ARKANSAS REGISTER

Transmittal Sheet

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Secretary of State
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For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

Contact Robert Nix E-mail robert.nix@dhs.arkansas.gov Phone 501-320-6177

Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-76-201

Rule Title: The Provider-led Arkansas Shared Savings Entity Program - Phase 1

Intended Effective Date (Check One)		Date
☐ Emergency (ACA 25-15-204)	Legal Notice Published	07/13/2017
☑ 10 Days After Filing (ACA 25-15-204)	Final Date for Public Comment	08/11/2017
☐ Other _____ (Must be more than 10 days after filing date.)	Reviewed by Legislative Council	
	Adopted by State Agency	10/01/2017

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Becky Murphy (Contact Person) becky.murphy@dhs.arkansas.gov (E-mail Address) (Date)

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Signature

(501) 371-2165 (Phone Number) rose.naff@dhs.arkansas.gov (E-mail Address)

Director (Title)

9-19-17 (Date)

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

Facesheet: 1. Request Information (1 of 2)

A. The **State** of **Arkansas** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

B. Name of Waiver Program(s): Please list each program name the waiver authorizes.

Short title (nickname)	Long title	Type of Program
CareCoordination	Arkansas Provider Led Care Coordination Program	PCCM;

Waiver Application Title (*optional - this title will be used to locate this waiver in the finder*):
Arkansas Provider Led Care Coordination Model

C. Type of Request. This is an:

☑ **Initial request for a new waiver.**

☐ **Migration Waiver** - this is an existing approved waiver

Provide the information about the original waiverbeing migrated

Base Waiver Number:

Amendment Number (if applicable):

Effective Date: (mm/dd/yy)

Requested Approval Period: *(For waivers requesting three, four, or five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **1 year** ○ **2 years** ○ **3 years** ○ **4 years** ◉ **5 years**

Draft ID:AR.055.00.00
Waiver Number:AR.0007.R00.00

D. Effective Dates: This waiver is requested for a period of 5 years. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

Proposed Effective Date: (mm/dd/yy)
10/01/17

Proposed End Date:09/30/22
Calculated as "Proposed Effective Date" (above) plus "Requested Approval Period" (above) minus one day.
Approved Effective Date: 10/01/17

Facesheet: 2. State Contact(s) (2 of 2)

E. State Contact: The state contact person for this waiver is below:

Name: Dawn Stehle **Phone:** (501) 682-6311 **Ext:** ☐ **TTY**

Fax: **E-mail:** Dawn.Stehle@dhs.arkans

If the State contact information is different for any of the authorized programs, please check the program name below and provide the contact information.
The State contact information is different for the following programs:

☐ **Arkansas Provider Led Care Coordination Program**

Note: If no programs appear in this list, please define the programs authorized by this waiver on the first page of the

Section A: Program Description

Part I: Program Overview

Tribal consultation.
For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.
There are no federally recognized tribes in the State of Arkansas.

Program History required for renewal waivers only.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):
   - **a.** ☑ **1915(b)(1)** - The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
     -- *Specify Program Instance(s) applicable to this authority*
     ☑ **CareCoordination**
   - **b.** ☐ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
     -- *Specify Program Instance(s) applicable to this authority*
     ☐ **CareCoordination**
   - **c.** ☐ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
     -- *Specify Program Instance(s) applicable to this authority*
     ☐ **CareCoordination**
   - **d.** ☑ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).
     -- *Specify Program Instance(s) applicable to this authority*
     ☑ **CareCoordination**

     The 1915(b)(4) waiver applies to the following programs
     ☐ **MCO**
     ☐ **PIHP**
     ☐ **PAHP**
     ☑ **PCCM** (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
     ☐ **FFS** Selective Contracting program

     Please describe:

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

   a. ☐ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
   -- *Specify Program Instance(s) applicable to this statute*
   ☐ **CareCoordination**

   b. ☑ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.
   -- *Specify Program Instance(s) applicable to this statute*
   ☑ **CareCoordination**

   c. ☑ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
   -- *Specify Program Instance(s) applicable to this statute*
   ☑ **CareCoordination**

   d. ☐ **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).
   -- *Specify Program Instance(s) applicable to this statute*
   ☐ **CareCoordination**

   e. ☐ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.
   -- *Specify Program Instance(s) applicable to this statute*
   ☐ **CareCoordination**

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
Act 775 of the 2015 Arkansas Regular Session was signed into law by Arkansas Governor, Asa Hutchinson, on March 31, 2017. This Act, known as the "Medicaid Provider Led Organized Care Act," is an innovative approach to managing the delivery of services for Medicaid beneficiaries with high medical needs. Under this unique model of organized care, Arkansas provider-led and owned organizations, known as Risk-based Provider Organizations (RBPOs) or Provider-led Arkansas Shared Savings Entities (PASSEs), are responsible for integrating the physical health care services, behavioral health services, and specialized developmental disability services for the approximately 30,000 individuals who have intensive levels of treatment or care needs due to mental illness, substance abuse, or intellectual and developmental

disabilities. These vulnerable Arkansans will benefit from the provision and continuity of all medically necessary services in a well-organized system of coordinated care.

Under this Act, the PASSEs do not assume full risk for the provision of care until January 1, 2019. Therefore, there are two phases of this model. The first phase is known as the "Arkansas Provider Led Care Coordination Program." In this phase, which will begin on October 1, 2017, the PASSEs will provide care coordination to each beneficiary attributed to its PASSE, but services will still be provided on a fee for service basis. This phase will last until the PASSEs assume full risk on January 1, 2019.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

1. **Delivery Systems.** The State will be using the following systems to deliver services:

   a. ☐ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

   b. ☐ **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

   ○ **The PIHP is paid on a risk basis**
   ○ **The PIHP is paid on a non-risk basis**

   c. ☐ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

   ○ **The PAHP is paid on a risk basis**
   ○ **The PAHP is paid on a non-risk basis**

   d. ☐ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

   e. ☐ **Fee-for-service (FFS) selective contracting:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.

   ○ **the same as stipulated in the state plan**
   ○ **different than stipulated in the state plan**
   Please describe:

   f. ☑ **Other:** (Please provide a brief narrative description of the model.)

   The delivery system is a PCCM Entity. Throughout this Waiver Application, PCCM refers to PCCM Entity.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

2. **Procurement.** The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

- [ ] **Procurement for MCO**
  - ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
  - ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
  - ○ **Sole source** procurement
  - ○ **Other** (please describe)
- [ ] **Procurement for PIHP**
  - ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
  - ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
  - ○ **Sole source** procurement
  - ○ **Other** (please describe)
- [ ] **Procurement for PAHP**
  - ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
  - ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
  - ○ **Sole source** procurement
  - ○ **Other** (please describe)
- [x] **Procurement for PCCM**
  - ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
  - ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
  - ○ **Sole source** procurement
  - ◉ **Other** (please describe)

    The RBPO will be licensed by the Arkansas Insurance Department (AID). To become licensed, the RBPO/PASSE must operate on a statewide basis.

    After receiving AID licensure, the RBPO will be required to sign the PASSE Provider Agreement, which will incorporate the PASSE Medicaid Provider Manual and the Federal Medicaid Managed Care regulations. If a PASSE wishes to receive the care coordination payment from DMS, it must agree to follow the terms of the PASSE Provider Agreement and Manual.

    Once the PASSE Provider Agreement has been signed and DHS has ensured that the PASSE meets the readiness review requirements, the PASSE will enroll as a Medicaid Provider in order to begin receiving care coordination payments.
- [ ] **Procurement for FFS**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (1 of 3)

1. **Assurances.**
   - ☑ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.
   - ☐ The State seeks a waiver of section 1932(a)(3) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.
2. **Details.** The State will provide enrollees with the following choices (please replicate for each program in waiver):

   Program: " **Arkansas Provider Led Care Coordination Program.** *"*

   - ☐ **Two or more MCOs**
   - ☐ **Two or more primary care providers within one PCCM system.**
   - ☐ **A PCCM or one or more MCOs**
   - ☐ **Two or more PIHPs.**
   - ☐ **Two or more PAHPs.**
   - ☑ **Other:**

     please describe

     There will be a choice of at least two PASSEs (PCCM Entities) for all beneficiaries, statewide.

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (2 of 3)

3. **Rural Exception.**
   - ☐ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52 (b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the

following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62 (f)(1)(ii)):

4. **1915(b)(4) Selective Contracting.**
   - ○ **Beneficiaries will be limited to a single provider in their service area**
     Please define service area.
   - ◉ **Beneficiaries will be given a choice of providers in their service area**

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (1 of 2)

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.
   - **Statewide** -- all counties, zip codes, or regions of the State
     -- *Specify Program Instance(s) for Statewide*
     - ☑ **CareCoordination**
   - **Less than Statewide**
     -- *Specify Program Instance(s) for Less than Statewide*
     - ☐ **CareCoordination**
2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Statewide	PCCM Entity	Empower Healthcare Solutions, LLC
Statewide	PCCM Entity	Arkansas Total Care
Statewide	PCCM Entity	Arkansas Advanced Care, Inc.
Statewide	PCCM Entity	Forevercare, Inc.
Statewide	PCCM Entity	Arkansas Provider Coalition

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:
All PASSEs must ensure care coordination will be provided on a statewide basis to all attributed beneficiaries no matter their location.

Currently, five PASSE entities have submitted letters of intent to become licensed as RBPOs and enroll as Medicaid PASSE providers. Because the PASSE's are licensed through AID and then enrolled as Medicaid Providers, this number may change as we move toward Phase II. However, Arkansas will ensure that at least two of these PASSE entities remain enrolled so that attributed beneficiaries will have a choice between at least two PASSEs.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. **Included Populations.** The following populations are included in the Waiver Program:

☐ **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.
- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.
- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.
- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.
- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.
- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.
- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.
- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☑ **Other** (Please define):

Enrollment in a RBPO is mandatory for all Tier 2 and Tier 3 Behavioral Health and Developmental Disabilities clients.

For individuals served by the Division of Behavioral Health, 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 office, and/or school.

Tier II: Rehabilitative Level Services
At this level of need, services are provided in a counseling services setting but the level of need requires a broader array of services to address functional deficits.

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

For Division of Developmental Disabilities Clients, 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 DDTCS, CHMS, personal care, occupational therapy, speech therapy, or physical therapy due to their developmental or intellectual disability or delay.

