EXHIBIT F

DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES

SUBJECT: Provider-Led Arkansas Shared Savings Entity (PASSE) 1-18 Program Medicaid Provider Manual

DESCRIPTION: This manual is being promulgated pursuant to Act 775 of 2017. It implements Phase II of the PASSE model, in which the PASSEs begin operating as Managed Care Organizations (MCOs) under CMS's regulations and assume full risk for providing all Home and Community Based Services (HCBS) under the 1915(c) Community and Employment Supports (CES) Waiver and all State Plan Medicaid Services, including HCBS services provided through the 1915(i) State Plan Amendment. The PASSE Manual incorporates requirements of the CES Waiver, the 1915(b) PASSE Waiver, and the 1915(i) State Plan Amendment. This model will allow for more flexibility in the provision of HCBS services to individuals with high behavioral health or developmental disabilities service needs. Under this model, the PASSE will be responsible for developing the Person Centered Service Plan (PCSP) and delivery of all needed services.

PUBLIC COMMENT: DHS held three public hearings, one in Little Rock on August 20, 2018, one in Monticello on September 4, 2018, and one in Hope on September 6, 2018. The public comment period ended on September 12, 2018. DHS received the following comments and provided its responses:

DHS Responses to Public Comments Regarding the PASSE Program

EMPOWER

Comment: "Appropriate level of care or coding" What does coding mean here?
Response: This references how a provider codes a service.

Comment: 9. "Inspections"- Please clarify what this means and if there will be a requirement of the PASSE to perform "Inspections".
Response: This is the current Medicaid definition of adverse action. There is a requirement that the PASSE conducts inspections of HCBS providers.

Comment: It is our understanding that an estimated 70,000-90,000 individuals receive a Tier 1 service today. How will this many individuals receive an IA in order to voluntarily enroll in the PASSE program beginning on 7/1/19. Please explain how the IA process will work for Tier 1 individuals.
Response: DHS does not anticipate that every individual who may have received limited behavioral health services will be referred and be screened as appropriate for an Independent Assessment.

Comment: Does an individual have to receive a Tier determination of Tier 1 to be eligible to voluntarily enroll? Does an individual receiving Tier 1 Behavioral Health or Intellectual or Developmental Disability services qualify to voluntarily enroll July 1 2019?

Response: Yes. DHS anticipates individuals who receive a Tier determination of Tier 1 (BH/DD) can voluntarily enroll on or after July 1, 2019.

Comment: Empower recommends that any one receiving a Tier 1 service be eligible to enroll in the PASSE program beginning 7/1/19.
Response: The requirement is that an individual who has received a tier determination of Tier 1 (BH/DD) may voluntarily enroll in the PASSE.
DHS does not anticipate that every individual who may have received limited behavioral health services will be referred and be screened as appropriate for an independent assessment.
The rate cells for these populations have not been developed by DHS actuaries at this point.

Comment: Medical Loss Ratio
Does the mega rule MLR expectations apply based on when the legislation was passed, PASSEs certified, etc.?
Response: The Federal Medicaid Managed Care mega rule with respect to Medical Loss Ratio (MLR) applies beginning January 1, 2019.

Comment: Open Enrollment Period
When is the open enrollment period?
Response: The first open enrollment period will be from March 1, 2019 to March 30, 2019. Subsequent open enrollment periods will be established by DHS no less frequently than annually.

Comment: PASSE Equity Partner
The definition should include an administrator of healthcare services.
Response: DHS agrees an administrator of healthcare services will be added to the definition of PASSE Equity Partner.

Comment: Risk-Based Comprehensive Global Payment
Defined as "Risk-based comprehensive global payment is a capitated payment that is made in monthly prorated payment to the PASSE for each assigned PASSE member. Only a licensed Risk-Based Provider Organization/ Provider-Led Arkansas Shared Savings Entity (PASSE) in good standing in the State of Arkansas is eligible to receive a global payment under the program. "
Please define in good standing.
Response: "Letter to Empower language"

Comment: What will be the process and timeframes to get these proposed services approved?
Response: "In lieu of services" will be sent to DHS for approval. Prior to utilizing "in lieu of services", they must be approved by DHS.

Comment: A. Excluded Services-Skilled Nursing Facility
Will the exception for the short term Skilled Nursing be added?
Response: Provider Agreement Language – short term SNF

Comment: Please define the word "Moratorium" as used above?
How often will the 53% be assessed? Monthly, Quarterly, Yearly?
During Phase 1, a state algorithm was established for attribution. What are the reasons that the DHS is transitioning to a proportional based assignment?
Response: Moratorium has the common language definition meaning a waiting period set by an authority.
53% will be assessed on a monthly basis.
During Phase I, DHS had access to FFS claims and had the ability to make the matches necessary for attribution. In Phase II, all members would be new to the system.
In addition, the OBHS changes allow additional providers which were not in place during Phase I attribution.

Comment: DHS reserves the right to cap assignment of additional members to the PASSE for any of the following reasons:
1. Consistently poor-quality performance;
2. Inadequate provider network capacity;
3. High number of member complaints about PASSE services or about access to care; and
4. Financial solvency concerns.

- As listed in C. [3.] above, please define "high number"

Response: The "high number" of complaints will be evaluated by DHS based on actual experience. Prior to taking action against a PASSE, DHS will provide a PASSE with notice.

Comment: A. The enrollee has access to services consistent with the access they previously had, and is permitted to retain their current provider for a period of time if that provider is not in the PASSE's network. Please define "period of time"?
Response: The question is raised in the context of transition plan. Period of time may vary by types of provider and should be described in an individual's PCSP.

Comment: Will ILPs currently employed with an OBHS Provider Type 26 be counted to meet adequacy standards?
Independently Licensed Clinicians (Provider Type 19, ILP)) only provides Tier 1 services. The PASSE program is for individuals who have been assigned a Tier 2 or Tier 3 due to their BH/IDD need. Empower is concerned that the providers who treat Tier 2 and Tier 3 members are not being included in network adequacy standards. It is critical that PASSEs have adequate networks of providers that treat the individuals that are being attributed to PASSEs. At a minimum, we request the addition of OBHS Provider Type 26 added to the network adequacy standards through 2019 until providers are credentialed/contracted as a HCBS provider.
There are also not enough ILPs in the state for any PASSE to meet network adequacy. The statement by DHS in section 226.000 also states: "Any provider that is not accepting new members or providing services to existing PASSE members cannot be counted towards meeting network adequacy." In the current system, it is rare for an ILP to treat a Tier 2 or Tier 3 member, so very few ILPs would count.

The ILP provider type 19 was previously the LMHP program which only treated children/adolescents. Therefore, the ILP provider type is not well developed.
The exclusion of OBHS providers from network adequacy does not hold PASSEs to the standards laid out in the manual of "A PASSE must maintain a network that is sufficient in numbers and types of providers to ensure that all needed services to attributed members will be adequately accessible without unreasonable delay and within the time and distance requirements set out in this policy."
What is DHS's rationale for not including the Provider Types 26 in the network adequacy standards that treat the Tier 2 and Tier 3 Behavioral Health members? Empower understands that Tier 2 and Tier 3 services are being removed from the OBHS (provider type 26) manual but if in fact provider type 26 will be grandfathered to provide HCBS services until 1/1/20, please accept their current provider type for network adequacy.
Will provider type 26 (OBHS) and provider types for IDD CES Waiver services such as 67, be grandfathered in during 2019 to provider HCBS services until such time as PASSEs credential HCBS prior to 1/1/20? If so, what HCBS services will these grandfathered providers during 2019 be able to provide, all services or a limited amount of services under the HCBS (1915i)?
In addition, can provider type 26 be counted to meeting adequacy standards for Board Certified Psychiatrist as each provider type 26 must have a Psychiatrist?
Response: Yes, if the ILP is enrolled in the Medicaid program as a Provider Type 19, they will be counted to meet network adequacy.
Provider Type 19s only provide Tier 1 services in Medicaid FFS.
DHS believes that requiring Provider Type 26 providers within network adequacy would be too restrictive for the PASSEs as they build their networks which now may include new types of providers due to the adoption of the OBHS manual. They will be counted during calendar year 2019, but other provider types for behavioral health services will also.
DHS agrees with comment regarding the statement and the entire sentence "*Any provider that is not accepting new members or providing services to existing PASSE members...*" and it will be deleted from the PASSE manual.
Provider Type 26s will be counted during calendar year 2019, but other provider types for behavioral health services will also.
A provider type 26 cannot be used for network adequacy of a Board Certified Psychiatrist as they are required to be enrolled as a Medicaid provider.
Provider Type 67s will be counted for network adequacy during calendar year 2019.

