

Facesheet: 1. Request Information (1 of 2)

- A. The **State of Arkansas** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.
- B. **Name of Waiver Program(s):** Please list each program name the waiver authorizes.

Short title (nickname)	Long title	Type of Program
PASSE	Provider-Led Arkansas Shared Savings Entity	MCO;

Waiver Application Title (optional - this title will be used to locate this waiver in the finder):

Provider-Led Arkansas Shared Savings Entity (PASSE) Model

- C. **Type of Request.** This is an:

Renewal request.

The State has used this waiver format for its previous waiver period.

The renewal modifies (Sect/Part):

Section A., Part I, D. 2
CareSource PASSE added.

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

- 1 year
- 2 years
- 3 years
- 4 years
- 5 years

Draft ID:AR.055.01.00

Waiver Number:AR.0007.R01.00

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

Proposed Effective Date: (mm/dd/yy)

01/01/22

Proposed End Date:12/31/26

Calculated as "Proposed Effective Date" (above) plus "Requested Approval Period" (above) minus one day.

Approved Effective Date: 01/01/22

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

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

Name:

Dawn Stehle

Phone:

(501) 682-6311

Ext:

TTY

Fax:

E-mail:

Dawn.Stehle@dhs.arkansas.gov

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

The State contact information is different for the following programs:

Provider-Led Arkansas Shared Savings Entity

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

Section A: Program Description

Part I: Program Overview

Tribal consultation.

For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

There are no federally recognized tribes in the State of Arkansas.

Program History.

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

Act 775 of the 2017 Arkansas Regular Session was signed into law by Arkansas Governor, Asa Hutchinson, on March 31, 2017. This Act, known as the “Medicaid Provider Led Organized Care Act,” is an innovative approach to organizing and managing the delivery of services for Medicaid beneficiaries with high medical needs. Under this unique model of organized care, Arkansas provider-led and owned organizations, known as Risk-Based Provider Organizations (RBPOs) or Provider-Led Arkansas Shared Savings Entities (PASSEs), are responsible for integrating the physical health services, behavioral health services, and specialized developmental disability services for approximately 38,000 individuals who have intensive levels of treatment or care needs due to mental illness, substance abuse, or intellectual and developmental disability. These vulnerable Arkansans will benefit from the provision and continuity of all medically necessary services in a well-organized system of coordinated care.

Under this Act, the PASSEs do not assume full risk for the provision of care until March 1, 2019. Therefore, there are two phases of this model. The first phase is known as the “Arkansas Provider Led Care Coordination Program.” In this Phase, which began on October 1, 2017, the PASSEs provide care coordination to each member attributed to the PASSE, but services are still provided on a fee for service basis. Readiness review activities began in October, 2017, including the drafting of the Provider Agreement. Readiness Review document review and site visits took place in the month of December 2017. By January 15, 2018, three PASSE’s were licensed and enrolled as a Medicaid Provider; and began receiving members through attribution. Care Coordination began on February 1, 2018. Within one month, another PASSE had been licensed and enrolled to begin receiving members through attribution. There are now a total of four licensed PASSEs who have enrolled with Medicaid to receive attributed members.

For Phase II, which will begin on March 1, 2019, the PASSEs will continue providing care coordination and will begin providing all other services under a “full-risk” MCO model. PASSE’s will enter into a PASSE Provider Agreement for terms of one-year and will be held accountable for performance metrics during that year. The state completed enrollment for eligible beneficiaries who were already receiving behavioral health service on July 1, 2018. The third party vendor conducting independent assessments is on track to complete assessments on already identified developmental disability clients by the end of 2018. All clients assessed prior to the last attribution run will be assigned a PASSE based on the attribution algorithm. After the last attribution is run on January 15, 2019, eligible beneficiaries will be auto-assigned to a PASSE. Medicaid will pay the PASSE an actuarially sound per member per month (PMPM) that must be used to cover all needed services for each of its members. DHS has created a new Office of Innovation and Delivery System Reform (IDSR) which will provide monitoring and oversight of the services provided to PASSE members. The IDSR includes Beneficiary Support, which will provide guidance to beneficiaries on the PASSE system.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

1. Waiver Authority. The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

- a. 1915(b)(1)** - The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
-- *Specify Program Instance(s) applicable to this authority*

PASSE

- b. 1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
-- *Specify Program Instance(s) applicable to this authority*

PASSE

- c. 1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
-- *Specify Program Instance(s) applicable to this authority*

PASSE

- d. **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).
 -- *Specify Program Instance(s) applicable to this authority*

PASSE

The 1915(b)(4) waiver applies to the following programs

MCO

PIHP

PAHP

PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)

FFS Selective Contracting program
 Please describe:

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

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

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

PASSE

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

PASSE

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

PASSE

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

-- Specify Program Instance(s) applicable to this statute

PASSE

- e. **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

-- Specify Program Instance(s) applicable to this statute

PASSE

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

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

With this renewal the state is adding a new PASSE, Caresource, to account for growth in the program and provider community and to ensure choice should one of the existing PASSE entities be subject to sanctioning, including suspension of enrollment or termination.

DHS conducted a readiness review of the new PASSE. The readiness review consisted of desk and onsite reviews as well as systems testing to assess the capacity of CareSource to perform satisfactorily in all major operational areas including Staffing, Grievances and Appeals, Provider Network, Provider Relations, Member Information, Marketing, Business Requirements, Quality and Utilization, Care Coordination, Program Integrity, Provider Reimbursement, Claims Management, Enrollment and Eligibility, Systems Testing.

The readiness review included a desk review of CareSource’s policies and procedures and an on-site review led by a DHS contracted external assessor and attended by DHS staff from the Division of Medical Services (“DMS”), Division of Disability Services (“DDS”), and the Division of Adult, Aging and Behavioral Health Services (“DAABHS”). The on-site review included demonstrations of network adequacy, required staffing positions, claims systems testing, the member Person-Centered Service Plan (“PCSP”), interviews with CareSource Care Coordinators and member hotline demonstration. The external assessor reviewed all of CareSource’s policies and procedures provided during the desk review after they were reviewed by DHS and made a final determination of the PASSE’s readiness.

CareSource has successfully satisfied all components of the readiness review and has begun receiving enrollment files for members that will be enrolled in the new PASSE as of January 1, 2022.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

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

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

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

The PIHP is paid on a risk basis

The PIHP is paid on a non-risk basis

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

The PAHP is paid on a risk basis

The PAHP is paid on a non-risk basis

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

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

the same as stipulated in the state plan

different than stipulated in the state plan

Please describe:

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

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

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

Procurement for MCO

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Any entity that meets the licensure and provider standards may participate. First, the entity must be licensed by the Arkansas Insurance Department as a Risk Based Provider Organization (RBPO)/Provider-Led Arkansas Shared Savings Entity (PASSE). Each licensed entity must then sign a Provider Agreement with DHS to enroll as a Medicaid Provider with Arkansas Medicaid. In Phase I, a PASSE was a PCCM entity.

For Phase II, the RBPO/PASSE will be required to sign a new PASSE Provider Agreement, which will incorporate the PASSE Medicaid Provider Manual and the Federal Medicaid Managed Care regulations. In Phase II, the PASSE will be a full risk MCO entity.

