenty (20) business days;

c. When receiving a transitioning member, PASSE must ensure continuity of current services, including working with providers to transition reimbursement and informing member if current service providers are not in network and if not, assist member with choosing new providers, if necessary to meet service and support needs.
d. Each new member who has a treatment plan for existing Medicaid services will carry that treatment plan with them when the individual is enrolled into the PASSE. The PASSE must continue reimbursing for any Medicaid services that are medically necessary for each newly enrolled member.
e. During transition, coordinates services with the receiving or relinquishing PASSE to ensure smooth transition and continuity of care for 60 calendar days or until the transition is completed, whichever is longer; and
f. Is consistent with federal requirements outlined in 42 CFR § 438.62.

3.6.6 The PASSE and its Subcontractors, providers, or vendors must assist in the transition of an 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 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 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 Members and Potential Members in accordance with 42 CFR § 438.10. Additionally, and in accordance with the above referenced CFR, the PASSE must notify 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 Members, whether required by the Agreement or otherwise, accessible. These materials 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. Additionally, the PASSE must notify all potential or 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, Spanish, and Marshallese.
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 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 visual impairment, hearing impairment, limited reading proficiency, or limited English proficiency.

g. Auxiliary aids and services must be made available upon request for Member and Potential Members with disabilities.

h. A Teletypewriter Telephone/Text Telephone (TTY/TDY) number must be provided for Members and Potential Member.

i. All written materials for members must include taglines in the prevalent non-English languages in a particular service area. Written materials that are critical to obtaining services are referenced in 42 CFR § 438.10(d)(3) and includes, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. Taglines must be in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand information provided, information on how to request auxiliary aids and services, and the toll-free and TTY/TDY telephone number of the PASSE's Member Support Services unit. Auxiliary aids and services must also be available upon request of the member or potential member at no cost.

4.1.4 The PASSE must mail all Member materials to the 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 Members by mail must include instructions for how a member can change or update their address.

c. If material sent to Members is returned to the PASSE as "undeliverable," the PASSE must notify the PASSE Unit within thirty (30) calendar days on a monthly undeliverable mail report.

d. The PASSE may send emails in lieu of mailing if the Member has agreed, in writing, to receive information by email.

e. If an Member agrees to receive information by email, the PASSE must provide an opt-out process for that Member to elect to no longer receive information by email.

f. 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.

4.1.5 Due to the high rate of undeliverable mail, the PASSE is allowed to utilize postal service address correction software when mailing Member materials.

4.1.6 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 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;

d. The DHS provided logo on the front of the member ID card; and

e. Replacement Member ID cards must be made available at the Member's request, without cost to the member.

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 described 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 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 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 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 selecting 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;

l. Procedures for reporting Medicaid fraud, waste, abuse and overpayment;

m. Information on the right to file a Grievance or Appeal an adverse benefit determination, 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;

n. 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;

o. Notice that a Member has the right to continue services upon Appeal of a denial of services, but that the Member may have to pay for the denied services if there is an adverse ruling;

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

q. Procedures for reporting abuse, neglect, or exploitation of the Member by the PASSE or PASSE representatives;

r. 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 Members aged 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 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 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 and complaints related to PASSE services may be filed with the state's PASSE Ombudsman hotline;
v. Information on how 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 Members;

s. Notice of the right to file a Grievance with the PASSE related to the PASSE or any of its representatives, including participating providers.
t. Notice that the PASSE cannot require the 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;
u. 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 Member may obtain information on those services and how to access them through DHS.
v. Contact information for the Consumer Advisory Council (CAC).
w. Contact information for the Division of Medical Services Office of the Ombudsman.
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 Members.
y. Any changes to the Member Handbook must be submitted to DHS, through the PASSE Unit, for review and approval prior to distribution to Members. The PASSE is required to provide each 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 paper Provider Directory must be updated at least quarterly.
g. The PASSE must ensure the Provider Directory being distributed to 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, using single and multiple search criteria, according to:
    i. Provider Name;
    ii. Specialty 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 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 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 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 Member or Potential Member directly to the online Provider Directory.

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

4.2.6 If the PASSE chooses to provide required information electronically to Potential Members and 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 set forth in Section 4 of the Agreement;

f. Notify the member that the information is available in paper form, without charge, and 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 365 days per year 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, Provider Complaints and Compliance.

4.3.8 The PASSE must make available on its website the contact information for the Division of Medical Services Office of the Ombudsman.

4.3.9 The PASSE may use its website to receive requests or questions from Member and/or Potential Members. If it chooses to use its website for these purposes, the PASSE must demonstrate to DHS prior to implementation, how all requests or questions will be processed and the timeframes for response.

4.4 MARKETING

4.4.1 The PASSE may only market to Potential Members through its website or through printed materials distributed by DHS' PASSE office or beneficiary support contractors.

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.

c. All allowable, written marketing materials will be translated into Spanish and Marshallese. All PASSEs must be able to provide written materials in any language requested by the member.

4.4.2 Marketing materials, written and oral, produced by the PASSE must NOT:

c. 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, DHS, the federal or state government, or a similar entity; or 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 In accordance with section 233.000 of the PASSE Manual, 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. Direct intent of marketing or solicitating to attract membership to their PASSE is strictly prohibited.

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 Members through writing, telephone, email, web-based transmission, and 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 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.) Abandoned calls meeting this criteria should not be included in calculating the wait time performance in section 4.5.3 (h)(iii) above.
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 State 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 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 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 Member adversely for exercising his or her rights, as outlined above.

4.7 RESTRICTIVE INTERVENTIONS IN AN HCBS SETTING

THE 1915(C) WAIVER THE 1915I STATE PLAN AMENDMENT OUTLINE THE REQUIREMENTS REGARDING RESTRAINTS AND SECLUSION.

4.7.1 PASSEs must have policies that prohibit maltreatment or corporal punishment of members and guarantee an array of rights which includes the right to be free from the use of a physical or chemical restraint, medications, or isolation as punishment for the convenience of the provider except when a physical restraint is necessary for the health and safety of the individual.

4.7.2 The PASSE is responsible for ensuring Risk Mitigation Plans are developed for all members. Risk mitigation plans are not behavior plans but may result in the development of a behavior plan.

4.7.2.1 If a member has a history of low-risk behaviors that could cause harm to himself/herself or the community, a Behavioral Prevention and Intervention Plan must be developed as outlined under the service Prevention, Intervention, and Stabilization in the 1915(c).

4.7.2.2 If a member has a history of high-risk behaviors that could cause harm to himself/herself or the community, a Positive Behavior Support must be developed as outlined under the 1915(c) and the 1915(i).

4.8 CULTURAL COMPETENCY PLAN

4.8.1 In accordance with 42 CFR § 438.206 (c) (2), the PASSE must have a written Cultural Competency Plan (CCP) to ensure that services and settings are provided in a culturally competent manner to all member and including those with limited English proficiency. The CCP must be submitted to DHS annually for review and approval.

4.8.2 The CCP must address the following:

a. A demographic description of the PASSE's members.
b. How the PASSE, PASSE employees, providers 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 Members and protects and preserves the dignity of each.
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.

4.8.3 The PASSE must conduct the annual CCP evaluation of the prior year which 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 in a culturally competent manner.
c. A description of the evaluation, its results, the analysis of the results and interventions to be implemented.

See Exhibit V for submission schedule.

4.8.4 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 General Provisions

4.9.1.1 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, Ark. Code Ann 20-77-1701 et seq. and the Arkansas Administrative Procedures Act (Ark. Code Ann. § 25-15-201 et seq.).

4.9.1.2 The PASSE must report on all provider complaints, grievances, and appeals to DHS and OMIG.

4.9.1.3 The PASSE must ensure that all adverse benefit determinations, 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. The decision involves an appeal of a denial based on lack of medical necessity;
b. The decision involves a grievance regarding denial of expedited resolution of an appeal; or
c. The decision involves a grievance of appeal involving clinical issues.

4.9.1.4 The PASSE must ensure that the decision makers on adverse benefit determinations, adverse actions, grievances, appeals, provider complaints are not:

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

4.9.1.5 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, including all applicable state and federal laws, rules, and regulations.

4.9.1.6 The PASSE shall not take any punitive action against an Member or a provider for filing or participating in a complaint, grievance or appeal.

4.9.2 Provider Complaints Procedure

4.9.2.1 The PASSE must have a process to take and resolve complaints made by Direct Service Providers. This process must be reviewed and approved by DHS prior to implementation.

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

4.9.2.3 The PASSE must respond to DHS and the provider regarding provider complaints escalated by DHS within three (3) business days with reportable action steps the PASSEs are putting into place to resolve the issue.

4.9.2.4 Complaints may be filed by a provider, whether or not it is a participating provider.

4.9.3 Grievance Procedure

4.9.3.1 The PASSE must have an internal grievance procedure that is reviewed and approved by DHS prior to implementation. Any changes must be approved by DHS and notification sent to all 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. An authorized representative on behalf of the member, the member's parent/legal guardian
b. A grievance may be filed either orally or in writing.
c. A member complaint received by DHS and forwarded to the PASSE must be treated as a Grievance and shall be considered as filed with the PASSE upon the day received by the PASSE from DHS.
d. 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 he 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.
    iv. If the timeframe is extended, the PASSE must:

c. 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

d. Provide written notice of the reason for the extension to the grievant within two (2) calendar days of the determination and inform the grievant of the right to file a grievance if he or she disagrees with the decision to extend the timeline and the request to extend the timeline did not originate with the grievant

4.9.3.2 If an member requests a for-cause transition to another PASSE, DHS may require the member to utilize the PASSE's grievance and appeal system to seek redress. If the PASSE fails to satisfactorily resolve the grievance or fails to provide DHS with the outcome of the grievance within thirty (30) calendar days, the member's request for transition will be considered approved.

4.9.3.3 The PASSE must refer members who are dissatisfied with the PASSE or its activities to the PASSE's grievance/appeal office for processing and documentation of the issue whose issues cannot be resolved by the PASSE.

4.9.3.4 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 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 the respective timeframes, 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, OMIG, OIG, AG or CMS. Each record must be maintained in compliance with 42 CFR § 438.416 and HIPAA, and for a period of no less than ten (10) years. The log must contain, at a minimum:

i. The date the appellant was sent a denial or adverse benefit determination notice;

ii. A description of the subject of the complaint, grievance or appeal;

iii. The date of receipt;

iv. The hearing date, if applicable;

v. The resolution of the complaint, grievance or appeal;

vi. The date of notice of the resolution;

vii. Name of the member or provider who was subject of the complaint, grievance or appeal; and

viii. Any other information required by 42 CFR 438.416, the DHS, 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.

4.9.4 PASSE Member Appeals Procedure

4.9.4.1 The PASSE must have an internal appeal procedure by which certain individuals (known as "appellants") may challenge an adverse benefit determination. DHS must approve the PASSE's appeal procedure and any changes to the appeal procedure prior to its implementation.

4.9.4.2 The PASSE must send written notice of significant changes to the appeals process to all 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 Member;
   ii. The Member's parent or legal guardian;
   iii. An attorney authorized to represent the Member;
   iv. Another authorized representative of the Member, including the representative of the Member's estate if that member is deceased;

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 Decision/Adverse Benefit Determination.
   i. The PASSE must ensure that oral requests to appeal are treated as appeals and confirmed in writing that an appeal was filed.
   ii. All appeal requests, oral and written, must be documented and maintained in the administrative record.

4.9.4.3 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 benefit determination. The date of oral filing constitutes the date of receipt of the appeal.
b. The PASSE must acknowledge all PASSE appeals in writing within five (5) business days of receipt, unless the appellant requested an expedited resolution.
c. 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.

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 State fair hearing.

4.9.4.4 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 benefit determination that is the subject of the appeal. This includes, without limitation, the member's case file, medical records, and 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.

4.9.4.5 The PASSE must provide the 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. 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 benefit determination.

4.9.4.6 Upon request by the appellant 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;
e. The member or his or her parent/legal guardian timely files for continuation of benefits in accordance with the PASSE's policy; and
f. The PASSE informs the member of its right to recover the cost of services furnished to the member while the appeal or fair hearing was pending if the final resolution of the appeal or fair hearing is adverse to the member.

4.9.4.7 A provider acting as an authorized representative consistent with 48 CFR § 438.400 (c) (1) (ii) may not request a continuation of benefits pending appeal as specified in 48 CFR § 438.420(b)(5).

4.9.4.8 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.

4.9.4.9 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 as permitted by 42 CFR § 438.420(d).

4.9.4.10 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.

4.9.4.11 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. The PASSE must resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

4.9.4.12 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.