Tier II: Institutional Level of Care
The individual meets the institutional level of care criteria but does not need 24 hours a day of paid support and services to maintain his or her current placement.

Tier III: Institutional Level of Care 24/7
The individual meets the institutional level of care and requires 24 hours a day of paid support and services to maintain his or her current placement.

DHS will refer presumptively eligible individuals to undergo an Independent Assessment (IA). The IA will determine the Tier level for these beneficiaries and will also develop a needs and risks report that will be used to develop the Person Centered Service Plan (PCSP) for developmental disabilities beneficiaries or Master Treatment Plan (MTP) for behavioral health beneficiaries. Although the PASSE is not currently developing the MTP or the PCSP, the PASSE's care coordinator can use the report to ensure that proper services are delivered to each attributed beneficiary and all identified needs are being met.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

☐ **Medicare Dual Eligible** --Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

- [ ] **Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.
- [ ] **Other Insurance** --Medicaid beneficiaries who have other health insurance.
- [ ] **Reside in Nursing Facility or ICF/IID** --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IID).
- [ ] **Enrolled in Another Managed Care Program** --Medicaid beneficiaries who are enrolled in another Medicaid managed care program
- [ ] **Eligibility Less Than 3 Months** --Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.
- [ ] **Participate in HCBS Waiver** --Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).
- [ ] **American Indian/Alaskan Native** --Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.
- [ ] **Special Needs Children (State Defined)** --Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.
- [ ] **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.
- [x] **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.
- [x] **Other** (Please define):
  Under Provider Led Care Coordination Program, only those individuals who are determined to be Tier 2 and Tier 3 DHS and BH clients and who are not residing in a Human Development Center, skilled nursing home, or assisted living facility can be attributed to a PASSE.

  Clients may not receive the following services through the PASSE:
  (1) Nonemergency Medical Transportation
  (2) Dental benefits
  (3) School-based services provided by school employees
  (4) Skilled nursing facility services
  (5) Assisted living facility services
  (6) Human Development Center services
  (7) ARChoices or Arkansas Independent Choices Waiver Services

  Beneficiaries who exclusively receive these services may not be enrolled in a PASSE.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. **Assurances.**

☑ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

☑ The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

☐ The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

Emergency Services Category General Comments (optional):

The beneficiary can receive emergency services without prior authorization and without contacting the PASSE care coordinator. A PASSE care coordinator must be available to the beneficiary if the beneficiary wishes to contact them regarding emergency services. Also, as described in quality metrics, the assigned PASSE care coordinator must follow up with the beneficiary within seven (7) business days of utilization of emergency services.

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

☐ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services.

☐ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.

☑ The State will pay for all family planning services, whether provided by network or out-of-network providers.

☐ Other (please explain):

☐ Family planning services are not included under the waiver.

Family Planning Services Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

4. **FQHC Services.** In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

☐ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

☐ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

☑ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

FQHC Services Category General Comments (optional):

5. **EPSDT Requirements.**

☑ The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

EPSDT Requirements Category General Comments (optional):

All children will still receive their EPSDT screens and be assigned a PCP either under the Patient Centered Medical Home (PCMH) program or by their care coordinator. The assigned PCP will be responsible for ensuring EPSDT services are received. The care coordinator will receive all results of screens to ensure no additional services are needed.

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. **1915(b)(3) Services.**

☐ This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

1915(b)(3) Services Requirements Category General Comments:

7. **Self-referrals.**

☑ The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Self-referrals Requirements Category General Comments:

Under the care coordination model, beneficiaries may self-refer for any service under the fee for service system that does not require a PCP referral. However, the PASSE care coordinator will be responsible for gathering health records from the services received by the beneficiary, providing necessary follow up information, and ensuring all needed services are identified for that beneficiary. The care coordinator may also assist the beneficiary in receiving needed services by making referrals to providers in its referral network.

8. **Other.**

☐ Other (Please describe)

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:
The PASSE must provide care coordination to each of its attributed beneficiaries. Care coordination under the PASSE model means ensuring that specialty services are coordinated and appropriately delivered by specialty providers (behavioral health and developmental disabilities services, as appropriate). The PASSE must hire care coordinators who will work with the beneficiary's assigned PCP/PCMH to ensure continuity of care across all services. Act 775 of the 2017 Arkansas Regular Session defined care coordination as including the following activities:

1) Health education and coaching;
2) Coordination with other healthcare providers for diagnostics, ambulatory care, and hospital services;
3) Assistance with social determinants of health, 3 such as access to healthy food and exercise;
4) Promotion of activities focused on the health of a patient and the community, including without limitation outreach, quality improvement, and patient panel management;
5) Coordination of Community-based management of medication therapy

As such, the care coordinator employed by the PASSE is responsible for the total plan of care for each beneficiary assigned to him or her. The total plan of care includes, but is not limited to, the following:

1) Behavioral Health Treatment Plan;
2) Person Centered Service Plan for Waiver Clients;
3) Primary Care Physician Care Plan;
4) Individualized Education Program;
5) Individual Treatment Plans for developmental clients in day habilitation programs;
6) Nutrition Plan;
7) Housing Plan; or
8) Any existing Work Plan

The care coordinator is responsible for obtaining copies of all treatment and service plans related to an individual beneficiary and coordinating services between those plans. The goal is to prevent duplication of services, ensure timely access to all needed services, and identify any service gaps for the beneficiary. The ultimate goal of the care coordinator is to assist the beneficiary in remaining in the most appropriate and least restrictive setting for that beneficiary.

The care coordinator will assume the responsibility of providing case management under the concurrent 1915(c) Home and Community Based Services Community and Employment Supports Waiver for attributed beneficiaries who are Waiver participant, including:

1) Coordinating and arranging all CES waiver services and other state plan services;
2) Identifying and accessing needed medical, social, educational and other publicly funded services (regardless of funding source);
3) Identifying and accessing informal community supports needed by eligible participants and their families.
4) Monitoring and reviewing services provided to the beneficiary to ensure all plan services are being provided and to ensure the health and safety of the participant;
5) Facilitating crisis intervention;
6) Providing guidance and support to meet generic needs;
7) Conducting appropriate needs assessments and referral for resources;
8) Monitoring services provided to ensure quality of care and case reviews which focus on the participants progress in meeting goals and objectives established on existing case plans;
9) Providing assistance relative to obtaining waiver Medicaid eligibility and ICF/IID level of care eligibility determinations;
10) Ensuring submission of timely (advanced) and comprehensive behavior and assessment reports, continued plans of care, revisions as needs change and information and documents required for ICF/IID level of care and waiver Medicaid eligibility determinations;
11) Arranging for access to advocacy services as requested by participant.
12) Providing assistance upon receipt of DDS or DHS notices or denials, including assistance with the reconsideration and appeal process.

Care coordination services must be available to attributed beneficiaries 24 hours a day through a hotline or web-based application.

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

1. **Assurances for MCO, PIHP, or PAHP programs**

   ☐ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

   ☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

   Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

   ☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

2. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.
   - **a.** ☑ **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.
     - **1.** ☑ PCPs

       Please describe:

       Each PASSE must have at least one PCP in its referral network within 60 minutes of normal transportation time or within 60 miles, which ever is shorter, for all beneficiaries attributed to that PASSE.
     - **2.** ☑ Specialists

       Please describe:

       Developmental Disability Providers. Each PASSE must have at least 1 of each type of developmental disability provider in its referral network within 60 minutes of normal

transportation time or within 60 miles, which ever is shorter, for all beneficiaries attributed to that PASSE.

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☑ Hospitals

Please describe:

Each PASSE must have at least one (1) hospital in its referral network within 60 minutes of normal transportation time or within 60 miles, which ever is shorter, for all beneficiaries attributed to that PASSE.

6. ☑ Mental Health

Please describe:

Each PASSE must have at least one (1) of each type of mental health provider in its referral network within 60 minutes of normal transportation time or within 60 miles, which ever is shorter, for all beneficiaries attributed to that PASSE.

7. ☑ Pharmacies

Please describe:

Each PASSE must have at least one (1) pharmacy in its referral network within 60 minutes of normal transportation time or within 60 miles, which ever is shorter, for all beneficiaries attributed to that PASSE.

8. ☑ Substance Abuse Treatment Providers

Please describe:

Each PASSE must have at least one (1) substance abuse treatment provider in its referral network within 120 minutes normal transportation time or 120 miles, whichever is shorter for all attributed beneficiaries.

9. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. **Details for PCCM program.** (Continued)

b. ☐ **Appointment Scheduling**means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Urgent care

Please describe:

8. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. **Details for PCCM program.** (Continued)

c. ☐ **In-Office Waiting Times**: The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. **Details for PCCM program.** (Continued)

   d. ☐ **Other Access Standards**

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

3. **Details for 1915(b)(4)FFS selective contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program.

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. **Assurances for MCO, PIHP, or PAHP programs**

   ☐ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

   ☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

   Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

   ☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

2. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.
   - **a.** ☑ The State has set **enrollment limits** for each PCCM primary care provider.

     Please describe the enrollment limits and how each is determined:

     Each Care Coordinator employed by a PASSE cannot have a caseload of more than 50 attributed beneficiaries.
   - **b.** ☐ The State ensures that there are adequate number of PCCM PCPs with **open panels**.

     Please describe the State's standard:
   - **c.** ☐ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver.

     Please describe the State's standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. **Details for PCCM program.** (Continued)
   - **d.** ☐ The State compares **numbers of providers** before and during the Waiver.

Provider Type	# Before Waiver	# in Current Waiver	# Expected in Renewal

     Please note any limitations to the data in the chart above:
   - **e.** ☑ The State ensures adequate **geographic distribution** of PCCMs.

     Please describe the State's standard:

     The State is requiring that each PASSE be able to provide care coordination services on a statewide basis. Each PASSE must have an adequate referral network to make referrals for needed services to all attributed beneficiaries across the State, and each PASSE must hire an adequate pool of care coordinators.

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. **Details for PCCM program.** (Continued)
   - **f.** ☐ **PCP:Enrollee Ratio**. The State establishes standards for PCP to enrollee ratios.

Area/(City/County/Region)	PCCM-to-Enrollee Ratio	

Please note any changes that will occur due to the use of physician extenders.:

g. ☐ **Other capacity standards**.