Comment: Will the PASSEs not be responsible for credentialing non-independently licensed staff?
Can LMSWs, LAMFTs, LACs, LPE-Is continue to provide therapy services such as Individual Therapy for Medicaid only beneficiaries?
When will PASSEs be held to adequacy standards for Mobile Crisis Available 24/7 as that is currently not a reimbursable service and only provided in some areas of the state?
Will Mobile Crisis and the other new HCBS services (Therapeutic Host Home, etc.) not need to meet adequacy standards until 1/1/20?
Response: The PASSE will be responsible for credentialing providers and have options for how they will complete the credentialing process. Each PASSE must inform DHS of how they credential providers.

The PASSE has the ability to determine if they will allow these providers to provide services.
Access to care requirements will be monitored by DHS and is required to be reported by the PASSEs to DHS.

Comment: Does the DHS currently collect all information as listed in A. in order for the PASSEs to add 1-8 to the Provider Directory? Or will the specific information that DHS does not collect currently be waived in 2019.
The PASSE Provider Agreement has removed the requirement to add cultural competency training; can this be removed from the PASSE Manual?
The PASSE manual states that the PASSE has to attest to meeting network adequacy standards in the directory, when this will be required as there are graduated adequacy standards in the PASSE agreement, as well as an allowance for Variances.
Response: DHS will provide further guidance based upon CMS approval. DHS recognizes there is some flexibility regarding cultural competency training within the provider directory and will provide further guidance.
Attestation of meeting network adequacy is required monthly to DHS from the PASSE.

Comment: Will the DHS send each PASSE information about identified TPLs? If so, how often?
How will the PASSEs report TPL information to the DHS?
Response: This is contained on the enrollment file. Exact timing will be discussed during the operational/IT meetings between the PASSEs and DHS.
This will be discussed during the operational/IT meetings between the PASSEs and DHS.

Comment: What if Empower denies a Prior Authorization (PA) of services such as acute psychiatric admission? This appears to say we must notify the member 10 days before we deny a PA.
Response: DHS will clarify when the 10-day prior notice is required. The manual will be clarified.

Comment: DHS has sought waivers on some of these edits? Do the waivers that DHS has obtained apply to the PASSE?
Can PASSEs seek NCCI edit waivers?
Will PASSEs be given a list of current approved edits for all Medicaid services?
Response: No, the PASSEs cannot seek or utilize any NCCI edit waivers.

Comment: Will provider sanctions imposed by one PASSE be shared with the other PASSEs with which the provider is in network with?
Response: Yes, DHS expects that if a PASSE sanctions a provider that it will be reported to DHS and other PASSEs.

Comment: There are no criteria listed for how you will be able to attain these payments. Is there an attachment we should be referencing?
Response: DHS will be developing the quality incentive pool in consultation with the PASSEs. There is not an attachment or criteria to be referenced.

Comment: Empower requests that the ratios be removed and that PASSEs are allowed to risk stratify our members, and report on the Quality Metrics as defined by DHS. Assigning caseloads based on need allows the highest need members to receive the clinically necessary follow up to attain their best functioning. We acknowledge the need to provide high quality care coordination services to all members, but also see the need to individualize services provided.
Response: The care coordinator to client ratios as defined in the PASSE manual will not be removed.

ARKANSAS TOTAL CARE
Comment: The PASSE Manual states, "DHS will, on an annual basis, offer an open enrollment period for all current enrollees to choose a different PASSE for coverage beginning January 1 of the following year." How does this work with open enrollment in 2019 being March 1 – March 31?
Response: There will be 2 open enrollment periods in 2019.

Comment: What are the current alternate formats available from Arkansas Medicaid?
Response: Information in alternative formats are made available per requests.

Comment: Can "skilled nursing facility services" be changed to "residential nursing home?"
Under medical hospitalization we often use a skilled nursing facility as a sub-acute setting to bridge from home or rehab when the member is too deconditioned to leave the hospital.
Response: This exclusion is specifically stated in Act 775 of 2017.

Comment: Is it possible to remove the approval requirement? In 2019 the PASSE is going to be at full risk. Requiring approval by DHS of all "In Lieu of Services" prior to service delivery will impact the PASSE's ability to assure timely and quality care is provided to the member.
Response: DHS agrees that prior approval of "flexible supports" and "in lieu of" services would be administratively burdensome and therefore will remove the approval requirement. DHS reserves the right to review the appropriateness of "flexible supports" and "in lieu of" services via retrospective review.

Comment: What is the formula for calculating the 53%? Is it based on county or region? Could it change based on the number of PASSE entities? Would it be more appropriate to address the methodology in the manual as opposed to specific percentages so that the formula could be changed if needed?
Response: The 53% is total of assigned members.

Comment: Sections 231.100, 231.200 and 231.300 cover the information more thoroughly.
Can 221.700 be removed?
Response: Section 221.700 is located in the state responsibility section of the provider manual, while the others are located in the rights and member protection section.

Comment: Currently, the PASSE does not receive an indicator of who the member is transitioning to in order for this to occur. Will the PASSE receive this information in order to offer more continuity of care between the PASSEs and if so, how will it be received?
Response: The PASSE is responsible for checking the eligibility of their members which would indicate previous PASSE membership.

Comment: Ratios for access to ALL provider types are problematic. Given the limited population that the PASSE will serve this standard defaults to a minimum of one specialty provider per provider type per county. Can a county be covered for the ratio test if the provider is located in another county?
Is it possible to allow specialty providers to service a 60-mile radius and PCPs to service a 30-mile radius so that both may serve across county lines? Other service providers may also have a broader service area than just their own county and may also need to be reviewed for consistency.
Response: Yes, the ratios are not county specific except for Providers that are certified/licensed by county. For example: Provider Type 24, AN.
The radius can cross county lines

Comment: The PASSEs have already established applications for network participation, credentialing and contracting that are already in place and in use. Mandating use of a universal process in this document will likely create issues among the PASSE entities. Can this statement be removed from the manual?
Perhaps submission of current forms being utilized for review and approval by DHS is more appropriate option that the PASSEs could consider? The outlined process does not recognize current propriety processes and already credentialed providers.
Response: We are clarifying the language to state "The PASSE must utilize a universal process for providers" … 226.000, Paragraph 4

Comment: Would DHS consider a threshold of 80% to 90% since CMS uses a 90% of their required standard as a threshold and still allows some waivers for special circumstances?
Response: DHS allows a network adequacy variance request as specified in Section 226.200.

Comment: What providers make up each specialty? Is there a taxonomy that can be used? Is it possible to narrow down the list of specialties?
Response: DHS has shared the specialties of Providers with each PASSE.

Comment: What area does the FQHC cover? Is it county or network?
Response: Each PASSE must have at least one FQHC in their network.

Comment: What providers fall into each provider specialty? Is there a taxonomy for each specialty and what is included? Where do we find it?
Response: DHS has shared the specialties of Providers with each PASSE.

Comment: How will a consistent standard will be applied?

Response: DHS & Contractors will apply the same standards to all PASSEs.

Comment: If membership within the county is less than the ratio for one member, will reporting that 1 provider is contracted be sufficient to meet this reporting requirement?
Response: Network Adequacy is measured on a statewide basis.

Comment: If the category is a service instead of a provider specialty, where the service may also be imbedded within a facility/group/organization such as an acute care hospital, should it be tracked and reported separately or included in the larger facility category?
Response: It should be tracked and reported separately.

Comment: Wouldn't it be difficult to reach this ratio in Arkansas counties that have only one Acute Inpatient Hospital? How would this ratio for Acute Inpatient Hospitals or Critical Care Services in the rural counties be met?
Response: Network Adequacy is measured on a statewide basis.