4.9.4.13 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. 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; and
e. The address, phone numbers, and e-mail for fair hearings.

Member 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 dhs.appeals@dhs.arkansas.gov

4.9.5 Provider Reconsideration Procedures

4.9.5.1 The PASSE must have an internal reconsideration procedure by which providers may request further review of an adverse decision/action. DHS must approve the PASSE's reconsideration procedure and any changes to the reconsideration procedure prior to its implementation.

4.9.5.2 The PASSE must send written notice of significant changes to the reconsideration procedure to all providers at least thirty (30) days prior to implementation.

4.9.5.3 At a minimum, the PASSE process must include the following provisions:

a. A service provider whose services (whether completed or proposed) are the subject of an adverse decision or action may file a request for reconsideration.

b. The request for reconsideration must be filed, in writing, within thirty (30) calendar days from the date on the notice of the adverse decision/action, and must include:
    i. a copy of the notice of the adverse decision or action to be reconsidered, and
    ii. any additional documentation to support medical necessity.
c. The PASSE must acknowledge and document all requests for reconsideration in writing within five (5) business days of receipt. The requests must be maintained in the administrative record.
d. The reconsideration must be assigned to a qualified reviewer who did not participate in the initial determination no later than twenty (20) calendar days from the date of receipt of the reconsideration request.
e. A provider is not required to utilize the reconsideration procedures prior to filing an appeal under the Medicaid Fairness Act.

f. Any adverse resolution of a reconsideration request can be appealed by the Provider within thirty (30) calendar days to the Department of Health utilizing the provider appeal procedures detailed in 4.9.7.

4.9.6 Member State Fair Hearing Process

4.9.6.1 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.

4.9.6.2 The PASSE must designate an email address for use by the DHS Office of Appeals and Hearings for all fair hearing related communications.

4.9.6.3 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. The member must exhaust the PASSE's grievance and appeal process before they may file a state fair hearing.

4.9.6.4 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.

4.9.6.5 The PASSE must timely notify the appellant that a request for a fair hearing must be filed with the appropriate office within ninety (90) calendar days of receipt of resolution of the appeal.

4.9.6.6 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.

4.9.6.7 The PASSE shall not create undue delay or obstruct the appellant's right to a fair hearing of an adverse resolution.

4.9.6.8 The PASSE must provide the appellant access to the fair hearing. This may include providing access to the conference line for telephone hearings, transportation to the hearing if in person, and address and phone number for their local DHS county office.

4.9.6.9 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 to DHS Office of Appeals and Hearings 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 to DHS Office of Appeals and Hearings 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.

4.9.6.10 If the 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.

4.9.6.11 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.

4.9.6.12 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.

4.9.6.13 Within ten (10) business days of the issuance of a final written opinion or order in a fair hearing, the PASSE will provide a copy of the Opinion or Order to OMIG and DHS.

4.9.7 Provider Administrative Appeals Pursuant to the Medicaid Fairness Act

4.9.7.1 In response to an adverse action, a provider may appeal on its own behalf directly to the Arkansas Department of Health pursuant to the Medicaid Fairness Act. A provider is not required to first utilize the PASSE appeal procedures prior to filing an appeal with the Department of Health.

4.9.7.2 Administrative appeals at the Department of Health will be conducted by an independent administrative law judge employed by the Arkansas Department of Health.

4.9.7.3 A provider will have (30) thirty days from the notice of action to file an appeal with the Department of Health, Office of Medicaid Provider Appeals.

4.9.7.4 Any Appeal from an adverse action must be received, in writing, by submitting appeal requests to:

Office of Medicaid Provider Appeals
4815 West Markham Street, Slot 31
Little Rock, AR 72205

4.9.7.5 Any appeal request must include a statement regarding the reason for the appeal and must include any notice of action received by the provider from which the provider is seeking an appeal.

4.9.7.6 The PASSE must designate an email address for use by the ADH Office of Medicaid Provider Appeals for all administrative hearing related communication.

4.9.7.7 The PASSE shall fully participate in the provider administrative appeal process. The PASSE is considered a party to the administrative hearing, and as such must attend the fair hearing with all necessary witnesses and evidentiary materials.

4.9.7.8 The provider administrative appeal process must comply with the Medicaid Fairness Act, Ark. Code Ann. §20-77-1701 et seq. and the Arkansas Administrative Procedures Act, Ark. Code Ann. § 25-15-201 et seq.

4.9.7.9 Within ten (10) business days of the issuance of a final written opinion or order in an administrative hearing, the PASSE will provide a copy of the Opinion or Order to OMIG and DHS.

4.9.8 Judicial Review Procedures

4.9.8.1 Should an appellant or provider appeal a Medicaid fair hearing final order or a provider appeal final order from the Department of Health to the appropriate

circuit court for judicial review under the Arkansas Administrative Procedures Act, the PASSE must fully participate in the judicial review process.

4.9.8.2 The PASSE must contact DHS within five (5) business days after receipt of notice of an appeal of a Medicaid fair hearing.

4.9.8.3 The PASSE is responsible for 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.

4.9.8.4 Within ten (10) business days of the issuance of a final written opinion or order in a Judicial Review, the PASSE will provide a copy of the Opinion or Order to OMIG and DHS.

5. SERVICES

5.1 GENERAL REQUIREMENTS

5.1.1 All medical services provided by the PASSE to 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 Members outside of the PASSE.

5.1.6 When the Adverse Benefit Determination denies a claim for previously authorized, covered medical assistance or NCSS, the PASSE must send the notice of the Adverse Benefit Determination no less than ten (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 Benefit Determination 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 benefit determination taken by the PASSE; and

iii. A statement of the basis of the Adverse Benefit Determination, including the facts that support the Adverse Benefit Determination 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 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 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 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 Members:

a. Care Coordination is defined under Act 775 of 2017(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 Members and to meet the required Care Coordination ratios as set forth in section 259.300 of the PASSE Medicaid Manual

c. Care Coordination services must be available to Members 24 hours a day, 7 days a week, 365 days per year (24/7/365), 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 PASSE members who have an ARIA score of Tier IV must receive enhanced care coordination. Enhanced care coordination includes:

a. A multi-disciplinary team including professionals who are licensed to provide the IDD/BH services needed by the member;
b. Crisis and transition planning developed by the multi-disciplinary team, representatives from systems, member, and family/guardian;
c. Team preparation and attendance at all required court staffing and court hearings as necessary to discuss the role of the PASSE and services in place or needed by the member;
    i. Pre-court staffing will be conducted, and a determination will be made as to the necessity of a PASSE representative attending the subsequent court hearing.
    ii. DHS will notify the PASSE at least forty-eight (48) hours in advance of any staffing or court hearings which would require the presence of a PASSE representative.
    iii. DHS will work with the PASSEs to develop a uniform court report to be used and which can be provided in lieu of court attendance when possible.
d. Quarterly case reviews that are led by the care coordinator and include representation from all systems in which the individual is involved in the adult justice system or the juvenile court system to ensure that all necessary services are being provided.

5.2.3 Each Member must be assigned a care coordinator.
a. Prior to the first care coordinator visit, the Member must be provided information on how to contact the designated care coordinator and how to access the 24/7/365 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. If a new care coordinator is assigned to the Member, the PASSE must provide written notification of the change to the member.

5.2.4 The assigned care coordinator or appropriate PASSE team member must make initial contact with each Member within fifteen (15) business days of PASSE enrollment including any contact between assignment and enrollment

5.2.5 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 Member has an ongoing source of care appropriate to their needs.
b. The PASSE must have care coordinators who will work with the Member's providers and care givers to ensure continuity of care across all services.

5.2.6 The PASSE is responsible for assisting the 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).

5.2.7 The PASSE must comply with Conflict Free Case Management rules pursuant to 42 CFR § 440.169, as a critical protection for 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 Members. Case Management activities are:
    i. Assisting members with scheduling an independent assessment or independent reassessment process required for PASSE eligibility;
    ii. Assistance with Medicaid eligibility process;
    iii. Development of a Person-Centered Service Plan;
    iv. Referral to services; and
    v. Monitoring activities.
c. 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 or providers.

5.2.8 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, Prepaid Ambulatory Health Plan (PAHP), or Prepaid Inpatient Health Plan (PIHP) (as those are defined by CMS and DHS);
c. Medicaid in the FFS environment; and
d. Any community or social support providers not participating in the PASSE model.

5.2.9 The PASSE care coordinator or appropriate PASSE team member must conduct an initial services assessment of each Member within thirty (30) days of enrollment of the member.

a. This initial services assessment must be used in the creation of the Member's PCSP, *see* Section 5.3.

b. The PASSE must share component parts of the services assessment as appropriate with DHS and any other MCO, PIHP, or PAHP serving the member on behalf of Medicaid to prevent duplication of activities between these entities.

5.2.10 The PASSE care coordinator is responsible for overseeing the development and implementation of 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 Members of the PASSE. The PCSP must adhere to content requirements as found at 42 CFR § 441.301(c) and 42 CFR § 441.540 in a standardized format for the specific PASSE. The planning process and the PCSP must include, without limitation:

a. The 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 Member; and
   v. Indication of whether or not an advance directive or living will has been created for or by the Member.
b. Reflect that the setting in which the individual resides is chosen by the individual;
c. Reflect the Member's strengths and preferences;
d. Reflect the clinical and support needs as identified;
e. Include individually identified goals and desired outcomes;
f. Reflect the services and supports that are important for the Member to meet the needs as identified through an assessment of functional need, including services and supports in the community to avoid placement in an institution;
g. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals and desired outcomes;
h. Reflect the risk mitigation plan
i. Includes strategies for solving conflict;
j. Be finalized and agreed to in writing; and
k. Prevent the provision of unnecessary or inappropriate care.

5.3.2 The PCSP must ensure that the Member's needs are being met in a way that is individualized and specific to that member's needs. The PCSP is the fundamental plan for assisting an individual live safely and successfully in his/her own home or community and deference to it must be given by interested parties.

a. It should be designed to meet the individual's goals and objectives for the next twelve (12) months.
b. It must reasonably reflect the daily and weekly activities and routine a member chooses that is age and developmentally appropriate. It should also reflect progress towards a future goal. examples include:
    i. activities to assist an adult with a developmental disability to plan to transition from an elderly parent's home into a community setting.
    ii. activities to assist DCFS and member's family to achieve the member's permanency plan, through obtaining needed medical services and supports.
    iii. activities to assist member transition out of residential or institutional setting.

5.3.3 Specifically, the PCSP must address any needs identified for the Member from the ARIA and Initial Services Assessment and the following sources, if made available:

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

5.3.4 When developing the PCSP, the PASSE care coordinator should give special attention to the following circumstances that an 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.
e. History of inpatient psychiatric services, current psychiatric inpatient services, and transition plans for return to home and community when this represents a significant change of condition.

5.3.5 For any Member without an existing PCSP the PASSE will have sixty (60) calendar days from date of enrollment to develop the PCSP, which shall include the initial services assessment as described in Section 5.2.8 above.

5.3.6 The PASSE will provide a quarterly PCSP report for DHS to review the number of approved, pending, and incomplete PCSPs for Members as well as the number of PCSP meetings held and number of PCSP meetings pending. This report should also include a comparison to the number of incomplete PCSPs in the previous submission to the number of those that have since been completed.

5.3.7 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; and
    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 regard 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.
f. It is the responsibility of HCBS service providers of nonmedical services and supports to work with the PASSE care coordinator to identify specific services that are needed to carry out the PCSP. As stated in federal regulations, there is no legitimate advantage to the individual or to Medicaid in providing unneeded services.

5.3.8 The PCSP must be updated at least every 12 months, as well as when the individual's conditions, circumstances, or needs change significantly or when the individual requests an update, for each Member in accordance with 42 CFR § 441.725(c). A change in condition, circumstances, or needs does not mean a change in a particular service or provider.

5.3.10 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, OMIG, and Attorney General, 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 Members have a PCSP that meets the member's needs and that all services are being provided in accordance with the member's PCSP. A determination of noncompliance may result in the imposition of sanctions by DHS in accordance with 42 CFR Part 438 Subpart I.

5.3.10 DHS or its agent will conduct random sampling of the PCPSs on a quarterly basis. 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.

5.3.11 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 member 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 (3) years as required by 45 CFR § 92.42.