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

3. **Details for 1915(b)(4)FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (1 of 5)

1. **Assurances for MCO, PIHP, or PAHP programs**

☐ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to

the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (2 of 5)

2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

a. ☐ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208.

Please provide justification for this determination:

b. ☐ **Identification**. The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State.

Please describe:

c. ☐ **Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe:

Please describe the enrollment limits and how each is determined:

d. ☐ **Treatment Plans**. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan.If so, the treatment plan meets the following requirements:

1. ☐ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee.
2. ☐ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
3. ☐ In accord with any applicable State quality assurance and utilization review standards.

Please describe:

e. ☐ **Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

Please describe:

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (3 of 5)

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.
   - **a.** ☑ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
   - **b.** ☐ Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.
   - **c.** ☑ Each enrollee is receives **health education/promotion** information.

     Please explain:

     Enrollees are attributed to a PASSE based on their historical claims data. This would include claims by a primary care provider made on behalf of that beneficiary. Therefore, each beneficiary may choose their PCP. Once enrolled in a PASSE, the care coordinator assigned to that beneficiary will ensure that the beneficiary has either (1) chosen a PCP; or (2) been assigned a PCP. The care coordinator will also provide health education and promotion material to the beneficiary based on identified health needs and will assist the beneficiary in accessing other needed services.
   - **d.** ☑ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
   - **e.** ☑ There is appropriate and confidential **exchange of information** among providers.
   - **f.** ☑ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
   - **g.** ☑ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
   - **h.** ☑ **Additional case management** is provided.

     Please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files.

     In the PASSE model, the Primary Care Case Manager is the PASSE Care Coordinator. This Care Coordinator will be responsible for gathering and keeping all medical records related to his or her assigned beneficiaries and ensuring proper follow-up. If any self-care training is needed, the Care Coordinator will be responsible for ensuring the beneficiary receives that self-care. For any emergency room, acute inpatient psychiatric, or urgent care clinic visits, the Care Coordinator must follow up with the beneficiary within seven (7) business days of discharge, and ensure that any follow up care is provided for.
   - **i.** ☑ **Referrals.**

     Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

     The PASSE will be responsible for creating a referral network. While the beneficiary can ultimately see any provider he or she chooses under the Care Coordination Model, the PASSE must ensure that there are adequate referral agreements in place that the Care Coordinator can make appropriate referrals to providers when the beneficiary does not already have an existing provider-patient relationship. Part of the PASSE's agreement will include how information will be transmitted between the Care Coordinators and the providers in the referral network. That information must be disclosed to and approved by DHS before the PASSE will be able to enter into a Provider Agreement.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (4 of 5)

4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.
Because this Waiver is only for care coordination, all enrolled beneficiaries will be able to continue with the provider of their choice without any disruption to those services. The PASSE will provide more comprehensive care coordination to ensure that all needed services are provided in a timely manner and each enrolled beneficiary has a primary care provider. We expect for care coordination and continuity of care to be positively impacted by this Waiver due to the model of care coordination that is being implemented.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part III: Quality

1. **Assurances for MCO or PIHP programs**

- ☐ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.
- ☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP programs.

  Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- ☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- ☐ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.
  The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on: *(mm/dd/yy)*
- ☐ The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004.
  Please provide the information below (modify chart as necessary):

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO				
PIHP				

Section A: Program Description

Part III: Quality

2. **Assurances For PAHP program**

☐ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

a. ☑ The State has developed a set of overall quality **improvement guidelines** for its PCCM program.

Please describe:

Each PASSE must report on the following Quality Metrics and meet the listed standards to continue to receive the Care Coordination PMPM:

1)Caseload assigned to each Care Coordinator must be 50 or less.
2)Care Coordinators must make monthly face-to-face contacts with beneficiaries (can be done by videoconferencing after the initial visit).
3)Care Coordinators must follow up with beneficiaries who have visited the emergency room or urgent care clinic, or been discharged from an inpatient psychiatric unit within seven business days.
4)Care Coordinators must ensure each beneficiary assigned to them has selected or been assigned to a PCP.

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)
   - b. ☑ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below.
     1. ☑ Provide education and informal mailings to beneficiaries and PCCMs
     2. ☑ Initiate telephone and/or mail inquiries and follow-up
     3. ☑ Request PCCM's response to identified problems
     4. ☑ Refer to program staff for further investigation
     5. ☑ Send warning letters to PCCMs
     6. ☑ Refer to State's medical staff for investigation
     7. ☑ Institute corrective action plans and follow-up
     8. ☑ Change an enrollee's PCCM
     9. ☑ Institute a restriction on the types of enrollees
     10. ☑ Further limit the number of assignments
     11. ☑ Ban new assignments
     12. ☑ Transfer some or all assignments to different PCCMs
     13. ☑ Suspend or terminate PCCM agreement
     14. ☑ Suspend or terminate as Medicaid providers
     15. ☐ Other

         Please explain:

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)
   - c. ☑ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.
     Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):
     1. ☑ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
     2. ☐ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
     3. ☑ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
        - **A.** ☑ Initial credentialing
        - **B.** ☑ Performance measures, including those obtained through the following (check all that apply):
          - ☐ The utilization management system.
          - ☐ The complaint and appeals system.

- ☐ Enrollee surveys.
- ☑ Other.

Please describe:

Performance measures will be submitted by the PASSE as part of its quarterly report and encounter data. This information will be compared against the DHS Claims data system, MMIS, and this is how performance measures will be reviewed. The performance measures and quality metrics must be met in order for the PASSE to continue to operate under the PASSE provider enrollment agreement and to receive PMPM payments.

4. ☐ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
5. ☑ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
6. ☐ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
7. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)

d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

4. **Details for 1915(b)(4) only programs:** Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:
The PASSE providers must be licensed by the Arkansas Insurance Department, demonstrate referral network adequacy, have the ability to provide care coordination services to attributed beneficiaries before beginning operations, sign the PASSE provider agreement, and successfully complete a Readiness Review. The readiness review will include a review of all beneficiary information, including the handbook and referral network directory; the composition of the organization and its bylaws; the PASSE's marketing materials; the PASSE's care coordination services, including the 24 hour hotline and training of its care coordinators; and the PASSE's ability to manage electronic health records.

After successful enrollment as a PASSE provider, the PASSE will be monitored on the quality metrics set forth in the PASSE Provider Manual on a quarterly basis. The five quality metrics are as follows:
1) Assigned caseload per care coordinator must be 50 or less (target=100%);
2) Care coordinators must make monthly face-to-face contacts, which may be done by videoconferencing after the initial in person contact (target=100%);

3) Care coordinators must initiate contact within 15 days of attribution (target=75%);
4) Care coordinators must follow up with beneficiaries who have visited an ED, an urgent care clinic, or an inpatient psychiatric unit within 7 business days of discharge (target=50%); and
5) Care coordinators are responsible for assisting the beneficiary with selecting a PCP (target=100%).

DHS may take action to correct failures or impose penalties on a PASSE that fails to meet 2 of the 5 quality metrics.

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. Assurances

- [x] The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.
- [ ] The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

  Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- [x] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- [ ] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. Details

a. Scope of Marketing

1. [ ] The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.

2. [x] The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general).

Please list types of indirect marketing permitted:

The State permits the PASSE organizations to market to potential enrollees. Specifically, the PASSE may create and run a website for information regarding its PASSE, provider network, and care coordination services. This website may be linked to the DHS PASSE webpage and is designed to provide information for beneficiaries when making the decision to change PASSEs.

The PASSE may also produce handouts that can be given to beneficiaries by DHS choice counselors when those beneficiaries are making a decision about a new PASSE.

No other direct or indirect marketing may be conducted by PASSEs to enrollees or potential

enrollees. The PASSE may freely market to providers regarding joining the PASSE's provider network.

3. ☐ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries).

Please list types of direct marketing permitted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. **Details** (Continued)

b. Description. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. ☑ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees.

Please explain any limitation or prohibition and how the State monitors this:

This is prohibited and will be monitoring by the Medicaid PASSE Oversight Team.

2. ☐ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan.

Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. ☑ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials.

Please list languages materials will be translated into. (If the State does not translate or require the translation of marketing materials, please explain):

Spanish

The State has chosen these languages because (check any that apply):

a. ☐ The languages comprise all prevalent languages in the service area.

Please describe the methodology for determining prevalent languages:

b.

☐ The languages comprise all languages in the service area spoken by approximately [ ] percent or more of the population.

c. ☑ Other

Please explain:

According to the U.S. Census Bureau, America Fact Finder, approximately 5.2% of Arkansas households speak Spanish. This is the only foreign language that is spoken in more than 5% of households across the state.

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

Additional Information. Please enter any additional information not included in previous pages:
The PASSE must have the ability to translate marketing materials for beneficiaries who do not speak English or Spanish, either through the use of a voice translator or through some other translation service. The PASSE may choose to provide their marketing materials in other languages to fulfill this requirement.

The PASSE may freely market to providers regarding joining the PASSE's provider network. All marketing materials, whether directed to enrollees or providers, must be approved by DHS.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (1 of 5)

1. Assurances

- [x] The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.
- [ ] The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

  Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- [x] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- [ ] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (2 of 5)

2. Details

a. Non-English Languages

1. [x] Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Please list languages materials will be translated into. (If the State does not require written materials to be translated, please explain):

Spanish

If the State does not translate or require the translation of marketing materials, please explain:

The State defines prevalent non-English languages as: (check any that apply):

a. ☐ The languages spoken by significant number of potential enrollees and enrollees.

Please explain how the State defines "significant.":

b. ☐ The languages spoken by approximately ____ percent or more of the potential enrollee/enrollee population.

c. ☐ Other

Please explain:

2. ☑ Please describe how oral translation services are available to all potential enrollees and enrollees, regardless of language spoken.

Each PASSE must provide access to information in the beneficiary's spoken language, either through oral translation services or by providing the materials in that language.

3. ☑ The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program.

Please describe:

The State's PASSE beneficiary support unit within the State Medicaid Agency that will assist enrollees in making the choice of which PASSE to join and answer any questions regarding PASSE enrollment, the appeals and grievance process, and what rights they have as PASSE beneficiaries.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (3 of 5)

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

☑ State
☐ Contractor

Please specify:

☐ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP.)

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (4 of 5)

2. **Details** (Continued)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

- [x] the State
- [ ] State contractor

Please specify:

- [ ] The MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:
The State will leverage existing employees to provide initial information and choice counseling to attributed beneficiaries. These employees will receive notice of who has been attributed from the DSS System and will then contact that beneficiary or their family to provide any information and choice counseling necessary.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. **Assurances**

- [x] The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.
- [ ] The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- [x] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- [ ] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. Details

Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. Outreach

☐ The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program.

Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. Details (Continued)

b. Administration of Enrollment Process

☑ State staff conducts the enrollment process.

☐ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

☐ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name:

Please list the functions that the contractor will perform:

☐ choice counseling

☐ enrollment

☐ other

Please describe:

☐ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries.

Please describe the process:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

c. Enrollment . The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

☑ This is a **new** program.

Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

Beneficiaries will be attributed to a PASSE based on the date of their Independent Assessment (IA). The IA will determine the beneficiaries Tier Level and skeleton Plan of Care. It is anticipated that approximately 20% of the total population will be attributed per quarter over five quarters. The estimated size of the mandatory population is 30,000 beneficiaries. DHS will have all identified eligible beneficiaries enrolled and attributed to a PASSE by December 31, 2018.

☐ This is an **existing program** that will be expanded during the renewal period.

Please describe: Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

☐ If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

i.

☐ Potential enrollees will have ○ **day(s)** / ○ **month(s)** to choose a plan.

ii. ☐ There is an auto-assignment process or algorithm.

In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs:

☑ The State automatically enrolls beneficiaries.

- ☐ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3).
- ☐ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1).
- ☐ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause.

Please specify geographic areas where this occurs:

☐ The State provides **guaranteed eligibility** of ____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

☐ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM.

Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

☑ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

d. Disenrollment

☑ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

- **i.** ☑ Enrollee submits request to State.
- **ii.** ☑ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
- **iii.** ☐ Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

☐ The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

☑ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of twelve months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

For all of the reasons listed in 42 C.F.R. 438.56(d)(2).

☐ The State does not have a **lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

☐ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees.

- **i.** ☐ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.

  Please describe the reasons for which enrollees can request reassignment

- **ii.** ☐ The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.
- **iii.** ☐ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.
- **iv.** ☐ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:
Each beneficiary who undergoes an IA and is determined to be a Tier 2 or Tier 3 BH or DD client will automatically be attributed to a PASSE by DHS. That attribution will be based upon the individual's existing relationships with providers using the previous twelve months of claims data. for beneficiaries who do not have enough claims data, attribution will be done randomly.

After this initial attribution, the individual will have 90 days to disenroll from their assigned PASSE and reenroll in another PASSE. DHS will provide Choice Counseling to each assigned Beneficiary and direct them to approved informational websites or provide them with written material to help them choose between PASSE's. If the beneficiary elects to change PASSE's, the change will take effect on the first day of the following month (for example, the beneficiary is automatically attributed to PASSE A on December 1; on January 15, the beneficiary elects to join PASSE C instead; the beneficiary will be disenrolled from PASSE A and reenrolled in PASSE C, effective on February 1). The beneficiary will be locked-in to that PASSE until the anniversary of their attribution, at which time they will be given thirty (30) days to elect a new PASSE.

A beneficiary may switch PASSE's at any time for cause. For cause is defined as the reasons listed in 42 CFR 438.56(d)(2).

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. **Assurances**

- [x] The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.
- [ ] The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

  Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- [x] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- [ ] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.
- [ ] The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

1. **Assurances for All Programs** States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

    a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
    b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
    c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

    ☑ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

2. **Assurances For MCO or PIHP programs**. MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

    ☐ The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

    Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

    ☐ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

3. **Details for MCO or PIHP programs**

    a. Direct Access to Fair Hearing

    ☐ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.
    ☐ The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

    b. Timeframes

    ☐ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is _____ days (between 20 and 90).

☐ The State's timeframe within which an enrollee must file a **grievance** is ____ days.

c. Special Needs

☐ The State has special processes in place for persons with special needs.

Please describe:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

4. **Optional grievance systems for PCCM and PAHP programs**. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

☑ The State has a grievance procedure for its ☑ PCCM and/or ☐ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):
The grievance procedures are operated by:

- ☐ the State
- ☐ the State's contractor.

  Please identify: ____
- ☑ the PCCM
- ☐ the PAHP

☑ Requests for review can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals):

Please describe:

The PASSE must establish a grievance procedure in its Enrollee Handbook. This procedure must have a mechanism for the Enrollee to request a review of a grievance in writing or orally; and set forth the timeframes for resolving a beneficiary's grievance.

☐ Has a committee or staff who review and resolve requests for review.

Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function:

☑ Specifies a time frame from the date of action for the enrollee to file a request for review.

Please specify the time frame for each type of request for review:

The beneficiary must request a review of his or her grievance within 45 days of the date of action.

☑ Has time frames for resolving requests for review.

Specify the time period set for each type of request for review:

Each PASSE must resolve the request for review of a grievance within 30 days of receiving the grievance or provide a written justification for exceeding that time frame.

☐ Establishes and maintains an expedited review process.

Please explain the reasons for the process and specify the time frame set by the State for this process:

☐ Permits enrollees to appear before State PCCM/PAHP personnel responsible for resolving the request for review.

☑ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

☐ Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:
The enrollee can request review of the PASSE's resolution of his or her grievance by the State. The State must complete review of the grievance within thirty (30) days of receipt of the request for review, or must provide a written justification of why it cannot complete the review within thirty (30) days. The State must provide notice to the enrollee and the PASSE of its final determination.
If the state determines the PASSE acted against the law or regulations governing it or against its own policies, the State may request a Corrective Action Plan be provided by the PASSE, reassign the beneficiary, or recoup the care coordination PMPM for that beneficiary. If the State takes adverse action against the PASSE (an action with a monetary consequence), the PASSE may appeal the decision through the Medicaid Provider Appeals Process outlined in the Medicaid Fairness Act, A.C.A. 20-77-1701 et seq.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. **Assurances**

☑ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
2. A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
3. A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

☑ The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2. Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3. Employs or contracts directly or indirectly with an individual or entity that is
   a. Precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   b. Could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

☐ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

☐ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Program Impact

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO	☐ MCO	☐ MCO

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ FFS	☐ FFS	☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

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  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Quality

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ FFS	☐ FFS	☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

For each program authorized by this waiver, please provide the details of its monitoring activities by editing each program listed below.

Programs Authorized by this Waiver:

Program	Type of Program
CareCoordination	PCCM;

Note: If no programs appear in this list, please define the programs authorized by this waiver on the

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Arkansas Provider Led Care Coordination Program

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.
For each activity, the state must provide the following information:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. ☐ **Accreditation for Non-duplication** (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

Activity Details:

☐ **NCQA**
☐ **JCAHO**
☐ **AAAHC**
☐ **Other**

Please describe:

b. ☐ **Accreditation for Participation** (i.e. as prerequisite to be Medicaid plan)

Activity Details:

☐ **NCQA**
☐ **JCAHO**
☐ **AAAHC**
☐ **Other**

Please describe:

c. ☑ **Consumer Self-Report data**

Activity Details:

The Consumer Advisory Council for each PASSE will provide annual reports that detail, at a minimum, the CACs feedback to the PASSE regarding their Enrollee Handbook and other educational information, as well as the quality of the care coordination services received.

- [ ] **CAHPS**

  Please identify which one(s):

- [ ] **State-developed survey**
- [ ] **Disenrollment survey**
- [ ] **Consumer/beneficiary focus group**

d. [x] **Data Analysis (non-claims)**

Activity Details:

Will be conducted by the Arkansas State Medicaid, PASSE Enrollment personnel. They will be responsible for producing monthly reports on the number of beneficiaries attributed to each PASSE, the number of enrollment notices sent and choice contacts made, and how many beneficiaries elected to change PASSE's during that period, either during their choice period or for cause. These reports will be reconciled with the PASSE's provider reports to ensure that the number of attributed beneficiaries is accurate.

- [ ] **Denials of referral requests**
- [x] **Disenrollment requests by enrollee**
  - [x] **From plan**
  - [ ] **From PCP within plan**
- [ ] **Grievances and appeals data**
- [x] **Other**

  Please describe:

  Choice counseling contacts and number of notices sent.

e. [ ] **Enrollee Hotlines**

Activity Details:

f. [ ] **Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

Activity Details:

g. [ ] **Geographic mapping**

Activity Details:

h. [ ] **Independent Assessment** (Required for first two waiver periods)

Activity Details:

i. [ ] **Measure any Disparities by Racial or Ethnic Groups**

Activity Details:

j. ☐ **Network Adequacy Assurance by Plan** [Required for MCO/PIHP/PAHP]

Activity Details:

k. ☐ **Ombudsman**

Activity Details:

l. ☐ **On-Site Review**

Activity Details:

m. ☐ **Performance Improvement Projects** [Required for MCO/PIHP]

Activity Details:

- ☐ **Clinical**
- ☐ **Non-clinical**

n. ☐ **Performance Measures** [Required for MCO/PIHP]

Activity Details:

- ☐ **Process**
- ☐ **Health status/ outcomes**
- ☐ **Access/ availability of care**
- ☐ **Use of services/ utilization**
- ☐ **Health plan stability/ financial/ cost of care**
- ☐ **Health plan/ provider characteristics**
- ☐ **Beneficiary characteristics**

o. ☐ **Periodic Comparison of # of Providers**

Activity Details:

p. ☐ **Profile Utilization by Provider Caseload** (looking for outliers)

Activity Details:

q. ☑ **Provider Self-Report Data**

Activity Details:

PASSE's will provide quarterly reports on the caseload of their care coordinators, the number of contacts they have made, the number of beneficiaries attributed each month, and details on grievances. These reports will be compared to the monthly reports generated by the Medicaid PASSE Enrollment personnel to confirm the number of beneficiaries attributed to each PASSE. These reports will also provide data on the quality metrics that must be measured under the PASSE Provider Manual, for example whether the care coordinator's caseload is 50 or fewer. These metrics will be monitored to ensure quality

services are being provided and can be audited by the State PASSE Oversight team for the purposes of ensuring quality services. A PASSE that fails to meet these quality metrics may have actions taken against it. In this manner, the quality metrics provided by the Provider reports will be used to protect the integrity of the program.