Procurement for PIHP

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Procurement for PAHP

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Procurement for PCCM

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Procurement for FFS

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

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

Section A: Program Description

Part I: Program Overview

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

1. Assurances.

The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

The State seeks a waiver of section 1932(a)(3) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries ability to access services.

2. Details. The State will provide enrollees with the following choices (please replicate for each program in waiver):

Program: " **Provider-Led Arkansas Shared Savings Entity.** "

Two or more MCOs

Two or more primary care providers within one PCCM system.

A PCCM or one or more MCOs

Two or more PIHPs.

Two or more PAHPs.

Other:
please describe

Section A: Program Description

Part I: Program Overview

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

3. Rural Exception.

The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. 1915(b)(4) Selective Contracting.

Beneficiaries will be limited to a single provider in their service area

Please define service area.

Beneficiaries will be given a choice of providers in their service area

Section A: Program Description

Part I: Program Overview

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

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

Section A: Program Description

Part I: Program Overview

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

1. General. Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

- **Statewide** -- all counties, zip codes, or regions of the State
 -- *Specify Program Instance(s) for Statewide*

PASSE

- **Less than Statewide**
 -- *Specify Program Instance(s) for Less than Statewide*

PASSE

2. Details. Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Statewide	MCO	Empower Healthcare Solutions, LLC
Statewide	MCO	Arkansas Total Care
Statewide	MCO	Arkansas Provider Coalition d/b/a Summit Community Care
Statewide	MCO	CareSource PASSE

Section A: Program Description

Part I: Program Overview

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

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

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

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

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

Section 1931 Children and Related Populations are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

Blind/Disabled Children and Related Populations are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

Mandatory enrollment

Voluntary enrollment

Aged and Related Populations are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

TITLE XXI SCHIP is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Childrens Health Insurance Program (SCHIP) through the Medicaid program.

Mandatory enrollment

Voluntary enrollment

Other (Please define):

Enrollment in a PASSE is mandatory for Medicaid beneficiaries, regardless of eligibility group, that have been identified through the Independent Assessment (IA) system as in need of behavioral health services or services for individuals with developmental disabilities at Tier II and Tier III levels of care. This includes all clients enrolled in the concurrent 1915(i) State Plan Amendment or the 1915(c) Community and Employment Supports (CES) Waiver.

For individuals served by the Division of Behavioral Health, the tiers are as follows:

Tier I: Counseling Level Services

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

Tier II: Rehabilitative Level Services (Mandatory Enrollment)

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

Tier III: Intensive Level Services (Mandatory Enrollment)

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

For Division of Developmental Disabilities Clients, the tiers are as follows:

Tier I: Community Clinic Level of Care

At this level of need, the individual receives services in a day habilitation setting, i.e., and EIDT or ADDT.

Tier II: Institutional Level of Care (Mandatory Enrollment)

The individual scored high enough in certain areas to be eligible for paid services and supports.

Tier III: Institutional Level of Care (Mandatory Enrollment)

The individual scored high enough in certain areas to be eligible for the most intensive level of services, including 24 hours a day/7 days a week paid services and supports.

For the existing BH and DD populations, an independent assessment (IA) was conducted during Phase I. The IA determined the tier level for the member so that they can be enrolled in a PASSE. The IA also generated a report that could be used to develop the care plans for those beneficiaries. The IA will continue to be used for all newly enrolled beneficiaries in Phase II.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

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

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

Poverty Level Pregnant Women -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

Other Insurance --Medicaid beneficiaries who have other health insurance.

Reside in Nursing Facility or ICF/IID --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IID).

Enrolled in Another Managed Care Program --Medicaid beneficiaries who are enrolled in another Medicaid managed care program

Eligibility Less Than 3 Months --Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

Participate in HCBS Waiver --Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

American Indian/Alaskan Native --Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

Special Needs Children (State Defined) --Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

SCHIP Title XXI Children Medicaid beneficiaries who receive services through the SCHIP program.

Retroactive Eligibility Medicaid beneficiaries for the period of retroactive eligibility.

Other (Please define):

Individuals residing in a Human Development Center (HDC), skilled nursing home, or assisted living facility are excluded.

Individuals enrolled in the ARChoices or Arkansas Independent Choices, and Autism Waiver are excluded.

Individuals who are receiving Arkansas Medicaid healthcare benefits on a medical spend-down basis are excluded; as well as individuals who are eligible for Arkansas Medicaid healthcare benefits under the 06, Medically Frail, Aid Category.

These services are excluded:

1. Nonemergency Medical Transportation (NET);
2. Dental Benefits (dental managed care); and
3. School-based services provided by school employees

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

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

All individuals who meet the mandatory criteria will be enrolled in a PASSE, unless:

- 1) They are residing in a human development center (HDC), a skilled nursing facility (SNF), or an assisted living facility (ALF);
- 2) They are enrolled in the ARChoices, Independent Choices, or Autism 1915(c) Waiver; or
- 3) They are Medicaid eligible through one of the excluded groups (i.e., 06 Medically Frail or Spend-down).

Individuals who are enrolled in a PASSE will not be able to remain enrolled in the 1932(a) Connect Care program.

Individuals who wish to voluntarily enroll may do so, unless they are in one of the three categories above.

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

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

1. Assurances.

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

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

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

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

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

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

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

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers

- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

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

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

Emergency Services Category General Comments (optional):

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

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

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

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

Other (please explain):

Family planning services are not included under the waiver.

Family Planning Services Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

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

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

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

Each PASSE will be required to have at least one FQHC in their network.

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

FQHC Services Category General Comments (optional):

[Empty text box for FQHC Services Category General Comments]

5. EPSDT Requirements.

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

EPSDT Requirements Category General Comments (optional):

[Empty text box for EPSDT Requirements Category General Comments]

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. 1915(b)(3) Services.

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

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

[Empty text box for 1915(b)(3) Services Requirements Category General Comments]

7. Self-referrals.

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

Self-referrals Requirements Category General Comments:

The PASSE must allow self-referrals for family planning services in accordance with 42 CFR 431.51(b).

8. Other.

Other (Please describe)

The PASSE must provide care coordination to each of its members. Act 775 of the 2017 Arkansas Regular Session defined care coordination to include 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 the community, including without limitation outreach, quality improvement, and patient panel management; and
5. Coordination of community-based management of medication therapy.

As such, the care coordinator is responsible for the person centered service plan (PCSP) for each member assigned to him or her. The PCSP includes all services and service plans related to the client. The care coordinator must gather all existing treatment plans for the member in order to create the PCSP. This includes, but is not limited to:

1. Behavioral Health Treatment Plans;
2. Person Centered Service Plan for Waiver Clients;
3. Primary Care Physician Care Plan;
4. Individualized Education Program;
5. Individual Treatment Plans for developmental clients in day habilitation programs;
6. Nutrition Plan;
7. Housing Plan;
8. Any existing Work Plan;
9. Justice system-related plan;
10. Medication Management Plan;
11. Discharge Plan; and
12. Service needs identified as the results of the member's IA.

The PCSP must prevent duplication of services, ensure timely access to all needed services, and identify service gaps for the member, as well as provide any health education and health coaching identified. The PCSP should also set forth treatment goals and objectives, as well as the strategies, activities, and services received by the member to achieve these goals and objectives.