5.3.13 In addition, DHS 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 member's rights, freedom choice of providers within PASSE networks, member 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 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, HCBS described in Exhibit II, 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 CFR Part 441 Subpart B that requires 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 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 Clean Claims, the PASSE shall not:

a. Deny payment for treatment obtained when a 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 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 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 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 Members, as set forth in the Act. However, drugs for which Federal Financial Participation is not available, pursuant to Section 1927 of the Social Security Act 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 National Drug Code (NDC).

b. The PASSE must update their pharmacy claims system within three (3) business days of receipt of the approved DHS weekly Drug file sent by email. If the PASSE cannot match DHS stated coding a retrospective encounter process must be in place for any impacted encounters.

c. For the regularly weekly Custom Drug file management and other off-cycle updates like upcoming PDL changes, the PASSE must update their pharmacy claims systems within thirty (30) day of receipt of the file to be in line with decisions made by DHS.

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

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

f. Drugs not defined by the Act may be excluded, consistent with the Medicaid State Plan.

g. The PASSE must, at a minimum, cover the over the counter (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 of 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 relatable exclusively to Arkansas Medicaid.

5.5.3 Pursuant to Section 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 Section 1927.

b. Pursuant to the requirements of Section 1004 of the SUPPORT Act, states and each PASSE shall implement minimum opioid standards to include:

i. Prospective safety edits and claims review automated process for opioids for early fills, therapeutic duplication, and quantity limits.

ii. Prospective safety edits and a claims review automated process for maximum daily morphine equivalents (MME) for treatment of chronic pain and for when the recipient exceeds maximum MME doses.

iii. A claims review automated process that monitors when a member is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics.

iv. A program to monitor and manage the appropriate use of antipsychotic medications by Medicaid children, especially for foster care children.

v. A process that identifies potential fraud, waste, or abuse of controlled substances by Medicaid clients, enrolled prescribers, and enrolled dispensing pharmacies.

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

d. The PASSE's DUR Committee will meet at least biannually. The DUR Committee must include a voting representative from DHS. The PASSE shall ensure all voting representatives have been timely notified of DUR Committee meetings with the DHS voting representative not missing two consecutive meetings. The PASSE must provide DHS with the minutes from each DUR Committee meeting within thirty (30) calendar days of the date of the meeting. The PASSE must provide additional DUR Committee meeting information as requested by DHS.

e. 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.

f. 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 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 Section 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). 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 twenty-four (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 Section1927, DHS requires encounters to include the actual NDC on the package or container from which the drug was administered and the appropriate drug-related Healthcare Common Procedure Coding System (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 Section 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 Section 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 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 Section 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 FFS Program.

a. The PASSE must respond to a prior authorization request within twenty-four (24) hours of receipt of request.
b. The PASSE must accept telephonic, facsimile, and 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 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 accordance with the Section1927.

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 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 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 Members at least thirty (30) calendar days prior to the effective date of the change.

5.5.15 PASSEs 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 the PASSE identifies a difference per claim between the amount paid to the pharmacy provider and the amount charged to the PASSE sponsor by its pharmacy benefit manager, the PASSE must report an itemization of all administrative fees, rebates, or processing charges associated with the claim to DHS.

5.5.16 The PASSE must submit an annual report to DHS 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, current data for all targeted medications, and related clinical edits.

5.5.17 The PASSE is responsible for all pharmacy expenses related to transplant services provided to PASSE members.

5.5.18 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.

5.5.19 The PASSE must follow all applicable state billing processes for 340B medical drug claims, and these claims will be subject to post payment review by DHS. PASSEs are responsible for auditing to ensure providers are maintaining documentation to support billed amounts.

5.6 HOME AND COMMUNITY BASED SERVICES (HCBS)

5.6.1 For those members not in an institutional setting, at least one HCBS is required whether under the 1915(c) or 1915(i) authority within 90 days of the completion of the PCSP. For a description of Home and Community Based Services, *see* Exhibit II.

5.7 INPATIENT AND RESIDENTIAL PSYCHIATRIC TREATMENT SERVICES FOR UNDER AGE 21

5.7.1 Arkansas Medicaid includes the following optional state plan services: Acute Unit in a Psychiatric Hospital, Sub-Acute Unit in a Psychiatric Hospital (Also called Residential Treatment Unit), and Psychiatric Residential Treatment Facility (PRTF, also called Residential Treatment Center)

5.7.2 PASSEs are responsible for authorizing and reimbursing providers for the provision of these services and only PASSE members are eligible to receive services from Sub-acute units and PRTFs.

5.7.4 PASSEs must provide results of any audit, concerns, and findings.

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 Early Intervention Day Treatment (EIDT) and Adult Development Day Treatment (ADDT)

c. Dental benefits in a capitated program;

d. School-based services provided by school employees or their contracted vendor when the service is listed on the Individualized Education Plan (IEP), in accordance with the Individuals with Disabilities Education Act (IDEA). When this occurs, the biller must utilize the school district provider number as well as the Local Education Agency (LEA) number;

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;

i. Transplant services as of May 27, 2020, forward and post-transplant services for one (1) year following the date of transplant; and

j. Abortions, except as allowed by State or Federal law.

5.9 IN LIEU OF SERVICES—IMD

5.9.1 The PASSE may provide In Lieu of Services to an Enrolled Member in an Institution for Mental Diseases when the member is only an inpatient in an IMD for fifteen (15) days during that month in accordance with 42 CFR § 438.6(e) when the PASSE determines that the In Lieu of Services is used as a medically appropriate and cost-effective alternative setting to those covered under the State plan. The PASSE will provide a monthly IMD report for DHS to review for all PASSE authorized stays of less than 15 days, PASSE members who remained in an IMD after their authorization and any admissions to an IMD that were not authorized by the PASSE of which the PASSE has knowledge for Enrolled Members aged twenty-one (21) to sixty-four (64).

5.10 FLEXIBLE SERVICE(S)

5.10.1 As permitted under Act 775 and 42 CFR §438.3(e), the PASSE may offer flexible services that are in addition to those required to be provided under the Agreement. Flexible services are provided at the PASSE's discretion and are described as part of their QAPI Strategic Plan.

5.10.2 The PASSE may offer and reimburse for Flexible Services, including a suite of services together. The member cannot be required by the PASSE to use the flexible service. When a flexible service is provided, it must be documented in the member's PCSP.

5.10.3 The PASSE must report on all flexible services quarterly using a template agreed upon by DHS and the PASSE. This report will be audited at a minimum annually.

5.11 CARE COORDINATION SERVICES FOR CHILDREN AND YOUTH IN DCFS CUSTODY

5.11.1 Each PASSE must have a DCFS Liaison to work with the Division of Medical Services ("DMS") and the Division of Children and Family Services ("DCFS") in overseeing care coordination and access to services for children and youth in DCFS custody or Tier IV post adoption members. The DCFS Liaison must:

a. Be knowledgeable about the child welfare system and focus on the needs of the DCFS population in collaboration with DCFS, foster and adoptive parents, and kinship guardians.

b. Act as the primary PASSE contact for members who are children and youth in foster care and serve as the liaison to DCFS and DMS to provide updates, reports and specific information on children and youth in the PASSE's care.

c. Partner with DCFS to ensure that children and youth are provided the necessary services and supports to maintain in/or return to home and community-based settings. Oversee case reviews of medical, mental health and intellectual/developmental disabilities for PASSE members involved with the child welfare system who require team reviews.

d. Facilitate and attend meetings that involve DCFS children and youth, including ensuring that all the necessary parties including providers, care coordinators, guardians, DCFS family services workers, the assigned Attorney Ad Litem and other appropriate team participants for the child/youth, and DHS/DCFS staff are properly notified prior to any meetings. Any cases that cannot be resolved and which require additional assistance from DHS must be sent to PASSEescalations@dhs.arkansas.gov.

e. Ensure that effective care coordination is being provided for the specialized population including arranging appropriate PASSE staff members attendance at court hearings and case staffing as requested by DCFS and necessary to guide treatment for symptoms related to mental health or intellectual/developmental disabilities disorders with at least forty-eight (48) hours-notice of required attendance at court hearings. DHS will work with the PASSEs to develop a

uniform court report to be used and provided in lieu of court attendance when possible.

f. Serve as representative to work with DCFS and PASSE unit to develop practice guidelines related to the foster care population.

g. In accordance with section 5.5.15 related to the SUPPORT Act, organize the collection of data related to antipsychotics in the foster care population and produce an annual report that describes the PASSE's interventions to prevent overuse of the antipsychotics in the foster care population

h. Consider trauma associated with abuse and neglect and account for the information in the member's PCSP.

i. Seek input from foster, adoptive and kinship parents, and DCFS staff members regarding members' needs, risks, and strengths. This input must be captured in the PCSP.

j. Coordinate with DCFS and discharging provide to arrange for appropriate discharge planning occurs for members in all U21 Inpatient Psychiatric settings and that all necessary parties are engaged in the discharge planning process.

k. Ensure that the PCSP addresses all professional, home and community-based services, and social supports outlined in the child welfare plan of care and any services or assessments that are reimbursed or provided by DCFS.

l. Ensure that DCFS children discharging from a hospital, ER, subacute or acute psychiatric facility have follow-up by a Care Coordinator within three (3) days of the discharge.

m. Ensure that DCFS children are assigned a primary care physician (PCP) or Advanced Practice Registered Nurse (APRN)and that those on psychotropic medication receive metabolic monitoring.

n. Within 15 days of DCFS notification of significant status change, the PASSE will schedule a PCSP update meeting and coordinate medical, behavioral health services and any services to address intellectual and/or developmental disabilities.

6. NETWORK AND PROVIDER REQUIREMENTS

6.1 NETWORK ADEQUACY STANDARDS

6.1.1 In addition to what is outlined in this section of the Agreement, the PASSE must maintain and monitor an adequate network of qualified providers that is sufficient to meet the Timely Access to Care Standards defined in the PASSE Manual and in the definition of services covered under the Agreement for all 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 full range of HCBS including both 1915 (i) and 1915 (c) services that is adequate for the anticipated number of 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.
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;
c. 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 bi-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 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 ensure the provision of medically necessary services to a particular Member within the Timely Access to Care Standards as set forth in the PASSE Manual for that type of Care which results in:
a. A preventable use of a hospital emergency department;
b. A preventable admission to inpatient hospitalization;
c. A delay in a discharge from a residential setting and re-admission to a different institutional or residential setting; or
d. A preventable institutionalization

The PASSE must:

a. provide adequately and timely access to cover the services through one or more out-of-network providers, including through a single case agreement with an out- of- network state providers that are Arkansas Medicaid providers, for as long as the PASSE's Provider Network is unable to provide them; or
b. authorize and arrange for an alternative array of services to prevent or ameliorate the effects of (a), (b), (c), (d); or
c. provide a written report and documentation to DHS of efforts by the PASSE to arrange for the service(s) to be delivered and all of the efforts being made by the PASSE; and
d. provide a written report and documentation to DHS of the reasons the Care Standard was not met due to a network provider refused to deliver care to the member.

6.1.4 If a female Member's designated PCP is not a women's health specialist, the PASSE must provide the 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 a 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 forty (40) miles in an urban county and within ninety (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 forty (40) miles of an urban county location or within ninety (90) miles of a rural county location.
    ii. 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 as defined in Section 226.000 of the PASSE Medicaid Provider Manual to care and services, considering the urgency of need for services.

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.
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 in compliance with the Americans with Disabilities Act, 42 U.S.C. 126 and other applicable federal and state laws.

6.1.8 DHS has the discretion to allow a variance of any of the network adequacy or Timely Access to Care Standards set forth in definitions of the Agreement and the PASSE Manual. The PASSE may request a variance of these standards. The reasons for the network adequacy variance request(s) must be documented and will be handled on a case-by-case basis. DHS may require a corrective action plan as a condition for approving the variance.

6.1.9 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.

6.1.10 The PASSE must enroll an Acute Crisis Unit (ACU) when there are no other Acute Crisis Units in that county, so long as the ACU agrees to the terms of the PASSE agreements under the Any Willing Provider laws, Ark. Code Ann. § 23-99-801 *et seq*.

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 one-hundred twenty (120) days.

6.2.2 All contracted providers must be enrolled in Medicaid.

6.2.3 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 thirty (30) calendar days prior to the effective termination date and help 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 thirty (30) calendar days prior to the effective termination date or 15 days after receipt whichever is later, and help the member select a new Behavioral Health or Developmental Disability Services specialty provider.

6.2.4 Per 42 CFR § 438.602(b) and 42 CFR § 438.608(b), the State will screen and enroll, and periodically revalidate all PASSE Network Providers as Medicaid providers in accordance with the requirements of 42 CFR Part 455 Subparts B and E.

6.2.5 The PASSE, its subcontractors, and all network providers must maintain enrollment as Medicaid providers.

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

a. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
b. Any information the Member needs to decide among all relevant treatment options.
c. The risks, benefits, and consequences of treatment or non-treatment.
d. The 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.

6.2.7 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.

