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

CONTENTS

200.000 DEFINITIONS

210.000 ATTRIBUTION, ENROLLMENT, TRANSITIONING AND CLOSURE

211.000 Purpose and Scope
211.200 Standard Contract Requirements
212.000 Actuarial Soundness
212.100 Rate Development Standards
213.000 Special Contract Provisions Related To Payment
213.100 Rate Certification Submission
214.000 Medical Loss Ratio (MLR) Standards
215.000 Information Requirements
216.000 Provider Discrimination Prohibited

220.000 STATE RESPONSIBILITIES

221.000 1915(b) Waiver
221.100 Requirements for PASSE Program Participation
221.200 Covered Services
221.210 Pharmacy Requirements
221.220 Therapeutic Classes of Drugs
221.230 Prohibition of More Restrictive Coverage Than Arkansas Medicaid Fee For Service
221.300 Payment
221.310 Prorated Payments
221.320 PASSE Member Disenrollment
221.400 Choice of PASSE
221.500 Member Enrollment
221.510 Eligibility Requirements for PASSE
221.520 Eligible Medicaid Beneficiaries and Mandatory Enrollment
221.530 Voluntary Enrollment
221.540 Enrollment Discrimination Prohibited
221.600 Member Disenrollment: Requirements and Limitation
221.700 Transitioning To a Different PASSE
222.000 Conflict of Interest Safeguards
223.000 Prohibition of Additional Payments For Services Covered By The PASSE
224.000 Continuity of Care and Services to Members
225.000 State Monitoring
225.100 Audited Financial Reports
225.200 Recordkeeping Requirements
226.000 Network Adequacy Standards
226.100 Access to Service/Waiting Time Standards
226.200 Network Adequacy Variance Request
226.300 Network Adequacy Reporting
227.000 Stakeholder Engagement in PASSE Program
228.000 Beneficiary Support System
229.000 State Oversight of the Minimum MLR Requirements

230.000 MEMBERS RIGHTS AND PROTECTIONS

231.000 Member Rights
231.100 Annual Enrollment Period
231.200 90 Day Period To Change PASSE
231.300 Right To Change PASSE For Cause
231.400 Provider Network Directory
231.500 Choice of Health Professional
232.000 Provider-Member Communications

233.000 Marketing Activities
234.000 Liability for Payment
235.000 Cost Sharing
236.000 Consumer Advisory Committee – CFR 42 § 438.110
237.000 Emergency and Post Stabilization Services
238.000 Solvency Standards

240.000 CARE COORDINATION REQUIREMENTS

241.000 Availability of Services and Readiness Review
241.100 Assurance of Adequate Capacity and Services
242.000 Coordination and Continuity of Care
242.100 Care Coordinator Qualifications
243.000 Coordination of Benefits: Third Party Liability (TPL)
244.000 Coverage and Authorization of Services
245.000 Provider Selection and Payment
245.100 Value-Based Payments
245.200 Assurance of Compliance with Arkansas Provider Consent Decrees
245.300 Assurance of Compliance with Arkansas Preferred Drug List Requirements
245.400 Assurance of Payment Methodology Requirements by the Arkansas Insurance Department
246.000 Confidentiality
247.000 PASSE Grievance System
247.100 Appeal of Adverse Action of DHS
247.200 Appeal of Adverse Benefit Determination of a PASSE
247.300 Request for DHS Hearing for Anti-Competitive Practices
248.000 Subcontractual Relationships and Delegation
248.100 Practice Guidelines
248.200 Health Information Systems
248.210 Reporting Requirements
248.220 Claims Payment and Claims Processing
248.230 Encounter Data
248.240 Recordkeeping Requirements
248.250 Reporting Provider Sanctions
248.260 Reporting Provider-Preventable Conditions
248.300 Provider Credentialing and Recredentialing
248.310 Uniform Credentialing Process Requirements

250.000 QUALITY MEASUREMENT AND IMPROVEMENT; EXTERNAL QUALITY REVIEW

251.000 Basis, Scope and Applicability
252.000 Definitions
253.000 Quality Assessment and Performance Review Program
254.000 State Review of the Accreditation Status of a PASSE
255.000 Medicaid Managed Care Quality Rating System
256.000 Managed Care State Quality Strategy
256.100 Quality Incentive Pool
257.000 External Quality Review
257.100 Nonduplication of Mandatory Activities with Medicare or Accreditation Review
257.200 Exemption from External Quality Review
257.300 External Quality Review Results
258.000 Failure To Meet Quality Metrics
259.000 Reporting Requirements and the Quality Assurance Performance Improvements (QAPI) Program
259.100 DHS Review of Outcomes
259.200 Quality Metrics
259.300 Reporting and Quality Metric Requirements
259.400 National Core Indicators

260.000 ADDITIONAL PROGRAM INTEGRITY SAFEGUARDS

261.000 Basic Program Integrity Safeguards
261.100 State Responsibilities
261.200 Source, Content, and Timing of Certification
261.300 Prohibited Affiliations
261.400 PASSE Program Integrity Activities

270.000 SANCTIONS
271.000 Sanctions
272.000 Basis for Imposition of Sanctions
272.100 Types of Intermediate Sanctions
272.200 Amounts of Civil Money Penalties
272.300 Special Rules for Temporary Management
272.400 Termination of a PASSE Provider Agreement
272.500 Notice of Sanction and Pre-Termination Hearing
272.600 Disenrollment During Termination Hearing Process
272.700 Notice to CMS
272.710 Sanction by CMS

200.000 DEFINITIONS

Adjusted Premium Revenue

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

Administrative Cost Ratio

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

Adverse Benefit Determination

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

A. Appropriate level of care or coding,

B. Medical necessity,

C. Prior authorization,

D. Concurrent reviews,

E. Retrospective reviews,

F. Least restrictive setting,

G. Desk audits,

H. Field audits and onsite audits

I. Inspections, and

J. Payment amounts due to or from a particular provider resulting from gain sharing, risk sharing, incentive payments or another reimbursement mechanism or methodology.

Arkansas Department of Human Services (DHS)

The Arkansas Department of Human Services (DHS) is the designated single state agency with responsibilities to administer the Medicaid program.

Arkansas Insurance Department (AID)

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

Assignment

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

Benefit Expenditure Report (BER)

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

Care Coordination

Activities involving a collaborative patient-centered engagement of the individual and their caregiver in service referral, follow up, and service navigation. The care coordination process includes assessing, collaborating on care planning, medication management, treatment plan follow-through, service coordination, monitoring the patient adherence, and reevaluating the patient for medically necessary care and service. These activities focus on ensuring the individual's healthcare and support service needs are met; through effective provider and patient communication, information sharing, follow up, care transitions, and assurance of timely access to care that promotes quality, cost-effective outcomes.

Case Management

Services furnished to assist individuals in gaining access to needed medical, social, educational, and others services in accordance with 42 CFR § 440.169.

Centers for Medicare & Medicaid Services (CMS)

The Centers for Medicare & Medicaid Services (CMS) is the federal agency delegated by the Secretary of the US Department of Health and Human Services to administer the Medicaid program under Title XIX of the Social Security Act and thereby has federal oversight responsibilities for the state and the PASSEs.

The state and the PASSEs must meet the requirements of a Medicaid managed care organization as defined in 42 CFR § Part 438.

Claims Payment

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

Claims Payment Process

A claims payment process involves all the business and operational processes, claims management information systems, and banking processes that are necessary to receive, validate, adjudicate, audit, and reimburse providers for services provided to eligible beneficiary.

These business and operational activities, processes, and systems are performed and managed by the PASSE organization to meet the claims payment standards of the State.

Direct Service Provider

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

Disenrollment

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

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

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

Flexible Supports

Flexible supports are a person-centered support developed for an individual need, and is generally provided on a case-by-case basis. These supports do not have to be pre-approved by DHS.

Fraud Prevention Activities

Fraud Prevention Activities are as defined in 42 CFR § 438.8

Incurred Claims

Incurred claims are as defined in 42 CFR § 438.8

Independent Assessment

An Independent Assessment (IA) is required prior to becoming a member of a PASSE. Not all Medicaid enrollees can be enrolled in a PASSE. Individuals must be in need of behavioral health or developmental disabilities services. An IA is conducted by qualified individual using an assessment instrument approved by DHS. Individuals who are assessed as meeting a Tier II or Tier III level of care condition will be assigned into an active PASSE and are required to obtain all non-excluded Medicaid services through the PASSE.

An individual who is assessed as meeting a Tier I level of care condition may voluntarily enroll in a PASSE as of July 1, 2019 or later as specified by DHS.

The Tier is also used by DHS in the determination of the actuarially sound rates to be paid to a PASSE for that individual.

Medical/Quality Management Committee

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

Medical Loss Ratio

Each PASSE must report its Medical Loss Ratio (MLR) to AID and DHS. Calculation of the MLR is defined at 42 CFR § 438.8.

Member

A Medicaid beneficiary who is enrolled in a PASSE.

Network Provider

The provider who, under a contract with a PASSE or with its contractor/subcontractor, has agreed to provide Health Care Services to persons with an expectation of receiving payments directly or indirectly from the PASSE.

Open Enrollment Period

DHS will, on an annual basis, offer an open enrollment period for all current enrollees to choose a different PASSE for coverage beginning January 1 of the following year. If an individual does not make an active choice to switch PASSEs during the open enrollment period, that individual will remain a member of the same PASSE for the twelve (12) months of the new coverage year provided the individual is otherwise eligible.

Out-of-Network Provider

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

If an out-of-network provider renders a service to a PASSE member, it must do so in conformance with the rights of a Medicaid enrollee. These rights include that the provider accept the PASSE payment for services as payment in full and not bill the individual.

PASSE Equity Partners

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

Person-Centered Service Plan (PCSP)

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

A. Services necessary for the member;

B. Any specific needs the member has;

C. The member's strength and needs; and,

D. A crisis plan for the member.

Performing Provider

Individual who is the rendering provider of a particular service.

Premium Revenue

Premium revenue is as defined in 42 CFR §438.8.

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 PASSE Equity Partners; 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.

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

Provider Network

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

Quality Improvement

Activities that improve healthcare quality as defined in 42 CFR § 438.8. These activities must be designed to:

A. Improve health quality;

B. Meet specified quality performance measures;

C. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and or producing verifiable results and achievements;

D. Be directed toward individual members incurred for the benefit of specified segments of members or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-members; and

E. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

Risk-Based Comprehensive Global Payment

Risk-based comprehensive global payment is a capitated payment that is made in monthly prorated payment to the PASSE for each assigned PASSE member. Only a licensed Risk-Based Provider Organization/ Provider-Led Arkansas Shared Savings Entity (PASSE) in good standing in the State of Arkansas is eligible to receive a global payment under the program. Comprehensive means that the PASSE is at financial risk and obligated to pay for medically necessary inpatient hospital, outpatient, institutional, professional services, pharmacy, ancillary, long term care services and supports, and any other covered service, not exclusive or carved out, for members as specified in the scope of services identified in the State plan section 1905(a).

Risk-based Provider Organization (RBPO)

An entity that

A. Is licensed by the Insurance Commissioner under the rules established for risk-based provider organizations by the Arkansas Insurance Commissioner;

B. Is obligated to assume the financial risk for the delivery of specifically defined healthcare services to an enrollable Medicaid beneficiary population; and

C. Is paid by DHS on a capitated basis with a global payment made, whether or not a particular member of an enrollable Medicaid beneficiary population receives service during the period covered by the payment.

Service Encounter

A standardized record of a health care-related service, procedure, treatment, or therapy rendered by a licensed provider or providers to a PASSE member. There are two types of

service encounters, paid claim encounter and non-paid encounters that were performed but are not reimbursable.

Telemedicine

The use of electronic information and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient. It included store-and-forward technology and remote patient monitoring.

The following activities will not be considered a reportable encounter when delivered to a member of the PASSE:

A. Audio-only communication, including without-limitation, interactive audio;

B. A facsimile machine;

C. Text messaging; or

D. Electronic mail systems.

The Act

Title XIX of the Social Security Act.

Transition

The movement of a member from one PASSE to another, either by choice or for cause as defined in section 213.000 of this manual.

Value-based Payments

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

Virtual and Home Visit Provider Services

Virtual services are telemedicine, telehealth, e-consulting, and provider home visits that are part of a patient care treatment plan and are provided at the individual's home or in a community setting. These services are provided using mobile secure telecommunication devices, electronic monitoring equipment, and include clinical provider care, behavioral health therapies, speech, occupational and physical therapy services, and treatment provided to an individual at their residence. Virtual provider services may use various evidence-based and innovative independence at-home strategies. They may include the provision of on-going care management, remote telehealth monitoring and consultation, face to face or through the use secure web-based communication and mobile telemonitoring technologies to remotely monitor and evaluate the patient's functional and health status. Virtual and telehealth services are provided in lieu of providing the same services at a practice site or provided at the individual's place of residence. Therefore, these services must have patient consent, be documented in the patient integrated medical records, and submitted as a claims or encounter from a contracted provider as medically necessary service. The provision of virtual care can include an interdisciplinary care team or be provided by individual clinical service provider.