Comment: Can Emergency Rooms be used to meet this measure?
Response: Yes

Comment: What is the criteria for the waiver? Is it possible to have permanent waivers for known specialties/providers not available in the network? What's the timing to get a waiver? Is there an appeal process? Is there a threshold or cap on waiver requests?
Response: Variance requests are handled on a case by case basis.
Any action by DHS can be appealed.

Comment: Does this statement refer to the time and distance by specialty, county and ratios by specialty and county, as well as the preceding table of Access to Service/Waiting times, collectively?
Response: Yes

Comment: Care Coordinator to Client Ratio does not seem to fit within the network adequacy section. This service is provided by PASSE employees and is not part of the actual network. Can this be removed from Network Adequacy Reporting 226.300 as it is reported in Reporting and Quality Metric Requirements 259.300?
Response: This will be removed from the section.

Comment: Why is this information included in this quarterly report? This is part of the information that is listed on our Find a Provider website tool.
Response: This is an annual report, so the EQRO can analyze their quality.

Comment: Why were Cultural/Linguistic Capabilities and ADA Accommodations left off of this list? Does DHS have an exception from CMS to not include this?
Response: It is number 7 and 8 on the list.

Comment: The waiver states:
"The State permits the PASSEs to market to potential enrollees. Specifically, each PASSE may create and run a website for information regarding its PASSE, provider

network, and care coordination services. This website may be linked to the DHS PASSE webpage and is designed to provide information for beneficiaries when making the decision to change PASSEs. The PASSE may also produce written marketing materials, radio and television ads, and print ads to distribute to enrollees and potential enrollees. The written materials may be distributed by the DHS PASSE Member support team, PASSE care coordinators, and PASSE network providers. All marketing materials and marketing strategies must be approved by DHS."
This conflicts with the manual. Will one of the documents, either manual or waiver, be updated? If so, which one?
Response: The manual language will be used regarding marketing activities. The waiver will be released for public comment in the near future.

Comment: If the PASSE entities are at risk in 2019 why is the PASSE provider manual prescribing the detail processes for the PASSE entities to follow for recoveries/recoupments related to TPL? Recoupment processes are typically determined in the PASSE contracts with their providers and described in their standard provider manuals and billing practice guides. TPL and Subrogation may also involve vendors who have detailed expertise in identifying potential opportunities for other insurance unknown at the time of payment. Would it be better to consider requiring approval by DHS of any vendor, policies/procedures and correspondence utilized? Reporting is also available for these activities.
Requiring approval by DHS prior to taking action on these items would limit the effectiveness of these programs by the PASSE entities and their vendors.
Response: The purpose is that the PASSEs understand their obligations under Federal law and Regulation. The activities described in this section are the responsibility of the PASSEs and will be monitored by DHS.

Comment: Can the 10-day window be given more flexibility? It is a very tight turn around for reporting, sanctions or other administrative remedy if violated.
Response: No, it will remain 10 business days. It is unclear why the PASSE would be unable to report this to DHS in 10 business days, after it has been identified.

Comment: The requirement contradicts current practice in the private sector. Credentialing is a required process dictated by an executed contract. Currently, the PASSE typically negotiates the contract and executes it with a requirement that all providers' must be credentialed to render services under the contract before implementation of the contract. Once the credentialing has been completed, the provider will then be loaded as participating in the network and displayed in the provider directory.
Response: We agree that our language was unclear as to the proper sequencing of contracting and credentialing. We will make this clear that the description provided here is an acceptable process.

Comment: Can the member or the PASSE be referenced? What if the PASSE wants to dispute or appeal? Sections 160.000 and 190.000 are not found in the manual. Where can they be found?
Response: Sections 160.000 & 190.000 can be found in section 1 of all Medicaid manuals and can be found on the Medicaid website.

Comment: Does Medicaid have non-par providers? If so, does Arkansas Medicaid allow nonpar providers to appeal on behalf of a member? If not, can it be indicated in this section?
Response: No

Comment: The definition of adverse action is extremely broad and includes items such as denial of a concurrent review. It is impossible to give 10 days' notice before a denial of a concurrent review. Would it be possible to better define the adverse actions that specifically need to have action taken?
Response: Adverse action is defined within existing Medicaid Manuals (Section 190.002). The PASSE manual utilizes the same definition to ensure consistency.

Comment: What are these policies and where can they be found? Will the PASSE be provided these policies?
Response: They are contained within the existing Section II of each Medicaid manual.

Comment: If the PASSE is at risk in 2019 why are the PASSEs being asked to detail the processes for recoveries/recoupments? Recoupment processes are typically determined in the proprietary PASSE contracts with their providers and described in their standard provider manuals and billing practice guides.
Response: The Office of Medicaid Inspector General (OMIG) and DHS wants to review these policies and procedures.

Comment: If the PASSE is at risk in 2019 why are the PASSEs being asked to detail the processes for recoveries/recoupments? Recoupment processes are typically determined in the proprietary PASSE contracts with their providers and described in their standard provider manuals and billing practice guides.
Response: The Office of Medicaid Inspector General (OMIG) and DHS wants to review these policies and procedures.

Comment: "The PASSE may deem the credential for providers who have already been approved and credentialed by another PASSE for up to 6 months pending completion of the full credential review. DHS may grant a variance for extending the temporary period." This does not comply with national quality accreditation guidelines.
Response: The PASSE is allowed the opportunity to use the credentialing from another PASSE if they choose. It is not a requirement, only an allowance.

Comment: Why would the PASSE credential a non-contracted provider? Currently, it is not standard practice to credential a non-contracted provider. Contracting occurs as a stipulation for network participation. Normally, credentialing occurs prior to a service being rendered, not after a provider is seeing members and provided directory display.
Response: If an out of network provider is providing services to more than 50 members, DHS requires that the PASSE credential the provider.

Comment: Is the PASSE required to join the CVO work group and share in the expense if the PASSE has already established an application, credentialing and contracting

process? Many of the providers that will make up the provider network have already been credentialed, therefore the expense has already occurred. Will the CVO workgroup meet all national quality accreditation standards?
Response: This is a requirement starting January 1, 2020. The accreditation of the CVO will be discussed during the credentialing work group.

Comment: How does this requirement co-exist with uses of the state medical board's CCVS program?
Response: The CCVS may continue to be utilized even within the CVO.

Comment: Can this be clarified to be HEDIS and CAHPS?
Response: These are CMS requirements set forth in the Act.

Comment: The "Metrics" column is using effective date as the measurement but "Target" and "Reporting to DHS" are using attribution date. Is it possible to make these consistent and use the same date across all three?
Response: This will be clarified; it is within 15 business days after effective date.

Comment: "Metric-Care coordinators must follow up with members within seven (7) business days of visit to Emergency Room or Urgent Care Clinic, or discharge from Hospital of In-Patient Psychiatric Unit/Facility. Target->50% of care coordinators will follow up with members within seven (7) business days of visit to Emergency Room, or discharge from Hospital or In-Patient Psychiatric Unit/Facility. Reporting to DHS (Frequency/Content)-Quarterly/Details of follow up with members within (7) business days of visit to Emergency Room, or discharge from Hospital or In-Patient Psychiatric Unit/Facility, including but not limited to action or treatment plan to prevent/avoid such visits in the future. Can urgent care be removed from this list? Urgent care is not considered emergent services. It is recommended to be used as an alternative to the ER when a member can't get in to see their PCP. Currently, notifications for urgent care visits are limited as the first notification we receive is when the claim is submitted and there is little to no opportunity to follow-up within 7 days.
Response: Urgent Care will be removed.

Comment: Regarding "the PASSE is responsible for the credentialing of home and community based service providers. All home and community based service providers must be nationally accredited."
Does this mean credentialing is required for all providers/services listed in section 283.000-284.002 or only those listed in section 248.300?
Which national accreditation will they be expected to meet? (Ex: there is no national accreditation for Meals on Wheels)
Is there going to be a grandfather period or time limit to obtain required accreditations for these providers? Our concern is smaller HCBS won't be able to afford to live up to this expectation and members will be affected.
Response: Credentialing of HCBS by the PASSE is required for an HCBS provider to be enrolled in Arkansas Medicaid.
National accreditation may be a best practice that the PASSE may wish to adopt, but it is not required to be credentialed as an HCBS provider.