6.2.8 The PASSE must implement written policies and procedures for selection and retention of Network Providers.

6.2.9 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.

6.2.10 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.

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

6.2.12 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 Members.

6.2.13 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. Before a provider can be considered a participating or in-network provider, the provider must be fully credentialed.

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. Inpatient Psychiatric Treatment Center (RTC) for under age 21
xv. Board Certified Behavioral Analysts (BCBAs) and
xvi. Provider groups made up of enrolled providers may be credentialed.

6.2.14 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.

6.2.15 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.

6.2.16 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.

6.2.17 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 All providers must be re-credentialed no less than every three years, unless more frequently due to a change in the clinical scope of services of a provider.

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

a. The Grievance, Appeal, and Fair Hearing procedures and timeframes as specified in 42 CFR Part 438 Subpart F, the Medicaid Fairness Act, the Medicaid Provider Manual, and as described in Section 4.9 of the Agreement.
b. 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.
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.
f. The providers' right to request an administrative hearing after the PASSE has made a determination, which is adverse to the provider.

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

6.3.0 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 When authorizations are required for services, Medical Necessity or NCSS must be based on member's need.

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 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 SUD benefits (*see* Section 7.1.29) and Prior Authorization Transparency (Arkansas Code Annotated § 23-99-1100 et seq.).

6.3.7 For standard authorization decisions and in accordance with 42 CFR § 438.404. the PASSE must provide notice as expeditiously as the Member's condition requires, but within two (2) business days of obtaining all necessary information to make the authorization or adverse determination.

6.3.8 When a provider indicates, or the PASSE determines, that following the standard timeframe could seriously jeopardize the 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 member's health condition requires and no later than one (1) business day after the utilization review entity receives all information needed to complete the review of the requested urgent healthcare service.

6.3.9 A utilization review entity shall:

a. Not require prior authorization for prehospital transportation or for provision of an emergency healthcare service;
b. Allow a member and the member's healthcare provider a minimum of twenty-four (24) hours following an emergency admission or provision of an emergency healthcare service for the member or healthcare provider to notify the utilization review entity of the admission or provision of an emergency healthcare service;

c. Not require notification until the next business day after the admission or provision of the emergency healthcare service, if the admission or emergency healthcare service occurs on a holiday or weekend.

6.3.10 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 Member.

6.3.11 After authorization of the PCSP, the PASSE must have a mechanism in place to allow Members to directly access services listed in the plan and emergency services.

6.3.12 If the PASSE entity fails to comply with the defined timeframes as specified in Prior Authorization Transparency Act (Arkansas Code Annotated § 23-99-1100 et seq.), the requested healthcare services shall be deemed authorized or approved.

6.4 PROVIDER SUPPORT SERVICES

6.4.1 The PASSE must have a process for handling and addressing the resolution of provider complaints, including those concerning claims and payment of claims, in compliance with § 4.9.2 of this Agreement. The PASSE must provide a quarterly report of all provider complaints and resolutions to DHS.

6.5 MEDICAL/CASE RECORDS

6.5.1 The PASSE must ensure that each provider furnishing services to 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. The PASSE must immediately 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.

6.5.3 LONG-TERM SERVICES AND SUPPORTS (LTSS)

a. 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 II for service descriptions.

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 reimburse providers in accordance with Arkansas Code 20-77-2706.

7.1.3 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; apply:

a. Process seventy percent (70%) of all Clean Claims submitted within seven (7) days of receipt;

b. Process ninety-five percent (95%) of all Clean Claims submitted within thirty (30) days of receipt;

c. Process ninety-nine percent (99%) of all Clean Claims submitted within sixty (60) days of receipt.

7.1.4 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.

7.1.5 The Clean Claims must be submitted for payment by the provider, either by mail or electronic submission, within three-hundred sixty-five (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.

7.1.6 Claims not submitted in compliance with section 7.1.4 of this agreement may be denied by the PASSE.

7.1.7 The PASSE must be able to accept electronically transmitted claims from providers in HIPAA compliant formats. HIPAA compliant 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 twenty-four (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.

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

a. Within twenty-four (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 one-hundred twenty (120) calendar days after receipt, whether contested or not.
d. Failure to pay or deny the claim within one-hundred forty (140) calendar days after receipt of the claim creates an uncontestable obligation of the PASSE to pay the claim.

7.1.9 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 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.

7.1.10 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.

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

7.1.12 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 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 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 Claims submission. The claim must be submitted so that the PASSE can pay the claim within six (6) months of notice of the disposition of the Medicare claim.

7.1.13 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.

7.1.14 The PASSE must incorporate all DHS approved NCCI edit 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 Title VI – Transparency and Program Integrity, Subtitle F – Additional Medicaid Program Integrity Provisions, Section 6507 – Mandatory State Use of National Correct Coding Initiative (NCCI).

7.1.15 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 member C directly for any amount not paid by the PASSE for the services provided. When the PASSE has been made aware of balance billing and is unable to rectify, the PASSE will report the occurrence to DHS.

7.1.16 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 Part 433 Subpart D, 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.

h. For PASSE only cases, DHS hereby assigns all lien or other recovery rights under Arkansas statutes and regulations to the PASSE when to the extent of any payments made or benefits provided by the PASSE under this Agreement.

7.1.17 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/

7.1.18 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.

7.1.19 The PASSE must pay the full amount of the claim according to the DHS Fee for Service (FFS) Schedule or the negotiated contracted rate and then seek reimbursement from any third party if the claim is for the following:

a. 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

b. Services covered by third party liability that are derived from an absent parent whose obligation to pay medical support under an order that is enforced by Child Support Enforcement. DHS shall transmit all necessary information needed by the PASSE to enforce the Third-Party Liability.

7.1.20 Section 53102(a)(1) of the Bipartisan Budget Act of 2018 requires the PASSE to use standard Coordination of Benefits cost avoidance when processing prenatal services claims. The PASSE must apply cost avoidance procedures to claims for prenatal services, including labor, delivery, and postpartum care services.

a. If the PASSE has determined that a third party is likely liable for a prenatal claim, it must cost avoid the claim and return the claim back to the provider, noting the third party to be legally responsible for payment. If after the provider bills the liable third party and a balance remains, or the claim is denied payment for a substantive reason, the provider can submit a claim to the PASSE for payment of the balance, up to the maximum Medicaid payment amount established for the service in the State Plan. If a provider bills prenatal services with other services the PASSE would otherwise attempt to pay and chase, such as labor and delivery services, the PASSE will have to cost avoid the entire claim. If the PASSE cannot differentiate costs for prenatal services on a claim bundled with other services allowed to pay and chase, the PASSE must cost avoid the entire claim.

b. The PASSE must make payments without regard to potential third-party liability for pediatric preventive services, unless the PASSE makes a determination related to cost-effectiveness and access to care that warrants cost avoidance for ninety (90) days.

c. The PASSE may make payments without regard to potential third-party liability for up to one hundred (100) days for claims related members covered by a child support enforcement medical support order.

7.1.21 For a period of two (2) 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.

7.1.22 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 may pursue recovery in the following circumstances:

a. Motor Vehicle Cases
b. Other Casualty Cases
c. Tortfeasors
d. Restitution Recoveries
e. Worker's Compensation Cases

7.1.23 Upon identification of a potentially liable third party for any of the above situations, the PASSE must, within ten (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.

7.1.24 In "total plan" cases, the PASSE is responsible for performing all research, investigation, and payment of 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 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.

7.1.25 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.

7.1.26 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 ten (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.

7.1.27 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 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 and OMIG 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.

7.1.28 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 the PASSE negotiated rate.

7.1.29 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 suspended or excluded from participation under Arkansas law or 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 suspended or excluded from participation under title Arkansas law or 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 suspension or exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

c. Furnished by an individual or entity against whom DHS or OMIG has suspended payments a pending investigation of a credible allegation of fraud against the individual or entity, unless DHS or OMIG 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.

7.1.30 The PASSE must ensure compliance with 42 CFR Part 438 Subpart K - Mental Health and Substance Abuse Parity Requirements:

a. The PASSE must not apply any financial requirement or treatment limitation to mental health or SUD 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 SUD benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or SUD 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 SUD benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established medical/surgical benefits in the same classification.

d. The PASSE may not impose non-quantitative treatment limitations (NQTLs) for mental health or SUD 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 SUD 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.

7.1.31 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 Member; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient; and

ii. has a negative consequence for the Member.

7.1.32 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 Strategic Plan ("Strategic Plan") for the services it covers and how the services will be delivered to Members. The Strategic Plan should cover at least a two-year period. The Strategic Plan must include:

a. improving the coordination of care with state agencies and non-medical service providers who also serve them;
b. improving training of care coordinators;
c. improving internal coordination between care coordination and utilization management;
d. expanding access by recruiting and enrolling more providers that specialize in providing in-home services;
e. expanding quality and access through value-based payment models;
f. reducing institutional lengths of stay by treating preventable ambulatory sensitive conditions through community providers;
g. increasing members' access to appropriate services for the following urgent needs populations:

i. Children and youth who have received residential treatment services
ii. Youth involved in the juvenile justice system
iii. Children and youth involved in or have a history with the child welfare system
iv. Adults involved in the forensic system and those coming out of the Arkansas State Hospital (ASH)

8.1.2 The Strategic Plan must consist of all requirements in 42 CFR § 438.330. Performance Improvement Projects (PIP)—These are specific projects designed to increase the quality of services to members. PASSEs must implement one clinical and nonclinical PIP. 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 clinical and nonclinical 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 one or more of the following and align with the PASSE's QAPI:

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 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 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 Member, that are based on the requirements for home and community-based waiver programs.

8.1.3 DHS shall implement a nonclinical PIP to increase access to all HCBS (1915 (i) and CES waiver) PASSEs will be required to participate in meetings and collaborate with DHS in support of the nonclinical PIP.

8.1.4 The PASSE is encouraged to utilize Provider Incentive Plans (PIP) to make incentive payments to providers under the Provider Contract that are based on value.

a. Incentive payments based on volume, or which 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 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.

i. The PASSE must make available to DHS any changes or proposed changes to Provider Incentive Plans that are currently in use for DHS review.

The PASSE must submit any new Provider Incentive Plans to DHS for review and approval. Plans the PASSEs have in place prior to this Agreement will not require approval. DHS will review, approve or deny within 30 calendar days.

iii. Payments under this section shall not supplant payments, including through rates, and must be reported separately to DHS.

iv. Payments under this subsection shall not be used to make payments to Out-of-Network Providers.

v. Payments to providers under this subsection shall be counted as medical expenditures.

vi. The PASSE will be notified of any Freedom of Information Act (FOIA) requests and given the opportunity to identify any confidential business information.

8.1.5 Withhold and/or incentive arrangements may be part of the Provider Contract but must be approved by DHS prior to implementation. However, if the PASSE utilizes withholding and/or incentive 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 specified in the state's quality strategy.

8.2 DHS-PASSE QUALITY REVIEW COMMITTEE AND QUALITY INITIATIVES

DHS and the PASSEs shall create a joint Quality Review Committee which shall meet on a quarterly basis beginning March 1, 2023. The PASSE shall designate a licensed clinician to participate on the Committee to review de-identified individual cases and incident reports to monitor access to residential services, including monitoring providers that impose limitations on accepting members, develop “best practices;” develop recommendations on improving provider quality; and develop recommendations on reducing multiple placements in residential settings. Such activities shall include but not limited to the following areas:

a. Assess trends across PASSEs for providers refusing to serve members

b. Identify potential solutions for quality gaps/disparities
c. Develop recommendations to potential revisions on Timely Access to Care Standards based on data including retrospective reviews of cases identified based on negative outcomes for members described in Section 6.1.4.
d. Develop recommendations to potential revisions to the PASSE agreement based on data and reports related to use of emergency departments, the Medicaid Core Sets, HEDIS measures, readmissions to inpatient hospitalization from a residential stay, average length of stay, and other quality measures.
e. Develop recommendations for DHS and other state agencies for improving quality through licensing and credentialing.

8.2.1 The PASSE shall participate in collaborative quality initiatives with DHS including but not limited to the following service areas:

a. Inpatient and Residential Psychiatric Treatment Services For Under Age 21
b. Recruitment and enrollment for providers of in-home, intensive, home and community-based services
c. Monitoring and evaluation of Psychotropic medications for members 18 years old or younger
d. Monitoring and evaluating that members are receiving active treatment that is effective for the member's behavioral health outcomes

8.2.2 The PASSE will collect data on the availability of services by provider type, as requested by DHS, related to quality initiatives, including providers. This information will be submitted in a format determined by DHS and agreed upon by the PASSE and in set intervals determined by DHS.