210.000 ATTRIBUTION, ENROLLMENT, TRANSITIONING AND CLOSURE

211.000 Purpose and Scope 3-1-19

The purpose of the Arkansas PASSE program, pursuant to Title XIX of the Social Security Act (The Act) and Arkansas Act 775, is to organize and manage the delivery of services for certain Medicaid beneficiaries who have complex behavioral health and intellectual and developmental disabilities service needs. The federal statutory and regulatory requirements that govern the PASSE Program are described in 42 CFR § 438. Under these authorities, DHS shall enter into a comprehensive PASSE Provider Agreement with eligible entities on an annual basis.

The scope of the PASSE program covered in this manual defines the services, standards and requirements of the PASSE organization. The PASSE organization is responsible for the provision of comprehensive medically necessary services to eligible beneficiaries who are enrolled (assigned) to the PASSE. In addition to medically necessary care and treatment services, the PASSE is responsible for:;

A. All Care Coordination activities pursuant to Ark. Code Ann. § 20-77-2703(3), including but not limited to:

   1. Assessment of an eligible individual.
   2. Development of a specific care plan.
   3. Referral to services.
   4. Monitoring activities.

B. Providing services that are responsiveness to the beneficiary's needs and choices regarding service delivery and personal goals and preferences that engages beneficiaries and caregivers or family/representative in shared decision making.

C. Integrated care services that supports the beneficiary in the least restrictive setting and assists member's full access to the benefits of supportive services and community living to prioritize the member's choice of living in their own home or choosing an Alternative HCBS Setting rather than residing in an institution.

INCORPORATION BY REFERENCE

The program descriptions, definitions, requirements, policies, procedures and standards presented in this PASSE manual are hereby incorporated by reference into the PASSE Provider Agreement.

211.200 Standard Contract Requirements 3-1-19

The Centers for Medicare & Medicaid Services (CMS) must review and approve the PASSE Provider agreement. The proposed final PASSE Provider Agreement must be submitted in the form and manner established by CMS. The proposed final PASSE Provider Agreement must be submitted to CMS for review no later than 90 days prior to the effective date of the contract.

The PASSE Provider Agreement must comply with 42 CFR § 438.3. The PASSE Provider Agreement includes:

A. Specific terms and conditions,

B. Capitation rate sheet;

C. Termination provision;

D. Notices and reporting provisions;

E. Performance period;

F. Dispute resolution;

G. Indemnity provisions; and,

H. Any other relevant information regarding the agreement between DHS and the PASSE.

212.000 Actuarial Soundness 3-1-19

Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the PASSE for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of 42 CFR § 438.4.

Capitation rates for PASSEs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:

A. Have been developed in accordance with standards specified in 42 CFR §438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.

B. Be appropriate for the populations to be covered and the services to be furnished under the contract.

C. Be adequate to meet the requirements on PASSEs in 42 CFR §§438.206, 438.207, and 438.208.

D. Be specific to payments for each rate cell under the contract.

E. Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.

F. Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in §438.3(c)(1)(ii) and (e).

G. Meet any applicable special contract provisions as specified in §438.6.

H. Be provided to CMS in a format and within a timeframe that meets requirements in §438.7.

212.100 Rate Development Standards 3-1-19

DHS must adhere to the Rate Development Standards as specified in 42 CFR §438.5.

213.000 Special Contract Provisions Related To Payment 3-1-19

Special contract provisions that are related to payment, if applicable, must comply with 42 CFR §438.6.

213.100 Rate Certification Submission 3-1-19

States must submit to CMS for review and approval, all PASSE rate certifications concurrent with the review and approval process for contracts as specified in §438.3(a). Requirements for rate certification are contained in 42 CFR §438.7.

214.000 Medical Loss Ratio (MLR) Standards 3-1-19

Medical Loss Ratio (MLR) refers to the proportion of total per member per month capitation payments that is spent on clinical services and for quality improvement. Pursuant to 42 CFR 438.8, each PASSE must report MLR to DHS and must attest to the accuracy of the calculation of MLR.

Each PASSE must calculate their MLR based upon premium revenue, incurred claims, expenditures for activities that improve health care quality, fraud prevention activities, and Federal, State, and local taxes and licensing and regulatory fees on a quarterly and annual financial report to DHS.

Any retroactive changes to capitation rates after the contract year end will need to be incorporated in the MLR calculation. If the retroactive capitation rate adjustment occurs after the MLR report has been submitted to DHS, a new report incorporating the change will be required to be submitted within 30 days of the capitation rate adjustment payment.

MLR reporting requirements are specified in the PASSE Provider Agreement.

215.000 Information Requirements 3-1-19

A. The PASSE must provide information to members in a manner and format (at least 12-point font) that is easily understood to a person who reads at the sixth (6^{th}) grade level and is readily accessible. All documents that are submitted to DHS that will be sent to members must have documentation of the reading level of that document.

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

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

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

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

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

G. The PASSE must provide each member a member identification card.

216.000 Provider Discrimination Prohibited 3-1-19

The PASSE may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. In all contracts with network providers, the PASSE must comply with the requirements specified in 42 CFR §438.214.

The above paragraph may not be construed to preclude the PASSE from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.

The PASSE must comply with all state insurance laws including the Patient Protection Act (“any willing provider”).

220.000 STATE RESPONSIBILITIES

221.000 1915(b) Waiver 3-1-19

The PASSE program operates under a waiver granted under section 1915(b) of the Act.

221.100 Requirements for PASSE Program Participation 3-1-19

To be eligible to participate 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 226.000 of this manual;

C. Have the ability to provide care coordination to attributed beneficiaries;

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, the PASSE agreement, and any applicable federal and state regulations; and

E. Successfully complete the Readiness Review outlined in Section 241.000 of this manual.

F. Meet financial and equity reserve requirements as specified by the Arkansas Insurance Department.

221.200 Covered Services 3-1-19

The PASSE is required to ensure that a member has access to all services covered under the Medicaid state plan, as well as under Section 1915(i) and DDS Community and Employment Supports (CES) waiver services, including therapy services and services through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program for children.

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

The PASSE cannot provide an incentive, monetary or otherwise, to Provider for withholding medically necessary services. With the exception of flexible services, all services provided to PASSE members must be medically necessary for each member. The PASSE must ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

The PASSE may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the enrollee. The PASSE may place appropriate limits on a service for utilization control, provided the services furnished can reasonably achieve their purpose.

The PASSE is responsible for the provision of services (except as excluded below) as described in each specific programmatic Medicaid Manual located at **https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx.** All services described in Section II of the manuals must be made accessible to PASSE members if medically necessary.

A. Excluded Services

1. Nonemergency Medical Transportation (NET);
2. Dental benefits in a capitated program;
3. School-based services provided by school employees;
4. Skilled nursing facility services;
5. Assisted living facility services;
6. Human development center services; or

7. Waiver services provided to the elderly and adults with physical disabilities through the ARChoices in Homecare program or the Arkansas Independent Choices program

In lieu of services are services that are provided in lieu of a covered benefit. These services are not part of the PASSE covered benefit, but because of special circumstances, it is deemed more cost effective to provide a non-covered service in lieu of more expensive institutional care which is covered under the PASSE program. The PASSE must determine that an "In Lieu of Service" will reduce cost and avoid institution placement or enhance the PASSE member's ability to transition from institutional or residential care. The cost of the service is claimable as a medical expense. The benefit to the PASSE is that provision of an "In Lieu of Service should reduce medical expenditures for institutional care. For example, if providing a mobile phone or paying for a WIFI connection allows the PASSE avoid skill nursing days by monitoring a member's health and vitals remotely, the cost of the mobile phone service or WIFI service would be an in lieu of service expense.

221.210 Pharmacy Requirements 3-1-19

The PASSE must use the most current version of the Arkansas Preferred Drug List (**https://arkansas.magellanrx.com/provider/documents/**), which is subject to periodic changes. The PASSE must use the Medicaid PDL developed by DHS or its Agent and may not develop and use its own PDL.

Any prior authorization program for covered outpatient drugs must comply with the requirements defined under Section 1927 of the Social Security Act.

The PASSE Provider Agreement requires that:

A. The PASSE provides coverage of covered outpatient drugs as defined in section 1927 of the Social Security Act, that meets the standards for such coverage imposed by section 1927 of the Social Security Act as if such standards applied directly to the PASSE.

B. The PASSE reports drug utilization data that is necessary for States to bill manufacturers for rebates in accordance with section 1927 of the Social Security Act, of which can be no later than 45 calendar days after the end of each quarterly rebate period. Such utilization information must include, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code of each covered outpatient drug dispensed or covered by the MCO, PIHP, or PAHP. Specific timeframes and guidelines on submission of drug utilization data is contained within the PASSE Provider Agreement.

C. The PASSE establishes procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program from the reports required in Section 1927 of the Social Security Act when states do not require submission of managed care drug claims data from covered entities directly.

D. The PASSE must operate a drug utilization review program that complies with the requirements described in Section 1927 of the Social Security Act and 42 CFR part 456, subpart K, as if such requirement applied to the PASSE instead of the State.

The PASSE must provide a detailed description of its drug utilization review program activities to the State on an annual basis as described in the PASSE Provider Agreement.

221.220 Therapeutic Classes of Drugs 3-1-19

If the PASSEs do not include a covered outpatient drug that is otherwise covered by the state plan, access to the off-formulary covered outpatient drug must be aligned with the prior authorization requirements as defined under Section 1927 of the Social Security Act.

221.230 Prohibition of More Restrictive Coverage Than Arkansas Medicaid Fee For Service 3-1-19

PASSEs must demonstrate prescription drug coverage for outpatient and physician-administered drugs that is not less than the amount, duration, and scope as described by Medicaid Fee-For-Service (FFS). All PASSEs will be required to guarantee access to Medicaid Fee-for-Service Covered Outpatient Drugs.

PASSEs must guarantee access to inpatient drugs at least at the level consistent with Medicaid FFS.

221.300 Payment 3-1-19

The global capitation payment made to a PASSE covers the costs of services, administration, and care coordination of members assigned to the PASSE in accordance with 42 CFR § 438.2. The global payment will be actuarially sound and made to each PASSE on a Per Member Per Month (PMPM) basis. The global capitation payment amount is determined on an annual basis and includes a variety of factors including the results of the Independent Assessment and cost trends.

221.310 Prorated Payments 3-1-19

The PASSE will receive a prorated PMPM for members beginning coverage the same month as assignment to a PASSE. Payments will be prorated for the number of days in the month in which the member is effective with the PASSE.

221.320 PASSE Member Disenrollment 3-1-19

PASSE Disenrollment will be based upon a determination by DHS that a member is no longer eligible to receive PASSE services. A member will be assigned to the same PASSE if re-enrollment occurs within one-hundred and eighty (180) days of previous disenrollment. Disenrollment will occur because of the following:

A. Member loses Medicaid eligibility.

B. Member is placed in a setting or receives services excluded from the PASSE, e.g. full admission to a Human Development Center, a skilled nursing or assisted living facility, or approval for waiver services provided through the ARChoices in Homecare or Independent Choices programs or successor waiver for the frail, elderly, or physically disabled.

221.400 Choice of PASSE 3-1-19

DHS complies with 42 CFR § 438.52 in offering a Medicaid beneficiary the choice of PASSE provider.

221.500 Member Enrollment 3-1-19

Any newly identified member that is mandatorily assigned to a PASSE will be assigned based upon the following rules:

A. A member will be assigned to a PASSE based upon proportional assignment. That is, the first member will be assigned to PASSE A, the next to PASSE B, the next to PASSE C, etc. This methodology will be utilized, unless the following condition(s) exist:

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

2. A PASSE fails to meet specified quality metrics as defined in the PASSE Provider Agreement; or

3. A PASSE is subject to a sanction that includes a moratorium on having members assigned to it.

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

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

2. There is cause for transition, as described in 42 CFR 438.56, is met.

The effective date of PASSE assignment will be 7 calendar days after the date of auto-assignment or voluntary enrollment. The PASSE will receive a prorated global payment for individuals beginning coverage the same month as auto-assignment or voluntary enrollment.

Voluntary enrollment into a PASSE is not allowed prior to July 1, 2019.

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

C. Consistently poor-quality performance;

D. Inadequate provider network capacity;

E. High number of member complaints about PASSE services or about access to care; and

F. Financial solvency concerns.

221.510 Eligibility Requirements for PASSE 3-1-19

An Independent Assessment (IA) is required prior to becoming a member of a PASSE. Not all Medicaid enrollees can be enrolled in a PASSE. Individuals must be in need of behavioral health or developmental disabilities services. An IA is conducted by qualified individual using an assessment instrument approved by DHS.

Beneficiaries who meet the following criteria will be put into Placement Suspension from the PASSE:

A. Residents of a Human Development Center (HDC)

B. Residents of a Skilled Nursing Facility (SNF)

C. Residents of an Assisted Living Facility (ALF)

D. Participants of waiver services provided to adults with physical disabilities through the ARChoices in Homecare program or the Arkansas Independent Choices program or any successor waiver for frail, elderly or physically disabled adults.