Comment: Regarding "Crisis Intervention"
This makes more sense for the definition of Mobile Crisis Intervention 282.012. Can the PASSE be given more information/clarification on Crisis Intervention?
Response: Crisis intervention is currently contained within the OBHS manual and CES waiver and can be provided in a variety of settings within the normal course of treatment. Mobile crisis intervention requires 24/7 availability of staff to respond to a member who is experiencing a crisis situation.

Comment: Regarding "Caregiver Respite"
Can the PASSE be given more information on Caregiver Respite? Are there units? Defined Hours/days? Are "planned" or "Emergency" are pooled?
Response: As you are working with members to develop the PCSP, a course of treatment would be created that would address these answers.

SUMMIT COMMUNITY CARE
Comment: Adverse Decision/Adverse Action –recommend definition include the right to appeal attribution and tier assignment.
Response: Every member has 90 days to switch their PASSE if they so choose. Members have the right to appeal their Tier assignment. Of the total 36,940 independent assessments for behavioral health needs, DHS has received 139 beneficiary appeals and 100 provider appeals for Tier assignment. 4 appeals went to a hearing, 2 of which the tier determination was upheld and 2 were reassessed.

Comment: Care Coordination—(a) The definition includes "assessing" and "reevaluating the patient for medically necessary care and service," which sounds like reassessment. Assessment and reassessment are not the job of the PASSE. (b) This does not match all the definitions in the draft 1915(b) and 1915(c) waivers and 1915(i) SPA. Are the others being changed to match? (c) Concepts from Act 775 such as assistance with social determinants do not appear to be included.
Response: In order to develop a PCSP for the member, the PASSE will need to complete a full assessment of the client, including face-to-face, review of client records and use other completed assessments, including the results of the independent assessment, and plans of care.
Care coordination is not a one-time activity. Assessment and reassessment will be continually performed by the care coordinator. Please reference PCSP development portions of the applicable waivers and SPA.

Comment: Case Management – What is the functional difference between "care coordination" and "case management"? Is there a need for two separate terms?
Response: PASSE Care Coordination is the equivalent of Waiver Case Management. The PASSE must follow the conflict-free case management rules.

Comment: Flexible Service – How does this differ from "in lieu of" services in 221.200?
Response: DHS recognizes the similarities and anticipate that the PASSEs will develop their own menus of flexible services for DHS approval.

Comment: Network Provider—Will PASSEs be required to get agreements with each provider to participate *specifically* in the Medicaid PASSE program? We believe Providers must indicate somehow that the provider is intending to participate in the PASSE program before they can be counted as part of the PASSE provider network.
Response: Yes, this is necessary in order to contract with individual providers or a group of providers, such as a physician group practice, for the services of a provider. In order to count towards network adequacy, contracts for the PASSE program will be reviewed. In order to bill for services and be paid, individual providers or provider groups will be entering into contracts with the PASSE.

Comment: PASSE Equity Partner – Equity partners include MCOs that do not deliver services. Proposed revising definition.
Response: Previously answered

Comment: Telemedicine— The definition of Telemedicine mixes the lawful professional use of telemedicine with coverage. The first paragraph is correct. But the excluded items A- D are excluded in Act 203 of 2017 only for purposes of mandated reimbursement. Summit asks that those activities be permitted as those are useful and effective methods of communication.
Response: Exclusion from reimbursement in Act 203 does not prevent the PASSE from using those methods of communication, but it is not considered a medical service delivered via telemedicine.

Comment: Virtual and Home Visit Provider Services—It is not clear whether this section is establishing different standards for telemedicine than those under state law and whether those standards are more or less stringent. Or is this an amalgamation of telemedicine and home and community-based services? This should be clarified. Also, while this definition appears to include mobile devices, it is not clear that it includes non-mobile telephonic communications. Similarly, if a client with limited technology consents, they should be allowed to use non-secure technology.
Response: These include all types of medical services including speech, occupational, and physical therapy services. DHS recognizes the importance providing these services via telemedicine in order to expand access for rural, remote, and mobility impaired members who otherwise lack access.

Comment: Recommend edit in second paragraph of this section to refer to PASSE "program."
Section "A" refers to care coordination activities in Arkansas Code 20-77-2703(3), but the four activities listed are the "conflict-free" functions from the federal HCBS regs, not the activities in the Arkansas Act. Summit recommends aligning with the cited statute as indicated in next column.
Response: DHS disagrees with the proposed edit because the PASSE program includes the responsibility of DHS while the PASSE organization is specific to the entity. DHS recognizes this has been an issue of discussion for several months and DHS maintains our position as previously described.

Comment: Item A and B appear to run afoul of the requirement that the PASSEs comply with the "Any Willing Provider" Act (Patient Protection Act). Under Arkansas law, any provider that meets a PASSE's terms and conditions must be able to participate in that PASSE under AWP.
Response: PASSEs must comply with all applicable federal, state regulations including the "Any Willing Provider" Act as DHS has consistently indicated throughout the development of the PASSE program.

Comment: Last Paragraph— "In Lieu Of" Services:
The requirement for DHS approval could be administratively burdensome for everyone and deter use of this valuable option. As we read the federal managed care rule, the state could identify types of approved "in lieu of" services in the PASSE Agreements, but not require approval on a case-by-case basis by DHS. Also, it should be considered a medical expense if it replaces a medical expense.
Response: The "in lieu of" services would be considered a medical expense if it replaces a medical expense.
"In lieu of" – array of services that might be provided to multiple individuals, such as a stay in an IMD in accordance with federal managed care rules
Flexible supports – more person centered approach, such as pest extermination for an individual with asthma
DHS agrees that prior approval of "flexible supports" and "in lieu of" services would be administratively burdensome and therefore will remove the approval requirement. DHS reserves the right to review the appropriateness of "flexible supports" and "in lieu of" services via retrospective review.

Comment: What is the basis for the 53% cap? This takes away client choice. Will the cap remain regardless of how many PASSEs participate in the program?
Summit requests that the methodology/algorithm be included in more detail in the Provider Manual.
Proportional auto-assignment will reduce the incentive for PASSEs to provide better services and better value to attract beneficiaries.
For some small providers in particular, random/proportional assignment that requires the provider to deal with four different care coordinators, four billing systems, four UR systems, etc. results in a significant cost to the provider. Summit believes assignment should be deliberate and align with PASSE provider networks in order to further the goals of the program.
Response: The 53% is only for auto-assignment. A member has the ability to switch to the PASSE of their choosing within 90 days of assignment.
DHS has indicated that we may adopt additional criteria for auto-assignment based upon quality in the future.
The number of PASSEs a provider wishes to join is up to them.

Comment: Are there limitations on the types of providers that can serve dually diagnosed individuals or the services they can receive? Any exclusion criteria?
What is the distinction now between the DD Tiers II and III? Specifically, what qualifies a member for Tier III? Edit recommended in 221.520(A)(2).

Response: There are no limitations on the types of providers that can serve dually diagnosed individuals as long as they are qualified to provide the service.
DD Tiers II and III are defined within the Independent Assessment manual.
The language in the PASSE manual will not be edited as it would represent a significant change in eligibility.

Comment: Exclusion of medical spenddown misses an opportunity to benefit some of the clients who need it the most. If spenddown members will be excluded, how will DHS ensure these members are taken care of?
Response: Individuals who qualify for Medicaid through spenddown eligibility will be served by FFS. DHS did not believe that the PASSEs should be held financially liable for cost incurred prior to Medicaid eligibility.

Comment: How will capitation rates be determined for voluntary enrollees (Tier I)? Will the rate include the same amount for care coordination as for Tier II and Tier III enrollees? Will care coordination be required or will it be at the PASSE's discretion? If required, at what ratio?
Will the state be requiring a PCP referral or setting any parameters (e.g., medical condition, total spend, etc.) around who can enter a PASSE as a voluntary enrollee?
Response: The rates for voluntary enrollees will be developed by DHS actuaries in the future.
DHS will be setting criteria for Tier 1 and will provide for public comment. The requirement is that an individual who has received a tier determination of Tier 1 (BH/DD) may voluntarily enroll in the PASSE.