8.3 QUALITY METRICS

8.3.1 The PASSE must report on the quality metrics outlined in Exhibit I of the Agreement and include Care Coordination Caseload, Initial Contact with Member, Monthly Contact with Member, Quarterly Contact with Member, PCP Assignment, Follow-Up Care, PCSP.

8.3.2 The PASSE must meet the quality metrics to avoid Recoupment or other sanctions under the Agreement, as outlined in Section 14.1.

8.3.3 Healthcare Effectiveness Data and Information Set (HEDIS®) measures

a. PASSEs must report HEDIS measures to the National Committee for Quality Assurance (NCQA) in accordance with their due dates. The PASSE must submit a finalized HEDIS report to DHS on June 15th. of the subsequent calendar year.
b. DHS may make any HEDIS® measures or performance results public.
c. The PASSE must track and report to DHS all current HEDIS® measures for that contract year. HEDIS® measures are subject to change, therefore the PASSE has

an obligation to stay abreast of the changes. HEDIS® measures should be based on the coinciding contract year HEDIS® measures set forth by the NCQA.

8.3.4 Child and Adult Core Set Measures for Medicaid

a. DHS is required to collect and submit data to CMS on the Child Core Set Measures for Medicaid and the Adult Core Set Measures for Medicaid on an annual basis beginning Federal Fiscal Year 2024 (October 1, 2023). The PASSE will be responsible for submitting ad hoc data reports to complete any encounter data submissions as necessary and as requested by DHS. DHS will delay sanctions related to this submission until January 1, 2024. To support this quality initiative, the PASSE must:
    i. Designate a contact to participate on the DHS Quality Performance Team on a regular basis;
    ii. If the data provided are deidentified, the PASSE agrees to provide DHS with a separate file that provides a cross reference between Member Medicaid IDs and the deidentified Member IDs in the data submitted;
    iii. Collaborate with DHS to establish interim measures for each of the Core Set Measures using CY 2019 and CY 2021 data with run-out through March 31, 2022, by December 31, 2022.
    iv. Collaborate with DHS to set final baseline measures for each of the Core Set measures using CY 2022 data with run-out through March 31, 2023, which will be used to meet the October 1, 2023, reporting requirement to CMS.
    v. Collaborate with DHS to set performance goals for each of the Core Set measures on an annual basis.

8.4 ENCOUNTER DATA AND UTILIZATION MANAGEMENT

8.4.1 The PASSE is required to collect encounter data for all services provided to Members, including In Lieu of Services. The encounter data must include characteristics of the member and the provider as specified by the state and the PASSE must 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.

e. If DHS determines a material change has occurred or will occur, the PASSE must submit documentation demonstrating that the PASSE will maintain its compliance with the required availability and accessibility of services, including but not limited to the adequacy of the Provider Network, access to member records, ability to perform utilization review, and program integrity.

8.4.2 DHS will revise and amend encounter data 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.

8.4.3 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.

8.4.4 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.

8.4.5 The PASSE must designate sufficient information technology (IT) and staffing resources to perform these encounter functions as determined by generally accepted best industry practices.

8.4.6 The PASSE must participate in DHS-sponsored workgroups directed at continuous improvements in encounter data quality and operations.

8.4.7 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 and allowed amounts 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.

8.4.8 The PASSE must implement and maintain review procedures to validate encounter data submitted by providers.

8.4.9 The PASSE must submit complete, accurate, and timely encounter data to DHS, as defined below.

a. For all services rendered to its 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/

8.4.10 Complete: The PASSE must submit encounters for ninety-five percent (95%) of the covered services provided by participating and non-participating providers.

8.4.11 Accurate: No less than ninety-five percent (95%) of the PASSE's encounter lines submission must pass MMIS system edits as specified by DHS.

8.4.12 The PASSE must collect and submit encounter data to DHS' fiscal agent. The PASSE must be held responsible for errors or noncompliance resulting from its 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 may impose sanctions pursuant to Section 14.1.

8.4.13 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.

8.4.14 The PASSE has the option to conduct prepayment, concurrent, and post-payment (retrospective) medical reviews of all claims including outlier claims.

8.4.15 Erroneously paid claims are subject to Recoupment.

8.4.16 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.

8.4.17 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.

8.5 EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO)

8.5.1 The PASSE must undergo annual, external independent reviews of the quality, timeliness, and access to the services as required by 42 CFR § 438.350 covered under the Agreement.

8.5.2 DHS will contract with an independent vendor to perform the External Quality Review.

8.5.3 The PASSE must grant DHS or its agents, including the EQRO, access to any files and facilities needed to perform the external quality review.

a. The PASSE must complete an annual ISCA tool to provide standard information about its Information Systems and must gather all requested documentation identified on the ISCA tools checklist. The PASSE should return the completed ISCA tool and documentation to the EQRO within a timeframe defined by DHS.
b. The PASSE must make any previously conducted assessments accessible to the EQRO and DHS.

8.6 CONSUMER ADVISORY COUNCIL (CAC)

8.6.1 The PASSE must establish and maintain a Consumer Advisory Council (CAC) in accordance with Act 775 of 2017 and the PASSE Provider Manual.

8.6.2 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.

8.6.3 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.

8.7 REPORTING REQUIREMENTS

8.7.1 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.

8.7.2 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.

8.7.3 The PASSE must submit certification concurrently with the submission of data, documentation, or information.

8.7.4 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.

8.7.5 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 plan.

k. HCBS data.

8.7.6 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 OMIG.

8.7.7 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 five (5) 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.

8.8 INCIDENT REPORTS

8.8.1 The PASSE and the provider 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 two (2) hours;
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.

8.8.2 Other than Immediate Reporting, all other Incidents must be reported within twenty-four (24) hours of the PASSE becoming aware of the occurrence. Incident reports must contain the following information:

a. Date of Incident;
b. Time of Incident;
c. Member's Name and Date of Birth;

d. Member's Medicaid ID;
e. Location of Incident;
f. Persons involved;
g. Persons notified: including APS, CPS, guardian/next of kin, law enforcement, and other agencies;
h. Incident Description;
i. Any action taken by the Provider, staff, or PASSE;
j. Any expected follow-up related to the incident; and
k. Name of Person that prepared the report with contact information.
l. Any other information required by DHS upon request.

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 an executive administration that includes the following:

a. Administrator/Chief Executive Officer/Chief Operating Officer (CEO), who is required to be located onsite in the Little Rock, Arkansas metropolitan area. The CEO oversees the entire operation of the PASSE, and has the authority to direct, implement and prioritize work, regardless of where work is performed to ensure compliance with Agreement requirements, and oversees all staff performing functions related to this Agreement.

b. Chief Financial Officer (CFO) The CFO oversees the budget, accounting systems, and financial reporting implemented by the PASSE.

c. Care Coordination Manager, who is required to be located onsite in the Little Rock Arkansas metropolitan area. 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 (CO) must be qualified by knowledge, training, and experience in health care or risk management, to promote, implement, and oversee the compliance program. The CO must exhibit knowledge of relevant regulations, provide expertise in compliance processes, and be qualified to design, implement, and oversee a fraud, waste, and abuse program designed to ensure program integrity through fraud, waste, 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 CO 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 CO must have unrestricted access to the PASSE's governing body for compliance reporting, including fraud, waste, abuse, and overpayment.

ii. The PASSE must have adequate Arkansas-based staff and resources to enable the CO to investigate indicia of fraud and abuse and develop and implement corrective action plans relating to fraud, waste, abuse, and overpayment.

f. Medical Director who is an Arkansas licensed physician. The Medical Director is responsible for all clinical decisions of the PASSE and oversees the proper provision of covered services to 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; and
g. Fraud Investigation Manager.

9.1.5 The PASSE must have sufficient Arkansas licensed medical professional staff, care coordination staff, and an investigator located in Arkansas to conduct daily business in an orderly manner. The PASSE must provide documentation of staffing level to DHS, upon request.

a. Member Support Services staff must be available during state 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 and OMIG that identifies members of key staff and management, as required by this Section of the Agreement. The PASSE must notify DHS and OMIG 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 or subcontractor 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 or subcontractor.
   v. Annually as required in Exhibit V.

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, in accordance with 42 U.S. Code § 300e-17:

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; and
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 I; 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, The Arkansas Attorney General, 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 ten (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 ten (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. All submissions shall be unredacted but may indicate where proprietary information is contained in said submission.

b. All subcontracts or agreements delegating requirements of the Agreement must comply with all applicable state and federal law, including without limitation, 42 CFR § 447.46, 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, to DHS and OMIG;
f. Require the Subcontractor or delegate to 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 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 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 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 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 Members, Potential Members, and DHS and OMIG 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 and OMIG, its designees, 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;

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 8.1.5, 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 by Arkansas law.

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, requirements of the manual, and 42 CFR § 438.230(b)(1) and 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 § 434.6 (b)) 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, the Arkansas Attorney General, or OMIG 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 review by DHS, the Arkansas Attorney General and OMIG.

9.3.5 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 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 and 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.

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 under Arkansas Law.

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) and 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) and 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) and 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 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) and 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; however, 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, DHS, OMIG, MFCU, Cthe 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).

aa. In the event the contract is terminated the PASSE will engage with any needed readiness review activities to transition activities performed under the contractor to another entity.

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 (3) 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 agreements shall include a provision requiring provider Subcontractors to participate in patient satisfaction, access to care, and network adequacy surveys administered by the PASSE or 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) and 42 CFR § 438.214(e)).

9.5.5 The PASSE shall provide all new subcontracts and terminated subcontracts agreements to DHS within thirty (30) days of the effective date, unless otherwise specified in the PA.

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; and

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 incorporate appropriate Arkansas DHS requirements.

9.7.2 The PASSE is not 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 (c) (1) (iii).

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 within 10 days of identification of deficiencies/development of corrective action plans

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 within ten days.

9.7.13 In the event the contract is terminated the PASSE will engage with any needed readiness review activities to transition activities performed under the contractor to another entity.

9.7.14 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 in accordance with Medicaid Fairness Act and by the Arkansas Consent Decree, as applicable.

9.8.1.2 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

9.8.1.3 The PASSE whose 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;

On and after July 1, 2022, payments to Out-of-Network Providers may not exceed twenty percent (20%) of the total payments for services by the PASSE in each calendar year.

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 its network providers in all service areas of the State. A PASSE whose 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.

9.8.2.2The PASSE shall, upon request, make available to DHS, OMIG, or the Arkansas Attorney General 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.

9.8.2.4 Regardless of the payment arrangement, the 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.

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 required within the PASSE Provider Agreement and PASSE Provider Manual.

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 Systems must comply with 42 C.F.R. § 438.818. This means that it must fully comply with all encounter data reporting requirements of the Medicaid Statistical Information System or any successor system. In addition, enrollee

encounter data must comply with the Health Insurance Portability and Accountability Act of 1996 security and privacy standards and be submitted in the format required by the Medicaid Statistical Information System, or the format required by any successor system to the Medicaid Statistical Information System.

9.9.8 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.

9.9.9 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).

9.9.10 The processes through which the data are generated should conform to the same standards, as needed.

9.9.11 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.

9.9.12 The PASSE is 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.

9.9.13 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.

9.9.14 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.

9.9.15 The IT Systems must possess mailing address standardization functionality in accordance with US Postal Service conventions.

9.9.16 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.

9.9.17 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.

9.9.18 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

9.9.19 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 DHSPrivacyInvestigator@dhs.arkansas.gov, to the DMS PASSE unit, at DMS.PASSECompliance@dhs.arkansas.gov,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.

9.9.20 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.

9.9.21 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.

9.9.22 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.

9.9.23 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.

9.9.24 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.

9.9.25 The PASSE must institute a process to ensure the validity and completeness of the data and reports it 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.

9.9.26 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.

9.9.27 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.

d. The PASSE must have a DHS approved Emergency Management Plan that is separate from the Business Continuity-Disaster Recovery Plan. The Emergency Management Plan should specify what actions the PASSE will take to help providers maintain the ongoing provision of required services to Members in the event of an emergency or disaster, whether natural or man-made, that is located in Arkansas or located outside of Arkansas but may affect Arkansas based operations. 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 such as tornadoes or flooding, accidents, technological emergencies, pandemics, and attack related emergencies. Examples of required services include, but are not limited to Care Coordination, PASSE Member Hotline, hospital, physician, pharmacy and HCBS services.

9.9.28 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.

9.9.29 For all IT systems available to 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.

9.9.30 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.

9.9.31 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.

9.9.32 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.

9.9.33 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.

9.9.34 The PASSE must develop, prepare, print, maintain, produce and distribute distinct IT systems processes and procedures manuals, user manuals, and quick-reference guides. DHS Information Technology group reserves the right to review.