- ☐ **Survey of providers**
- ☐ **Focus groups**

r. ☐ **Test 24/7 PCP Availability**

Activity Details:

s. ☑ **Utilization Review** (e.g. ER, non-authorized specialist requests)

Activity Details:

The PASSE Oversight team of the State Medicaid Office will conduct quarterly utilization review for services used by beneficiaries attributed to the PASSE. In this manner, the PASSE Oversight team can track the quality of care coordination being provided and the effectiveness of the Provider-Led Care Coordination Program at more efficiently and effectively coordinating services for attributed beneficiaries.

t. ☑ **Other**

Activity Details:

The PASSE Oversight Team (employed by the State Medicaid Office) will evaluate and monitor all marketing and information materials that will be distributed to beneficiaries to ensure accuracy and readability, as well as compliance with the federal and state regulations governing marketing and information. The marketing materials will be evaluated prior to use. Therefore the PASSE Oversight Team will review marketing materials on an ongoing and as needed basis.

This team will also review the PASSE's quarterly reports to ensure compliance with all applicable laws and regulations and that care coordination services were provided in accordance with this Waiver and the PASSE Provider Manual. The PASSE Certification team will also be looking at whether the PASSE met the required quality metrics according to the data provided on their Provider Report.

Section C: Monitoring Results

Initial Waiver Request

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is an Initial waiver request.

☑ **The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.**

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	10/01/0017	09/30/0022		
Enrollment Projections for the Time Period*				
**Include actual data and dates used in conversion - no estimates *Projections start on Quarter and include data for requested waiver period				

Section D: Cost-Effectiveness

Services Included in the Waiver

Document the services included in the waiver cost-effectiveness analysis:

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Care Coordination	☐	☐	☑	

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

Signature:	Elizabeth Pitman
	State Medicaid Director or Designee
Submission Date:	Sep 7, 2017
	Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

b. Name of Medicaid Financial Officer making these assurances:

David McMahon

c. Telephone Number:

(501) 396-6421

d. E-mail:

David.McMahon@dhs.arkansas.gov

e. The State is choosing to report waiver expenditures based on

- (●) **date of payment.**
- ( ) **date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.**

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in A.I.b.

- **a.** [ ] **MCO**
- **b.** [ ] **PIHP**
- **c.** [ ] **PAHP**
- **d.** [ ] **PCCM**
- **e.** [ ] **Other**

Please describe:

Section D: Cost-Effectiveness

Part I: State Completion Section

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a. [✓] **Management fees are expected to be paid under this waiver.**

The management fees were calculated as follows.

1. [✓] **Year 1: $** 173.33 **per member per month fee.**
2. [✓] **Year 2: $** 173.33 **per member per month fee.**
3. [✓] **Year 3: $** 173.33 **per member per month fee.**

4. ☑ **Year 4: $** 173.33 **per member per month fee.**

b. ☐ **Enhanced fee for primary care services.**

Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c. ☐ **Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization.** Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

d. ☑ **Other reimbursement method/amount.**

$ 208.00

Please explain the State's rationale for determining this method or amount.

This amount will be paid to the PASSE upon the beneficiary's initial attribution to that PASSE, in lieu of the care coordination fee, as a foundation payment. The purpose of this fee is to assist with covering staffing, IT, and administrative costs to ensure that care coordination is available to the beneficiary on day 1 of attribution. The fee can also be used to conduct initial assessments of the beneficiary and to begin collecting health information from existing providers so that the Care Coordinator can identify unmet health needs of the beneficiary.

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

a. ☑ Population in the base year data

1. ☑ Base year data is from the same population as to be included in the waiver.
2. ☐ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b. ☑ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

We are phasing in enrollment over the first year and an half of the waiver. Approximately, 1,695,400 member months will be served over the 5 year life of this Waiver approval. As eligible individuals receive the Independent Assessment, they will be attributed to and enrolled in a PASSE. We anticipate enrolling everyone during calendar year 2018 (or quarters 2-5 of the Waiver).

c. ☐ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

d. ☐ [Required] Explain any other variance in eligible member months from BY to P2:

e. ☑ [Required] List the year(s) being used by the State as a base year:

2016

If multiple years are being used, please explain:

f. ☑ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:
Federal Fiscal Year

g. ☐ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

Appendix D1 – Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers:

a. ☑ **[Required] Explain the exclusion of any services from the cost-effectiveness analysis.**
For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

The intent is to limit services for the cost effectiveness analysis to solely care coordination because care coordination is the only service being provided by the PASSE.

Appendix D2.S: Services in Waiver Cost

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Care Coordination	☐	☐	☑	☐	☐	☐	☐

Section D: Cost-Effectiveness

Part I: State Completion Section

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*
For Initial Waivers:

a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. Appendix D5 should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administrative Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
Care Coordination	$72,953,062	$0.00	$25,380,138
Total:	$72,953,062	$0.00	$25,380,138

The allocation method for either initial or renewal waivers is explained below:

a. ☐ **The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees***Note: this is appropriate for MCO/PCCM programs.*

b. ☐ **The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled.***Note: this is appropriate for statewide PIHP/PAHP programs.*

c. ☑ **Other**

Please explain:

The state is only allocating direct administrative costs.

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

a. ☐ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

b. ☐ **The State is including voluntary populations in the waiver.**

Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c. ☐ **Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage:** Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1. ☐ **The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.**
2. ☐ **The State provides stop/loss protection**

Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

d. ☐ **Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:**

1. ☐ **[For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program.** The costs associated with any bonus arrangements must be accounted for in the capitated costs (Column D of Appendix D3 Actual Waiver Cost). Regular State Plan service capitated adjustments would apply.

Document

i. **Document the criteria for awarding the incentive payments.**
ii. **Document the method for calculating incentives/bonuses, and**
iii. **Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.**

2. ☐ **For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (Column G of Appendix D3 Actual Waiver Cost).**). For PCCM providers, the amount listed should match information provided in D.I.D Reimbursement of Providers. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (See D.I.I.e and D.I.J.e)

Document:

i. **Document the criteria for awarding the incentive payments.**
ii. **Document the method for calculating incentives/bonuses, and**
iii. **Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.**

Appendix D3 – Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (1 of 8)

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. ☑ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present)
The actual trend rate used is:
0.00
Please document how that trend was calculated:
No trend rate adjustment is proposed as there were no changes necessary for inflation.
2. ☐ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (i.e., trending from present into the future)
i. ☐ State historical cost increases.
Please indicate the years on which the rates are based: base years

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii. ☐ National or regional factors that are predictive of this waiver's future costs.

Please indicate the services and indicators used.

Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3. ☐ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (2 of 8)

b. State Plan Services Programmatic/Policy/Pricing Change Adjustment: This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

- **Additional State Plan Services (+)**
- **Reductions in State Plan Services (-)**
- **Legislative or Court Mandated Changes to the Program Structure or fee**

1. ☐ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2. ☑ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i. ☑ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
Please list the changes.
The case managers who serve the DD population receive $117.00 per month and the supportive living provider receives $100.00 per month to provide care coordination services, for a total of $217.00. If AR does not implement the PASSE model of care coordination, it would need to pay $217.00 for each attributed BH Beneficiary to ensure the same type of care coordination to all beneficiaries.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☐ Determine adjustment for Medicare Part D dual eligibles.

E. ☑ Other:
Please describe
The State is making a -19.83% adjustment to account for the $43.03 pricing reduction after the transition to the PASSE program.

ii. ☐ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii. ☐ Changes brought about by legal action:
Please list the changes.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☐ Other
Please describe

iv. ☐ Changes in legislation.
Please list the changes.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA
PMPM size of adjustment

D. ☐ Other
Please describe

v. ☐ Other
Please describe:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☐ Other
Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (3 of 8)

c. Administrative Cost Adjustment*: The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1. ☐ No adjustment was necessary and no change is anticipated.
2. ☑ An administrative adjustment was made.
i. ☐ FFS administrative functions will change in the period between the beginning of P1 and the end of P2.

Please describe

A. ☐ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B. ☐ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP)

Please describe

C. ☐ Other

Please describe

ii. ☑ FFS cost increases were accounted for.

A. ☑ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B. ☐ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. ☑ Other

Please describe

The PMPM cost of the contract before the waiver was $.66 and was derived from the salary cost of $250,000. The new cost associated with the waiver is the $5,170,000 of the Independent Assessment contract attributable to the PASSE model. This amounts to an adjusted PMPM of $14.97, or a 2168% increase in PMPM costs.

iii. ☐ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate.
Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate.

Please indicate the years on which the rates are based: base years

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate.
Please indicate the State Plan Service trend rate from Section D.I.I.a. above

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (4 of 8)

d. 1915(b)(3) Adjustment: The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in ***Section D.I.H.a*** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. ☐ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (i.e., trending from 1999 to present).
The actual documented trend is:

Please provide documentation.

2. ☐ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (i.e., trending from present into the future), the State must use the State's trend for State Plan Services.

i. State Plan Service trend

A. Please indicate the State Plan Service trend rate from Section D.I.I.a. above

e. Incentives (not in capitated payment) Trend Adjustment: If the State marked **Section D.I.H.d ,** then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from Section D.I.I.a

2. List the Incentive trend rate by MEG if different from Section D.I.I.a

3. Explain any differences:

f. Graduate Medical Education (GME) Adjustment: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1. ☐ We assure CMS that GME payments are included from base year data.

2. ☐ We assure CMS that GME payments are included from the base year data using an adjustment.
Please describe adjustment.

3. ☐ Other
Please describe

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5.**

1. ☐ GME adjustment was made.

i. ☐ GME rates or payment method changed in the period between the end of the BY and the beginning of P1.
Please describe

ii. ☐ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2.
Please describe

2. ☐ No adjustment was necessary and no change is anticipated.