E. Beneficiaries receiving Arkansas Medicaid healthcare benefits on a medical Spenddown basis.

221.520 Eligible Medicaid Beneficiaries and Mandatory Enrollment 3-1-19

The following beneficiaries are eligible for mandatory assignment to a PASSE:

A. Beneficiaries identified to meet Tier II or Tier III Level of Care as determined by an independent assessment under criteria established DHS.

1. For beneficiaries with BH service needs:

a. 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.

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

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

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

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

3. For beneficiaries who are dually-diagnosed (Behavioral Health and Developmental Disabilities services needs):

a. The member meets the institutional level of care criteria by the Division of Developmental Disabilities (DDS) and has received an Independent Assessment and been determined to meet Tier II or Tier III Level of Care.

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

ii. Have met the institutional level of care for ICF/IID; and

iii. Have received an IA and are eligible for Tier II or Tier III behavioral health services.

iv. The DHS Dual Diagnosis Evaluation Committee must review and approve all members that will be placed into the dually-diagnosed category.

221.530 Voluntary Enrollment 3-1-19

Voluntary enrollment into a PASSE may begin on or after July 1, 2019. In order to voluntarily enroll into a PASSE, a beneficiary must have BH or DD services needs and be identified as meeting a Tier I level of care through the Independent Assessment.

221.540 Enrollment Discrimination Prohibited 3-1-19

The PASSE will not, on the basis of health status or disability or need for health care services, discriminate against individuals eligible to enroll. The PASSE shall comply with 42 CFR § 438.3(d).

The PASSE cannot transition any assigned member and is responsible for all eligible services provided to that member during the time the member is eligible and a member of that PASSE.

221.600 Member Disenrollment: Requirements and Limitation 3-1-19

The PASSE may not request disenrollment of a member because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when, as determined by DHS, his or her continued enrollment in the PASSE seriously impairs the PASSE's ability to furnish services to either this particular member or other members).

The PASSE cannot transition any assigned member and is responsible for all eligible services provided to that member during the time the member is eligible and a member of that PASSE.

221.700 Transitioning To a Different PASSE 3-1-19

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

There will be a yearly open enrollment period when a mandatorily enrolled member may voluntarily transition to a different PASSE. The annual open enrollment period when a member can transition their PASSE will be established by DHS and will be for no shorter than 30 days on a yearly basis. If no action is taken by the member, they will remain in 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 for the following year.

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

A. The member moves out of the state;

B. The PASSE for which the member is assigned is sanctioned pursuant to Sections I and II of this manual, the PASSE Provider Agreement, or any state or federal regulations and laws;

C. The PASSE does not, because of moral or religious objections, cover the service the member 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 member's care needs.

Transition from a PASSE will be processed by DHS after request of change by the member. 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 member request for transition was received.

To request a transition, a member should contact:

Arkansas Department of Human Services, Beneficiary Support Center

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

222.000 Conflict of Interest Safeguards 3-1-19

As a condition for contracting with the PASSE, DHS has safeguards against conflict of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to the PASSE contracts or the enrollment processes specified in 42 CFR §438.54(b).

223.000 Prohibition of Additional Payments For Services Covered By The PASSE 3-1-19

No payment will be made by DHS to a provider other than the capitated payment to a PASSE for services covered under the PASSE Provider Agreement.

224.000 Continuity of Care and Services to Members 3-1-19

DHS must arrange for Medicaid services to be provided without delay to any member of a PASSE of which the PASSE Provider Agreement is terminated and for any member who is disenrolled from a PASSE for any other reason than ineligibility for Medicaid.

DHS must have in effect a transition of care policy to ensure continued access to services during a transition from FFS to a PASSE entity or transition from one PASSE to another when a member, in absence of continued services, would suffer serious determent to their health or be at risk of hospitalization or institutionalization.

The transition of care policy must include the following:

A. The enrollee has access to services consistent with the access they previously had, and is permitted to retain their current provider for a period of time if that provider is not in the PASSE's network.

B. The enrollee is referred to appropriate providers of services that are in the network.

C. The PASSE that was previously serving the member, fully and timely complies with requests for historical utilization data from the new PASSE in compliance with Federal and State law.

D. Consistent with Federal and State law, the member's new provider(s) are able to obtain copies of the member's medical records, as appropriate.

E. Any other necessary procedures as specified by CMS to ensure continued access to services to prevent serious detriment to the member's health or reduce the risk of hospitalization or institutionalization.

DHS will require in the PASSE Provider Agreement that PASSEs implement a transition of care policy consistent with the requirements of this section and at least meets the State defined transition of care policy.

At a minimum, all members who have an existing Person Centered Service Plan (PCSP) will carry that care plan with them when they are enrolled into a PASSE. Each member will be assigned a Care Coordinator who must make contact with that member within 15 business days of the effective date of PASSE enrollment. The PASSE Care Coordinator will have 60 days from PASSE enrollment to conduct a health questionnaire and coordinate a PCSP Development meeting with the member. The PCSP must address any needs noted in the Independent Assessment, the health questionnaire, or any other assessment or evaluation used at the time of PCSP development.

DHS will make its transition of care policy publicly available and provide instructions to members and potential members on how to access continued services upon transition. At a minimum, the transition of care policy must be described in the quality strategy, under § 438.340, and explained to individuals in the materials to members and potential members, in accordance with 42 CFR § 438.10.

In the case of transitioning between PASSEs, the relinquishing PASSE is responsible for timely notification to the receiving PASSE regarding pertinent information related to any special needs of transitioning members. The PASSE, when receiving a transitioning member with special needs, is responsible to coordinate care with the relinquishing PASSE in order that services are not interrupted, and for providing the new member with new accountable providers and care coordinator as well as service information, emergency numbers and instructions on how to obtain services. The PASSE shall assure appropriate medical records, care treatment plans, and care management files are transitioning to the receiving PASSE.

The PASSE should give special attention to beneficiaries that experience the following circumstances:

A. Living in their own home who have significant conditions or treatments such as pain control, hypertension, enteral feedings, oxygen, wound care, and ventilators;

B. Are receiving ongoing services such as daily in-home care, crisis behavioral health care, dialysis, home health, specialized pharmacy prescriptions, medical supplies, chemotherapy and/or radiation therapy, or who are hospitalized at the time of transition;

C. Members who have received prior authorization for services such as scheduled surgeries, post- surgical follow up visits, therapies to be provided after transition or out-of-area specialty services;

D. Have significant medical conditions requiring ongoing monitoring or screening, and

E. Have submitted service grievance and appeal that is pending resolution.

The PASSE shall have appropriate policies, procedures, and trained staff to manage these transitions and assure continuity of care.

It is the PASSE's responsibility to assure a smooth beneficiary transition and provide continuity of service for at least ninety (90) days or until transition process is complete. [42 CFR 438.1]

225.000 State Monitoring 3-1-19

DHS will monitor the activities of each PASSE and the PASSE program as a whole as defined in CFR 42 §438.66. This includes the conduct of hearings requested by a PASSE or a provider due to alleged anti-competitive practices.

As required by 42 CFR § 447.203, DHS will monitor PASSE organization network providers to ensure members have adequate access to care. DHS has established access standards which the PASSE is required to meet. DHS requires that the PASSE and contract provider networks cooperate with DHS's analysis for access and provide any requested data required to carry out DHS's process for monitoring access to care.

DHS will seek public comment from time to time to identify any areas of concern about access to care or service availability. As required by federal regulation DHS shall perform an analysis of timely access to care at the end of the first year of the PASSE program and at least every three years thereafter for each of the following provider:

A. Primary care services – including those provided by a physician, federally qualified health center (FQHC), clinic, and community health centers;

B. Physician specialist services;

C. Behavioral health services – including mental health and substance use disorder;

D. Home health services;

E. Additional types of services where the state or the Centers for Medicare and Medicaid Services (CMS) has received a significantly higher than usual volume of beneficiary, provider, or other stakeholder access complaints, and

F. For any services that can prevent ambulatory care, preventable emergency room visits, hospitalization, re-admissions or if it is determined that circumstances have change that would result in diminished access to care for enrollees.

G. Developmental Disability Services

225.100 Audited Financial Reports 3-1-19

The PASSE must submit audited financial reports as outlined in the PASSE Provider Agreement and this manual on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

225.200 Recordkeeping Requirements 3-1-19

The PASSE must retain, and require subcontractors to retain, as applicable, the following information: member grievance and appeal records in § 438.416, base data in § 438.5(c), MLR reports in § 438.8(k), and the data, information, and documentation specified in §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

226.000 Network Adequacy Standards 3-1-19

A PASSE must maintain a network that is sufficient in numbers and types of providers to ensure that all needed services to attributed members will be adequately accessible without unreasonable delay and within the time and distance requirements set out in this policy. At a minimum, the PASSE must contract with all provider types specified in the Provider Network Standards Table below. The PASSE must ensure provider ratios and provider-specific geographic access standards for members in urban or rural counties are met and maintained throughout the agreement year. For purposes of assessing adequate number and types of providers, DHS will determine provider ratios based upon one hundred twenty percent (120%) of the PASSE's actual monthly enrollment.

Network adequacy is determined based upon the inclusion of Medicaid enrolled providers that have signed a contract with the PASSE to provide services to members that have been attributed to a PASSE. A provider not enrolled as a Medicaid provider will not be counted towards meeting network adequacy.

Provider types listed in the chart below are the providers that are counted towards meeting network adequacy. A performing provider that is a contracted network provider of a PASSE who works at a facility does not mean that the facility will be counted towards meeting network adequacy. For purposes of network adequacy, "facility" includes a site, clinic, group practice, or other organization or business arrangement in which the performing provider is not an employee. The facility must have a signed contract with the PASSE in order for the facility to be counted towards meeting network adequacy. The PASSE must provide the National Provider Identifier (NPI) of the provider and the facility/group NPI if the entity bills at the facility level (including, if available, the Medicaid ID of the provider) in the required bi-annual network submission on January 30th and July 30th for the previous six (6) months.

The PASSE must prepare, submit to DHS for approval, and follow a documented process for credentialing and recredentialing of providers who have signed contracts/agreements with the PASSE. The PASSE must utilize a universal process for providers as described in 249.300 and approved by DHS.

Urban counties are those with a population greater than 90,000 citizens as estimated by the United State Census Bureau for the current calendar year.

Urban counties include:

A. Benton

B. Craighead

C. Faulkner

D. Garland

E. Pulaski

F. Saline

G. Sebastian

H. Washington

Distance from members to Specialty Provider types and Provider to Enrollee ratio for different provider types will be reported in the required bi-annual network submission that is due to DHS on January 30th and July 30th for the previous 6 months. Each PASSE shall attest and submit documentation that demonstrates the PASSE provider network is compliant with the below standards. If the PASSE is utilizing telemedicine, the PASSE must document what services they

allow the usage of telemedicine for, the settings allowed to utilize telemedicine at, and the qualifications for individuals to perform services via telemedicine.

Provider Specialty	**Provider Type**	**Urban**	**Rural**	**Provider Ratio**
	Arkansas Medicaid Provider Type and associated specialty, if applicable	Maximum Distance (miles)	Maximum Distance (miles)	Providers per Member
Primary Care	01, 02, 03, 04, 58, 62	30	60	1:250 members
Pediatrics – Routine/Primary Care	01, 02, 03, 04, 58, 62	30	60	1:250 members
Ambulatory Surgical Center	28	40	90	1:1,000 members
Allergy and Immunology		40	90	1:500 members
Cardiothoracic Surgery		40	90	1:1,000 members
Cardiovascular Disease		40	90	1:500 members
Dermatology		40	90	1:1,000 members
Supportive Living / Respite / Supplemental Support	67	n/a	n/a	Ability to provide service in all Arkansas counties
Environmental Modifications / Adaptive Equipment	72	n/a	n/a	Ability to provide service in all Arkansas counties
Specialized Medical Supplies	73	n/a	n/a	Ability to provide service in all Arkansas counties
Supported Employment	75	n/a	n/a	Ability to provide service in all Arkansas counties
Diagnostic Radiology		40	90	1:1,000 members
Endocrinology		40	90	1:750 members
ENT/Otolaryngology		40	90	1:750 members

Provider Specialty	Provider Type	Urban	Rural	Provider Ratio
Federally Qualified Health Center (FQHC)	49	n/a	n/a	Must have at least 1 FQHC enrolled as a network provider
Gastroenterology		40	90	1:750 members
General Surgery		40	90	1:500 members
Gynecology, OB/GYN		30	60	1:250 members
Hematology		40	90	1:750 members
Home Health	14	n/a	n/a	Ability to provide service in all Arkansas counties
Hyperalimentation	33	n/a	n/a	Ability to provide service in all Arkansas counties
Intermediate Care Facility	12, 13	n/a	n/a	Ability to provide service in all Arkansas counties
Infectious Diseases		40	90	1:1,000 members
Nephrology		40	90	1:1,250 members
Neurology		40	90	1:1,000 members
Neurosurgery		40	90	1:1,000 members
Oncology		40	90	1:1,000 members
Ophthalmology	22	40	90	1:1,000 members
Optometry	22	40	90	1:800 members
Orthopedic Surgery		40	90	1:1,000 members
Orthotics and Prosthetics	16	40	90	1:1,000 members
Outpatient Dialysis	34	40	90	1:1,000 members
Outpatient Infusion/Chemotherapy		40	90	1:3,000 members
Personal Care	32	n/a	n/a	Ability to provide service in all Arkansas counties
Pharmacy	07	20	50	1:1,000 members
Physical medicine and rehabilitation, Psychiatry		40	90	1:1,000 members