For those members who are enrolled in the Community and Employment Supports (CES) 1915(c) waiver or the 1915(i) HCBS State Plan Services, the PASSE will also provide case management services, including:

1. Developing the Person Centered Service Plan (PCSP) in conjunction with the plan development team;
2. Coordinating and arranging all Waiver services, HCBS State Plan Services and other state plan services;
3. Identifying and accessing needed medical, social, educational and other publicly funded services (regardless of funding source);
4. Monitoring and reviewing services provided to the member to ensure all PCSP services are being provided and to ensure the health and safety of the participant;
5. Identifying and accessing informal community supports needed by eligible participants and their families;
6. Facilitating crisis intervention;
7. Providing guidance and support to meet generic needs;
8. Monitoring services provided to ensure quality of care and case reviews which focus on the participant's progress in meeting goals and objectives established on existing case plans;
9. Providing assistance relative to obtaining waiver Medicaid eligibility and ICF/IID level of care eligibility determinations;
10. Ensuring submission of timely (advanced) and comprehensive behavior and assessment reports, continued PCSP with revisions as needs change, and information and documents required for ICF/IID level of care and waiver Medicaid eligibility determinations;
11. Conducting appropriate needs assessments and referrals for resources;
12. Arranging for access to advocacy services, as requested by the member; and
13. Providing guidance upon receipt of a PASSE, DDS or DHS notice of denial on how to appeal that denial;
14. Providing assistance for reassessment of functional needs by the Independent Assessment Vendor; and
15. Engaging the member, family and caregivers in the treatment planning process with providers and ensuring members and their caregivers have access to all treatment plans for the beneficiary.

The PASSE must comply with Conflict Free Case Management rules in accordance with 42 CFR 440.169.

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

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

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

The PASSE is responsible for providing all services to its members, including services contained in:

1) The State Plan

2) The 1915(i) State Plan Amendment, which includes the following services:

- Supported Employment
- Behavior Assistance
- Adult Rehabilitation Day Treatment
- Peer Support
- Family Support Partners
- Pharmaceutical Counseling
- Supportive Life Skills Development
- Child and Youth Support
- Therapeutic Communities
- Residential Community Reintegration
- Respite
- Mobile Crisis Intervention
- Therapeutic Host Home
- Recovery Support Partners (for Substance Abuse)
- Substance Abuse Detoxification (Observational)
- Supportive Housing

3) The 1915(c) Community and Employment Supports Waiver for Home and Community Based Services, which includes the following services:

- Supported Employment
- Supportive Living
- Adaptive Equipment
- Community Transition Services
- Consultation
- Crisis Intervention
- Environmental Modifications
- Supplemental Support
- Respite
- Specialized Medical Supplies

These services are EXCLUDED and the PASSE will not be responsible for providing them:

- 1) Non-emergency 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
- 7) Waiver services provided to the elderly and adults with physical disabilities through the ARChoices in Homecare program or the Arkansas Independent Choices Program.

The PASSE must provide, at a minimum, what is available through the State Plan or the other listed authorities.

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b)

Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries access to emergency services and family planning services.

1. Assurances for MCO, PIHP, or PAHP programs

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

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

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

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

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

a. Availability Standards. The States PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees access to the following providers. For each provider type checked, please describe the standard.

1. PCPs

Please describe:

2. Specialists

Please describe:

3. Ancillary providers

Please describe:

4. Dental

Please describe:

5. Hospitals

Please describe:

6. Mental Health

Please describe:

7. Pharmacies

Please describe:

8. Substance Abuse Treatment Providers

Please describe:

9. Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

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

1. PCPs

Please describe:

2. Specialists

Please describe:

3. Ancillary providers

Please describe:

4. Dental

Please describe:

5. Mental Health

Please describe:

6. Substance Abuse Treatment Providers

Please describe:

7. Urgent care

Please describe:

8. Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

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

1. PCPs

Please describe:

2. Specialists

Please describe:

3. Ancillary providers

Please describe:

4. Dental

Please describe:

5. Mental Health

Please describe:

6. Substance Abuse Treatment Providers

Please describe:

7. Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. Details for PCCM program. (Continued)

d. Other Access Standards

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

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

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. Assurances for MCO, PIHP, or PAHP programs

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

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements

listed for PIHP or PAHP programs.

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

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

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

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

- a. The State has set **enrollment limits** for each PCCM primary care provider.

Please describe the enrollment limits and how each is determined:

- b. The State ensures that there are adequate number of PCCM PCPs with **open panels**.

Please describe the States standard:

- c. The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver.

Please describe the States standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. Details for PCCM program. (Continued)

- d. The State compares **numbers of providers** before and during the Waiver.

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

Please note any limitations to the data in the chart above:

- e. The State ensures adequate **geographic distribution** of PCCMs.

Please describe the States standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. Details for PCCM program. (Continued)

- f. **PCP:Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios.

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

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

- g. **Other capacity standards.**

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

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

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

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

Section A: Program Description

Part II: Access

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

1. Assurances for MCO, PIHP, or PAHP programs

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

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

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

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

Section A: Program Description

Part II: Access

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

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

The following items are required.

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

Please provide justification for this determination:

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

Please describe:

All individuals who have high behavioral health or developmental disability needs must undergo an Independent Assessment (IA) prior to being enrolled in a PASSE. This IA identifies areas of functional needs for each member and identifies the member as either a high needs behavioral health or developmental disabilities client. Additionally, all developmental disabilities clients who are enrolled in a PASSE will have already been deemed to meet the institutional level of care by either the Community and Employment Supports Waiver eligibility unit or the Office of Long Term Care.

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

Please describe the enrollment limits and how each is determined:

In addition to the IA that beneficiaries receive prior to PASSE enrollment, each PASSE must complete a health questionnaire within 60 days of the member being enrolled in that PASSE and complete the Person Centered Service Plan (PCSP). The health screen must include a psycho-social evaluation.

- d. **Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:
1. Developed by enrollees primary care provider with enrollee participation, and in consultation with any specialists care for the enrollee.
 2. Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
 3. In accord with any applicable State quality assurance and utilization review standards.

Please describe:

The care coordinator should engage the member, family and caregivers in the treatment planning process with providers and ensure members and their caregivers have access to all treatment plans for the member.

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

Please describe:

The PASSE must have a process to allow members direct access to behavioral health and developmental disability services that are listed in the member's PCSP.

Section A: Program Description

Part II: Access

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

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

- a. Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollees needs.
- b. Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollees overall health care.
- c. Each enrollee is receives **health education/promotion** information.

Please explain:

- d. Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
- e. There is appropriate and confidential **exchange of information** among providers.
- f. Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
- g. Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
- h. **Additional case management** is provided.

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

i. Referrals.

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

Section A: Program Description

Part II: Access

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

4. Details for 1915(b)(4) only programs: If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

All member who have an existing care plan 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 enrollment. The PASSE Care Coordinator will then have 60 days to conduct a health questionnaire and coordinate a Person Centered Service Plan (PCSP) Development meeting. 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.

Section A: Program Description

Part II: Access

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

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

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs

The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

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

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

The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on:

10/01/18 (mm/dd/yy)

The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004.

Please provide the information below (modify chart as necessary):

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

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

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

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

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

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

Section A: Program Description

Part III: Quality

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

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

Please describe:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

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

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

- c. Selection and Retention of Providers:** This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
 - A. Initial credentialing
 - B. Performance measures, including those obtained through the following (check all that apply):
 - The utilization management system.
 - The complaint and appeals system.
 - Enrollee surveys.
 - Other.