Method:

1. ☐ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2. ☐ Determine GME adjustment based on a pending SPA.
3. ☐ Determine GME adjustment based on currently approved GME SPA.
4. ☐ Other
Please describe

Section D: Cost-Effectiveness

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I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (5 of 8)

g. ***Payments / Recoupments not Processed through MMIS Adjustment:*** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in ***Appendix D5.***

1. ☐ Payments outside of the MMIS were made.
Those payments include (please describe):

2. ☐ Recoupments outside of the MMIS were made.
Those recoupments include (please describe):

3. ☐ The State had no recoupments/payments outside of the MMIS.

h. ***Copayments Adjustment:*** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1. ☐ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2. ☐ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3. ☐ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4. ☐ Other

   Please describe

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1. ☐ No adjustment was necessary and no change is anticipated.
2. ☐ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

***Method*:**

1. ☐ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2. ☐ Determine copayment adjustment based on pending SPA.
3. ☐ Determine copayment adjustment based on currently approved copayment SPA.
4. ☐ Other

   Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (6 of 8)

i. **Third Party Liability (TPL) Adjustment:** This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:

1. ☐ No adjustment was necessary
2. ☐ Base Year costs were cut with post-pay recoveries already deducted from the database.
3. ☐ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4. ☐ The State made this adjustment:*
   - i. ☐ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in Appendix D5.
   - ii. ☐ Other

     Please describe

j. **Pharmacy Rebate Factor Adjustment:** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year

costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

***Basis and Method*:**

1. ☐ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population which includes accounting for Part D dual eligibles. Please account for this adjustment in Appendix D5.
   Please describe
2. ☐ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS or Part D for the dual eligibles.
3. ☐ Ohter
   Please describe

k. Disproportionate Share Hospital (DSH) Adjustment: Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1. ☐ We assure CMS that DSH payments are excluded from base year data.
2. ☐ We assure CMS that DSH payments are excluded from the base year data using an adjustment.
3. ☐ Other
   Please describe

l. Population Biased Selection Adjustment (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1. ☐ This adjustment is not necessary as there are no voluntary populations in the waiver program.
2. ☐ This adjustment was made:
   - **i.** ☐ Potential Selection bias was measured.
     Please describe
   - **ii.** ☐ The base year costs were adjusted.
     Please describe

m. FQHC and RHC Cost-Settlement Adjustment: Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1. ☐ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs.
   Payments for services provided at FQHCs/RHCs are reflected in the following manner:
2. ☐ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
3. ☐ We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.
4. ☐ Other
   Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (7 of 8)

Special Note Section:

Waiver Cost Projection Reporting: Special note for new capitated programs:

The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a. ☐ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

b. ☐ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

Special Note for initial combined waivers (Capitated and PCCM) only:

Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain capitated-only adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	Capitated Program	PCCM Program	

Section D: Cost-Effectiveness

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I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (8 of 8)

n. ***Incomplete Data Adjustment (DOS within DOP only)*** – The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including "lag factors," "incurred but not reported (IBNR) factors," or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods.

Documentation of assumptions and estimates is required for this adjustment.:

1. ☐ Using the special DOS spreadsheets, the State is estimating DOS within DOP.
   Incomplete data adjustments are reflected in the following manner on Appendix D5 for services to be complete and on Appendix D7 to create a 12-month DOS within DOP projection:
2. ☐ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
3. ☐ Other
   Please describe

o. ***PCCM Case Management Fees (Initial PCCM waivers only)*** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on ***Appendix D5.***

1. ☐ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
2. ☑ Other
   Please describe
   We calculated an average PMPM over the five year period, this amount was $173.97. This a blended rate based on a $208.00 foundation payment for the initial month the member is attributed, and a $173.33 PMPM for every month thereafter.

p. ***Other adjustments:*** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - Excess payments addressed through transition periods should not be included in the 1915(b) cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

1. ☐ No adjustment was made.
2. ☐ This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5.
   Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (1 of 5)

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (2 of 5)

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (3 of 5)

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (4 of 5)

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (5 of 5)

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in Section D.I.I and D.I.J above.

Two adjustments were made: (1) the reduction of cost for providing care coordination under the (b) waiver; and (2) the increase in administrative costs attributable to the Independent Assessment Contract.

Appendix D5 – Waiver Cost Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in Section D.I.E. above.

Appendix D6 – RO Targets

Section D: Cost-Effectiveness

Part I: State Completion Section

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in Section D.I.E.c & d:

2. Please explain unit cost changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in Section D.I.I and D.I.J:

3. Please explain utilization changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in Section D.I.I and D.I.J:

b. Please note any other principal factors contributing to the overall annualized rate of change in Appendix D7 Column I.

Appendix D7 - Summary

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers – Provider-Led Arkansas Shared Savings Entity (PASSE) Program**

EFFECTIVE DATE: **October 1, 2017**

SUBJECT: **Provider Manual Update Transmittal PASSE-New-17**

REMOVE		**INSERT**	
Section	**Effective Date**	**Section**	**Effective Date**
____	____	ALL	10-1-17

Explanation of Updates

A new Provider-Led Arkansas Shared Savings Entity (PASSE) Program policy manual is available for all PASSE providers.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Rose M. Naff
Director

SECTION II - PROVIDER-LED ARKANSAS SHARED SAVINGS ENTITY (PASSE) PROGRAM

CONTENTS

200.000 DEFINITIONS

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:

A. Is 51% owned by participating providers; and

B. Has the following Members or Owners:

1. An Arkansas licensed or certified direct service provider of Developmental Disabilities (DD) services;
2. An Arkansas licensed or certified direct service provider of Behavioral Health (BH) services;
3. An Arkansas licensed hospital or hospital services organizations;
4. An Arkansas licensed physician's practice; and
5. A Pharmacist who is licensed by the Arkansas State Board of Pharmacy.

Risk-based Provider Organization (RBPO)

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

Participating Provider

An organization or individual that is a member of or has an ownership interest in a PASSE and delivers healthcare services to beneficiaries attributed to a PASSE.

Direct Service Provider

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

The Act

Title XIX of the Social Security Act.

Enrollment

A RBPO's successful completion of all requirements to become a Medicaid PASSE provider.

Attribution

The method by which DHS assigns a beneficiary to a PASSE.

Transition

The movement of a beneficiary from one PASSE to another.

Abeyance

A temporary suspension of PASSE services, due to:

A. A temporary loss of Medicaid eligibility;

B. Placement in a setting excluded from the PASSE; or

C. Loss of contact with the beneficiary or guardian for more than forty-five (45) days.

Closure

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

Medical/Quality Management Committee

A committee developed by the PASSE to oversee Quality Assurance of PASSE services.

Referral Network

The Direct Service Providers that join the PASSE.

210.000 ATTRIBUTION, ENROLLMENT, TRANSITIONING AND CLOSURE

211.000 PASSE Enrollment Eligibility 10-1-17

To be eligible to enroll as a Provider-Led Arkansas Shared Savings Entity (PASSE) with Arkansas Medicaid, the entity must:

A. Be licensed by the Arkansas Insurance Department (AID) as a risk-based provider organization under Act 775 and the risk-based provider organization regulations issued by the Insurance Commissioner;

B. Demonstrate a network adequate to ensure coverage of services as outlined in Section 230.000 of this manual;

C. Have the ability to provide care coordination to attributed beneficiaries who have been identified by the Department of Human Services (DHS) as requiring Tier II and Tier III levels of BH and DD services beginning on October 1, 2017;

D. Sign the Provider-Led Arkansas Shared Savings Entity (PASSE) Agreement to operate as a PASSE provider type and agree to adhere to all requirements of this Manual and any applicable federal regulations; and

E. Successfully complete the Readiness Review outlined in Section 212.000 of this manual.

212.000 Readiness Review 10-1-17

The PASSE must provide the following items for review and approval by DHS:

A. Beneficiary handbook,

B. Referral network directory,

C. Composition of and by-laws for the Medical/Quality Management Committee,

D. Key staff members and organizational charts,

E. Marketing materials,

F. Proof of 24 hour a day 7 days a week access to care coordination,

G. Proof of hiring and training an adequate number of care coordinators,

H. Proof of the ability to manage and maintain Electronic Health Records,

I. Beneficiary notices,

J. Beneficiary rights policies, and

K. Proof of Referral Network adequacy according to Section 231.000.

213.000 Beneficiary Attribution

213.100 Attribution Methodology 10-1-17

A. DHS will attribute beneficiaries in a PASSE using a methodology based on the individual's relationship with Direct Service Providers who joined that PASSE's Referral Network. For existing Medicaid clients, DHS will examine the previous twelve (12) months of claims history to determine specialty service providers, primary care providers, pharmacists, and other providers used by the individual. Then, the individual will be attributed to a PASSE according to a methodology that will be weighted toward the individual's DD and BH specialty providers.

B. A beneficiary will be attributed to a PASSE based upon their "relationship score" with Direct Service Providers. The relationship score is equal to the product of the visit points and the specialty points, plus the cost points.

1. Visit Points - Using available databases, DHS will determine if there is an established relationship between the individual and providers based on whether an individual received at least one service from a provider in any month in the previous twelve (12) month period. Each provider that rendered a service to an individual in a month will be recognized for that month. There are no additional points for multiple visits within the same month. A visit must include direct contact with the individual to deliver a reimbursable service in that month and must not be incidental.
2. Specialty Points - Weights will be assigned amongst provider classes to reflect the importance of specialty providers for this population. Provider Classes will be classified as follows:
    a. Provider class 5
        i. Certified Behavioral Health Provider
        ii. Intermediate Care Facilities/DD/ID
        iii. Supportive Living Provider
        iv. Developmental Day Treatment Clinic Services (DDTCS) and successor programs
        v. Child Health Management Services (CHMS) and successor programs
    b. Provider class 4
        i. Physician – Primary Care Physician
        ii. Pharmacy
        iii. Federally Qualified Health Center (FQHC)
        iv. Person-Centered Medical Home (PCMH)
    c. Provider class 3
        i. Physician – non-Primary Care Physician
        ii. Nurse Practitioners
        iii. Outpatient Clinic
        iv. Inpatient Hospital Services including psychiatric stays for adults
    d. Provider class 2
        i. Speech therapist
        ii. Physical therapist
        iii. Occupational therapist
        iv. Care Coordinator who is not otherwise a provider of direct services
    e. Provider class 1

i. Durable Medical Equipment provider

ii. Personal Care provider

iii. Home Health provider

3. Cost Points - The cost of care is also an important consideration in determining the relationship between the individual and the provider. DHS will use all available Medicaid claims data that is fully adjudicated and refreshed on a quarterly basis.

C. If a single provider accounts for at least fifty percent (50%) of both visits and spending for a beneficiary, the beneficiary will be attributed to that provider and assigned into the PASSE that providers has joined. If there is no majority provider, the beneficiary will be attributed to the PASSE with the highest relationship score that is greater than thirty-five percent (35%) of the total possible score.

D. If there is no majority provider and no PASSE represents a total of 35% of the total possible relationship score, then DHS will review an additional twelve (12) months of claims data.

E. When a tie-breaker is needed: for example when the majority provider is in more than one PASSE or when two PASSEs have an equal relationship score, or no PASSE has a relationship score of greater than 35%, proportional assignment will be used. That is, the first member will be assigned to PASSE A, the next to PASSE B, the next to PASSE C, etc.