Provider Specialty	Provider Type	Urban	Rural	Provider Ratio
Plastic Surgery		40	90	1:1,000 members
Podiatry	17, 48	40	90	1:1,000 members
Pulmonary		40	90	1:1,000 members
Rheumatology		40	90	1:1,500 members
Rural Health Clinic	29	n/a	n/a	Must have at least 1 RHC enrolled as a network provider
Therapist (Occupational)	21, 42	30	60	1:500 members
Therapist (Physical)	21, 42	30	60	1:500 members
Therapist (Speech)	21, 42	30	60	1:500 members
Urology		40	90	1:1,000 members
Vascular Surgery		40	90	1:1,250 members
Ventilator Equipment	37	n/a	n/a	Ability to provide service in all Arkansas counties

Facility/Group/Organization				
Provider Specialty	**Provider Type**	**Urban**	**Rural**	**Provider Ratio**
Acute Inpatient Hospital	05	30	60	1 bed: 400 members
Adult Developmental Day Treatment (ADDT)	24, AN	n/a	n/a	Ability to provide service in all Arkansas counties
Critical Care Services – Intensive Care Units (ICUs)	05	30	90	1 bed: 800 members
DME	16	n/a	n/a	Ability to provide service in all Arkansas counties
Outpatient Hospital	05	30	60	n/a

Behavioral Health				
Provider Specialty	**Provider Type**	**Urban**	**Rural**	**Provider Ratio**
Independently Licensed Clinician – Master's/Doctoral	19	40	75	1:750 members
Board Certified Psychiatrist	01, 02, 03, 04	40	75	1:500 members
Inpatient Psychiatric Facility for Individuals Under the Age of 21	25	n/a	n/a	1 bed: 300 members
Substance Abuse Treatment Provider	26, R6	40	120	1:750 members

226.100 Access to Service/Waiting Time Standards 3-1-19

A PASSE must meet the following time frame standards:

Service Type	Time Frame	Time Frame Goal
Emergency Care – Medical, Behavioral Health, Substance Abuse	24 hours a day, 7 days a week	Met 100% of the time
Behavioral Health Service and Developmental Disability Service Mobile Crisis Response	24 hours a day, 7 days a week	Met 100% of the time
Urgent Care – Medical, Behavioral Health, Substance Abuse	Within 24 hours	Met 100% of the time
Primary Care – Routine, non-urgent symptoms	Within 21 calendar days	Met ≥ 90% of the time
Behavioral Health, Substance Abuse Care – Routine, non-urgent, non-emergency	Within 21 calendar days	Met ≥ 90% of the time
Prenatal Care	Within 14 calendar days	Met ≥ 90% of the time
Primary Care Access to after-hours care	Office number answered 24 hours / 7 days a week by answering service or instructions on how to reach a physician	Met ≥ 90% of the time
Preventive visit/well visits	Within 30 calendar days	Met ≥ 90% of the time
Specialty Care – non-urgent	Within 60 calendar days	Met ≥ 90% of the time

226.200 Network Adequacy Variance Request 3-1-19

DHS has the sole discretion to allow a variance of any of these network adequacy standards. 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.

226.300 Network Adequacy Reporting 3-1-19

A PASSE must monitor, on an ongoing basis, the ability of its participating providers to furnish all required benefits to members. The state must approve the network monitoring methodology used by the PASSE to validate that network adequacy and access to care standards are being met. A PASSE must monitor and report on the following within the specified timeframe listed: bi-annual (reports due January 30th and July 30th for the previous 6 months) basis:

A. Bi-Annual Basis (reports due January 30th and July 30th for the previous 6 months)

1. Provider to member ratios by specialty;
2. Primary Care Professionals to member ratios; and
3. Geographic accessibility.

B. Annual Basis (reports due January 30th for the previous 12 months)

1. Waiting times for appointments with participating providers;
2. General hours of operation, including part of full time status and weekend and after hour availability;
3. If the PASSE allows the use of telemedicine, it must do so in compliance with the Arkansas Telemedicine Act. Ark. Code Ann. § 17-80-401 et seq. The PASSE must document what services the PASSE allows, the settings allowed, and the qualifications for individuals to perform services via telemedicine; and
4. Gaps in service capacity or capability and proactively develop a plan to correct in gaps in network services or area of inadequate capacity to serve members.

227.000 Stakeholder Engagement in PASSE Program 3-1-19

In accordance with 42 CFR §438.70, DHS must ensure the views of beneficiaries, individuals representing beneficiaries, providers, and other stakeholders are solicited and addressed during the design, implementation, and oversight of the PASSE program.

228.000 Beneficiary Support System 3-1-19

DHS shall maintain a Beneficiary Support System in accordance with 42 CFR §438.71. The Beneficiary Support System will offer choice counseling for all beneficiaries, assistance for members understanding organized care, and assistance for members who use or express a desire to receive home and community based supportive services.

229.000 State Oversight of the Minimum MLR Requirements 3-1-19

DHS will annually submit to CMS a summary description of the report(s) received from the PASSEs according to 42 CFR §438.8(k), with the rate certification required in 42 CFR §438.7. The summary description must include, at a minimum, the amount of the numerator, the amount of the denominator, the MLR percentage achieved, and the number of member months for that MLR reporting year.

The PASSE shall submit the Medical Loss Ratio (MLR) report annually in compliance with 42 CFR § 438.8. In the event of retroactive changes to capitation rates after the contract year end, the PASSE will need to be incorporated into the MLR calculation. If the retroactive capitation rate adjustment occurs after the MLR report has been submitted to the State, a new report

incorporating the change will be required to be submitted within 30 days of the capitation rate adjustment payment is made.

230.000 MEMBERS RIGHTS AND PROTECTIONS

231.000 Member Rights 3-1-19

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 member adversely.

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

H. The right to a member handbook and referral network directory to be sent or made available to the member within five (5) business days of assignment.

231.100 Annual Enrollment Period 3-1-19

DHS will, on an annual basis, offer an open enrollment period for all current enrollees to choose a different PASSE for coverage beginning January 1 of the following year. If an individual does not make an active choice to switch PASSEs during the open enrollment period, that individual will remain a member of the same PASSE for the 12 months of the new coverage year provided the individual is otherwise eligible.

The annual open enrollment period when a member can transition their PASSE will be established by DHS and will be for no shorter than 30 days on a yearly basis.

231.200 90 Day Period To Change PASSE 3-1-19

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

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

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

To request a transition, a member should contact:

Arkansas Department of Human Services, Beneficiary Support Center

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

231.300 Right To Change PASSE For Cause 3-1-19

A member may not change their PASSE outside of the 90-day period following initial assignment or during the annual open enrollment period, unless cause for transition is met.

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

A. The member moves out of the state;

B. The PASSE for which the member is assigned is sanctioned pursuant to this manual, the PASSE Provider Agreement, or any state or federal regulations and laws;

C. The PASSE does not, because of moral or religious objections, cover the service the member 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 member's care needs, as determined by DHS in its sole discretion.

231.400 Provider Network Directory 3-1-19

The PASSE must submit to DHS an electronic file of the PASSE provider network directory and network services on a monthly basis. The PASSE provider network directory or a link to the PASSE provider network directory will be posted on the Arkansas Medicaid website. The PASSE must maintain a provider 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 Provider Network:

1. Names, as well as any group affiliations.
2. Street addresses.
3. Telephone numbers.
4. Website URLs, as appropriate;
5. Specialties, as appropriate; and
6. If provider is accepting new Medicaid clients.
7. Provider's cultural and linguistic capabilities, including languages offered by the provider or skilled medical interpreter at the provider's office and whether provider has completed cultural competence training; and
8. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

B. Clearly explains differences of in-network providers versus out of network providers to members.

C. Updated at least monthly, with the updates posted on the PASSE's website and on the Arkansas Medicaid website. The Provider network Directory must be placed on the PASSE website and be made available to members and DHS.

D. Attestation from the PASSE that their network meets the State's required network adequacy standards.

231.500 Choice of Health Professional 3-1-19

The PASSE must allow each member to choose his or her health professional to the extent possible and appropriate.

The PASSE is responsible for assigning each member to a PCP.

232.000 Provider-Member Communications 3-1-19

The PASSE must adhere to all provider-member (enrollee) communication requirements as described in 42 CFR § 438.102.

A. The PASSE must provide information to members in a manner and format (at least 12-point font) that is easily understood to a person who reads at the sixth (6th) grade level and is readily accessible. All documents that are submitted to DHS that will be sent to members must have documentation of the reading level of that document.

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

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

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

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

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

G. The PASSE must provide each member a member identification card.

H. The PASSE must provide each member notification of their primary care provider.

233.000 Marketing Activities 3-1-19

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

Marketing means any communication from the PASSE, or any of its agents, participating providers, direct service providers, or independent contractors, to a member of another PASSE or a potential member that can reasonably be interpreted as intended to influence that individual to enroll, remain enrolled or reenroll in the PASSE, or to disenroll from or not enroll in another PASSE.

A PASSE may only distribute information to a current member of their PASSE. Other than the welcome information if a member transitions to their PASSE, a PASSE cannot provide any information to a Medicaid member that is a member of another PASSE. Participating providers and direct service providers cannot distribute information to a Medicaid member about enrolling in a specific PASSE. The only allowable information that can be distributed to Medicaid beneficiaries by participating providers and direct service providers will be information that is provided by DHS.

All marketing materials and activities must be approved by DHS in advance of use. DHS may impose sanctions on the PASSE, participating providers, and direct service providers if there is a failure to adhere to the marketing material requirements and restrictions.

234.000 Liability for Payment 3-1-19

The PASSE must ensure that its members are not held liable for any of the following:

A. The PASSE's debts, in the event of the PASSE's insolvency;

B. Covered services provided to the Member, for which:

1. DHS does not pay the PASSE; or
2. The State or PASSE does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.

C. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the PASSE covered the services directly.

235.000 Cost Sharing 3-1-19

Cost sharing is not allowed for members assigned to a PASSE.

236.000 Consumer Advisory Committee – CFR 42 § 438.110 3-1-19

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. The PASSE is required to submit to DHS minutes and/or reports indicating the activities carried out by the Consumer Advisory Council on a quarterly basis.

At a minimum, the Consumer Advisory Council must:

A. Conduct meetings at least quarterly to discuss matters within the scope of Consumer Advisory Council business;

B. Review marketing materials for content and appropriateness;

C. Review other informational materials for content and appropriateness;

D. Review the results of the PASSE administered satisfaction survey; and

E. Monitor and provide quality assurance to grievances filed by PASSE members.

237.000 Emergency and Post Stabilization Services 3-1-19

The PASSE must adhere to 42 CFR § 438.114 in regards to coverage and payment for emergency and post stabilization services.

238.000 Solvency Standards 3-1-19

The Arkansas Insurance Department (AID) will ensure that each PASSE meets solvency standards to remain licensed as a Risk-Based Provider Organization.

240.000 CARE COORDINATION REQUIREMENTS

241.000 Availability of Services and Readiness Review 3-1-19

The PASSE is required to ensure that a member has access to all allowed Medicaid state plan services, including those authorized under the 1915(i) amendment, and CES waiver services. State plan services also include therapy services and services through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program for children.

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

The PASSE must ensure that network providers and the PASSE itself complies with 42 CFR § 438.206.

Pursuant to 42 CFR § 438.66 governing state monitoring requirements and this Manual, DHS will assess the ability and capacity of the PASSE to satisfactorily perform in the following areas:

A. Administrative staffing and resources, which includes key staff members and organizational charts;

B. Delegation and oversight of Care Coordination responsibilities, which includes proof of 24 hours a day, 7 days a week access to care coordination;

C. Program Integrity/Compliance protocols;

D. Proof of the ability to manage and maintain Electronic Health Records;

E. Member handbook;

F. Provider handbook;

G. Grievance and appeals process;

H. Provider Network directory;

I. Proof of infrastructure to pay and actively monitor claims submitted by providers,

1. This includes:

a. Ability to pay claims in a timely manner (no less than 30 days after a clean claim has been submitted);

b. Proof that any applicable audits and edits that reject claims that do not conform to PASSE provider handbooks requirements, including but not limited to, claims that require prior authorization, pre-payment review, daily/weekly/monthly/yearly billing restrictions, etc. result in the denial of a claim.