Please describe:

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

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

4. Details for 1915(b)(4) only programs: Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. Assurances

The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

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

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

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. Details

a. Scope of Marketing

- 1. The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.
- 2. The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general).

Please list types of indirect marketing permitted:

The State permits the PASSE to market to potential enrollees through a website or printed material distributed through DHS choice counselors. Specifically, each PASSE may create and run a website for information regarding its PASSE, provider network, and care coordinator services. This website may be linked to the DHS PASSE webpage and is designed to provide information for beneficiaries when making a decision to change PASSEs.

The PASSE may also produce written marketing materials to distribute to enrollees and potential enrollees. The written materials may be distributed by DHS choice counselors.

All marketing materials and marketing strategies must be approved by DHS.

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

Please list types of direct marketing permitted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

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

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

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

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

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

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

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

marketing materials.

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

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

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

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

Please describe the methodology for determining prevalent languages:

- b. The languages comprise all languages in the service area spoken by approximately 5.0 percent or more of the population.

- c. Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

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

The PASSE must have the ability to translate marketing materials for beneficiaries who do not speak English or Spanish, either through the use of a voice translator or through some other translation service. The PASSE may choose to provide their marketing materials in other languages to fulfill this requirement.

A PASSE may only directly 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 choice counselors.

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

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

Section A: Program Description

Part IV: Program Operations

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

1. Assurances

The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

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

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

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

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

2. Details

a. Non-English Languages

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

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

Spanish

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

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

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

Please explain how the State defines significant.:

- b. The languages spoken by approximately 5.00 percent or more of the potential enrollee/enrollee population.

- c. Other

Please explain:

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

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

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

Please describe:

DHS’s PASSE Member support team will assist enrollees in making the choice of which PASSE to join and answer any questions regarding PASSE enrollment, the appeals and grievance process, and what rights they have as PASSE beneficiaries.

Section A: Program Description

Part IV: Program Operations

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

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

State

Contractor

Please specify:

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

Section A: Program Description

Part IV: Program Operations

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

2. Details (Continued)

c. Enrollee Information

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

the State

State contractor

Please specify:

The MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

Section A: Program Description

Part IV: Program Operations

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

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

The State will leverage existing employees to provide initial information and choice counseling to enrolled members. These employees will receive notice of who has been enrolled from the DSS System and will then contact that member or their family to provide any information and conduct any choice counseling necessary.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. Assurances

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

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

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

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. Details

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

a. Outreach

The State conducts outreach to inform potential enrollees, providers, and other interested parties of the

managed care program.

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

Websites for the Arkansas Waiver Association, the Developmental Disabilities Provider Association and Arkansas Medicaid contain information about the Waiver amendments. The information was posted to the Arkansas Medicaid Website around September 1st, 2018. The link is <https://humanservices.arkansas.gov/about-dhs/dms/passe/passe-beneficiary-support>. Other websites would have posted the information soon thereafter. DMS and DDS staff participated at provider conferences and took comments by phone and email from providers and people receiving or applying for services.

The following meetings were held where agency representatives spoke regarding these amendments:

October 2017:

- 9-13: AFMC PASSE Webinars, statewide
- 10: Independent Assessment Informational Session, Little Rock
- 17: Parent Meeting, Searcy
- 25: School-Based Mental Health Task Force

December 2017:

- 6: Medicaid Educational Conference

January 2018:

- 19: Facebook Live presentation, statewide

February 2018:

- 16: Independent Assessment Information Session, Little Rock
- 28: Arkansas Department of Education, Little Rock

March 2018:

- 27: Independent Living, Inc. Conference, Harrison

April 2018:

- 20: Family Bistro for Title V Families and DD Stakeholders
- 25: ACAAAA Annual Conference, Little Rock

May 2018:

- 25: Natural Wonders Committee presentation, Little Rock

June 2018:

- 20: Webinar on Care Coordinator Rules and Responsibilities, Statewide

July 2018:

- 5: Meeting with DCFS and PASSE Care Coordinators, Little Rock
- 11-13: Arkansas Waiver Association Conference, Hot Springs

August 2018:

- 20: DDS Staff training on PASSE, Little Rock
- 20: Public Hearing on PASSE Provider Manual, Little Rock
- 23: Webinar on PASSE for Medical Providers, Statewide

September 2018:

- 4: Public Hearing on PASSE Provider Manual, Monticello
- 6: Public Hearing on PASSE Provider Manual, Hope
- 11: Facebook Live on PASSE, Statewide
- 11: Rate Setting Meeting with PASSE CEOs and Actuaries, Little Rock
- 17: Webinar on PASSE for Families, Statewide

DMS and DDS leaders continue to conduct statewide Webinars and Townhalls directed toward providers and beneficiaries. These meetings will continue until the start date of Phase II, March 1, 2019.

Additionally, the state will ask for PASSE participation in outreach activities such as public forums or beneficiary/provider trainings. If the State asks for such participation, it will ask for a representative of each PASSE to be a part of the outreach.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. Details (Continued)

b. Administration of Enrollment Process

State staff conducts the enrollment process.

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

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

Broker name:

Please list the functions that the contractor will perform:

- choice counseling
- enrollment
- other

Please describe:

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

Please describe the process:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

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

This is a **new** program.

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

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

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

Beginning on March 1, 2019, all beneficiaries already enrolled in a PASSE and receiving care coordination service will begin receiving all services through the PASSE. This includes beneficiaries who have been designated as a Tier II or Tier III behavioral health or developmental disability client by the Independent Assessment (IA) and mandatorily enrolled in a PASSE.

Also, beginning on March 1, 2019, those beneficiaries who meet the eligibility requirements to enroll in the 1915(i) waiver for HCBS state plan services will be enrolled in the PASSE program. Once enrolled, all services for those beneficiaries will be provided by the assigned PASSE.

Beneficiaries who have already been attributed to a PASSE will be offered an open enrollment period during the first quarter of PASSE implementation.

All assigned beneficiaries will have 90 days from date of initial assignment to change their PASSE. DHS's Beneficiary Support will assist with this process.

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

- i. Potential enrollees will have **day(s) / month(s)** to choose a plan.
- ii. There is an auto-assignment process or algorithm.

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

The State automatically enrolls beneficiaries.

on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3).

on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1).

on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause.

Please specify geographic areas where this occurs:

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

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

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

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

d. Disenrollment

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

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

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

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

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

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

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

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

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

Please describe the reasons for which enrollees can request reassignment

- ii. The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

- iii. If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCMs caseload.
- iv. The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

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

Each beneficiary who undergoes an IA and is determined to be a Tier 2 or Tier 3 BH or DD client will automatically be assigned to a PASSE by DHS. Auto assignment will be proportionally distributed across all four PASSE’s. Market share will be taken into account to ensure fair competition among PASSE’s. Once a PASSE reaches a certain percentage of the market share, that PASSE will be removed from the auto-assignment algorithm until their market share falls below that percentage. Beginning in 2020, DHS anticipates the auto-assignment algorithm will also remove a PASSE from participation in auto-assignment if quality metrics are not met.

After auto-assignment, the member will have 90 days to dis-enroll from their assigned PASSE and re-enroll in another PASSE. DHS will provide choice counseling to each assigned member and direct them to approved informational websites or provide them with written material to help them choose between PASSE's. If the member elects to change PASSE's, the change will take effect seven days after the request is processed.