Comment: A sanction resulting in for cause transition should not be just any sanction. It should be a serious sanction, and it should relate in some way to the reason for the transition.
How will Item D be determined in order to ensure proper notice and advocacy for the beneficiary?
Response: DHS agrees that a sanction for cause would be a serious violation as enumerated in the CFR.
DHS must follow all federal and state regulations regarding notification of adverse action.

Comment: Almost any service could potentially fall into category F. This should be more clearly defined or notification given to PASSEs of which provider types will be included in this criterion before the access measurement period begins.
Response: DHS will inform the PASSE of what will be measured.

Comment: What is the rationale for basing measurement of provider ratios on 120% of a PASSE enrollment? Once Phase II begins in 2019, enrollment will be largely static—no PASSE is going to experience a sudden 20% increase in enrollment. This seems arbitrary and should be changed to 100%.
Are any of these standards based on national standards? Does it make sense that the ratio for primary care and OB/GYN is the same when only a small portion of the clients are likely to get pregnant and presumably about half will be male? Do the number of board-certified psychiatrists required to meet the ratio even exist within the state?

We agree that telemedicine should be a valuable resource in meeting the access standards, but it is not clear how the use of telemedicine impacts compliance with this standard or how DHS will determine adequate access for these vulnerable populations exists through telemedicine. This section states that a provider will not be counted for access purposes if the provider "is not accepting new members and is not providing services to existing PASSE members." These are two different situations. Did you mean "or" instead of "and"?
Is "Intermediate Care Facility" a reference to large or small ICFS? There are not ICFs in all Arkansas counties.
Need to clarify that "Supportive Living/Respite/Supplemental Support" is DD.
Is "Supported Employment" in this context DD or BH? A provider should not be considered interchangeable for access purposes.
What is "mobile crisis response" service for DD? DD has not typically had this service. ArkSTART exists, but it is not a mobile crisis unit in the BH sense and not what is described in the draft 1915(c) waiver on page 69.
"Early Intervention Day Treatment" is missing.
Response: Based upon review of practices in other States, DHS chose to use the 120% of the PASSEs actual enrollment to ensure sufficient member access to services.
The network adequacy standards were developed based upon information gathered from multiple sources.
For all provider types, there is the availability of a network adequacy variance.
DHS agrees with comment regarding the statement and the entire sentence "*Any provider that is not accepting new members or providing services to existing PASSE members...*" and it will be deleted from the PASSE manual.
The requirement is that the PASSE must have providers with the ability to provide services within an ICF for a member, regardless of where that member is located within the State.
The provider types that will be assessed for network adequacy purposes are defined within the manual.
The PASSE program allows the same provider to provide services to individuals with developmental disability service needs as well as behavioral health service needs.
Access to care requirements will be monitored by DHS and is required to be reported by the PASSEs to DHS. Mobile crisis response is defined within the PASSE manual.
EIDT providers were not included for network adequacy purposes as the majority of individuals on the CES waiver do not receive services at EIDT providers.

Comment: Can mobile crisis response be satisfied through the use of telemedicine and other technology?
What is the definition of "urgent care"? Depending on the definition, a 24-hour time frame may not be reasonable, particularly since the next category goes all the way to 21 days.
Why is DD not included except for crisis?
Response: No, mobile crisis response cannot be satisfied through the use of telemedicine.

Urgent care, in this section of the manual for network adequacy access standards, means medical services that are necessary within 24 hours to prevent further deterioration of the member's condition.

DD services are HCBS services that are identified on the individual's PCSP and typically are non-medical in nature and therefore will not be considered for network adequacy access standards.

Comment: Request that a set of guidelines be developed that PASSEs can use to determine when a standard does not have to be met. Summit recommends a request template that can be used to request a variance.
Response: Variance requests are handled on a case by case basis.

Comment: These two requirements (freedom to choose vs. PASSE making assignment) appear to be contradictory. Summit proposed the language as edited in next column.
Response: The PASSE is required to make assignment to a PCP in the case where a member has not made a choice of PCP.

Comment: While we understand the need for marketing materials to be accurate and appropriate, these provisions eliminate necessary business communications. For example, at a minimum, a provider should be able to tell an existing patient which PASSE(s) that provider is in-network for, and which one(s) it is an investor in, both for disclosure purposes and as a demonstration of the provider's commitment, which may be relevant to a patient. Members need this basic information to make informed choices, just as members in commercial insurance plans are allowed to obtain that type of information from their providers.
Response: DHS will not make any changes to the marketing material requirements. The examples provided do not seem relevant to member choice. Individuals will have access to the PASSE's provider network at all times. Any materials to be used for marketing purposes must be submitted for review and approval by DHS.

Comment: 242.100 is not related to 242.000 Coordination and Continuity of Care and should be placed elsewhere for better understanding and flow.
Response: DHS agrees and will amend the manual to make this stylistic change.

Comment: Will Summit provide subrogation services for the it's program? Or is DHS keeping recovery in-house?
Response: Each PASSE is responsible for the recovery of any TPL payments.

Comment: Add educational requirement to (A)
Response: The PASSE is free to add these additional educational requirements of their care coordinators.

Comment: The language says providers do not have standing to appeal on a non-payment decision if provider has not furnished any service for which payment has been denied. This is contrary to the Medicaid Fairness Act, 20-77-1702, which permits providers to appeal denials of prior authorizations and other adverse actions for which no service has been provided if the action has a monetary consequence. While the provider can still appeal to the state under the MFA, it would seem best to make the appeals to the PASSE align with the MFA.
Where it says the PASSE must adhere to the Administrative Procedure Act, it also should

say the PASSE must adhere to Sections 160.000 and 190.000 of the Medicaid Provider Manual on beneficiary and provider appeals and hearing rights.
Response: DHS intention is to ensure compliance with the Medicaid Fairness Act and will clarify any language which conflicts with those provisions.
By reference, those sections are also included as PASSE requirements.

Comment: We maintain that our rates are proprietary trade secrets. Mandating disclosure of upper and lower rates in a public hearing would reveal that information. Therefore, Summit proposes striking that language.
Response: DHS acknowledges that providers and payors are willing to accept different payment levels based upon a number of variables, including volume. DHS recognizes that there are competing interests and that the current manual is a reasonable balance of those competing interests and will not be amended.

Comment: Uses term HCBS Occupational Therapists category is missing.
Why are dental hygienists included if dentistry is excluded from the PASSE program?
Where is provider right to appeal adverse credentialing decisions?
Response: DHS agrees and will add occupational therapists to the credentialing requirement.
Credentialing of Dental Hygienists are covered through the Dental Managed Care contracts which is excluded from PASSE contracts and therefore, DHS will remove the reference of Dental Hygienists from the manual.
Each PASSE must have provider appeal rights. DHS also has appeal rights as specified in the Medicaid Provider Manual.

Comment: Item E references LTSS. Does that include the PASSE?
Is Item L applicable to the PASSE population?
Response: Yes, both of these items are applicable to the PASSE program.

Comment: Use of the word "may" indicates that the Quality Incentive Pool is discretionary. That is not what was discussed in the early development of the provider-led program and is contrary to the language in Act 775.
Response: DHS intends to fund a quality incentive pool and will work with interested parties to define the quality measures. DHS believes "may" is appropriate as it would not allow payments to a PASSE if the quality measures are not met.

Comment: In Item E, "any" sanction is too broad. Any sanction imposed should be proportionate to the particular failure to meet the quality metric.
Two "E"s are used by mistake.
Response: Section 258.200 provides for a variety of sanctions based upon the severity of the deficiency. DHS believes these variations are appropriate based upon federal regulation. PASSEs have the authority to appeal any sanction.
This will be corrected.

Comment: How will responsibility for sanctioned behavior be apportioned between the PASSE and the involved provider?
Item L—Any sanction imposed should be proportionate to the failure to comply.

Response: Sanctions are assessed against the PASSE. Whatever action the PASSE takes against a provider is up to the PASSE.
PASSEs have the authority to appeal any sanction.