J. Member notices and ID cards;

K. Member rights policies;

L. Composition of and by-laws for the Medical/Quality Management Committee;

M. Any allowed marketing materials;

N. Demonstration of the ability to process claims and provider payments;

O. Medical Management policies and procedures;

P. Financial management, banking, and financial control policies and procedures;

Q. Demonstration of ability to provide to DHS any required reports;

R. Demonstrated ability to connect with the Arkansas Medicaid Management Information System (MMIS) to provide encounter claims and other information as necessary to ensure appropriate monitoring of the PASSE;

S. Proof of Provider Network adequacy according to Section 222.000.

241.100 Assurance of Adequate Capacity and Services 3-1-19

A PASSE must monitor, on an ongoing basis, the ability of its participating providers to furnish all required benefits to members. The state must approve the network monitoring methodology

used by the PASSE to validate that network adequacy and access to care standards are being met. A PASSE must monitor and report on the following within the specified timeframe listed: bi-annual (reports due January 30th and July 30th for the previous 6 months) basis:

A. Bi-Annual Basis (reports due January 30th and July 30th for the previous 6 months)

1. Provider to member ratios by specialty;
2. Primary Care Professionals to member ratios;
3. Care Coordinator to Client ratios; and
4. Geographic accessibility.

B. Annual Basis (reports due January 30th for the previous 12 months)

1. Waiting times for appointments with participating providers;
2. General hours of operation, including part of full time status and weekend and after hour availability;
3. The volume of technological and specialty services available to serve the needs of members requiring technologically advanced or specialty care;
4. If the PASSE allows the use of telemedicine, the PASSE must document what services the PASSE allows, the settings allowed, and the qualifications for individuals to perform services via telemedicine; and
5. Gaps in service capacity or capability and proactively develop a plan to correct in gaps in network services or area of inadequate capacity to serve members.

242.000 Coordination and Continuity of Care 3-1-19

A. The PASSE must provide care coordination to each of its assigned beneficiaries. Care coordination ensures that all services are coordinated and appropriately delivered by providers. The PASSE must have care coordinators who will work with the member'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 PASSE must comply with Conflict Free Case Management rules pursuant to 42 CFR 441.330(c)(1)(iv). The PASSE must hire Care Coordinators or contract with entities who will work with the PASSE Member’s providers to ensure continuity of care across all services while maintaining independence from direct service providers. Conflict-free care coordination is a critical protection for members and a matter of program integrity.

Care Coordinators or case managers who are employed or subcontracted by an organization that has responsibility for the development and delivery of a service plan for an enrollee shall not fulfill the responsibility of the PASSE to provide care coordination for that individual. Additionally, Care Coordinators shall not be related by consanguinity (3rd degree or less) or marriage to the individual enrollee, his or her paid caregivers, or anyone financially responsible for the individual.

C. The PASSE care coordinator is responsible for assisting the member with moving between service settings, for example with the move from the residential treatment setting to community based care and to ensure that the member is placed in or remains at the most appropriate and least restrictive setting that meets that member's needs.

D. Care coordination services must be available to PASSE members 24 hours a day through a hotline or web-based application.

242.100 Care Coordinator Qualifications 3-1-19

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;

B. Successfully complete the following background checks:

1. Criminal background check;
2. Child maltreatment registry check; and
3. Adult maltreatment registry check.

AND

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

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

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

243.000 Coordination of Benefits: Third Party Liability (TPL) 3-1-19

Coordination of Benefits (COB) refers to the activities involved in determining Medicaid benefits when an enrollee has coverage through an individual, entity, insurance, or program that is liable to pay for health care services. The PASSE is responsible for TPL.

Medicaid is the payor of last resort unless specifically prohibited by applicable State or Federal law. This means the PASSE shall pay for covered services only after all other sources of payment have been exhausted, e.g. the insurance carrier of a tortfeasor. The PASSE shall take reasonable measures to identify potentially legally liable third party sources.

If the PASSE discovers the probable existence of a liable third party that is not known to DHS, or identifies any change in coverage, the PASSE must report the information within thirty (30) days of discovery via the TPL File. Failure to report these cases may result in a sanction.

The PASSE shall coordinate benefits in accordance with 42 CFR § 433.135, so that costs for services otherwise payable by the PASSE are cost avoided or recovered from a liable third party [42 CFR § 434.6(a)(9)]. The term "State" shall be interpreted to mean "PASSE" for purposes of complying with the Federal regulations referenced above. The PASSE may require subcontractors to be responsible for coordination of benefits for services provided pursuant to the PASSE Provider Agreement. The two methods used for coordination of benefits are Cost

Avoidance and Post-Payment Recovery. The PASSE shall use these methods as described in Federal and State policies.

The PASSE shall cost avoid a claim if it has established the probable existence of a liable party at the time the claim is filed. There may be limited circumstances when cost avoidance is prohibited, and the PASSE must apply post-payment recovery processes.

For purposes of cost avoidance, establishing liability takes place when the PASSE receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or service delivered to a PASSE member. If the probable existence of a party's liability cannot be established, the PASSE must adjudicate the claim, and then utilize post-payment recovery if necessary. If DHS determines that the PASSE is not actively engaged in cost avoidance activities, the PASSE may be subject to sanctions.

If a third-party insurer requires the member to pay any copayment, coinsurance or deductible, the PASSE is responsible for making these payments for Medicaid covered services.

The PASSE is delegated the responsibility for coordination of benefits payment activities with legally liable third parties, including Medicare. For dual eligible members, the PASSE shall coordinate Medicare fee-for-service (FFS) crossover claims payment activities with the Medicare Benefits Coordination and Recovery Center (BCRC) in accordance with 42 CFR § 438.3(t).

The PASSE shall be registered with the BCRC as a trading partner to electronically process Medicare FFS crossover claims. An Attachment to the existing DHS Medicare FFS Coordination of Benefits Agreement (COBA) shall be executed by PASSE to register as a BCRC trading partner. Upon completion of the registration process, the BCRC shall issue each PASSE a unique COB ID number. The PASSE will electronically receive data from the BCRC to coordinate payment of Medicare FFS crossover claims only. The PASSE shall be exempt from BCRC crossover processing fees to the same extent as DHS.

Upon completion of trading partner registration, PASSE shall coordinate with the BCRC regarding the sending, receipt and transmission of necessary BCRC-provided data files and file layouts, including eligibility and claim data files. PASSE shall begin adjudicating Medicare FFS crossover claims upon completion of BCRC readiness review activities and receipt of BCRC approval.

Further information and resources for PASSE regarding the Medicare FFS COBA process and BCRC requirements are available at:

A. Medicare Benefits Coordination and Recovery Center (BCRC) webpage: **https://https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview Benefits-and-Recovery-Overview/Overview.html**

B. COBA Implementation User Guide: **https://www.cms.gov/files/document/coba-implementation-user-guide-version-71-april-2021.pdf**

C. Electronic File Layouts: **https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/COBA-Trading-Partners/COBA-File-Formats-and-Connectivity/COBA-File-Formats-and-Connectivity-page**

The PASSE shall not deny a claim for timeliness if the untimely claim submission results from a provider's reasonable efforts to determine the extent of liability.

Post-payment recovery is necessary in cases where the PASSE has not established the probable existence of a liable third-party at the time services were rendered or paid for, was unable to cost-avoid, or post-payment recovery is required. In these instances, the PASSE must adjudicate the claim and then utilize post-payment recovery processes which include: Pay and Chase, Retroactive Recoveries Involving Commercial Insurance Payor Sources, and other third-party liability recoveries.

A. Pay and Chase - The PASSE shall pay the full amount of the claim according to the DHS Fee-For-Service Schedule or the negotiated contracted rate and then seek reimbursement from any third party if the claim is for the following:

1. Prenatal care for pregnant women, including services which are part of a global OB Package
2. Preventive pediatric services, including Early and Periodic Screening Diagnosis and Treatment (EPSDT) and administration of vaccines to children under the Vaccines for Children (VFC) program, or
3. Services covered by third party liability that are derived from an absent parent whose obligation to pay support is being enforced by Child Support Enforcement.

B. Retroactive Recoveries Involving Commercial Insurance Payor Source: For a period of two years from the date of service, the PASSE shall engage in retroactive third party recovery efforts for claims paid to determine, if there are commercial insurance payor sources that were not known at the time of payment. In the event a commercial insurance payor source is identified, the PASSE must seek recovery from the commercial insurance. The PASSE is prohibited from recouping related payments from providers, requiring providers to take action, or requiring the involvement of providers in any way, unless the provider was paid in full from both the PASSE and the commercial insurance.

C. Other Third- Party Liability Recoveries: The PASSE shall identify the existence of potentially liable parties using a variety of methods, including referrals, and data mining. The PASSE shall not pursue recovery in the following circumstances, unless the case has been referred to the DHS or DHS' authorized representative:

1. Motor Vehicle Cases
2. Other Casualty Cases
3. Tortfeasors
4. Restitution Recoveries
5. Worker's Compensation Cases

Upon identification of a potentially liable third party for any of the above situations, the PASSE shall, within 10 business days, report the potentially liable third party to DHS for determination of a mass tort, total plan case, or joint case. Failure to report these cases may result in sanctions or other administrative remedy. A mass tort case is a case where multiple plaintiffs or a class of plaintiffs have filed a lawsuit against the same tortfeasor(s) to recover damages arising from the same or similar set of circumstances (e.g. class action lawsuits) regardless of whether any reinsurance or Fee-For-Service payments are involved. A total plan case is a case where payments for services rendered to the member are exclusively the responsibility of the PASSE; no reinsurance or Fee-For-Service payments are involved. By contrast, a "joint" case is one where Fee-For-Service payments and/or reinsurance payments are involved. The PASSE shall cooperate with DHS's authorized representative in all collection efforts.

D. In "total plan" cases, the PASSE is responsible for performing all research, investigation, the mandatory filing of initial liens on cases that exceed $250, lien amendments, lien releases, and payment of other related costs in accordance with DHS guidelines. The PASSE shall use the DHS-approved casualty recovery correspondence when filing liens and when corresponding to others in regard to casualty recovery. The PASSE may retain up to 100% of its recovery collections if all of the following conditions exist:

1. Total collections received do not exceed the total amount of the PASSE's financial liability for the member,
2. There are no payments made by DHS related to Fee-For-Service, or applied DHS administrative costs (i.e., lien filing fee, etc.), and,

3. Such recovery is not prohibited by State or Federal law.

Prior to negotiating a settlement on a total plan case, the PASSE shall notify DHS to ensure that there is no reinsurance or Fee-For-Service payment that has been made by DHS. Failure to report these cases prior to negotiating a settlement amount may result in sanction or other administrative remedy.

The PASSE shall report settlement information to DHS using a format specified by DHS, within 10 business days from the settlement date. Failure to report these cases may result in sanctions or other administrative remedy determined by DHS.

E. Joint and Mass Tort Cases: DHS is responsible for performing all research, investigation and payment of lien-related costs, subsequent to the referral of any and all relevant case information to DHS by the PASSE. In joint and mass tort cases, DHS is also responsible for negotiating and acting in the best interest of all parties to obtain a reasonable settlement and may compromise a settlement in order to maximize overall reimbursement, net of legal and other costs. The PASSE is responsible for responding to requests from DHS to provide a list of claims related to the joint or mass tort case within 10 business days of the request. The PASSE will be responsible for their prorated share of the contingency fee. The PASSE's share of the contingency fee will be deducted from the settlement proceeds prior to DHS remitting the settlement to the PASSE organization.

F. Other Reporting Requirements

All TPL reporting requirements are subject to validation through periodic audits and/or operational reviews which may include the PASSE submission of an electronic extract of the casualty cases, including open and closed cases. Data elements may include, but are not limited to: the member's first and last name; Medicaid ID; date of incident; claimed amount; paid/recovered amount; and case status. DHS shall provide the format and reporting schedule for this information to PASSE.

244.000 Coverage and Authorization of Services 3-1-19

The PASSE is required to ensure that a member has access to all allowed Medicaid state PASSE and CES waiver services, including therapy services and services through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program for children.

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

The PASSE cannot provide an incentive, monetary or otherwise, to Provider for withholding Medically Necessary Services. All services provided to PASSE members must be medically necessary for each member. The PASSE must ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

The PASSE may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the enrollee. The PASSE may place appropriate limits on a service for utilization control, provided the services furnished can reasonably achieve their purpose.

The PASSE must ensure compliance with 42 CFR § 438.210.

245.000 Provider Selection and Payment 3-1-19

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

The PASSE may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.

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

245.100 Value-Based Payments 3-1-19

Payments made by a PASSE to its providers to promote efficiency and effectiveness of services, improve quality of care, and promote most appropriate utilization in the most appropriate setting. Such payments may be made as part of a PASSE's Quality Assessment and Performance Improvement (QAPI) strategy.

Provider incentives based on value are allowed and encouraged. Payments based on volume to increase inappropriate utilization (including denial of services) will not be permitted.

The PASSE must disclose any value-based payment arrangement with AID.

245.200 Assurance of Compliance with Arkansas Provider Consent Decrees 3-1-19

The PASSE must provide DHS an assurance of compliance with any applicable consent decrees impacting Arkansas Medicaid providers.

245.300 Assurance of Compliance with Arkansas Preferred Drug List Requirements 3-1-19

The PASSE must provide DHS an assurance of compliance with the current Arkansas Preferred Drug List.