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;
    ii. 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.

9.9.35 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.

9.9.36 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 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.

9.10.2 The PASSE must provide continuous education to Care Coordinators that meet all state and federal requirements. This includes, but is not limited to, training on PCSP development, Cultural Competency, Advance Directives, and full-service continuum including all Home and Community Based services and how each is used to meet the needs of members and their families.

9.11 PRACTICE GUIDELINES

9.11.1 Per 42 CFR §§ 438.236 – 438.236(b), The PASSE must adopt practice guidelines that meet the following requirements:

i. Are based on reliable clinical evidence or a consensus of providers in the particular field;
ii. Consider the needs of the PASSE's members;
iii. Are adopted in consultation with network providers; and
iv. Are reviewed and updated periodically as appropriate

9.11.2 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).

9.11.3 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 In accordance with 42 CFR § 438.610, 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. Excluded from participation under Arkansas law or regulation;

c. Convicted of crimes described in section 1128(b)(8)(B) of the Act; and

d. Convicted of crimes described in section 1128(b)(8)(B) of the Act; and

e. 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; or

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, checking 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 excluded providers at the DHS website below, to ensure the PASSE does not include any non-Medicaid eligible providers in its network: https://dhs.arkansas.gov/dhs/portal/Exclusions/PublicSearch/

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 Social Security Act, §§ 1128, 1902, 1903, and 1932; 42 CFR §§ 431, 433, 434, 435, 438, 441, 447, 455 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, to be reported to DHS and OMIG. Any suspected incidents of fraud must be reported within five (5) business days of discovery to DHS and OMIG.

10.2.2 The PASSE Compliance Officer and the Fraud Investigation Unit 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 prior to amendment, annually for re-certification by September 1st of each year.

a. The compliance plan must be fully implemented within sixty (60) days of approval. Failure to implement an approved plan within sixty (60) days may result in liquidated damages in accordance with Section 14.1.

b. If the compliance plan is not fully implemented within sixty (60) days, DHS or OMIG may reassess the implementation of the compliance plan every sixty (60) days until DHS deems the PASSE to be in compliance.

c. The compliance plan is subject to inspection by DHS and OMIG upon request by that agency. The plan 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 include the PASSEs 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 state 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 CO and the PASSE's employees, and how employees can access the Compliance Officer
h. Enforcement of standards through well-publicized statutory requirements, the Agreement requirements, and related disciplinary guidelines;
i. Provision for internal monitoring and auditing;
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, waste, 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 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, waste, and abuse.

10.2.7 At a minimum, the PASSE must ensure that:

a. All officers, directors, managers and employees have signed an acknowledgement that they have read 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 in accordance with the timelines set forth within this Agreement;

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 five (5) 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;

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, waste, 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.

10.2.10 DHS will investigate complaints and information received regarding the accuracy and/ or adequacy and capacity of services of the PASSE, its Subcontractors, and/or Network Providers.

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 (within 30 days) to DHS when it receives information about

changes in an Member's circumstances that may affect the 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 within ten (10) business days 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 Members and the application of such verification processes on a regular basis.

10.3.5 If the PASSEs makes or receives 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 referral of any potential fraud, waste, or abuse the PASSE identifies and reports to DHS and 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 good cause exception as determined by DHS or OMIG. 42 CFR § 455.23 (e).

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 by Arkansas law or 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 by Arkansas law or 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 fraud, waste, 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 or OMIG 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 or OMIG.

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 receive approval from 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 Medicaid 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 will be included as a tab in the quarterly financial data requests submitted to DHS and 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.
p. Fraud prevention activities as defined at 42 CFR § 438.8 (e) (4).

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. 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 in accordance with 42 CFR § 438.3(m). These reports should be submitted to the Arkansas Insurance Department and DHS.

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 through the Quarter 1 financial data template on Tab XIV.1-Federal MLR following the end of an MLR (Reporting Year, in a format and in the manner prescribed by DHS.

11.2 FINANCIAL DATA REQUEST

11.2.1 The PASSE must submit a quarterly Financial Data Request to DHS that summarizes how much the PASSE paid to Direct Service Providers for services provided to Members. The template will be submitted by DHS and submission timelines are outlined in Exhibit V.

11.2.2 Community Investments —For purposes of the State Medical Loss Ratio, the PASSE may count the expenditures for Community Investments, consistent with the standards as defined in 45 CFR § 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 State MLR ratio for the calendar year in which the activities occur. "Community Investments", however, may not be counted as "losses" in the risk corridors under Section 11.3 of the PASSE Agreement. All Community Investments are subject to DHS' approval.

a. The PASSE shall ensure that all persons and entities receiving Community Investment funds meet the requirements in 42 CFR 455 subparts B and E, as required by 42 CFR § 438.608.

b. All subcontractors and subcontractor contracts must meet the requirements contained within this Agreement, specifically those outlined in § 9.2.2, and all applicable state and federal law, including without limitation, 42 CFR §§ 447.45-46, 42 CFR § 438.230, and 42 CFR §§ 455.14-106.

i. The PASSE may not delegate responsibility for obtaining approval of Community Investment Activities, for ensuring the activities occur in accordance with the contract, or for the accurate reporting of Community Investment Expenditures.

ii. While the PASSE may delegate the performance of the approved community activities, the PASSE must monitor the Activities and certify in writing that the community investment activities have occurred in accordance with the original contract requirements before the PASSE claims the Community Investment Expenditure as a benefit expenditure for purposes of the State MLR ratio.

iii. All subcontracts and proposed delegation of responsibility must be submitted to DHS for prior written approval, including a disclosure of the ownership and control of the subcontractor or delegate, and existing business relationships with the PASSE, member/owners of the PASSE, officers of the PASSE and board members of the PASSE.

iv. Any further subcontracting and sub-delegation also require prior written approval of DHS and shall be subject to all requirements of subcontracts or delegation by the PASSE.

v. The subcontract and staff must not be on the Medicaid Exclusion list, and all employees must have background checks.

c. Community Investment expenditures are payments for approved Community Investment activities that occur within the Contract Year and in a manner consistent with prior approval of DHS.

d. All Community Investment recipients **must** agree to the requirements in 42 CFR § 438.8, 42 CFR § 438.230 and all subcontractor requirements provided for under this Agreement and 42 CFR Part 438.

e. Community Investments, like other direct services, must be delivered and documented according to program rules and the DHS' approved plan. The PASSE must ensure that Community Investment expenditures reflect approved activities and costs that occurred during the approved period in accordance with the contract and state and federal law.

f. The transfer, disbursement, or distribution of Community Investment funds to a subcontractor, financial intermediary, or other third party is not a Community Investment activity and may not be reported as a Community Investment expenditure.

g. All Community Investment recipients must agree that the State of Arkansas, DHS, MFCU, OMIG, HHS, the Comptroller General, or their designees may, at any time, inspect and audit any records or documents of the PASSE, its subcontractors (including any subcontractors of the PASSE's subcontractors), or delegates, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

i. Any activity that will be considered a Community Investment must be submitted in writing and approved by DHS prior to being included as a benefit expenditure for purposes of the State MLR ratio. Any community investment expenditure that is made prior to DHS approval must be excluded from a benefit expenditure in the State MLR ratio.

ii. For a PASSE or subcontractor's Community Investment expenditure to be included as a benefit expenditure for the State MLR ratio purposes, the expenditure must be consistent with the submitted proposal and the approval granted and occur prior to the close of the reporting year for reconciliation of the PASSE Agreement.

iii. Any change in the approved plan or budget must be approved in advance by DHS.

iv. Community Investments may not be retained or spent on contracts for goods or services to be provided after the final day of the reporting year to calculate the State MLR ratio, by either the PASSE or its subcontractors.

v. The Community Investment program cannot be used to circumvent the reconciliation process or rate development process by setting aside funds to be used at a later date or paying for services to be provided in a future contract year.

h. DHS shall only approve a Community Investment activity for one contract year at a time. Any Community Investment activity that may last longer than one Contract Year must be re-submitted and reapproved by DHS for each Contract

year in which the Community Investment activity will occur and for which the Community Investment expenditure will be reported as a benefit expenditure.

i. For the purpose of Community Investments**,** activities that improve health care quality must be in one of the following general categories:

(1) Any PASSE activity that meets the requirements of 45 CFR § 158.150(b) and is not excluded under 45 CFR § 158.150(c).

(2) Any PASSE activity related to any EQR-related activity as described in 42 CFR § 438.358(b) and (c).

(3) Any PASSE expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 CFR § 158.151, and is not considered incurred claims, as defined in paragraph (e)(2) of this section.

j. Activities conducted by a PASSE or its subcontractors to improve quality must meet the following requirements:

(1) The activity **must** be designed to:

(i) Improve health quality.

(ii) Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

(iii) Be directed toward individual members or 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.

(iv) 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.

(2) The activity **must** be primarily designed to:

(i) Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.

(A) Examples include the direct interaction of the PASSE (including those services delegated by contract for which the PASSE retains ultimate responsibility under the PASSE Agreement), providers and the member or the member's representative (for example, face-to-face, telephonic, web-based interactions or

other means of communication) to improve health outcomes, including activities such as:

(1) Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives including through the use of the medical homes model as defined in section 3502 of the Affordable Care Act.

(2) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence-based medicine.

(3) Quality reporting and documentation of care in non-electronic format.

(4) Health information technology to support these activities.

(5) Accreditation fees directly related to quality-of-care activities.

(ii) Prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include:

(A) Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;

(B) Patient-centered education and counseling.

(C) Personalized post-discharge reinforcement and counseling by an appropriate health care professional.

(D) Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.

(E) Health information technology to support these activities.

(iii) Improve patient safety, reduce medical errors, and lower infection and mortality rates.

(A) Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:

(1) The appropriate identification and use of best clinical practices to avoid harm.

(2) Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns.

(3) Activities to lower the risk of facility-acquired infections.

(4) Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions.

(5) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors.

(6) Health information technology to support these activities.

(iv) Implement, promote, and increase wellness and health activities:

(A) Examples of activities primarily designed to implement, promote, and increase wellness and health activities, include—

(1) Wellness assessments;

(2) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;

(3) Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;

(4) Public health education campaigns that are performed in conjunction with State or local health departments;

(5) Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs), that are not already reflected in premiums or claims should be allowed as a quality improvement activity for the group market to the extent permitted by section 2705 of the PHS Act;

(i) For MLR reporting years before 2021, actual rewards, incentives, bonuses, and reductions in copayments (excluding administration of such programs) that are not already reflected in premiums or claims should be allowed as a quality improvement activity for the group market to the extent permitted by section 2705 of the PHS Act;

(ii) Beginning with the 2021 MLR reporting year, actual rewards, incentives, bonuses, reductions in

copayments (excluding administration of such programs) that are not already reflected in premiums or claims, to the extent permitted by section 2705 of the PHS Act;

(6) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;

(7) Coaching or education programs and health promotion activities designed to change member behavior and conditions (for example, smoking or obesity); and

(8) Health information technology to support these activities.

(v) Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology consistent with 45 CFR § 158.151.

(A) Health Information Technology - A PASSE may include as activities that improve health care quality such Health Information Technology (HIT) expenses as are required to accomplish the activities allowed in 45 CFR § 158.150 and that are designed for use by the PASSE, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with Medicare and/or Medicaid meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

(1) Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their "meaningful use" as defined by HHS to the extent such payments are not included in reimbursement for clinical services as defined in 45 CFR § 158.140;

(2) Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicare and Medicaid incentive payments;

(3) Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;

(4) Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law;

(5) Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;

(6) Advancing the ability of members, providers, the PASSE or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic Health Records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history and to support care management;

(7) Reformatting, transmitting, or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease; and

(8) Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

(l) Excluded Expenditures and Activities - Expenditures and activities that **must** not be included in quality improving activities are:

i) Those that are designed primarily to control or contain costs;
ii) The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans;
iii) Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from premium revenue;
iv) Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;
v) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are

designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), *42 U.S.C. 1320d-2*, as amended.

vi) That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;

vii) All retrospective and concurrent utilization review;

viii) Fraud prevention activities;

ix) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a subcontractor for the same reason;

x) Provider credentialing;

xi) Marketing expenses;

xii) Costs associated with calculating and administering individual member or employee incentives;

xiii) That portion of prospective utilization that does not meet the definition of activities that improve health quality; and

xiv) Any function or activity not expressly included in paragraph (a) or (b) of 45 CFR § 158.150

11.2.3 The Financial Data Request must be submitted quarterly to DHS in the format and in the manner prescribed by DHS.

11.3 RISK CORRIDORS

11.3.1 The PASSE program for calendar year 2022 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 and calculated within the Financial Data Request document as defined in § 11.2 of the PASSE Agreement.