Comment: Item B—The "directly or indirectly" language seems to make the PASSE responsible for all network providers, even if the provider acts contrary to directives from the PASSE. Again, this gets back to the question of apportioning responsibility between the PASSE and the provider for sanctions.
Response: The PASSE is responsible for the actions of its providers.

Comment: The prescriptive manner behind many of the service requirements limits the ability of the PASSE to determine the best and most appropriate manner of addressing beneficiary needs.
If it not specifically described as a BH or DD service, can it be provided to either population as needed? It is not clear in each case, which population the service applies to. In 282.006 it is confusing. It appears to be for both BH and DD, but the language for DD is more descriptive of Personal Care, not DD services. There is language in the 1915(c) DD waiver for this.
In 284.001, CES Supported Employment should not be an "all or nothing" description or it further deters providers from offering this underused service.
Item 284.002 Supportive Living does not include a reference to habilitation, which is the category under the waiver that these services fall.
Response: DHS believes that the PASSE has the ability to determine the best and most appropriate manner of addressing member needs identified through the development of the PCSP.
Yes, the PASSE has sufficient flexibility to deliver services as identified in the member's PCSP.
DHS disagrees with the characterization that Supported Employment has an "all or nothing" description and will appropriately encourage PASSEs and providers to expand the use of these services.
Supportive Living under Section 284.002 specifically references habilitation.

DDPA
Comment: Adverse Decision/Adverse Action – Please add the right to appeal attribution or tier assignment?
Response: Previously answered in response to Summit Community Care

Comment: Care Coordination—(a) The definition includes "assessing" and "reevaluating the patient for medically necessary care and service," which sounds like reassessment. Assessment and reassessment are not the job of the PASSE. (b) This does not match all the definitions in the draft 1915(b) and 1915(c) waivers and 1915(i) SPA. Are the others being changed to match? (c) Concepts from Act 775 such as assistance with social determinants do not appear to be included.
Response: Previously answered in response to Summit Community Care

Comment: Case Management – What is the functional difference between "care coordination" and "case management"? Is there a need for two separate terms?

Response: Previously answered in response to Summit Community Care

Comment: Flexible Service – How does this differ from "in lieu of" services in 221.200? (There is a grammatical mistake in this definition.)
Response: Previously answered in response to Summit Community Care

Comment: Independent Assessment – This wording sounds as though Tier I voluntary enrollees get to choose which PASSE to join rather than being auto-assigned under proportional attribution. Is that correct?
Response: Yes.

Comment: Network Provider—What does the language mean "under contract with a PASSE or its contractor/subcontractor"? PASSEs should be required to get an agreement with each provider to participate specifically in the Medicaid PASSE program. To include them without their consent or knowledge does not give a true indication of access since there is no way to know if the provider is intending to participate in the program.
Response: Previously answered in response to Summit Community Care

Comment: Person-Centered Service Plan—It is not clear what constitutes the "total plan of care" or who is responsible for its development. This definition is generally confusing, and it is not clear what the difference is among the components. Clarification is required to indicate whether Care Coordinator is responsible for developing/writing the PCSP or coordinating its development with other parties.
Response: The PASSE is responsible for the development of the PCSP.

Comment: Will PMPM rates includes the cost for preparing the currently required care plans as well as the additional plans includes in the "total plan of care"?
Response: This is not a PASSE Manual question. Rate Setting is a separate process.

Comment: Telemedicine— The definition of Telemedicine mixes the professional use of telemedicine with coverage. The first paragraph is correct. But the excluded items A- D are excluded Act 203 of 2017 only for purposes of mandated reimbursement. It would be ill advised to exclude those activities from the definition itself as the PASSEs will make use of those methods of communication.
Response: Previously answered in response to Summit Community Care

Comment: Virtual and Home Visit Provider Services—It is not clear whether this section is establishing different standards for telemedicine than those under state law and whether those standards are more or less stringent. Or is this an amalgamation of telemedicine and home and community-based services? This should be clarified. Also, while this definition appears to include mobile devices, it is not clear that it includes non-mobile telephonic communications. Similarly, if a client with limited technology consents, they should be allowed to use non-secure technology.
Response: Previously answered in response to Summit Community Care

Comment: Section "A" refers to care coordination activities in Arkansas Code 20-77-2703(3), but the four activities listed are the "conflict-free" functions from the federal HCBS regs, not the activities in the Arkansas Act.
Response: Previously answered in response to Summit Community Care

Comment: Item A and B appear to run afoul of the requirement that the PASSEs comply with the "Any Willing Provider" Act (Patient Protection Act). Under Arkansas law, any provider that meets a PASSE's terms and conditions must be able to participate in that PASSE under AWP.
Response: Previously answered in response to Summit Community Care

Comment: The requirement for DHS approval could be administratively burdensome for everyone and deter use of this valuable option. As we read the federal managed care rule, the state could identify types of approved "in lieu of" services in the PASSE Agreements, but not require approval on a case-by-case basis by DHS.
What is the rationale for restricting "in lieu of" services to those that avoid institutionalization? That is more restrictive than the federal managed care rule, 42 CFR 438.3, and Arkansas Act 775 ("flexible benefits"). If it improves the client's health status or reduces costs without reducing care, it should be allowed even if it doesn't make the difference between institutionalization and staying in the community.
This section says "The benefit to the PASSE is that provision of an 'In Lieu of Service' should reduce medical expenditures for institutional care." Given that nursing facilities and HDCs are exempt from the PASSE, this does not seem to be true. In early discussions, the state intended to incentivize the PASSES to provide HCBS for more complex conditions in order to avoid a perverse incentive favoring institutionalization (otherwise, the PASSEs actually fare better financially by allowing someone to be placed in an institution).
Response: Previously answered in response to Summit Community Care

Comment: What is the basis for the 53% cap? This takes away client choice. Does it make sense to have the same cap no matter how many PASSEs are in the program? Does this same cap encompass Tier I voluntary enrollees too?
Response: Previously answered in response to Summit Community Care

Comment: The quality metrics that must be met should be specified and promulgated in the manual rather than just being left for DHS to define when the time comes.
Response: DHS expects that future Quality metrics will be promulgated.

Comment: Proportional auto-assignment will reduce the incentive for PASSEs to provide better services and better value to attract beneficiaries.
Response: Previously answered in response to Summit Community Care

Comment: What is "geographical competitive balance"? How will it be determined and monitored? If this is to be used, the criteria should be promulgated beforehand with adequate opportunity for public notice and comment.
Response: Section 221.500 does not reference geographical competitive balance.

Comment: Criteria for all of the reasons for DHS to cap assignment should be spelled out; without the criteria it could become extremely arbitrary.
Response: DHS may cap enrollment based on actual experience. Prior to taking action against a PASSE, DHS will provide a PASSE with notice.

Comment: Random/proportional assignment that requires the provider to deal with four different care coordinators, four billing systems, four UR systems, etc. results in a significant cost to the provider. If clients are to be assigned, the assignment should be deliberate and further the goals of the program rather than being simply proportional. A fundamental premise of the provider-led model was that DD and BH providers would help lead a PASSE in which their clients were members since that takes advantage of the frequent contact by the direct provider, the knowledge, history and close relationship between the provider and member, thereby enhancing the ability to keep the client healthy. Another premise of the PASSE process is that the different PASSE's would be motivated to orchestrate their services in a manner that would encourage consumers to select their PASSE. Auto assignment basically destroys this incentive.
Response: Previously answered in response to Summit Community Care.

Comment: Exclusion of medical spenddown cases raises serious problems. By excluding spenddown clients from the benefits of care management in a PASSE, the state is missing an opportunity to benefit some of the clients who need it the most.
Response: Previously answered in response to Summit Community Care.

Comment: Are there limitations on the types of providers that can serve dually diagnosed individuals or the services they can receive? Any exclusion criteria?
Response: Previously answered in response to Summit Community Care.

Comment: The DD Tiers have been reworded. What is the distinction now between Tiers II and III – what make someone "intensive" enough to qualify for Tier III?
Response: Previously answered in response to Summit Community Care.

Comment: What is the reason for adding "and is eligible…" for each DD tier?
Response: Previously answered in response to Summit Community Care.