245.400 Assurance of Payment Methodology Requirements by the Arkansas Insurance Department 3-1-19

The PASSE must provide DHS an assurance of compliance with payment methodology requirements by the Arkansas Insurance Department.

246.000 Confidentiality 3-1-19

For any medical records and any other health and enrollment information that identifies a particular member, each PASSE must use and disclose such individually identifiable health information in accordance with the privacy requirements in § 42 CFR Part 2 and 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.

247.000 PASSE Grievance System 6-1-25

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

A. Allow the member forty-five (45) days from the date of the action to file the grievance;

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

C. Result in written notice of the resolution being sent to the member. This notice must include:

1. A statement of the relief requested by the member;

2. A clear explanation of the decision, including the rationale and the applicable law or policy; and

3. The member's right to request a state fair hearing.

D. The PASSE grievance system must be approved by DHS. This requires that:

1. Any proposed changes to the grievance system must be approved by DHS prior to implementation; and

2. The PASSE must send written notice to members of significant changes to the grievance system at least thirty (30) days prior to implementation.

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

247.100 Appeal of Adverse Action of DHS 6-1-25

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

To do so, the member or PASSE must follow the procedures in Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

247.200 Appeal of Adverse Benefit Determination of a PASSE 7-1-26

When an adverse benefit determination has been made by a PASSE, the member may file an appeal in accordance with the procedures found in Section 192.000 of this Manual. A guardian, legal representative, or direct service provider may file an appeal on behalf of the member.

247.300 Request for DHS Hearing for Anti-Competitive Practices 3-1-19

In general, payment to providers is based on good faith negotiation between the PASSE and providers reflecting rates and quality. If a PASSE or a provider believes that the other party is not negotiating in good faith and is engaged in anti-competitive practices, either party may request DHS to convene a hearing to present evidence to support its claim. Such evidence must include upper and lower payment amounts paid for the same services, except for value-based payments, to other providers. The hearing will be public. Such a hearing is not mediation. There is no obligation on the part of DHS to make a determination of wrong doing. A PASSE must disclose the use of value based payments to the provider type at issue, but shall not be required to disclose the methodology for making value based payments.

248.000 Subcontractual Relationships and Delegation 3-1-19

The PASSE must ensure compliance with 42 CFR § 438.230. The PASSE entity maintains ultimate responsibility for adhering and otherwise fully complying with all terms and conditions of this provider manual and the PASSE Provider Agreement.

248.100 Practice Guidelines 3-1-19

The PASSE must adopt practice guidelines that adhere to 42 CFR § 438.236. The PASSE must disseminate the guidelines to all affected providers and, upon request, to members and potential members. All decisions for utilization management, member education, coverage of services, and other areas to which the practice guidelines apply are consistent with the guidelines.

248.200 Health Information Systems 3-1-19

Each PASSE must have a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of 42 CFR § 438.242. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

DHS requires that the PASSE health information system complies with the following:

A. Section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act.

B. Collects data on member and provider characteristics as specified by the State, and on all services furnished to members through an encounter data system specified by the State in the PASSE Provider Agreement.

C. Ensures that data received from providers is accurate and complete.

D. Make all collected data available to the State and upon request to CMS.

248.210 Reporting Requirements 3-1-19

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 member satisfaction survey.

B. The PASSE must also implement and carry out a Quality Assurance and Performance Improvement (QAPI) program. 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.

DHS requires that the PASSE submits to DHS the following data:

A. Encounter data in the form and manner described in § 438.818.

B. Data on the basis of which the State certifies the actuarial soundness of capitation rates to a PASSE under § 438.4, including base data described in § 438.5(c) that is generated by the PASSE.

C. Data on the basis of which the State determines the compliance of the PASSE with the medical loss ratio requirement described in § 438.8.

D. Data on the basis of which the State determines that the PASSE has made adequate provision against the risk of insolvency as required under § 438.116.

E. Documentation described in § 438.207(b) on which the State bases its certification that the PASSE has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in § 438.206.

F. Information on ownership and control described in § 455.104 of this chapter from the PASSE and subcontractors as governed by § 438.230.

G. The annual report of overpayment recoveries as required in § 438.608(d)(3).

248.220 Claims Payment and Claims Processing 3-1-19

The PASSE shall operate and maintain claims operational processes and systems that ensure the verification, processing, accurate and timely adjudication and payment of claims. This includes appropriate auditing of claims for NCCI edits. The claim process and systems shall result in timely payment of provider claims for eligible PASSE members. The PASSE shall have a process for resolution of provider claim disputes and member grievance and appeals for denial of claims payment. [42 CFR § 438.242(a)].

A. The PASSE must utilize nationally recognized methodologies to correctly pay claims including but not limited to:

1. Medicaid National Correct Coding Initiative (NCCI) for Professional, ASC and Outpatient services,
2. Multiple Procedure/Surgical Reductions, and
3. Global Day E & M Bundling standards.

B. The claims payment management must be able to monitor and access the claims system and apply appropriate claims edits. Claims management must have oversight of the claims process and system handling of:

1. Covered benefits and site of care service restrictions
2. Timeliness standards
3. Claims payment fraud detection and prevention
4. Adherence to DHS payment policies.
5. Provider rate schedules changes
6. Provider contract limitations and service scope
7. Member service date eligibility and enrollment in the PASSE
8. Claims audit for payment accuracy

C. The PASSE must produce a provider remittance advice attached to the provider payments and/or denials that includes at a minimum:

1. The reason(s) for denials and adjustments;
2. A detailed explanation/description of all denials, payments and adjustments;
3. The amount billed;
4. The amount paid;
5. Application of coordination of benefits (COB);
6. Provider rights for claim disputes

Additionally, the PASSE must include information in its remittance advice which informs providers of instructions and timeframes for the submission of claim disputes and corrected claims. All paper remittance advices must describe this information in detail. Electronic remittance advices must either direct providers to the link where this information is explained or include a supplemental file where this information is explained.

The related remittance advice must be sent with the payment, unless the payment is made by electronic funds transfer (EFT). Any remittance advice related to an EFT must be sent to the provider, no later than the date of the EFT. The PASSE must provide provider with electronic file transfer and Data Exchange Requirements, for specific standards related to electronic claims and receiving electronic remittance advice and EFT payment.

When PASSE needs to recoup a claim payment due to a claim being determined to be the payment responsibility of another PASSE organization or third party insurer; the PASSE is responsible to inform the provider to file with the correct financial responsible payer. The responsible PASSE shall not deny a clean claim on the basis of lack of timely filing if the provider submits a clean claim to the responsible PASSE no later than 60 days from the date of the recoupment, 12 months from the date of service, or 12 months from date that eligibility is posted, whichever date is later.

The PASSE shall ensure that for each form type (Professional/Institutional), that 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

The PASSE is required to reimburse providers for previously denied or recouped claims, if the provider was subsequently denied payment by the primary insurer based on timely filing limits or lack of prior authorization and the member failed to initially disclose additional insurance coverage.

The provider shall have 90 days from the date they become aware that payment will not be made to submit a new claim to the PASSE which includes the documentation from the primary insurer that payment will not be made. Documentation includes but is not limited to any of the following items establishing that the primary insurer has or would deny payment based on timely filing limits or lack of prior authorization.

The PASSE's claims processes, as well as its prior authorization and concurrent review process, must minimize the likelihood of having to recoup already-paid claims. Any individual recoupment in excess of $50,000 per provider, or Tax Identification Number within a Contract year or greater than 12 months after the date of the original payment must be approved by DHS.

When recoupment amounts for a Provider TIN cumulatively exceed $50,000 during a Contract year (based on recoupment date), the PASSE must report the cumulative recoupment monthly to the designated DHS contact.

The Contractor must void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters must be submitted. DHS may validate the submission of applicable voids and replacement encounters upon completion of any approved recoupment. Replaced or voided encounters must reach adjudicated status within 120 days of the approval of the recoupment.

If the PASSE or DHS reverses a decision to deny, limit, or delay authorization of services, and the member received the disputed services while an appeal was pending, the PASSE shall process a claim for payment from the provider in a manner consistent with the PASSE's decision or DHS direction and applicable statutes, rules, policies, and PASSE Provider Agreement terms. The provider shall have 90 days from the date of the reversed decision to submit a clean claim to the PASSE for payment. For all claims submitted as a result of a reversed decision, the PASSE is prohibited from denying claims for untimeliness if they are submitted within the 90 day timeframe. The PASSE is also prohibited from denying claims submitted as a result of a reversed decision because the member failed to request continuation of services during the appeals/hearing process as a member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.

The PASSE shall submit a Claims operations performance report as specified by DHS in the PASSE Provider Agreement. The PASSE shall develop and implement an internal ongoing claims audit function that will include, at a minimum, the following:

A. Verification that provider contracts are loaded correctly

B. Accuracy of payments against provider contract terms

C. NCCI edits are implemented

The PASSE shall audit that provider contract terms and rates are loaded correctly. This can be performed on a regular or periodic basis and consist of a random, statistically significant sampling of all claims and contracts in effect at the time of the audit. The audit sampling methodology must be documented in policy and the PASSE should review the contract loading of both large groups and individual practitioners at least once during a PASSE contract cycle, in addition to any time a contract change is initiated during that timeframe. The findings of the audits described above must be documented and any deficiencies noted in the resulting reports must be met with corrective action.

In addition, in the event of a system change or upgrade, the PASSE shall also be required to initiate an independent audit of the Claim Payment/Health Information Systems. The findings and recommendation from the audit should be submitted to DHS.

248.230 Encounter Data 3-1-19

Encounter data submission to DHS is specified in the PASSE Provider Agreement, including the specifications for submitting encounter data to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. As part of the readiness review process, DHS will review and validate that the encounter data collected, maintained, and submitted to the State by the PASSE meets the requirements of this section. The State must have procedures and quality assurance protocols to ensure that enrollee encounter data submitted is a complete and accurate representation of the services provided to the enrollees under the PASSE Provider Agreement between the State and the PASSE.

The PASSE is required to submit encounter data reports on a monthly basis to DHS. An encounter is a service or procedure provided to a PASSE member by a provider that is compensated by any possible means (e.g. Fee-for-service, capitation, fee-for-time, or salary). This includes any service or procedure that is provided directly by the PASSE. The PASSE Provider agreement will specify the exact requirements for encounter claims submission to DHS.

The PASSE must report encounter data in the following standard format:

A. Form HCFA-1500 for professional services

B. Form UB-92 for institutional care

C. National Standard Drug Claim Form for prescription and over-the-counter drugs.

248.240 Recordkeeping Requirements 3-1-19

The PASSE must retain, and require subcontractors to retain, as applicable, the following information: member grievance and appeal records in § 438.416, base data in § 438.5(c), MLR reports in § 438.8(k), and the data, information, and documentation specified in §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

248.250 Reporting Provider Sanctions 3-1-19

The PASSE must report to DHS any sanctions imposed upon any provider, both in-network an out of network.

248.260 Reporting Provider-Preventable Conditions 3-1-19

The PASSE Provider Agreement must comply with mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in § 434.6(a)(12) and § 447.26 of this chapter. The PASSE must report all identified provider-preventable conditions to DHS.

248.300 Provider Credentialing and Recredentialing 3-1-19

Provider credentialing is a detailed process that reviews provider qualifications and career history including their education, training, residency and licenses as well as specialty certificates. DHS will accept the standards set by regulatory and accreditation organizations such as the National Committee for Quality Assurance (NCQA), Commission on the Accreditation of Rehabilitation Facilities (CARF), and The Joint Commission (TJC).

Starting January 1, 2020 the PASSE must have a credential review committee that approves or denies the final credentialing of its providers. The PASSE must demonstrate that it verifies primary source qualification data including:

A. Verifying the training and education through the applicable regulatory and accreditation organizations;

B. Verifying current state medical licensure;

C. Specialty verification;

D. Verification of employment history;

E. Checking the Medicare and Medicaid exclusion list;

F. Reviewing to ensure providers in its network are in good standing, including that no for any federal or state sanctions that have been imposed against them;

G. Querying the National Practitioner Data Back on closed and settled claims history; and

H. Verifying the status of the provider applicant's privileges at hospitals and other health care facilities listed on the application.

All current Medicaid providers will be deemed as credentialed during calendar year 2019. Starting January 1, 2020, the PASSE must credential all network providers.

The PASSE may approve temporary provider credentials for up to 6 months pending completion of the full credential review. DHS may grant a variance for extending the temporary period following a demonstration of good cause.

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

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

Credentialing and recredentialing is required on the following provider types:

I. Medical Doctor (MD)

J. Doctor of Osteopathic Medicine (DOM)

K. Doctor or Podiatric Medicine (DPM)

L. Psychologists

M. Optometrists

N. Nurse practitioners (NP)

O. Physician Assistants (PA)

P. Certified Nurse Midwives

Q. Speech and Language Pathologists

R. Physical Therapists

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

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

U. Board Certified Behavioral Analysts (BCBAs) and;

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

Providers must be recredentialed not less than every three years unless more frequently due to a change in the clinical scope of services of a provider.