The member will be locked-in to that PASSE until open enrollment, at which time they will be given thirty (30) days to select a new PASSE.

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

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. Assurances

The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

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

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

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do

not apply.

The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

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

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

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

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

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

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

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

3. Details for MCO or PIHP programs

a. Direct Access to Fair Hearing

The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

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

b. Timeframes

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

The States timeframe within which an enrollee must file a **grievance** is days.

c. Special Needs

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

Please describe:

Each PASSE must provide auxiliary aids and services to beneficiaries with special needs upon request, including, but not limited to, interpreter services and toll-free numbers with TTY/TTD capability.

If an oral inquiry or request for a grievance or appeal is made, the PASSE or State must treat it as a formal request and begin the grievance or appeal process.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

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

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

- the State
- the States contractor.

Please identify:

- the PCCM
- the PAHP

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

Please describe:

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

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

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

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

Has time frames for resolving requests for review.

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

Establishes and maintains an expedited review process.

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

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

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

Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

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

It is the responsibility of DHS to inform the person or the legally responsible representative of appeal rights specific to the applicant or of program denial.

It is the responsibility of DHS staff to inform the person or legally responsible representative of appeal rights specific to closure of an application case for failure of the person or legal representative to comply with requests for required application assessment information. When the applicant is determined to meet eligibility criteria, DHS informs the person or the legally responsible person of appeal rights specific to:

- 1) Continued choice for institutional or community based services;
- 2) Provider choice, including the right to change providers;
- 3) Service denials;
- 4) When their chosen providers refuse to serve them, and
- 5) Case closure.

Thereafter, the PASSE care coordinator provides continued education at each annual review regarding the PASSE's appeal process. The member or the legal representative may file an appeal with the PASSE. The member or legal representative may appeal the PASSE's decision to DHS following those processes, which the care coordinator must also inform the member of. Before an appeal may be brought to DHS, the member or care giver must exhaust the PASSE's appeal process.

All PASSE appeal processes must meet the requirements of CMS's managed care regulations. Additionally, DMS will use an appeal process in accordance with the Medicaid Provider Manual, Sections 190.000 and 191.000 and the Arkansas Administrative Procedures Act, A.C.A. 25-15-201 et seq. Each PASSE must make its members aware of the appeal process and the members' appeal rights.

Each PASSE must have a process by which a member can file a complaint or grievance regarding, at a minimum, the type of services available to PASSE members, the denial of a specific service or provider, the quality of service provide, or regarding a provider in the PASSE's network, including a care coordinator.

Each PASSE must have a process by which a member can file a complaint or grievance regarding, at a minimum, the type of services available to PASSE members, the denial of a specific service or provider, the quality of service provide, or regarding a provider in the PASSE's network, including a care coordinator.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

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

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

The prohibited relationships are:

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

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

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

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

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

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

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

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

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

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

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

The Arkansas Insurance Department will require background checks for each PASSE officer, owner, and partner. Additionally, the PASSE will provide an attestation of compliance with the criminal background check requirements each year at the time of the review and recertification as a PASSE.

All PASSE providers will be required to enroll as Medicaid Providers and undergo criminal background checks, and child maltreatment and adult maltreatment registry checks.

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to

provide a big picture of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

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

Summary of Monitoring Activities: Evaluation of Program Impact

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

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS
Independent Assessment	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Measure any Disparities by Racial or Ethnic Groups	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Network Adequacy Assurance by Plan	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Ombudsman	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
On-Site Review	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Improvement Projects	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Measures	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
Periodic Comparison of # of Providers	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Profile Utilization by Provider Caseload	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Provider Self-Report Data	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Test 24/7 PCP Availability	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Utilization Review	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Other	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

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

Please note:

- MCO, PIHP, and PAHP programs:
 - There must be at least one checkmark in each column.

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

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
Accreditation for Non-duplication	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Accreditation for Participation	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Consumer Self-Report data	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Data Analysis (non-claims)	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Enrollee Hotlines	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Focused Studies	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Geographic mapping	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
Independent Assessment	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Measure any Disparities by Racial or Ethnic Groups	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Network Adequacy Assurance by Plan	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Ombudsman	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
On-Site Review	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Improvement Projects	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Measures	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Periodic Comparison of # of Providers	MCO PIHP PAHP PCCM	MCO PIHP PAHP PCCM	MCO PIHP PAHP PCCM

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
	FFS	FFS	FFS
Profile Utilization by Provider Caseload	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Provider Self-Report Data	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Test 24/7 PCP Availability	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Utilization Review	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Other	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

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

Please note:

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

Summary of Monitoring Activities: Evaluation of Quality

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Accreditation for Participation	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Consumer Self-Report data	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Data Analysis (non-claims)	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Enrollee Hotlines	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Focused Studies	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Geographic mapping	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Independent Assessment	MCO PIHP PAHP PCCM	MCO PIHP PAHP PCCM	MCO PIHP PAHP PCCM

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
	FFS	FFS	FFS
Measure any Disparities by Racial or Ethnic Groups	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Network Adequacy Assurance by Plan	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Ombudsman	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
On-Site Review	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Improvement Projects	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Measures	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Periodic Comparison of # of Providers	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Profile Utilization by Provider Caseload	MCO PIHP PAHP	MCO PIHP PAHP	MCO PIHP PAHP

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
	PCCM FFS	PCCM FFS	PCCM FFS
Provider Self-Report Data	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Test 24/7 PCP Availability	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Utilization Review	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Other	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

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

Programs Authorized by this Waiver:

Program	Type of Program
PASSE	MCO;

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

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Provider-Led Arkansas Shared Savings Entity

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

For each activity, the state must provide the following information:

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

a.

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

Activity Details:

NCQA

JCAHO

AAAHHC

Other

Please describe:

b.

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

Activity Details:

NCQA

JCAHO

AAAHHC

Other

Please describe:

c.

Consumer Self-Report data

Activity Details:

1) Responsible personnel is the The DHS Office of Innovation and Delivery System Reform (IDSR).

2) The CAHPS and portions of the NCI to develop a state administered consumer survey, participants will be chosen randomly based on sample created by the DHS Division of Research and Statistics.

3) The survey will occur annually.

4) The survey will be used to monitor member satisfaction and ensure adequate and appropriate services are being provided that meet the member's needs.

CAHPS

Please identify which one(s):

The HCBS CAHPS survey.

State-developed survey

Disenrollment survey

Consumer/beneficiary focus group

d.

Data Analysis (non-claims)

Activity Details:

1) Responsible personnel is IDSR.
 2) Data analysis will be run on all data listed below submitted by the PASSE either directly to IDSR or through the MMIS system.
 3) Data analysis will be conducted on a quarterly basis.
 4) If initial analysis indicates a quality or program issue may exist, the ISDR will refer the data to the EQR or another program integrity unit, such as OMIG or the Ombudsmen.

Denials of referral requests

Disenrollment requests by enrollee

From plan

From PCP within plan

Grievances and appeals data

Other

Please describe:

Choice counseling contacts and number of notices sent.
 Quarterly reports provided by the PASSE and encounter data collected through MMIS.

e.