Comment: How will capitation rates be determined for voluntary enrollees (Tier I)? Will the rate include the same amount for care coordination as for Tier II and Tier III enrollees? Will care coordination be required or at the PASSE's discretion? If required, at what ratio?
Response: Previously answered in response to Summit Community Care.

Comment: Does DHS or its contractor have the necessary capacity to assess the large number of Tier 1 clients who are potentially voluntary enrollees?
Response: Yes, we believe Optum has the capacity to complete Independent Assessments on clients who are identified as possibly Tier I.

Comment: Will the state be requiring a PCP referral or setting any parameters (e.g., medical condition, total spend, etc.) around who can enter a PASSE as a voluntary enrollee?
Response: Previously answered in response to Summit Community Care.

Comment: A sanction in Item B that results in cause for transition should not be just any sanction. It should be a serious sanction, and it should relate in some way to the reason for the transition.
Response: Previously answered in response to Summit Community Care.

Comment: How will Item D be determined in order to ensure proper notice and advocacy for the beneficiary?
Response: The PASSE must identify how a member can transition to a different PASSE in their member handbook. In addition, the Beneficiary Support Center will provide information on member rights. The member will make the request to transition to a different PASSE 'for cause.'

Comment: When will we see the DHS "transition of care policy"?
Response: DHS and the PASSEs are developing the transition of care policy plans which must be approved by CMS prior to the implementation of Phase II.

Comment: Almost any service could potentially fall into category F. This should be more clearly defined or notification given to PASSEs of which provider types will be included in this criterion before the access measurement period begins.
Response: Previously answered in response to Summit Community Care.

Comment: What is the rationale for basing measurement of provider ratios on 120% of a PASSE enrollment? Once Phase II begins in 2019, enrollment will be largely static—no PASSE is going to experience a sudden 20% increase in enrollment. This seems arbitrary and should be changed to 100%.
Response: Previously answered in response to Summit Community Care.

Comment: The number of categories for which there are ratio and timeframe requirements seems excessive. This creates unnecessary administrative burden on the PASSE without resulting in any improvement in access to care.
Response: The PASSEs will be serving very vulnerable populations and these requirements have been developed to ensure access to services for members.

Comment: Are any of these standards based on national standards? Does it make sense that the ratio for primary care and OB/GYN is the same when only a small portion of the clients are likely to get pregnant and presumably about half will be male? Do the number of board-certified psychiatrists required to meet the ratio even exist within the state?
Response: Previously answered in response to Summit Community Care.

Comment: We agree that telemedicine should be a valuable resource in meeting the access standards, but it is not clear how the use of telemedicine impacts compliance with this standard or how DHS will determine adequate access for these vulnerable

populations exists through telemedicine. This section states that a provider will not be counted for access purposes if the provider "is not accepting new members and is not providing services to existing PASSE members." These are two different situations. Did you mean "or" instead of "and"?
Response: Previously answered in response to Summit Community Care.

Comment: Is "Intermediate Care Facility" a reference to large or small ICFS? There are not ICFs in all Arkansas counties.
Response: Previously answered in response to Summit Community Care

Comment: Need to clarify that "Supportive Living/Respite/Supplemental Support" is DD.
Response: Previously answered in response to Summit Community Care.

Comment: Is "Supported Employment" in this context DD or BH? A provider should not be considered interchangeable for access purposes.
Response: Previously answered in response to Summit Community Care.

Comment: What is "mobile crisis response" service for DD? DD has not typically had this service. ArkSTART exists, but it is not a mobile crisis unit in the BH sense and not what is described in the draft 1915(c) waiver on page 69.
Response: Previously answered in response to Summit Community Care.

Comment: "Early Intervention Day Treatment" is missing.
Response: Previously answered in response to Summit Community Care.

Comment: Can mobile crisis response be satisfied through the use of telemedicine and other technology?
Response: Previously answered in response to Summit Community Care.

Comment: What is the definition of "urgent care"? Depending on the definition, a 24-hour time frame may not be reasonable, particularly since the next category goes all the way to 21 days.
Response: Previously answered in response to Summit Community Care.

Comment: Why is DD not included except for crisis?
Response: Previously answered in response to Summit Community Care.

Comment: Giving DHS sole discretion to grant waivers with no guidelines provided is vague and subjective and will require a costly waiver process. Either something less than 100% of the network adequacy standards should be required, or a set of guidelines developed that a PASSE can use to determine when a standard does not have to be met.
Response: DHS allows a network adequacy variance request as specified in Section 226.200. Variance requests will be handled on a case by case basis.
If the PASSE meets 100% of the network adequacy requirements, there is no need to seek a variance from DHS.

Comment: What mechanism will DHS use to ensure the stakeholder engagement?
Response: DHS has been provided for stakeholder engagement in a variety of methods over many months.

Comment: What training and qualifications will the "choice counselors" have and how will they help members choose a PASSE? Will they inform members if they are currently receiving services from a provider that does not have a relationship with the PASSE they are auto assigned to?
Response: DHS employees who have expertise in serving both DD and BH clients will staff the Beneficiary Support Center. They will have access to the provider directories that each PASSE is required to have and update on a monthly basis.

Comment: A PASSE should not be allowed to deny services based on moral or religious objections. If one provider will not provide a service, the PASSE should have other providers who will.
Response: If the PASSE has no religious or moral objection to providing coverage for a particular service, then there is no issue.
This is a federal requirement that a Medicaid Managed Care Organization may not cover particular services based upon moral or religious objections.
In the case in which a PASSE does have a moral or religious objection for a particular service, then it is the responsibility of DHS to provide access to those services.

Comment: These two requirements (freedom to choose vs. PASSE making assignment) appear to be contradictory. Can a PASSE auto-assign to a PCP as long as the client has the opportunity to change within a certain time period? Will the capitation rate take this requirement into account, given that not all clients currently have a PCP, and financial premiums may be required to reach 100% PCP coverage?
Response: Previously answered in response to Summit Community Care.

Comment: While we understand the need for marketing materials to be accurate and appropriate, these provisions eliminate necessary business communications. For example, at a minimum, a provider should be able to tell an existing patient which PASSE(s) that provider is in-network for, and which one(s) it is an investor in, both for disclosure purposes and as a demonstration of the provider's commitment, which may be relevant to a patient. Members need this basic information to make informed choices, just as members in commercial insurance plans are allowed to obtain that type of information from their providers.
Response: Previously answered in response to Summit Community Care.

Comment: A timeframe should be specified within which DHS must approve or disapprove marketing materials submitted by the PASSE.
Response: DHS has reviewed a number of marketing materials and timeliness has not been an issue.

Comment: In the third paragraph, the last sentence could have unintended consequences. Clients will expect their providers to help them navigate the PASSE program and the

benefits available through each PASSE without being confined only to materials provided by DHS. This should not be swept up as "marketing."
Response: This policy is in conformance with federal requirements. Restrictions on marketing are intended to protect members from undue pressure.

Comment: High school diploma or GED is missing.
Response: Previously answered in response to Summit Community Care.

Comment: 242.100 is not related to 242.000 and should be placed elsewhere for better understanding and flow.
Response: Previously answered in response to Summit Community Care.

Comment: There is no reference to provider grievance and appeal rights. Providers must have the right to file grievances as well as appeal to the state under the Medicaid Fairness Act.
Response: Previously answered in response to Summit Community Care.

Comment: This section does not address rights under the Medicaid Fairness Act, which applies to contractors including PASSEs.
Response: Previously answered in response to Summit Community Care.

Comment: The language says providers do not have standing to appeal on a member's behalf if provider has not furnished any service for which payment has been denied. This is contrary to the Medicaid Fairness Act, 20-77-1702, which permits providers to appeal denials of prior authorizations and other adverse actions for which no service has been provided if the action has a monetary consequence. While the provider can still appeal to the state under the MFA, it would seem best to make the appeals to the PASSE align with the MFA.
Response: Previously answered in response to Summit Community Care.

Comment: Where it says the PASSE must adhere to the Administrative Procedure Act, it also should say the PASSE must adhere to Sections 160.000 and 190.000 of the Medicaid Provider Manual on beneficiary and provider appeals and hearing rights.
Response: Previously answered in response to Summit Community Care.