248.310 Uniform Credentialing Process Requirements 3-1-19

No later than January 1, 2020, the PASSEs shall use a uniform standard credential application that must be submitted on-line and electronically and jointly select a single Contracted Credentialing Vendor Organization (CVO) according to specifications established by DHS. The costs of a CVO will be equally shared by the PASSEs. DHS shall establish a credentialing work group among the PASSEs for the purpose of setting credentialing process requirements.

250.000 QUALITY MEASUREMENT AND IMPROVEMENT; EXTERNAL QUALITY REVIEW

251.000 Basis, Scope and Applicability 3-1-19

Pursuant to sections 1932(c), 1903(a)(3)(C)(ii), 1902(a)(4), and 1902(a)(19) of the Act, CMS sets forth:

Specifications for a quality assessment and performance improvement program (QAPI) that DHS must require each PASSE to implement and maintain.

A. Requirements for DHS review of the accreditation status of all PASSEs.

B. Specifications for a Medicaid managed care quality rating system plan.

C. Specifications for a Medicaid managed care quality strategy that each PASSE must implement to ensure the delivery of quality health care.

D. Requirements for annual external quality reviews of each PASSE, including:

1. Criteria that DHS must use in selecting entities to perform the reviews.
2. Specifications for the activities related to external quality review.
3. Circumstances under which external quality review may use the results of Medicare quality reviews or private accreditation reviews,
4. Requirements for making the results of the reviews publicly available.

252.000 Definitions 3-1-19

As used in these sections of the PASSE Medicaid Provider Manual:

A. Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under § 438.68 (Network adequacy standards) and § 438.206 (Availability of services).

B. EQR stands for external quality review.

C. EQRO stands for external quality review organization.

D. External quality review means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that a PASSE or their contractors furnish to Medicaid beneficiaries.

E. External quality review organization means an organization that meets the competence and independence requirements set forth in § 438.354, and performs external quality review, other EQR-related activities as set forth in § 438.358, or both.

F. Financial relationship means:

1. A direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means, and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest; or

2. A compensation arrangement with an entity.

G. Health care services means all Medicaid services provided by a PASSE under contract with the State Medicaid agency in any setting, including but not limited to medical care, behavioral health care, and long-term services and supports.

H. Outcomes means changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services.

I. Quality, as it pertains to external quality review, means the degree to which a PASSE increases the likelihood of desired outcomes of its enrollees through:

1. Its structural and operational characteristics.

2. The provision of services that are consistent with current professional, evidenced-based-knowledge.

3. Interventions for performance improvement.

J. Validation means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

253.000 Quality Assessment and Performance Review Program 3-1-19

DHS requires that each PASSE establishes and implements an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its members that includes the elements identified in this section.

The comprehensive quality assessment and performance improvement program must include at least the following elements:

A. Performance improvement projects.

B. Collection and submission of performance measurement data.

C. Mechanisms to detect both underutilization and overutilization of services.

D. Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

E. For PASSE, which provide long-term services and supports:

1. Mechanisms to assess the quality and appropriateness of care furnished to members using long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan; and

2. Participate in efforts by DHS to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per §§ 441.302 and 441.730(a) of this chapter) that are based, at a minimum, on the requirements on the State for home and community-based waiver programs per § 441.302(h) of this chapter.

DHS must:

F. Identify standard performance measures relating to the performance of PASSEs; and

G. Identify standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving long-term services and supports.

H. Require that each PASSE annually:

1. Measure and report to the State on its performance, using the standard measures required by DHS;

2. Submit to DHS data, specified by DHS which enables DHS to calculate the PASSE's performance using the standard measures identified by the State under paragraph (c)(1) of this section; or

3. Perform a combination of the activities described above in a. and b. of this section.

I. DHS requires that PASSEs conduct performance improvement projects, including any performance improvement projects required by CMS, which focus on both clinical and nonclinical areas.

J. Each performance improvement project must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include the following elements:

1. Measurement of performance using objective quality indicators.

2. Implementation of interventions to achieve improvement in the access to and quality of care.

3. Evaluation of the effectiveness of the interventions based on the performance measures.

4. Planning and initiation of activities for increasing or sustaining improvement.

K. DHS requires that each PASSE must report the status and results of each project conducted to DHS as requested, but not less than once per year.

L. The State may permit an MCO, PIHP, or PAHP exclusively serving dual eligibles to substitute an MA Organization quality improvement project conducted under § 422.152(d) of this chapter for one or more of the performance improvement projects otherwise required under this section.

M. DHS must review, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each PASSE. The review must include:

1. The PASSE's performance on the measures on which it is required to report.
2. The outcomes and trended results of each PASSE's performance improvement projects.
3. The results of any efforts by the PASSE to support community integration for enrollees using long-term services and supports.
4. DHS may require that a PASSE develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program.

254.000 State Review of the Accreditation Status of a PASSE 3-1-19

Each PASSE must inform DHS if they have been accredited by a private independent accrediting entity. If a PASSE has been accredited by a private independent accrediting entity, the PASSE must authorize the private independent accrediting entity to provide DHS a copy of its most recent accreditation review, including:

A. The accreditation status, survey type and level (as applicable);

B. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and

C. Expiration of the accreditation

DHS will make the accreditation status of each PASSE available to the general public on the Arkansas Medicaid PASSE website.

255.000 Medicaid Managed Care Quality Rating System 3-1-19

Each year, DHS must collect data from each PASSE with which it contracts and issue an annual quality rating for each PASSE based on the data collected, using the Medicaid managed care quality rating system adopted under 42 CFR § 438.334.

256.000 Managed Care State Quality Strategy 3-1-19

DHS, in accordance with 42 CFR § 438.340, must draft and implement a written quality strategy for assessing and improving the quality of health care services furnished by the PASSE. This State quality strategy must be made available on the Arkansas Medicaid website.

256.100 Quality Incentive Pool 3-1-19

DHS may provide quality incentive payments from the quality incentive pool to PASSEs who meet specific performance measurements as identified in the PASSE Provider Agreement. Quality incentive payments would be in addition to the global payment.

257.000 External Quality Review 3-1-19

DHS, in accordance with 42 CFR § 438.350, must ensure that an External Quality Review Organization (EQRO) performs an annual External Quality Review for each PASSE. DHS must ensure that the EQRO meets the minimum requirements of 42 CFR § 438.354. DHS must contract with an EQRO in accordance with 42 CFR §438.356. The EQR must contain the mandatory activities as required in 42 CFR § 438.358 and can contain the optional activities listed in the same section.

257.100 Nonduplication of Mandatory Activities with Medicare or Accreditation Review 3-1-19

To avoid duplication, DHS may use information from a Medicare or private accreditation review of a PASSE to provide information for the annual EQR instead of conducting one or more of the EQR activities if the following conditions are met:

A. The PASSE is in compliance with the applicable Medicare Advantage standards established by CMS, as determined by CMS or its contractor for Medicare, or has obtained accreditation from a private accrediting organization recognized by CMS as applying standards at least as stringent as Medicare under the procedures in § 422.158 of this chapter;

B. The Medicare or private accreditation review standards are comparable to standards established through the EQR protocols (§ 438.352) for the EQR activities described in § 438.358(b)(1)(i) through (iii); and

C. The PASSE provides to the State all the reports, findings, and other results of the Medicare or private accreditation review activities applicable to the standards for the EQR activities.

If DHS uses information from a Medicare or private accreditation review, DHS must ensure that all such information is furnished to the EQRO for analysis and inclusion in the report described in § 438.364(a).

DHS must identify in its quality strategy under § 438.340 the EQR activities for which it has exercised the option described in this section, and explain the rationale for DHS's determination that the Medicare review or private accreditation activity is comparable to such EQR activities.

257.200 Exemption from External Quality Review 3-1-19

DHS may exempt a PASSE from EQR if the following conditions are met:

A. The PASSE has a current Medicare contract under part C of Title XVIII or under section 1876 of the Act, and a current Medicaid contract under section 1903(m) of the Act.

B. The two contracts cover all or part of the same geographic area within the State.

C. The Medicaid contract has been in effect for at least 2 consecutive years before the effective date of the exemption and during those 2 years the PASSE has been subject to EQR under this part, and found to be performing acceptably for the quality, timeliness, and access to health care services it provides to Medicaid beneficiaries.

When the State exercises this option, the State must obtain either of the following:

D. Information on Medicare review findings. Each year, DHS must obtain from each PASSE that it exempts from EQR the most recent Medicare review findings reported on the PASSE including:

1. All data, correspondence, information, and findings pertaining to the PASSE's compliance with Medicare standards for access, quality assessment and performance improvement, health services, or delegation of these activities.
2. All measures of the PASSE's performance.
3. The findings and results of all performance improvement projects pertaining to Medicare enrollees.

If an exempted PASSE has been reviewed by a private accrediting organization, DHS must require the PASSE provides DHS with a copy of all findings pertaining to its most recent accreditation review if that review has been used for either of the following purposes:

4. To fulfill certain requirements for Medicare external review under subpart D of part 422 of this chapter.

5. To deem compliance with Medicare requirements, as provided in § 422.156 of this chapter.

These findings must include, but need not be limited to, accreditation review results of evaluation of compliance with individual accreditation standards, noted deficiencies, corrective action plans, and summaries of unmet accreditation requirements.

257.300 External Quality Review Results 3-1-19

DHS must ensure that the EQR results in an annual detailed technical report that summarizes findings on access and quality of care, including:

A. A description of the manner in which the data from all activities conducted in accordance with § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the PASSE entity (described in § 438.310(c)(2)).

B. For each EQR-related activity conducted in accordance with § 438.358:

1. Objectives;

2. Technical methods of data collection and analysis;

3. Description of data obtained, including validated performance measurement data for each activity conducted in accordance with § 438.358(b)(1)(i) and (ii); and

4. Conclusions drawn from the data.

C. An assessment of each PASSE's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.

D. Recommendations for improving the quality of health care services furnished by each PASSE, including how DHS can target goals and objectives in the quality strategy, under § 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.

E. Methodologically appropriate, comparative information about all PASSEs, consistent with guidance included in the EQR protocols issued in accordance with § 438.352(e).

F. An assessment of the degree to which each PASSE has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

DHS cannot substantively revise the content of the final EQR technical report without evidence of error or omission.

DHS contract with a qualified EQRO to produce and submit to DHS an annual EQR technical report in accordance with this section. The State must finalize the annual technical report by April 30th of each year.

DHS must:

A. Post the most recent copy of the annual EQR technical report on the Web site required under § 438.10(c)(3) by April 30th of each year.

B. Provide printed or electronic copies of the information specified in paragraph (a) of this section, upon request, to interested parties such as participating health care providers, enrollees and potential enrollees of the PASSE, beneficiary advocacy groups, and members of the general public.

DHS must make the information specified in this section available in alternative formats for persons with disabilities, when requested. The information released under section may not disclose the identity or other protected health information of any patient.

258.000 Failure To Meet Quality Metrics 3-1-19

If a PASSE fails to meet the quality metrics, as specified in the PASSE Provider Agreement, DHS may take action to correct the failure of 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. Impose any Sanction allowable in Section 271.000 of this Manual;

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

G. Impose any sanction identified in §152.000 of the Medicaid Provider Manual; or

H. Suspend new assignment, enrollment and voluntary transitions to the PASSE, including automatic mandatory assignment and enrollment until performance improves.

259.000 Reporting Requirements and the Quality Assurance Performance Improvements (QAPI) Program 3-1-19

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 member satisfaction survey.

B. The PASSE must also implement and carry out a Quality Assurance and Performance Improvement (QAPI) program. 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.

259.100 DHS Review of Outcomes 3-1-19

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.

E. Implementation of Person-Centered Service Plan.

259.200 Quality Metrics 3-1-19

Each PASSE must report on and meet the quality metric reporting standards as outlined in this provider manual and the PASSE Provider Agreement.

259.300 Reporting and Quality Metric Requirements 3-1-19

A. Care Coordinator to Client Caseload

Metric	**Target**	**Reporting to DHS (Frequency/Content)**
The care coordinator's assigned caseload will be limited to a maximum of 50 attributed members.	≥90% of care coordinators will have a caseload of ≤50 members	Quarterly/ Details of monthly caseload for each care coordinator employed, including the names of each member in the care coordinator's caseload

B. Initial Contact of Client

Metric	**Target**	**Reporting to DHS (Frequency/Content)**
Care coordinators must initiate contact with each member within 15 business days after effective date of PASSE coverage.	≥75% of care coordinators will contact each member within 15 business days after effective date of PASSE coverage	Quarterly/ Details of initial contact time frame with each member after attribution to PASSE, including, but not limited to, date of attribution, date of initial contact and date of completed contact

C. Follow-Up Care

Metric	**Target**	**Reporting to DHS (Frequency/Content)**

Care coordinators must follow up with members within seven (7) business days of visit to Emergency Room, or discharge from Hospital or In-Patient Psychiatric Unit/Facility	≥50% of care coordinators will follow up with members within seven (7) business days of visit to Emergency Room, or discharge from Hospital or In-Patient Psychiatric Unit/Facility	Quarterly/ Details of follow up with members within (7) business days of visit to Emergency Room, or discharge from Hospital or In-Patient Psychiatric Unit/Facility, including but not limited to action or treatment plan to prevent/avoid such visits in the future

D. PCP Assignment

Metric	**Target**	**Reporting to DHS (Frequency/Content)**
Care coordinator must ensure that all members have selected a Primary Care Physician (PCP), confirm that the member is seeing the PCP as needed, and if necessary, to assist members with selecting/providing a referral to a PCP	≥80% of members will have selected a PCP and are on a PCP's caseload	Quarterly/ Details about: 1. The number of members that have been referred to and have been assigned a PCP;

259.400 National Core Indicators 3-1-19

The PASSE must report on the National Core Indicators (NCI) for its Developmental Disabilities specialty providers on a yearly basis. This report is due to DHS no later than July 31 each year for the previous 12 months.