Enrollee Hotlines

Activity Details:

1) Personnel responsible is a DHS procured contract vendor.
 2) The Vendor operates a hotline that provides high level information on choice of PASSEs to potential members.
 3) The hotline operates on an ongoing basis.
 4) The contract vendor provides data to the state regarding call volume, subject and dispositions of call, and other standard call center metrics, which allows the state to track member requests to change PASSEs.

f.

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

Activity Details:

1) IDSR and DDS personnel will conduct focused studies.
 2) Focused studies will monitor the following activities:
 • Enrollment/Disenrollment, specifically individuals who are disenrolled due to loss of Medicaid eligibility.
 • Coverage/Authorization, studies will be conducted on specific services as needed to ensure that savings are not achieved through across the board rate cuts or discouraging use of certain services.
 • Quality of Care, studies will center on quality of services provided to subpopulations to ensure the PASSE is providing evidence-based services that demonstrate quality outcomes.
 3) The Frequency will be as needed.
 4) The focused study will be designed to yield information relevant to the question being asked by the study.

g.

Geographic mapping

Activity Details:

- 1) IDSR is responsible for geographic mapping.
- 2) Geographic mapping is conducted by mapping all providers in the PASSE network across the state by provider type.
- 3) At a minimum, mapping will occur annually.
- 4) Geographic mapping will ensure that all PASSEs are meeting the network adequacy requirements.

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

Activity Details:

- 1) The EQR procured by DHS will conduct an independent assessment of the PASSE program.
- 2) The activities will be designed by the EQR.
- 3) Activities will be conducted at a minimum, annually.
- 4) The purpose of EQR activities is to analyze the PASSE program with regards to the four pillars.

i. Measure any Disparities by Racial or Ethnic Groups

Activity Details:

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

Activity Details:

- 1) The PASSE is the responsible party.
- 2) The PASSE must update their network with IDSR
- 3) Network updates must occur at least monthly.
- 4) Network updates provide assurance of the adequacy of the PASSE's network.

k. Ombudsman

Activity Details:

- 1) IDSR will house a PASSE Ombudsman
- 2) The Ombudsman will take complaints and monitor PASSE activities for the following areas:
 - Information to Beneficiaries
 - Grievances
 - Timely Access
 - Coordination/Continuity
- 3) Will occur on an on-going basis.
- 4) The purpose of the Ombudsman is to monitor quality of the services provided by the PASSE and ensure the protection of members enrolled in the PASSE.

l. On-Site Review

Activity Details:

- 1) IDSR and DDS personnel are responsible for on-site review.
- 2) During the on-site review, DHS staff will review the PASSE's systems and process.
- 3) On-site review will occur annually.
- 4) The purpose of the onsite review is to ensure that the PASSE can provide timely access to services, PCP and specialist capacity to meet members' needs, and appropriate care coordination to ensure continuity of care.

m.

Performance Improvement Projects [Required for MCO/PIHP]

Activity Details:

- 1) The PASSE will be responsible for conducting Performance Improvement Projects (PIP).
- 2) Specific PIP activities will be determined by the PASSE and approved by DHS and will be designed to collect the information needed based on the area of focus.
- 3) PIPs will occur annually.
- 4) The PASSE will provide outcome data on the PIP to the EQR, who will review Performance Improvement Projects (the specifications of which will be set forth in the Provider Agreement).

Clinical

Non-clinical

n.

Performance Measures [Required for MCO/PIHP]

Activity Details:

- 1) The PASSE is the responsible party.
- 2) Data on the quality metrics, as described below, will be reported by each PASSE to the IDSR.
- 3) Each PASSE will be required to report performance metrics on a quarterly basis.
- 4) The quality metrics will be used to determine the success of the PASSE and the quality of the services being provided.

Process

Health status/ outcomes

Access/ availability of care

Use of services/ utilization

Health plan stability/ financial/ cost of care

Health plan/ provider characteristics

Beneficiary characteristics

o.

Periodic Comparison of # of Providers

Activity Details:

p.

Profile Utilization by Provider Caseload (looking for outliers)

Activity Details:

- 1) IDSR is the responsible party.
- 2) IDSR will evaluate encounter data provided by the PASSE through MMIS.
- 3) This will occur on an ongoing basis.
- 4) The data will be used to determine utilization and outliers and to monitor program integrity, quality of care, and coverage/authorization of services by PASSEs.

q.

Provider Self-Report Data

Activity Details:

- 1) The PASSEs are required to report encounter data reports on quality metrics.
- 2) The reports are self-reported data on the quality metrics laid out below, and encounter data collected through MMIS on the types of encounters members are experiencing.
- 3) The reports must be provided quarterly.
- 4) These self-reported data will track:
 - Enrollment/disenrollment
 - Program integrity
 - Information to beneficiaries
 - Grievances
 - Timely Access
 - PCP/Specialists Capacity
 - Coordination/Continuity of Care
 - Coverage/Authorization of Services
 - Provider Selection
 - Quality of Care

Survey of providers

Focus groups

r.

Test 24/7 PCP Availability

Activity Details:

- 1) IDSR is the responsible party.
- 2) IDSR will monitor the PASSE's network adequacy and the encounter data submitted.
- 3) This will be done on an on-going basis as new updates are made to the network adequacy.
- 4) The purpose of this monitoring is to ensure access to PCP's by members.

s.

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

Activity Details:

- 1) IDSR is the responsible party.
- 2) Encounter data provided by the PASSEs will be analyzed.
- 3) This will be done on an ongoing basis.
- 4) The purpose is to monitor the coverage and authorization of services and the quality of care provided to PASSE members.

t.

Other

Activity Details:

- 1) IDSR is one of the responsible parties.
 - 2) It will approve and monitor:
 - all marketing materials and strategies used by the PASSEs;
 - That enrollment and disenrollment from PASSE's happens in a timely manner;
 - That all information is provided to members and potential enrollees timely and in an appropriate format; and
 - Utilization of services to ensure that they are being properly authorized by the PASSEs.
 - 3) These activities will occur on an ongoing basis.
 - 4) The various activities are done for the purposes listed above. Additionally, a readiness review will ensure that all PASSE monitoring functions are in place, and that PASSE's are able to provide all needed member services on March 1, 2019. IDSR will assess the PASSE's ability to provide 24/7 access to care coordination at initial readiness review, and through analysis of quarterly reports and encounter data.
-
- 1) Another responsible party is The Office of Medicaid Inspector General (OMIG)
 - 2) OMIG will monitor PASSE program integrity, as part of their statutory duty to ensure the integrity of the State Medicaid Program.
 - 3) This monitoring occurs on an ongoing basis.
 - 4) The monitoring ensures the integrity of the PASSE program.
-
- 1) IDSR is also responsible for the PASSE Member Support System.
 - 2) This system will collect data on choice, enrollment and disenrollment, grievances, continuity of care, PCP and specialist capacity and selection, and the quality of care, as well as provide information to beneficiaries.
 - 3) This will occur on an ongoing basis.
 - 4) This data will be analyzed by IDSR to improve the Member Support System and the PASSE program.

Section C: Monitoring Results

Renewal Waiver Request

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

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

This is a renewal request.

This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.

The State has used this format previously The State provides below the results of the monitoring activities conducted during the previous waiver period.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.

- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

The Monitoring Activities were conducted as described:

Yes No

If No, please explain:

Provide the results of the monitoring activities:

Consumer Report Data : DHS collects information from NCI survey/CAPHS surveys. Some issues with surveys related to human error when entering information. Additional information and training was done to remediate this. To verify questions were answered accurately DHS followed-up directly with respondents and verified answers. DHS received CAPHS surveys from the MCOs in 2019 and 2020 (two PASSEs did not submit in 2019). Surveys were used to monitor member satisfaction/ensure adequate services are provided. CAPHS survey scores revealed overall PASSEs were surpassing NCQA standards, but for several questions MCOs reported below standards. DHS will continue to monitor surveys for improvement. The PASSE unit collected information on PASSE member and provider surveys. Surveys showed general satisfaction with PASSE services and care coordination. DHS is working with the EQRO to standardize surveys across all PASSEs. Data Analysis:DHS collected and reviewed PASSE member grievance and appeals data on a quarterly basis and tracks complaints received through the PASSE Ombudsman to monitor the quality of services/satisfaction with PASSEs. Some issues related to acknowledging complaints within the required timeframes. DHS met with the PASSEs and continues to monitor timeliness through letters PASSEs send members and quarterly reports. The EQR reviewed grievances and appeals through the Compliance Assessment (CA) and Performance Measure Validation (PMV) protocols. One AON was found for two of the PASSEs related to CA involving conflicting notification timelines or specific verbiage missing within a related policy. PASSEs corrected policies and resubmitted to DHS. Disenrollment requests and provider/member complaints are received through PASSE Ombudsman and reviewed monthly. Enrollee Hotlines/ Ombudsman: DHS contracts with a vendor to operate an enrollee hotline and houses a PASSE Ombudsman.DHS receives a weekly report on call volume/subject of calls. Disenrollment requests are handled by the PASSE Ombudsman and monitored monthly. Information is used to analyze specific issues with PASSEs/services provided. Issues are addressed with PASSEs during monthly operations meetings.Focused Studies: EQRO is conducting focus studies, including a review of coverage of services for high risk/high needs PASSE members. Information will be used to analyze quality of care outcomes/identify issues with services for these populations. Geo Mapping/Network Adequacy: PASSEs provide geo maps with network adequacy submissions bi-annually. DHS works with a vendor to do geo mapping of network adequacy reports as of July 2021. PASSEs must improve access within a six month period or they submit a corrective action plan (CAC) around deficiencies. PASSEs addressed AONs related to network adequacy in year 1 of the EQR. Independent Assessment: DHS is currently in the second year of the EQR. Findings provide information on access, timeliness and quality of PASSE services as well as a review grievance and appeals systems and processes, utilization review,and PCSP review. During year one, the EQRO found some areas of noncompliance related to PIPs, PMV, CA, critical incident reporting, PCSPs, and ANA. PASSEs were required to submit CACs related to AONs.A contracted vendor has performed an assessment on the 1915 (b) waiver and results will be used to improve program quality and DHS oversight activities.Onsite Review: DHS conducted an on-site review of the PASSEs prior to the implementation of Phases I (PCCM) and Phase II (full risk). Information was used to ensure the PASSE's readiness and capability to serve clients. DHS monitors the PASSEs ability to provide timely access of services through review of network adequacy reports, information from the PASSE ombudsman and PCSP review. Deficiencies are addressed with the PASSE. Currently the PASSEs have CACs around PCSP creation and implementation.Performance Improvement Projects (PIPs): PASSEs conduct one clinical/one non-clinical PIP each year. PIPs are reviewed by EQRO. In year two of the EQRO, DHS is requiring PASSEs to conduct a shared PIP related to PCSP development. The EQRO found some deficiencies in the methodology cited in the PASSE's PIPs. PASSEs resubmitted PIPs based on feedback. The EQRO has reviewed these PIPs again in year 2 and provided additional feedback as it relates to data collected for specified PIP interventions. Performance Measures: DHS collects monthly and quarterly PMs from PASSEs. Reports are analyzed and used to ensure PASSE's compliance with regulations and to monitor quality of, access to and timeliness of care for members. Reports collected include utilization, care coordination metrics related to contact with members, PCSP creation, care coordinator caseload, utilization, grievances and appeals, call center metrics, HEDIS, and provider quality metrics. Problems were found with the timeliness of PCSP. PASSEs have corrective actions around this metric. Other deficiencies relate to quarterly contact in 2020 and the first quarters of 2021 due to the PHE and members not wanting to receive face to face visits. There have been denials related to call center metrics, but were remediated.Profile Utilization by Provider Caseload: PASSEs send monthly utilization reports to the DHS PASSE unit. These are reviewed to determine outliers. The EQRO reviewed specific utilization components. These were addressed as AONs with the PASSEs and submitted CACs. The PASSE unit has not been reviewing encounter data but the EQRO conducts Encounter Data Validation and any AONs found are addressed by the PASSEs. 27/7 PCP Availability: Monitored through network adequacy and reports from PASSEs.No issues have been identified. Other: The PASSE unit reviews and must approve all marketing materials.Any issues that are discovered require the PASSEs to make changes.A readiness review was conducted prior to the launch of the PCCM program (2018) and the full risk program (2019).

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
DD/ID & Dual Diagnosis (Child)	
Behavioral Health (Adult)	

Title	
DD/ID & Dual Diagnosis (Adult)	
Behavioral Health (Child)	
Behavioral Health-CHIP	
DD/ID-CHIP	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	10/01/0017	12/31/2021		
Enrollment Projections for the Time Period*	01/01/2022	12/31/2026		

**Include actual data and dates used in conversion - no estimates

*Projections start on Quarter and include data for requested waiver period

Section D: Cost-Effectiveness

Services Included in the Waiver

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

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Family Planning				
HH/Personal Care				
Day Treatment				
Inpatient				
DDS Waiver Community Support				
Pharmacy				
Professional				
PT/OT/Speech				
Care Coordination				
Outpatient				
ICF				
OBH Other				
OBH Evaluation				
DDS Waiver Case Management				
Other				
OBH Therapy				
Dental/Vision/Hearing				
Inpatient-Psych				
OBH Community Support and Psycho-social Rehab				

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
DDS Waiver-Other				

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

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

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

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Cost-effectiveness spreadsheet is required for all 1915b waiver submissions.

b. Name of Medicaid Financial Officer making these assurances:

c. Telephone Number:

d. E-mail:

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

date of payment.

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

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review*

at the discretion of CMS and OMB.

- b. The State provides additional services under 1915(b)(3) authority.
- c. The State makes enhanced payments to contractors or providers.
- d. The State uses a sole-source procurement process to procure State Plan services under this waiver.
- e. The State uses a sole-source procurement process to procure State Plan services under this waiver. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Your waiver will not be reviewed by OMB at the discretion of CMS and OMB.

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

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

Please describe:

The PASSEs will become Medicaid enrolled providers and will have to enter into a PASSE Provider Agreement; as part of this agreement, the PASSE' will be required to follow the PASSE provider manual. Dental services and Non-Emergency Medical Transportation (NET) will continue to be capitated by other vendors.

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

- a. **Management fees are expected to be paid under this waiver.**
The management fees were calculated as follows.
 1. Year 1: \$ per member per month fee.

- 2. Year 2: \$ per member per month fee.
- 3. Year 3: \$ per member per month fee.
- 4. Year 4: \$ per member per month fee.

b. Enhanced fee for primary care services.