213.200 Mandatory Beneficiary Attribution 10-1-17

The following beneficiaries must be attributed to a PASSE and undergo an Independent Assessment (IA):

A. Beneficiaries identified to meet Tier II or Tier III Level of Care as defined by DHS.

B. For beneficiaries with BH service needs:

1. Tier II – At this level of need, services are provided in a counseling services setting but the level of need requires a broader array of services.

2. Tier III – Eligibility for this level of need will be identified by additional criteria, which could lead to inpatient admission or residential placement.

C. For beneficiaries with Developmental Disabilities (DD) service needs:

1. Tier II – The individual meets the institutional level of care criteria but does not currently require 24 hours-a-day of paid support and services to maintain his or her current placement.

2. Tier III – The individual meets the institutional level of care criteria and does require 24 hours-a-day of paid support and services to maintain his or her current placement.

213.300 Services Excluded from Attribution Methodology 10-1-17

The following services are excluded from consideration when attributing a beneficiary to a PASSE:

A Payment for Medicare covered services for individuals who are eligible for Medicare and Medicaid (“dual eligible”);

B. Services covered by private insurance and private payment;

C. Costs of transplants reimbursed by Arkansas Medicaid;

D. Emergency department visits reimbursed by Arkansas Medicaid; and,

E. Psychiatric Residential Treatment Units or Center Placements reimbursed by Arkansas Medicaid.

214.000 Transitioning to another PASSE 10-1-17

A beneficiary may voluntarily transition from their attributed PASSE and choose another PASSE within ninety (90) days of initial attribution. A beneficiary will not be permitted to change their PASSE more than once within a twelve (12) month period, unless cause for transition, as described in 42 CFR 438.56, is met.

On the beneficiary's annual anniversary of attribution to a PASSE, the beneficiary will have the ability to transition to a different PASSE. If no action is taken by the beneficiary, they will remain attributed to their current PASSE and will not be permitted to change their PASSE, unless cause for transition, as described in 42 CFR 438.56, is met.

Cause for transition, as described in 42 CFR 438.56, is as follows:

A. The beneficiary moves out of the state;

B. The PASSE for which the beneficiary is attributed is sanctioned pursuant to section 152.000 of this manual;

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

D. Other reasons, including poor quality of care, lack of access to services covered under the PASSE agreement, or lack of access to providers experienced in dealing with the beneficiary's care needs.

Transition from a PASSE will be processed by DHS after receipt of oral or written request. The effective date of an approved transition must be no later than the first day of the second month following the month in which the beneficiary request for transition was received. Failure by DHS to process a timely transition request will result in an automatic approval of request.

To request a transition, a beneficiary should contact:

Arkansas Department of Human Services, PASSE Enrollment

Mailing Address

Little Rock, AR 72201

Phone: 501-XXX-XXXX

The PASSE cannot transition any attributed beneficiary.

DHS reserves the right to transition beneficiaries in compliance with 42 CFR 438.56.

215.000 Closure 10-1-17

DHS reserves the right to close any beneficiary's PASSE service after held in Abeyance for ninety (90) days.

220.000 BENEFICIARY INFORMATION

221.000 General Information 10-1-17

A. The PASSE must provide attributed beneficiaries information in a manner and format (at least 12-point font) that is easily understood and is readily accessible.

B. The PASSE must provide written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbooks, appeal and grievance notices, and marketing material.

C. All materials provided by the PASSE must available in English and Spanish.

D. The PASSE must make available all materials (or information) in alternative formats upon request, of the beneficiary or potential beneficiary at no cost.

E. The PASSE must make available auxiliary aids and services upon request of the potential beneficiary or beneficiary at no cost.

F. The PASSE must notify beneficiaries of their right to obtain information in alternative formats.

222.000 Beneficiary Policy 10-1-17

The PASSE must have written policies addressing the following:

A. The right to be treated with respect and with due consideration for his or her dignity and privacy.

B. The right to receive information on available treatment options and alternatives, presented in an appropriate format.

C. The right to participate in decisions regarding his or her health care, including the right to refuse treatment.

D. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

E. The right to request and receive a copy of his or her medical records, and to request that they be amended or corrected.

F. The right to exercise his or her rights without the PASSE treating the beneficiary adversely.

G. The right to be provided written notice of a change in the beneficiaries care coordination provider within seven (7) calendar days.

H. The right to a beneficiary handbook and referral network directory within a reasonable amount of time after attribution.

223.000 Beneficiary Handbook 10-1-17

A. The PASSE must provide each attributed beneficiary with a handbook that contains, at a minimum, the following:

1. A description of care coordination that includes, at a minimum, the definition contained in Section 241.000 of this Manual.
2. All information contained in the Section 222.000 of this Manual regarding beneficiary rights.
3. The process of selecting and changing the beneficiary's PCP.
4. The process for filing a grievance, including timeframes.
5. How a beneficiary can exercise an advance directive.
6. The toll-free telephone number the beneficiary can use to access care coordination and member support services

B. The PASSE must provide notice of any significant change in the information specified in the beneficiary handbook, at least thirty (30) days before the intended effective date of the change.

C. The PASSE will disseminate the beneficiary handbook as follows:

1. Mail a printed copy of the information to the mailing address on file for the beneficiary;
2. Provide the information by email after obtaining the beneficiary's agreement to receive information by email;
3. Post the information on its website and advise the beneficiary in paper or electronic form that the information is available on the Internet, including the applicable Internet address. The PASSE must ensure that beneficiaries with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or,
4. Provide the information by any other method that can reasonably be expected to result in the beneficiary receiving that information.

224.000 Marketing Materials 10-1-17

The PASSE may only market to potential beneficiaries through its website or printed material distributed by DHS's choice counselors.

All marketing materials and activities must be approved by DHS in advance of use.

230.000 NETWORK REQUIREMENTS

231.000 Referral Network Requirements 10-1-17

The PASSE must have the ability to make arrangements with or referrals to a sufficient number of Direct Service Providers enrolled as Arkansas Medicaid providers to ensure that needed services can be furnished to beneficiaries promptly and without compromising the quality of care.

At a minimum, the PASSE must meet the following time and distance requirements:

A. Have the ability to make referrals for the following providers to all attributed beneficiaries which includes at least one (1) of the each of following provider types within sixty (60) minutes of normal transportation time or within sixty (60) miles, whichever is shorter, for all attributed beneficiaries:

1. Hospital
2. DD provider
3. BH provider
4. Pharmacy
5. Primary Care Physician

B. At least one (1) substance abuse provider within one hundred and twenty (120) minutes of normal transportation time or within one hundred twenty (120) miles, whichever is shorter, for all attributed beneficiaries.

The PASSE may request a variance of these standards in certain geographic areas of the state. DHS may grant a variance upon consideration of the number of providers of that type and the rural nature of the geographic area for which the variance is requested.

231.100 Referral Network Directory 10-1-17

The PASSE must create a Referral Network Directory that, at a minimum, does the following:

A. Provides the following information to beneficiaries for each Direct Service Provider that has joined its Referral Network:

1. Names, as well as any group affiliations.
2. Street addresses.
3. Telephone numbers.
4. Website URLs, as appropriate.
5. Specialties, as appropriate.

B. Clearly explains that the Referral Network is a list of preferred providers only, and that the beneficiary may access services from any enrolled Medicaid provider until January 1, 2019.

C. Updates at least monthly, with the updates posted on the PASSE website.

240.000 CARE COORDINATION REQUIREMENTS

241.000 Definition of Care Coordination 10-1-17

A. The PASSE must provide care coordination to each of its attributed beneficiaries. Care coordination means ensuring that specialty services are coordinated and appropriately delivered by specialty providers (BH and DD services, as appropriate). The PASSE must provide care coordinators who will work with the beneficiary's providers to ensure continuity of care across all services. Act 775 of the 2017 Arkansas Regular Session defined care coordination as including the following activities:

1. Health education and coaching;
2. Coordination with other healthcare providers for diagnostics, ambulatory care, and hospital services;
3. Assistance with social determinants of health, such as access to healthy food and exercise;
4. Promotion of activities focused on the health of a patient and their community, including without limitation outreach, quality improvement, and patient panel management; and
5. Coordination of Community-based management of medication therapy

B. The care coordinator employed by the PASSE is responsible for the total plan of care for each beneficiary assigned to him or her. The total plan of care is all services and plans related to the client. The total plan of care may include, but is not limited to, the following:

1. Behavioral Health Treatment Plan;
2. Person Centered Service Plan for Waiver Clients;
3. Primary Care Physician Care Plan;
4. Individualized Education Program;
5. Individual Treatment Plans for developmental clients in day habilitation programs;
6. Nutrition Plan;
7. Housing Plan;
8. Any existing Work Plan;
9. Justice system-related plan;

10. Child welfare plan; or
11. Medication Management Plan

The PASSE care coordinator is responsible for obtaining copies of all treatment and service plans related to an individual beneficiary and coordinating services between those plans. The goal is to prevent duplication of services, ensure timely access to all needed services, and identify any service gaps for the beneficiary, as well as provide any health education and health coaching identified by those plans. The PASSE care coordinator should also obtain the report from the beneficiaries IA.

C. The PASSE care coordinator will assume the responsibility of providing case management under the concurrent 1915(c) Home and Community Based Services Community and Employment Support (CES) Waiver for attributed beneficiaries who are Waiver participants, including:

1. Coordinating and arranging all CES waiver services and other state plan services;
2. Identifying and accessing needed medical, social, educational and other publicly funded services (regardless of funding source);
3. Identifying and accessing informal community supports needed by eligible participants and their families;
4. Monitoring and reviewing services provided to the beneficiary to ensure all plan services are being provided and to ensure the health and safety of the participant;
5. Facilitating crisis intervention;
6. Providing guidance and support to meet generic needs;
7. Conducting appropriate needs assessments and referral for resources;
8. Monitoring services provided to ensure quality of care and case reviews which focus on the participants progress in meeting goals and objectives established on existing case plans;
9. Providing assistance relative to obtaining waiver Medicaid eligibility and ICF/IID level of care eligibility determinations;
10. Ensuring submission of timely (advanced) and comprehensive behavior and assessment reports, continued plans of care, revisions as needs change and information and documents required for ICF/IID level of care and waiver Medicaid eligibility determinations;
11. Arranging for access to advocacy services as requested by participant;
12. Providing assistance upon receipt of DDS or DHS notices or denials, including assistance with the reconsideration and appeal process.