11.3.2 The pricing assumptions for CY2022 are contained within the CY2022 Rate Certification (attached to this agreement). PASSE specific MLR ratios will be calculated based upon their rate cell mix. CY2022 PASSE rates will be reconciled upon CMS approval.

11.3.3 The risk corridor settlement will occur after the PASSE CY 2022 agreement period has ended and enough time has passed to collect and validate CY 2022 PASSE encounter data and financial data. An initial settlement using CY 2022 contract year data with three months of claim runout may be completed and a final settlement using data with fifteen months of claim runout will be completed as described below in § 11.4 of the PASSE Agreement.

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 State

MLR 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 State MLR calculation, consistent with the development of the PASSE specific risk corridor target state MLR. All capitation revenue will be included in the denominator of the State MLR calculation for the risk corridor program.

11.3.5 The PASSE and its subcontractors must agree that the State of Arkansas, DHS, MFCU, OMIG, HHS, the Comptroller General, or their designees may, at any time, inspect and audit any records or documents of the PASSE, its subcontractors, or delegates, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

Based on any such inspection, audit, or review, DHS reserves the right to adjust the risk corridor calculation as necessary to reflect market level reimbursement of providers.

11.3.6 2021 Risk Corridor Settlement

c. The CY 2021 risk corridor settlement shall include all claims and revenue incurred between January 1, 2021, and December 31, 2021 with allowable claims runout for CY 2021 submitted by providers to the PASSE through March 31, 2023.
d. The CY 2021 risk corridor with fifteen months of claims runout information will be provided by the PASSE to DHS no later than April 20, 2023 which DHS will use to calculate the final 2021 Risk Corridor settlement.
e. The CY 2021 risk corridor settlement will be paid in the manner mutually agreed upon by parties no later than June 30, 2023.
f. This section shall survive the termination or replacement of this Agreement.

11.3.7 2022 Risk Corridor Settlement

a. CY 21 risk corridor was 92.5% based on administrative allowance of 4.0%, margin of 1.0%: AR state premium tax of 2.5%.
b. CY 22 risk corridor is **90.3%** based on administrative allowance of **6.2%** on average, margin of 1.0%, AR state premium tax of 2.5%.
c. CY 22 Actuarial Certification: the risk corridor settlement will occur after the PASSE CY 2022 contract period.
d. The initial CY 2022 risk corridor reconciliation will include all claims and revenue incurred between January 1, 2022 and December 31, 2022 with allowable claims runout for CY 2022 submitted to the PASSE through March 31, 2023.

e. The initial CY 2022 risk corridor financial template with three months of claims runout information will be provided by the PASSE to DHS no later than April 20, 2023, which DHS will use to calculate the CY 2022 initial risk corridor settlement.

f. The initial CY 2022 risk corridor settlement may be paid in a manner mutually agreed upon by parties no later than October 31, 2023.

g. The final CY 2022 risk corridor settlement shall include all claims and revenue incurred between January 1, 2022, and December 31, 2022, with allowable claims runout for CY 2021 submitted by providers to the PASSE through March 31, 2023.

h. The final CY 2022 risk corridor with fifteen months of claims runout information will be provided by the PASSE to DHS no later than April 20, 2024, which DHS will use to calculate the final 2022 Risk Corridor settlement.

i. The final CY 2022 risk corridor settlement will be paid in the manner mutually agreed upon by parties no later than June 30, 2024.

j. This section shall survive the termination or replacement of this Agreement.

11.4 DEVELOPMENT OF CY 2023 RATES AND CY 2023 RISK CORRIDOR

11.4.1 DHS shall solicit information from the PASSEs to be used by the actuarial firm to develop the capitation rates no later than May 31, 2022.

11.4.2 DHS shall provide draft CY 2023 rates to the PASSE no later than September 1, 2022. This draft will be provided in advance of a plenary session to discuss the rate development in September of 2022.

11.4.3 The draft CY 2023 rates may describe the proposed methodology for discounting the experience in CY 2020 due to the COVID-19 pandemic. Such methodology may describe the use of adjusted data to discount the effects of the COVID-19 pandemic on enrollment, utilization, and excess costs on CY 2023 rates.

11.4.4 The PASSE shall provide DHS with written comments and supporting data to make recommendations to adjust the proposed rates no later than September 15, 2022. Each PASSE may request individual meetings with DHS to discuss specific topics.

11.4.5 DHS shall provide the proposed final CY 2023 rates and CY 2023 risk corridor to the PASSE no later than October 15, 2022.

11.4.6 The PASSE shall provide DHS with comments and supporting data to make recommendations to the proposed final rates no later than November 15, 2022.

11.5 DEVELOPMENT OF CY 2024 RATES AND CY 2024 RISK CORRIDOR

11.5.1 DHS shall solicit information from the PASSEs to be used by the actuarial firm to develop the capitation rates no later than May 31, 2023.

11.5.2 DHS shall provide draft CY 2024 rates to the PASSE no later than September 1, 2023. This draft will be provided in advance of a plenary session to discuss the rate development in September of 2023.

11.5.3 The draft CY 2024 rates may describe the proposed methodology for discounting the experience in CY 2020 due to the COVID-19 pandemic. Such methodology may describe the use of adjusted data to discount the effects of the COVID-19 pandemic on enrollment, utilization, and excess costs on CY 2024 rates.

11.5.4 The PASSE shall provide DHS with written comments and supporting data to make recommendations to adjust the proposed rates no later than October 1, 2023. Each PASSE may request individual meetings with DHS to discuss specific topics.

11.5.5 DHS shall provide the proposed final CY 2024 rates and CY 2024 risk corridor to the PASSE no later than October 15, 2023.

11.5.6 The PASSE shall provide DHS with comments and supporting data to make recommendations to the proposed final rates no later than November 15, 2023.

12. PAYMENT UNDER THE AGREEMENT

12.1 CAPITATION PAYMENTS

12.1.1 DHS will make capitation payments to the PASSE for all Medicaid-eligible Members.

12.1.2 Capitation payments will be determined as described in Exhibit IV. Capitation rates must be actuarially sound as required by 42 CFR § 438.4.

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. The capitation payment will be reconciled for the portion of time from the 16th day until the end month in which the member was admitted. PASSE capitation payments will be suspended in subsequent months until the member is discharged from the IMD. If a PASSE member is court ordered into the Arkansas State Hospital (ASH) and ASH determines that the member does not meet medical necessity criteria for the service, the PASSE shall report the members admission and capitation payments will be reconciled to the date of admission. In order for the PASSE to receive full or partial capitation payments, the following criteria must be met:

a. The facility is a hospital providing psychiatric or SUD inpatient care or a sub-acute facility providing psychiatric or SUD crisis residential services.
b. The PASSE has reviewed documentation submitted by the IMD that the member has an inpatient level of care need and can respond to those services and potentially be stabilized in less than fifteen (15) days during the period of the monthly capitation payment.
c. The member is discharged from the facility prior to the 16th day in the month of admission or the 16th day of the following month if member received less than 15 days of treatment in the first month.

The PASSE must maintain contact with IMD for member and provide care coordination support upon notification of discharge to assist with transition, development of updated PCSP and timely authorization of post discharge services.

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 and/or sanctions for failure to report on or meet the quality metrics.

12.1.5 DHS will implement an internal process to run encounter data on PASSE members and the PASSEs shall provide detailed information on members not receiving HCBS services and/or personal care once per quarter. Reports will be run two quarters in arrears. Consideration will be made for members who are in an institutional setting.

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 From July 1, 2022, to December 31, 2023, the State 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.

12.3 RECONCILIATION OF CY 2022 RATES

The CY 2022 rates are effective January 1, 2022. 2022 rate reconciliation will take place prior to any risk corridor action but no sooner than August 2023.

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 Members are not to be held liable for the PASSE's debts, in the event the PASSE becomes insolvent.

13.2.2 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 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 Per 42 CFR § 438.116 (a)(1), the PASSE must provide satisfactory assurances to DHS that its provision against the risk of insolvency is adequate to ensure that Members will not be liable for the PASSE's debt if the PASSE becomes insolvent.

14. SANCTIONS AND DAMAGES

14.1 SANCTIONS

14.1.1 42 CFR Part 438 Subpart I provides the authority and basis for imposing sanctions and civil money penalties on the PASSE. Arkansas Code 20-77-903 provides the authority for imposing damages on the PASSE. The state may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status or any other source. DHS will provide the PASSE with 30 days' notice prior to issuing any sanctions and provide the PASSE with the opportunity to respond in writing with additional information to be considered by DHS. In addition to the financial sanctions described below, DHS may also impose the following sanctions:

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; and
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.

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:

14.1.2 If the PASSE fails to timely submit an acceptable FAPP or fails to timely submit the reports referenced in Section 8.7, and specified in the PASSE Report Guide, a sanction of up to $1,000 per day, from the date the report is due to DHS and OMIG, may be imposed under the Agreement until DHS and OMIG deem the PASSE to be in compliance with the reporting requirements in Sections 8.7.1 through 8.7.5, or until OMIG deems the PASSE to be in compliance with the reporting requirements in Sections 8.7.6 and 8.7.

14.1.3 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.

14.1.4 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 five (5) 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 OMIG deems the PASSE to be in compliance.

14.1.5 If DHS determines that the failure to provide a service resulted in a negative impact on a member as described in Section 6.1.3, DHS may impose an additional sanction of up to $2,000 per day for each day a service was not provided if there is insufficient documentation or evidence of the PASSE's efforts to secure needed services.

14.1.6 If the PASSE imposes premiums or charges on 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).

14.1.7 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.

14.1.8 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.

14.1.9 If the PASSE misrepresents or falsifies information that it furnishes to a Member, Potential Member, or health care provider, DHS may impose a fine of up to $25,000 for each instance of misrepresentation.

14.1.10 If the PASSE fails to comply with the Medicare physician incentive plan requirements as set forth in 42 CFR § 422.208 and 42 CFR § 422.210, DHS may impose a fine of up to $25,000 for each failure to comply.

14.1.11 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.

14.1.12 If DHS determines that the PASSE's actions have resulted in the delay or failure of the State to report enrollee encounter data to the Medicaid Statistical Information System in a timely manner, as determined by CMS and in compliance with 42 C.F.R. § 433.120 and 42 U.S.C. § 1396b(i)(25), DHS may impose a fine equal to the greater for each instance or for the amount of lost FMAP suffered by DHS as a result of the PASSE's failure.

14.1.13 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; and

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.

14.1.14 DHS may impose additional sanctions provided for under state statutes, rules or regulations to address noncompliance, including but not limited to requiring a Corrective Action Plan (CAP), withholding or reducing payment until noncompliance is corrected, maintaining a negative Vendor Performance Report, and utilizing any of the remedies available in the Medicaid PASSE Provider Manual.

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 in accordance with 42 CFR § 438.730 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 Members' health; or

c. The sanction is necessary to ensure the health of the PASSE's 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 **must** 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 When 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 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 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 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 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. Notwithstanding the above, if state or federal law, rules or regulations, are amended and are then in conflict with this agreement, this agreement is automatically amended to become compliant without the need for a written amendment.

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 twenty (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. The PASSE must immediately make available to DHS all records and documentation of the PASSE and its Subcontractors for inspection by DHS or its designee. The PASSE shall not take any actions to impede DHS' transition of the PASSE's members.

15.5.3 A termination of Agreement by the PASSE will require prior notification to DHS, OMIG, 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 Member 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 transfer to DHS and any other PASSE as directed by DHS records and data on through secure electronic data files all necessary for a seamless transition including outstanding Encounter Claims information.

15.5.6 Thirty (30) days following turnover of operations the PASSE must provide DHS with a transition results report.

15.5.7 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.

15.8 ENTIRE AGREEMENT

15.8.1 Except as modified by this Amendment, the Provider Agreement will remain in full force and effect. This Amendment, together with the Provider Agreement as modified by this Amendment: (a) is intended by the parties as a final, complete and exclusive expression of the terms of their agreement, and (b) supersedes all prior agreements and understandings between the parties with respect to the subject matter hereof. Provisions memorialized in this Amendment may not be modified except as provided in the Provider Agreement.

15.9 COUNTERPARTS AND FACSIMILE DELIVERY

15.9.1 This Amendment may be executed in two or more counterparts, each of which will be deemed an original and all of which taken together will be deemed to constitute one and the same document. The parties may sign and deliver this Amendment by electronic scan or facsimile transmission.

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	The PASSE _____
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

EXHIBIT I
Performance Standards

These performance standards and penalties are in addition to those listed elsewhere in this agreement.