260.000 ADDITIONAL PROGRAM INTEGRITY SAFEGUARDS

261.000 Basic Program Integrity Safeguards 3-1-19

The PASSE must comply with the requirements in 42 CFR §§ 438.604, 438.606, 438.608 and 438.610, as applicable.

261.100 State Responsibilities 3-1-19

DHS must comply with the requirements of 42 CFR §438.602.

261.200 Source, Content, and Timing of Certification 3-1-19

For the data, documentation, or information specified in 42 CFR § 438.604 and § 260.300 of this provider manual, DHS requires that the data, documentation or information the PASSE submits to DHS must be certified by either the PASSE's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

The certification provided by the individual in paragraph (a) of this section must attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR § 438.604 and §260.300 of this provider manual is accurate, complete, and truthful.

DHS requires that the PASSE must submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR § 438.604(a) and (b) and §260.300 of this provider manual.

261.300 Prohibited Affiliations 3-1-19

The PASSE may not knowingly have an individual involved in a relationship with the PASSE that 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.

The PASSE may not knowingly have an individual involved in a relationship with the PASSE who is an individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in paragraph (a)(1) of this section.

The PASSE may not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

The relationships described above are as follows:

A. A director, officer, or partner of the PASSE

B. A subcontractor of the PASSE

C. A person with beneficial ownership of 5 percent or more of the PASSE entity’s equity

D. A network provider or person with an employment, consulting or other arrangement with the PASSE for the provision of items and services that are significant and material to the PASSE entity's obligations under its contract with the State.

261.400 PASSE Program Integrity Activities 3-1-19

The PASSE must establish functions and activities governing program integrity in order to reduce the incidence of Fraud and Abuse and shall comply with all state and federal program integrity requirements, including but not limited to the applicable provisions of the Social Security Act, § § 1128, 1902, 1903, and 1932; 42 CFR § § 431, 433, 434, 435, 438, 441, 447, and 455; 45 CFR Part 75; Arkansas Law and Rules, and the PASSE Provider Agreement.

270.000 SANCTIONS

271.000 Sanctions 3-1-19

In accordance with applicable law, this provider manual, and the terms of the PASSE Provider Agreement, DHS may impose sanctions and/or remedies for failure to comply with any provision of applicable law, this provider manual, or the terms of the PASSE Provider Agreement.

Each PASSE will be monitored by DHS to ensure that all requirements set forth in this manual and the PASSE Provider Agreement are adhered to. This includes adherence with any applicable laws or regulations. Sanctions or remedies that can be imposed by DHS include, but are not limited to, one (1) or more of the following:

A. Appoint temporary management of the PASSE;

B. Cancel or shorten the PASSE’s existing provider agreement(s);

C. Suspend or terminate/de-certify the PASSE's participation as a Medicaid Enrolled Provider (PASSE Provider Type) and/or in the Arkansas Medicaid Program;

D. Evaluate staffing allocations and require staffing enhancements;

E. Impose civil monetary penalties or assessments not to exceed $25,000 per violation or incident;

F. Require the PASSE submit a Corrective Action Plan (CAP);

G. Require a PASSE to adhere to a Directed Corrective Action Plan;

H. Suspend new assignment, enrollment and voluntary transitions to the PASSE, including automatic mandatory assignment and enrollment after the effective date of the sanction;

I. Grant PASSE Members the right to terminate enrollment, and transition some or all PASSE Members to another PASSE;

J. Suspend, withhold, recoup, adjust or recover payments, or any combination thereof, made to the PASSE until there is a satisfactory resolution of the default;

K. Require a PASSE to exclude a network provider from its network; and

L. Impose any/all sanctions contained in the PASSE Provider Agreement, §152.000 of the PASSE Medicaid Provider Manual, and those allowed under federal law.

272.000 Basis for Imposition of Sanctions 3-1-19

DHS may impose sanctions specified in this provider manual, in the PASSE Provider Agreement and any sanction specified in 42 CFR § 438 based upon determinations on findings from onsite surveys, member or other complaints, financial status, or any other source. DHS may impose intermediate sanctions if it makes any determinations specified below:

A. DHS determines that a PASSE acts or fails to act as follows:

1. Fails to substantially provide medically necessary services that the PASSE is required to provide, under law or under its contract with DHS, to a member covered under the contract.
2. Imposes on members premiums or charges that are in excess of premiums or charges permitted under the Medicaid program.
3. Acts to discriminate among members on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.
4. Misrepresents or falsifies information that it furnishes to DHS, Office of Medicaid Inspector General, CMS, the Office of the Inspector General, the Comptroller General, and any designees.
5. Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
6. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in §§ 422.208 and 422.210 of this chapter.

B. DHS determines that a PASSE has distributed directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.

C. DHS determines that:

1. A PASSE has violated any of the other requirements of sections 1903(m) or 1932 of the Act, or any implementing regulations.

272.100 Types of Intermediate Sanctions 3-1-19

The types of intermediate sanctions that DHS may impose include the following:

A. Civil money penalties in the amounts specified in § 438.704.

B. Appointment of temporary management for a PASSE as provided in § 438.706.

C. Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll.

D. Suspension of all new enrollment, including default enrollment, after the date the Secretary or the State notifies the PASSE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.

E. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

Other State agencies retain authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in § 438.700, as well as additional areas of noncompliance. Nothing in this section prevents State agencies from exercising that authority.

272.200 Amounts of Civil Money Penalties 3-1-19

If the DHS imposes civil monetary penalties as provided under 42 CFR § 438.702(a)(1), the maximum civil money penalty DHS may impose varies depending on the nature of the PASSE's action or failure to act, as provided in this section.

Specific limits:

A. The limit is $25,000 for each determination under 42 CFR § 438.700(b)(1), (5), (6), and (c) and § 271.100, A., 1., § 271.100, A., 5., § 271.100, A., 6, and § 271.100, B.

B. The limit is $100,000 for each determination under § 438.700(b)(3) or (4) § 271.100, A., 3 or § 271.100, A., 5.

C. The limit is $15,000 for each beneficiary the State determines was not enrolled because of a discriminatory practice under § 438.700(b)(3) and § 271.100, A., 3. (This is subject to the overall limit of $100,000 under B. of this section).

For premiums or charges in excess of the amounts permitted under the Medicaid program, the maximum amount of the penalty is $25,000 or double the amount of the excess charges, whichever is greater. The State must deduct from the penalty the amount of overcharge and return it to the affected enrollees.

272.300 Special Rules for Temporary Management 3-1-19

If DHS imposes temporary management under 42 CFR § 438.702 (a)(2), DHS may do so only if it finds (through onsite surveys, member or other complaints, financial status, or any other source) any of the following:

A. There is continued egregious behavior by the PASSE including but not limited to behavior that is described in 42 CFR § 438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Act.

B. There is substantial risk to members' health.

C. The sanction is necessary to ensure the health of the PASSE's members:

1. While improvements are made to remedy violations under § 438.700.

2. Until there is an orderly termination or reorganization of the PASSE.

DHS must impose temporary management (regardless of any other sanction that may be imposed) if it finds that a PASSE has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Act. DHS must also grant members the right to terminate enrollment from the PASSE which has been sanctioned without cause, as described in § 438.702(a)(3), and must notify the affected members of their right to terminate enrollment from the PASSE which has been sanctioned.

DHS may not delay imposition of temporary management to provide a hearing before imposing this sanction.

DHS may not terminate temporary management until it determines that the PASSE can ensure that the sanctioned behavior will not recur.

272.400 Termination of a PASSE Provider Agreement 3-1-19

DHS has the authority to terminate a PASSE Provider Agreement and enroll that PASSE's members in other PASSEs, if the State determines that the PASSE has failed to do either of the following:

A. Carry out the substantive terms of its PASSE Provider Agreement.

B. Meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Act.

272.500 Notice of Sanction and Pre-Termination Hearing 3-1-19

DHS must give the affected entity timely written notice that explains the following:

A. The basis and nature of the sanction.

B. Any other appeal rights.

Before terminating a PASSE agreement, DHS must provide the PASSE a pre-termination hearing. The State must do all of the following:

C. Give the PASSE written notice of intent to terminate, the reason for termination, and the time and place of the hearing.

D. After the hearing, give the PASSE written notice of the decision affirming or reversing the proposed termination of the PASSE provider agreement and, for an affirming decision, the effective date of termination.

E. For an affirming decision, give members of the PASSE notice of the termination and information, consistent with § 438.10, on their options for receiving Medicaid services following the effective date of termination.

272.600 Disenrollment During Termination Hearing Process 3-1-19

After DHS notifies a PASSE that it intends to terminate the PASSE Provider Agreement, DHS may do the following:

A. Give the PASSE's members written notice of the State's intent to terminate the contract.

B. Allow members to transition PASSE's immediately without cause.

272.700 Notice to CMS 3-1-19

DHS must give CMS written notice whenever it imposes or lifts a sanction for violations listed in § 438.700.

The notice must adhere to all of the following requirements:

A. Be given no later than 30 days after DHS imposes or lifts a sanction.

B. Specify the affect PASSE, the kind of sanctions, and the reason for DHS's decision to impose or lift a sanction.

272.710 Sanction by CMS 3-1-19

DHS may recommend that CMS impose a denial of payment sanction on a PASSE if DHS determines that the PASSE acts of fails to act as specified in § 438.700(b)(1) through (6).

DHS' determination becomes CMS' determination for purposes of section 1903(m)(5)(A) of the Act unless CMS reverses or modifies it within 15 days.

If DHS's determination becomes CMS' determination under this section, DHS must take all of the following actions:

A. Gives the PASSE written notice of the nature and basis of the proposed sanction.

B. Allows the PASSE 15 days from the date it receives the notice to provide evidence that it has not acted or failed to act in the manner that is the basis for the recommended sanction.

C. May extend the initial 15-day period for an additional 15 days if

1. The PASSE submits a written request that includes a credible explanation of why it needs additional time.
2. The request is received by CMS before the end of the initial period.
3. CMS has not determined that the MCO's conduct poses a threat to an enrollee's health or safety.

If the PASSE submits a timely response to the notice of sanction, DHS-

D. Conducts an informal reconsideration that includes review of the evidence by a State agency official who did not participate in the original recommendation.

E. Gives the PASSE a concise written decision setting forth the factual and legal basis for the decision.

F. Forwards the decision to CMS.

DHS's decision under this section becomes CMS' decision unless CMS reverses or modifies the decision within 15 days from date of receipt by CMS.

If CMS reverses or modifies DHS's decision, the agency sends the PASSE a copy of CMS' decision.

CMS, based upon the recommendation of DHS, may deny payment to DHS for new members of the PASSE under section 1903(m)(5)(B)(ii) of the Act in the following situations:

G. If a CMS determination that a PASSE has acted or failed to act, as described in paragraphs (b)(1) through (6) of 42 CFR § 438.700, is affirmed on review under paragraph (d) of this section.

H. If the CMS determination is not timely contested by the PASSE under paragraph (c) of this section.

Under 42 CFR § 438.726(b), CMS' denial of payment for new members automatically results in a denial of agency payments to the PASSE for the same enrollees. (A new member is a member that applies for enrollment after the effective date that the PASSE is notified of the sanction.)

Effective Date-of Sanction - If the PASSE does not seek reconsideration, a sanction is effective 15 days after the date the PASSE is notified under this section of the decision to impose the sanction.

If the PASSE seeks reconsideration, the following rules apply:

I. Except as specified in paragraph (d)(2) of this section, the sanction is effective on the date specified in CMS' reconsideration notice.

J. If CMS, in consultation with DHS, determines that the PASSE's conduct poses a serious threat to a member's health or safety, the sanction may be made effective earlier than the date of the agency's reconsideration decision under paragraph (d)(1)(ii) of 42 CFR § 438.730.

CMS retains the right to independently perform the functions assigned to DHS under paragraphs (a) through (d) of §438.730

At the same time that DHS sends notice to the PASSE under paragraph (c)(1) of 42 CFR § 438.730, CMS forwards a copy of the notice to the OIG.

CMS conveys the determination described in paragraph (b) of 42 CFR § 438.730 to the OIG for consideration of possible imposition of civil money penalties under section 1903(m)(5)(A) of the Act and part 1003 of this title. In accordance with the provisions of part 1003, the OIG may impose civil money penalties on the PASSE in addition to, or in place of, the sanctions that may be imposed under this section.