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

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

d. Other reimbursement method/amount.

\$

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

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

- a. [Required] Population in the base year and R1 and R2 data is the population under the waiver.
- b. For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*
- c. [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

No enrollment trend is assumed from SFY2017 forward.

- d. [Required] Explain any other variance in eligible member months from BY/R1 to P2:

The only variance in member months from BY to P2 is the annual enrollment trend described above.

- e. [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:

State Fiscal Year

Appendix D1 Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

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

For Conversion or Renewal Waivers:

- a. **[Required] Explain if different services are included in the Actual Waiver Cost from the previous period in Appendix D3 than for the upcoming waiver period in Appendix D5.**

Explain the differences here and how the adjustments were made on Appendix D5:

- b. **[Required] Explain the exclusion of any services from the cost-effectiveness analysis.**

For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

Appendix D2.S: Services in Waiver Cost

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Family Planning							
HH/Personal Care							
Day Treatment							
Inpatient							
DDS Waiver Community Support							
Pharmacy							
Professional							
PT/OT/Speech							
Care Coordination							
Outpatient							
ICF							
OBH Other							
OBH Evaluation							
DDS Waiver Case Management							
Other							
OBH Therapy							
Dental/Vision/Hearing							
Inpatient-Psych							
OBH Community Support and Psycho- social Rehab							
DDS Waiver-Other							

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

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

- a. The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. Note: this is appropriate for MCO/PCCM programs.
b. The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. Note: this is appropriate for statewide PIHP/PAHP programs.
c. Other
Please explain:

Empty rectangular box for explanation.

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

- a. The State is requesting a 1915(b)(3) waiver in Section A.I.A.1.c and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.
b. The State is including voluntary populations in the waiver.
Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

Empty rectangular box for description of selection bias.

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

Basis and Method:

- 1. The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.
2. The State provides stop/loss protection
Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

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

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

Document

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

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

Document:

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

Appendix D3 Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

a. State Plan Services Trend Adjustment the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. .

This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.

1. **[Required, if the States BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present).**

The actual trend rate used is:

Please document how that trend was calculated:

The waiver R2 is SFY 2021. However, the waiver renewal begins January 1, 2022 (P1=CY 2022). As a result, the R2 cots are trended to P1 using an inflation trend an a program change factor. Since the CY 2022 MCO capitation rates are already developed, we relied on the actual capitation rates for each MEG to estimate P1 costs.

The state plan services trend from SFY 2021 to P1 is set equal to the actual trend included in the CY 2022 PASSE capitation rate certification, which is 3.4% annually. This trend is applied for 18 months from the midpoint of SFY 2021 (1/1/21) to the midpoint of CY 2022 (7/1/22) for a total adjustment of 5.1%. Additionally, each MEG has a programmatic /policy/pricing adjustment that captures other changes in expected P1 costs relative to R2, such as rate cell mix, impact of the PHE, emerging claims experience, etc.

2. [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (i.e., trending from present into the future).

i. State historical cost increases.

Please indicate the years on which the rates are based: base years. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the States cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii. National or regional factors that are predictive of this waivers future costs.

Please indicate the services and indicators used. In addition, please indicate how this factor was determined to be predictive of this waivers future costs. Finally, please note and explain if the States cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

To project costs from P1 to future years, we used high level total costs trend rates based on national data included in the 2018 Actuarial Report on the Financial Outlook for Medicaid, published by CMS Office of the Actuary. We reviewed the annual trend rates beginning in FFY 2021 derived from table 22 of the report. The annual trend rates range from 4.6% to 5.2% for the adult, child, and disabled populations. As such, we selected an annual trend rate of 5.0% for all populations to trend from P1 to P2 and subsequent years. We did not rely on historical cost increases observed in the program due to the PHE as well as significant risk corridor recoveries in the initial years of the program.

3. The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase.

Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

- i. Please indicate the years on which the utilization rate was based (if calculated separately only).**
- ii. Please document how the utilization did not duplicate separate cost increase trends.**

Section D: Cost-Effectiveness

Part I: State Completion Section

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

b. State Plan Services Programmatic/Policy/Pricing Change Adjustment: This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
 - Reductions in State Plan Services (-)
 - Legislative or Court Mandated Changes to the Program Structure or fee
 - Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
 - Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.
1. The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
 2. An adjustment was necessary. The adjustment(s) is(are) listed and described below:
 - i. The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
Please list the changes.

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

- A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment
- B. The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment
- C. Determine adjustment based on currently approved SPA.
PMPM size of adjustment
- D. Determine adjustment for Medicare Part D dual eligibles.

E. Other:
Please describe

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

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

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

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

PMPM size of adjustment

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

Approximate PMPM size of adjustment

C. Determine adjustment based on currently approved SPA.

PMPM size of adjustment

D. Other

Please describe

iv. Changes in legislation.
Please list the changes.

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

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

PMPM size of adjustment

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

Approximate PMPM size of adjustment

C. Determine adjustment based on currently approved SPA

PMPM size of adjustment

D. Other

Please describe

- v. Other
Please describe:

As noted in item J.A.1, a programmatic/policy/pricing change adjustment was made in the projection of P1 costs using R2 costs. An adjustment was also applied to the projection of P2 costs for the behavioral health MEGs to reflect the change in population acuity from P1 to P2.

- A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment
- B. The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment
- C. Determine adjustment based on currently approved SPA.
PMPM size of adjustment
- D. Other
Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

- 1. No adjustment was necessary and no change is anticipated.
- 2. An administrative adjustment was made.
 - i. Administrative functions will change in the period between the beginning of P1 and the end of P2.
Please describe:

- ii. Cost increases were accounted for.

- A. Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
- B. Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
- C. State Historical State Administrative Inflation. THE actual trend rate used is PMPM size of adjustment

0.00

Please describe:

[Empty text box]

- D. Other
Please describe:

Administrative expenses are trended to P1-P5 the same annual trend rate as the state plan service costs.

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

[Empty text box]

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

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

[Empty text box]

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

[Empty text box]

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

[Empty text box]

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

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

The actual documented trend is:

Please provide documentation.

2. [Required, when the States BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (i.e., trending from present into the future), the State must use the lower of State historical 1915(b)(3) trend or States trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. A. State historical 1915(b)(3) trend rates

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

2. Please provide documentation.

B. State Plan Service trend

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

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

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

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

3. Explain any differences:

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p. Other adjustments including but not limited to federal government changes.

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the States FFS institutional excess UPL is phased out, CMS will no longer match excess

institutional UPL payments.

- Excess payments addressed through transition periods should not be included in the 1915(b) cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
- For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only) ***: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

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

Please describe:

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

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K. Appendix D5 Waiver Cost Projection

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

The original Waiver application used rounded values for the administrative costs in BY reflected in Appendix D5. These values were updated in this amendment to tie into Appendix D3. In order to arrive at the same P1 cost as the original Waiver, the administrative cost was adjusted slightly.

Appendix D5 Waiver Cost Projection

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L. Appendix D6 RO Targets

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

Appendix D6 RO Targets

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M. Appendix D7 - Summary

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

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

Please see the discussion of enrollment changes found in Section D.I.E.c.

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

Please see the discussion of trends in Section D.I.I. and D.I.J.

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

Please see the discussion of trends in Section D.I.I. and D.I.J.

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

Appendix D7 - Summary