The PASSE must comply with Conflict Free Case Management rules.

D. The PASSE care coordinator will also be responsible for assisting the beneficiary with moving between service settings, for example with the move from the residential treatment setting to community based care.

E. Care coordination services must be available to attributed beneficiaries 24 hours a day through a hotline or web-based application.

F. If a beneficiary has already been assigned to or selected a PCP or PCMH, that PCP or PCMH will be responsible for coordinating the beneficiary's medical care. If the beneficiary does not have a PCP selected, the PASSE care coordinator must assist the beneficiary with selecting a PCP or provide a referral to a PCP.

G. A PASSE care coordinator cannot have more than 50 beneficiaries on its caseload at any one time.

H. The PASSE care coordinator must make a monthly face-to-face contact with each beneficiary assigned.

I. If the beneficiary is seen in an emergency room or urgent care clinic or is admitted to an acute inpatient psychiatric facility, the care coordinator must follow up with the beneficiary within seven (7) days of discharge from the facility. The follow up visit is to ensure that all discharge instructions are being followed and any follow-up appointments have been scheduled.

J. The PASSE care coordinator will assist the beneficiary in remaining in the most appropriate and least restrictive setting for that beneficiary.

242.000 Care Coordinator Qualifications 10-1-17

An individual must meet the following qualifications to provide care coordination to PASSE beneficiaries:

A. Be a Registered Nurse (R.N.), a physician, or have a bachelor's degree in a social science or health-related field;

or

Have at least one (1) year of experience working with developmentally or intellectually disabled clients or behavioral health clients;

AND;

C. Successfully complete a background check, that includes a criminal background and child and adult maltreatment registry check;

D. Successfully pass an initial drug screen prior to providing care coordination and working directly with clients;

E. Successfully pass an annual drug screen to continue to be allowed to provide care coordination; and

F. Cannot be excluded or debarred under any state or federal law, regulation or rule or not eligible or prohibited to enroll as a Medicaid provider.

243.000 Payments 10-1-17

A. **Care Coordination Payment**. – For each attributed beneficiary, the PASSE will be paid a per-member, per-month fee for care coordination, unless Beneficiary's PASSE service is in abeyance.

B. **Foundation Payment.** – In lieu of the care coordination fee, the PASSE will receive a one-time foundation payment upon the beneficiary's initial attribution to the PASSE.

1. The foundation payment is non-transferable. It may only be paid to one PASSE for each beneficiary and will not continue past December 31, 2018.
2. The purpose of the foundation payment is to assist the PASSE with providing the initial care coordination contact and services. The payment may be used to conduct initial assessments of the beneficiary and to begin collecting the required health information from existing providers.

250.000 METRICS, ACCOUNTABILITY, REPORTS, AND QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI)

251.000 Quality Metrics 10-1-17

In order to continue to receive the full Care Coordination PMPM for attributed beneficiaries, the PASSE must meet the following standards:

A. The caseloads assigned to each Care Coordinator must be no more than 50 beneficiaries.

1. The PASSE must provide quarterly reports to DHS that detail the monthly caseload for each Care Coordinator employed.
2. The target is 100% of the Care Coordinators will have a caseload of no more than 50 beneficiaries.

B. Care Coordinators must make monthly face-to-face contacts with beneficiaries within their caseload assignment. After the initial in person face-to-face contact, ongoing face-to-face contact can be accomplished utilizing video conferencing. If a face-to-face contact is not made, the care coordinator must have documented at least three (3) attempts to make face-to-face contact at the beneficiary's place of residence during that month. These three attempts must be at least 24 hours apart.

1. The PASSE must provide quarterly reports to DHS that contain encounter data for the monthly contacts with beneficiaries within their caseload assignment.
2. The target is that 100% of care coordinators will make monthly face-to-face contacts with all beneficiaries assigned to their caseload.

C. Care Coordinators must initiate contact within 15 days of attribution to a PASSE.

1. The PASSE must provide quarterly reports to DHS that contains data indicating initial contact time frame with beneficiaries who are attributed to the PASSE.
2. The target is that care coordinators will initiate contact within 15 days in 75% of all cases assigned to their caseload.

D. Care Coordinators must follow-up with beneficiaries who have visited an Emergency Room or an urgent care clinic or been discharged from an inpatient psychiatric unit within seven (7) business days of discharge.

1. The PASSE must provide quarterly reports to DHS indicating follow-up for these beneficiaries.
2. The target is that care coordinators will conduct follow up within seven days in 50% of the cases where a beneficiary goes to an Emergency Room, an urgent care clinic, or has been discharged from an inpatient psychiatric unit.

E. Care Coordinators are responsible for assisting the beneficiary with selecting a PCP or provide a referral to a PCP.

1. The PASSE must provide quarterly reports to DHS indicating the number of beneficiaries that have been referred to and have been assigned a PCP.
2. The PASSE must provide quarterly reports to DHS on PCP appointment attendance rates for attributed beneficiaries.
3. The target is that care coordinators will assist beneficiaries in obtaining a PCP in 100% of their assigned cases.

252.000 Failure to Meet Quality Metrics 10-1-17

If the PASSE fails to meet 2 of the 5 quality metrics for care coordination, DHS may take action to correct the failure or impose penalties on the PASSE. DHS's actions may include, but are not limited to:

A. Require the PASSE submit a Corrective Action Plan (CAP) to address proposed activities to improve adherence to quality metrics;

B. Suspend, withhold, recoup, or recover payments, or any combination thereof, made to the PASSE;

C. Terminate the PASSE from participation as a PASSE Medicaid Provider type;

D. Suspend the PASSE's participation in the Medicaid Program;

E. Cancel or shorten the PASSE's existing provider agreement; or

F. Impose any sanction identified in §152.000 of the Medicaid Provider Manual.

253.000 Reporting Requirements and the Quality Assurance Performance Improvement (QAPI) Program 10-1-17

A. Pursuant to Act 775 of the 2017 Arkansas General Session, the PASSE is responsible for reporting to DHS on a quarterly basis, the following:

1. Care Coordination encounter Data;
2. Unique Identifiers of beneficiaries;
3. Geographic and demographic information of beneficiaries; and
4. Satisfaction scores from the PASSE administered beneficiary satisfaction survey.

B. The PASSE must also implement and carry out a Quality Assurance and Performance Improvement (QAPI) program for care coordination. The QAPI must include, at a minimum:

1. Collection of and reporting on the quality metrics required by Section 251.000 of the Manual; and
2. Mechanisms to detect both underutilization and overutilization of services.

C. All reports submitted must include an attestation by the CEO or CFO of the PASSE (or their designee) that the information submitted is accurate, truthful and complete.

D. The PASSE must retain all reports and data submitted, as well as all other records regarding the provision of care coordination for a minimum of ten (10) years from the final date of the contract period or the date of completion of an audit, whichever is later.

254.000 DHS Review of Outcomes 10-1-17

Pursuant to Act 775 of the 2017 Arkansas General Session, DHS will utilize data submitted from the PASSE to measure the performance of the following:

A. Delivery of services;

B. Patient outcomes;

C. Efficiencies achieved; and

D. Quality measures, which include:

1. Reduction in unnecessary hospital emergency department utilization;
2. Adherence to prescribed medication regimens;

3. Reduction in avoidable hospitalizations for ambulatory-sensitive conditions; and
4. Reduction in hospital readmissions.

260.000 GRIEVANCES, APPEAL RIGHTS, SANCTIONS, AND THE CONSUMER ADVISORY COUNCIL

261.000 Grievances 10-1-17

The PASSE must have an internal grievance process to address beneficiary concerns and complaints. This grievance process must:

A. Allow the beneficiary 45 days from the date of the action to file the grievance;

B. Be completed and resolved within 30 days of the filing date; and

C. Result in written notice of the resolution being sent to the beneficiary. This notice must include the beneficiary's right to appeal to the State.

The PASSE must submit a grievance log with their quarterly report.

262.000 Appeal Rights 10-1-17

When the Division of Medical Services (DMS) denies PASSE eligibility or takes an adverse action against a PASSE or beneficiary, the PASSE or beneficiary may request a fair hearing to appeal the adverse action.

To do so, the beneficiary or provider must follow the procedures laid out in the Medicaid Provider Manual, Sections 160.000 & 190.000.

263.000 Sanctions 10-1-17

DHS may impose the following sanctions, as well as those listed in Section 252.000 of this Manual:

A. Grant beneficiaries the right to transfer without cause;

B. Suspend attribution into the PASSE;

C. Appoint temporary management to the PASSE; and,

D. Impose civil penalties as allowed by state and federal law.

264.000 Consumer Advisory Council 10-1-17

The PASSE must have and maintain a consumer advisory council consisting of at least one (1) consumer of DD services, one (1) consumer of BH services, and one (1) consumer of substance abuse treatment services.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Janet Mann

TELEPHONE 501.682.1573 **FAX** _____ **EMAIL:** Janet.mann@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE PASSE

1. Does this proposed, amended, or repealed rule have a financial impact? Yes x No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes x No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes x No

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$ 4,521,160	General Revenue	$ 3,683,314
Federal Funds	$10,999,472	Federal Funds	$ 8,961,087
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$15,520,632	Total	$12,644,401

(b) What is the additional cost of the state rule?

Current Fiscal Year		Next Fiscal Year	
General Revenue	$ 4,521,160	General Revenue	$ 3,683,314
Federal Funds	10,999,472	Federal Funds	$ 8,961,087
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$15,520,632	Total	$12,644,401

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year
$ _____

Next Fiscal Year
$ _____

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year
$ 15,520,632

Next Fiscal Year
$ 12,644,401

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes x No ☐

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

This proposed rule implements Act 775.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

A PASSE is a new type of Medicaid provider; the proposed rule describes the responsibilities of a PASSE.

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule;

The proposed rule describes the responsibilities of the PASSE that will meet the federal requirements for a Primary Care Casement Management waiver under Section 1915.

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

The cost of a care coordination system will offset by savings in Medicaid benefits.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule; N/A

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule; N/A

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; N/A

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

DHS will continue to monitor the cost and benefits to the PASSE system.