DHS reserves the right to impose additional penalties, including, without limitation, withholding payment until the PASSE is in full compliance, maintaining a below standard Vendor Performance Report (VPR) in the PASSE file and terminating the contract for failure to meet any performance standard listed in Exhibit I.

Component	Performance Standard	Damages
Out-of-Network Provider Payment	No greater than 20% percent of the total dollars paid to the PASSE shall be paid 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 Member or Provider returned within 1 Business Day of receipt; ii. For calls received during non-Business hours, return calls to Beneficiaries and Providers made on the next Business Day.	$500 per telephone call that the PASSE fails to return in accordance with standards (i or ii) during each one-month reporting period.
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	Process, which means deny or approve and	$250.00 for each

Submission of Claims	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. ii. The PASSE must process ninety-five percent (95%) of all Clean Claims submitted within thirty (30) days. iii. The PASSE must process ninety-nine percent (99% of all Clean Claims submitted within sixty (60) days.)	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.
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,	$750 per each day after the 30th day that a

	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.	suitable replacement has not been submitted. The suitability of the Replacement is at the sole discretion of the State.
Person Centered Service Plans	≥90% of Members will have a PCSP or Interim Service Plan.	$1,000 for each percentage point below the standard during the reporting period.
Person Centered Service Plans	≥80% of the 90% of required PCSPs or Interim Plan of Care of Members will have a PCSP that includes all needed HCBS services.	$1,000 for each percentage point below the standard during the reporting period.
Care Coordinator to Member 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 with Member	≥75% of members will be contacted by a care coordinator or appropriate PASSE team member within 15 business days after Assignment to PASSE	$1,000 for each percentage point below the standard during the reporting period.
Monthly Contact with Member	≥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 or appropriate PASSE team	$1,000 for each percentage point below the standard during the reporting period.

	member within seven (7) business days.	
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 Appeal resolution sent to the member no later than thirty (30) calendar days from the date of receipt of the Appeal.	$1,000 per day past the deadline.

EXHIBIT II
Required Services

All services must be medically necessary or found necessary for Nonmedical Community Supports and Services (NCSS). The Arkansas Division of Medical Services defines Medical Necessity as "All Medicaid benefits are based upon Medical Necessity or NCSS. 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 member 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."

A service is NCSS necessary if the supports and services are nonmedical in nature and are available under the federal authority of sections 1905, 1915(c), or 1915(i) or under state authority under Act 775 to provide such supports and services through an AR Medicaid enrolled provider as approved by a PASSE for an individual. NCSS are provided with the intention to prevent or delay entry into an institutional setting or to assist or prepare an individual to leave an institutional setting, meaning the service should assist the individual to live safely and successfully in his/her own home or in the community. The need for these supports and services is established by the functional deficits identified on the Independent Assessment (IA). The IA is an objective assessment that identifies that the need for services exists. However, the types and levels of supports and services needed to achieve his/her goals are beyond the scope of the IA and instead are developed by the PCSP process and ultimately described in the PCSP. The actual supports and services for each member are described in the member's PCSP which must be reviewed by the care coordinator and the member not less than monthly. To ensure the integrity of the PCSP, prior authorization and utilization review procedures should use criteria which would allow appropriately enrolled providers to perform nonmedical services and supports. The PASSE must ensure there are appropriate firewalls between the PASSE and providers and between internal staff and processes used to ensure services and supports are approved or denied in a conflict-free manner. The "independent review" requirement of 1915(i) also means there should be internal firewalls within the PASSE to separate the development of the PCSP from staff with fiscal duties or utilization review.

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 III
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) <u>Unequal access to information</u> – 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 Department of Human Services 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 Department of Human Services 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 IV
RATES

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 2022 PASSE Capitation Rates”.

EXHIBIT V
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 business day.

PASSEs will be given a minimum of thirty (30) days to implement any new templates or reports. DHS will meet with the PASSEs to determine implementation timeframes.

Once DCFS identifying information is available, the PASSE must stratify data for the foster care population in the following reports it submits to DHS:

a. Utilization Reports
b. Avoidable Encounters inclusive of Avoidable Institutional Length of Stay, Avoidable Emergency Department Encounter, Preventable Hospitalization
c. Grievances and Appeals logs
d. HEDIS
e. Complaints and Grievances logs
f. Quality Metrics Follow-Up Care

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 V
REPORTS

Monthly PASSE Reports

Report	**Applicable Agreement/Manual Section**	**Expected Deliverables**
Institution for Mental Diseases (IMD) for stays greater than 15 days	PA- 5.9.1	Report to DHS via SFTP
Monthly Report on HCBS and BH Residential Providers Not Accepting Beneficiaries	PA – 8.2.2	Report to DHS via SFTP
Monthly report on the use of psychotropic medication among youth in foster care	PA-5.11.1 g	Report to DHS via SFTP (starting July 1, 2023)
The use of Antipsychotic Medication among youth in foster care.	PA-5.11.1 g	Report to DHS via SFTP (starting July 1, 2023)
PASSE Online Provider Directory	PA- 4.2.4 a./4.2.4 e. PM-231.400	Report to DHS via SFTP Attestation may be filed in lieu of the directory if there were no changes for the month.
Risk Corridor	PA – 11.3	Report to DHS via SFTP by the 20th of each month
Third Party Liability Activities	PA- 7.1.16	Report to DHS via SFTP
Undeliverable Mail Report	PA- 4.1.4 c.	Report to DHS via SFTP
Utilization Report		Report to DHS via SFTP

EXHIBIT V
REPORTS

Quarterly PASSE Reports

Report	**Applicable Agreement/Manual Section**	**Expected Deliverables**
Appeals Log	PA- 4.9.1.2/4.9.1.5/4.9.3.4 b, c & d	Report to DHS via SFTP Report to OMIG
Avoidable Encounters	PA- Definitions for Institutional Length of Stay, Avoidable Emergency Department, and Preventable Hospitalization	Report to DHS via SFTP
Call Center	PA- Exhibit I/4.5.3 e./4.5.6	Report to DHS via SFTP
Claims Expenditure Report		Report to DHS via SFTP
Claims Operation Performance Report	PA- 7.1.	Report to DHS via SFTP
Community Investment	PA-11.2.2	Report to DHS via SFTP
Consumer Advisory Committee	PA- 8.6	Meeting Minutes/Reports Report to DHS via SFTP
Drug Utilization Data	PA- 5.5.6 c.	Report to DHS via SFTP
Electronic Status File of Providers	PA- 6.2.17	Report to DHS via SFTP
Flexible Services	PA – 5.10	Report to DHS via SFTP as a part of the Claims Expenditure Report

Fraud, Waste, Abuse and Overpayment Report	PA- 8.7.6/10.2.2	Report to DHS via SFTP Report to OMIG
Financial Data Request	PA- 11.2.1/11.2.3	Report to DHS via SFTP Q4 of Previous Calendar Year = March 31st Q1 of Current Calendar Year = May 31st Q2 of Current Calendar Year =August 31st Q3 of Current Calendar Year=November 30th
Out-of-Network Provider Payment	PA- 7.1.3	Report to DHS via SFTP
PASSEs Complaint & Grievance Log	PA- 4.9	Report to DHS via SFTP Report to OMIG
Person Centered Service Plans	PA- 5.3	Report to DHS via SFTP
Provider-preventable conditions	PA- 7.1.31	Report to DHS via SFTP
Provider Incentive Plans (PIP)	PA – 8.1.5	Report to DHS via SFTP
Quality Metrics (Care Coordination)	PA-Exhibit I Performance Standards	Report to DHS via SFTP
Satisfaction Scores from Member Surveys	PA-Exhibit I Performance Standards/8.7.5.c/4.8.3	Report to DHS via SFTP
Unique PASSE Identifiers (IDs) of Beneficiaries	PA-4.2.2	Report to DHS via SFTP

Website and Portal Availability	PA- 4.3	Report to DHS via SFTP

EXHIBIT V
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. d	Report to DHS via SFTP	Within 30 days of the meeting
Medical Management Committee	PA- Definitions/8.7.5. i/9.1.3 e.	Report to DHS via SFTP	Within 30 days of the meeting
Network Adequacy	PA- 6.1 .	Report to DHS via SFTP	January 31 and July 31

EXHIBIT V
REPORTS

Annual PASSE Reports

Report	Applicable Agreement/Manual Section	Expected Deliverables	Due Date to DHS
Accreditation Review/ Medicare Review/ External Quality Review (EQR) results	PA- 9.1.2	Report to DHS via SFTP	April 30th
Administrative Services Subcontractor's	PA- 9.7.10	Report to DHS via SFTP	February 28th
Adult and Child Core Set Measures	P.A. 8.3.4	Report to DHS via SFTP	January 31, 2024
Audited Financial Reports	PA- 8.7.5 e./ 11.1.9	Report to DHS via SFTP Report to Arkansas Insurance Department	June 1st
BC-DR Comprehensive Tests	PA- 9.9.27 c.	Report to DHS via SFTP	April 30th
Business Continuity-Disaster Recovery (BC-DR) Certification	PA- 9.9.27 a. i. 9.9.26 b.	Report to DHS via SFTP	April 30th
Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results	PA – 4.8.3.a/11.2.2.J.4	Report to DHS via SFTP	September 1st
Compliance Plan & Anti-Fraud Plan	PA- 10.2.3/10.2.4	Report to DHS via SFTP Report to OMIG	September 1st

Cultural Competency Plan	PA- 4.8.1/4.8.4	Report to DHS via SFTP	April 1st
Cultural Competency Plan Evaluation (for previous year)	PA- 4.8.3	Report to DHS via SFTP	April 1st
CY 2021 Risk Corridor (Final) & CY 2022 Risk Corridor (Initial)	PA- 11.3.9	Report to DHS via SFTP	April 15, 2023
CY 2022 Risk Corridor (Final)	11.3.10 h.	Report to DHS via SFTP	April 15, 2024
Disclosure of Ownership or Control Interest	PA- 9.1.10/9.1.11 b.	Report to DHS via SFTP	December 31 and as required in 9.1.11 b.
Drug Utilization Review Program Activities/ DUR Annual Report	PA- 5.5.6 c.	Report to DHS via SFTP	April 30th
Emergency Management Plan- Recertify	PA- 9.9.27 d.	Report to DHS via SFTP	February 28th
Healthcare Effectiveness Data & Information Set (HEDIS)	PA- 8.3. 3	Report to DHS via SFTP	June 15th
Information Reports- Improvement for PASSE Performance	PA- 8.6	Report to DHS via SFTP	June 15th
Interventions targeted to prevent controlled substance abuse	PA- 5.5.16	Report to DHS via SFTP	February 28th
Interventions to prevent overuse of the antipsychotics in the foster care population	PA - 5.11.1 g	Report to DHS via SFTP	February 28th
Medical Loss Ratio (MLR)	PA- 11.1 PM- 214.000/ 229.000	Report to DHS via SFTP Report to AID	May 31st

			(Located in the Q1 Financial Data Request)
Network Adequacy	PA 6.1	Report to DHS via SFTP	January 30th
Overpayment Recoveries	PA- 7.1.27 c. & e.	Report to DHS via SFTP Report to OMIG	February 28th
Quality Assessment & Performance Implementation Strategic Plan	PA- 8.1.1	Report to DHS via SFTP	February 28th
Satisfaction Scores from Provider Surveys	PA- 8.7.5 d.	Report to DHS via SFTP	Due with any quarterly report submission during the report year

EXHIBIT V
REPORTS

PASSE Reports Upon Occurrence

Report	**Applicable Agreement/Manual Section**	**Expected Deliverables**	**Due Date to DHS**
Cumulative Recoupment for provider TIN > $50,000	PA 7.1.30 c.	Report to DHS via SFTP	Upon occurrence
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 of Suspected Fraud, Waste, or Abuse	PA – 8.7.6/14.1.3	Report to DHS via SFTP Report to OMIG	Within 5 business days of discovery
Incident of Balanced Billing	PA- 7.1.14	Report to DHS via SFTP	Upon occurrence
Incident Reporting	PA- 8.7	Report to DHS via SFTP	Upon occurrence, timelines are referenced in Section 8.7 of the Provider Agreement
Key Personnel Vacancy Report	PA- 9.1.7/Exhibit I PM- 241. 000.a	Notification to DHS PASSE Office	Upon occurrence

Pharmacy Itemization- 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	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 /7.1.25 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-7.1.21/7.1.22	Report to DHS via SFTP	Upon identification within 10 business days
Unauthorized access, use, or disclosure of DHS info	PA- 9.9.19 g.	Email to DHS Chief Information Security Officer at DHSSecurity@dhs.arkansas.gov	Upon occurrence, within 2 business days of discovery