Comment: Claims payment in 30 days would be significantly less than what providers are used to under the current Medicaid fee-for-service system. This may create serious cash-flow problems
Response: This issue is between the provider and the PASSE.

Comment: Occupational Therapists category is missing.
Response: Previously answered in response to Summit Community Care.

Comment: Where is provider right to appeal adverse credentialing decisions?
Response: Previously answered in response to Summit Community Care.

Comment: What type of "accreditation" is referred to here for the PASSE?
Response: Each PASSE must inform DHS if they have been accredited by a private independent accrediting entity pursuant to Section 254.000 of the manual.

Comment: Item E references LTSS. Does that include the PASSE?
Is Item L applicable to the PASSE population?
Response: Previously answered in response to Summit Community Care.

Comment: Use of the word "may" indicates that the Quality Incentive Pool is discretionary. That is not what was discussed in the early development of the provider-led program and is contrary to the language in Act 775.
Response: Previously answered in response to Summit Community Care.

Comment: Is this exemption requirement already applicable for any of the licensed PASSEs?
Response: If the PASSE informs DHS that they meet the exemption requirement, DHS will honor that upon verification.

Comment: In Item E, "any" sanction is too broad. Any sanction imposed should be proportionate to the particular failure to meet the quality metric.
Response: Previously answered in response to Summit Community Care.

Comment: Two "E"s are used by mistake.
Response: Previously answered in response to Summit Community Care.

Comment: How will responsibility for sanctioned behavior be apportioned between the PASSE and the involved provider?
Response: Previously answered in response to Summit Community Care.

Comment: Item L—Any sanction imposed should be proportionate to the failure to comply.
Response: Previously answered in response to Summit Community Care.

Comment: Item B—The "directly or indirectly" language seems to make the PASSE responsible for all network providers, even if the provider acts contrary to directives from the PASSE. Again, this gets back to the question of apportioning responsibility between the PASSE and the provider for sanctions.
Response: Previously answered in response to Summit Community Care.

Comment: Why is DHS specifying in such prescriptive manner the services that PASSEs must provide? The idea behind the provider-led model is to let the providers through the PASSE determine the best and most appropriate means for addressing beneficiary needs. Requiring the PASSEs to essentially duplicate the Medicaid fee-for-service model but paying the PASSE less money to do so is setting the provider-led program up for failure
Response: Previously answered in response to Summit Community Care.

Comment: If it not specifically described as a BH or DD service, can it be provided to either population as needed? It is not clear in each case, which population the service applies to. Again, why is the state mandating services in such specificity rather than allowing the provider-led model more flexibility? In 282.006 is confusing. It appears to be for both BH and DD, but the language for DD is more descriptive of Personal Care, not DD services. There is language in the 1915(c) DD waiver for this.
Response: Previously answered in response to Summit Community Care.

Comment: In 284.001, CES Supported Employment should not be an "all or nothing" description or it further deters providers from offering this underused service.
Response: Previously answered in response to Summit Community Care.

Comment: Item 284.002 Supportive Living does not include a reference to habilitation, which is the category under the waiver that these services fall.
Response: Previously answered in response to Summit Community Care.

Stephanie Hall
Comment: Section 221.200-A: School-based services provided by school employees are listed as Excluded Services. Does this mean that the schools cannot bill Medicaid for ST provided by an SLP employed by the school system? If this is the case, I agree with the proposed ruling. Schools receive federally directed funds for special education services and restricting the school's ability to double-bill for these services will certainly save Medicaid money.
Response: School-based services provided by school employees are excluded from being paid by the PASSE.
This manual only applies to services being reimbursed by the PASSE.

Comment: The PASSE cannot provide an incentive, monetary or otherwise, to Provider for withholding medically necessary services. With the exception of flexible services, all services provided to PASSE members must be medically necessary for each member. The PASSE must ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
The PASSE may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the enrollee. The PASSE may place appropriate limits on a service for utilization control, provided the services furnished can reasonably achieve their purpose.
I am happy to see this listed in the PASSE Requirements. I feel that abuse of providers could occur, as the PASSEs are financially motivated and incentivized to save money.
Response: Thank you for your comment.

Comment: DHS must arrange for Medicaid services to be provided without delay to any member of a PASSE of which the PASSE Provider Agreement is terminated and for any member who is disenrolled from a PASSE for any other reason than ineligibility for Medicaid.
Does this mean that when a beneficiary's Medicaid account is "turned off" during processing after re-applying, the beneficiary will be disenrolled from the PASSE temporarily? What will the re-enrollment process be like? I am concerned that the

beneficiary will have to re-apply for Medicaid during routine re-application periods, and subsequently have to re-enroll with their PASSE, potentially losing months of coverage. Or, conversely, would the beneficiary be automatically re-enrolled into their PASSE once Medicaid has been reinstated?
Response: When a member is transitioned from one PASSE to another because the Provider Agreement is terminated with the original PASSE, there should be no break in Medicaid eligibility or their services described within the members PCSP as those would be carried over into the second PASSE.

In the second example, if an individual loses Medicaid eligibility but is subsequently reenrolled, they would go back into their most recent PASSE if the break in Medicaid eligibility is less than 180 days.

Comment: Section 242.100: If a third-party insurer other than Medicare requires the member to pay any copayment, coinsurance or deductible, the PASSE is responsible for making these payments for Medicaid covered services. This is in compliance with Arkansas Medicaid services. Thanks for including this.
Response: Thank you for your comment.

Comment: Section 248.300 Provider Credentialing and Re-Credentialing: SLPs and PTs are required to be credentialed. OT is not listed. Why?
Response: Previously answered in response to Summit Community Care.

Debbie Riggs
Comment: Concerns about equality in the attribution to PASSE from all that I have been seeing there seems to be 2 PASSE entities that have the majority of attributions. We have changes coming to eliminate the concerns of "conflict" in case management.
Response: In Phase II, a member will be assigned to a PASSE based upon proportional assignment. A member has the ability to switch to the PASSE of their choosing within 90 days of assignment. Any PASSE with more than 53% of the market share will be excluded from the attribution methodology. The 53% will be assessed on a monthly basis.

Amy Jamison-Casas
Comment: As a private clinic owner and provider, as well as the mother to an amazing young man with autism (Steven, age 25), I am submitting my current concerns. First, as a mother…then, as a clinician.
Prior to sharing my concerns, however, I will list some positive changes I think are being made at this time. Section 215.00: All materials provided by the PASSE must be available in English and Spanish. There is such a growing need for Spanish correspondence. Thank you for making this available. Section 221.200-A: School-based services provided by school employees are listed as Excluded Services. Does this mean that the schools cannot bill Medicaid for ST provided by an SLP employed by the school system? If this is the case, I agree with the proposed ruling. Schools receive federally directed funds for special education services, and restricting the school's ability to double-bill for these services. I have seen so many Medicaid Provider violations through the years with school therapies, and I believe this will save money for Medicaid, halt

abuse of Medicaid funds by lazy therapists and greedy school districts, protect the amazing therapists who would rather spend their time working with the children versus additional paperwork required by Medicaid in addition to their already suffocating paperwork loads, and ultimately, ensure that the children receive the most appropriate therapies, which is the most important. Section 242.100: If a third-party insurer other than Medicare requires the member to pay any copayment, coinsurance or deductible, the PASSE is responsible for making these payments for Medicaid covered services. This is in compliance with Arkansas Medicaid services. Thanks for including this. To be clear, the PASSES cannot take that out of clinician's reimbursement either, correct?
Now, to my lengthy concerns:
To be honest, as a private clinic owner and speech-language pathologist, I am EXTREMELY concerned about how I'm going to be able to make a living with the new changes, and I will address those at the end of this letter. HOWEVER, my primary concern at this time is the effect on the individuals who need speech/language therapy that will be disqualified from it given Medicaid's insistence on keeping an outdated and discriminatory means of rationing care/disqualifying children aged 10 and over from speech-language services. This absolutely archaic practice is known as cognitive referencing and it violates many of the assertions of practice promised in the PASSE and Medicaid manuals being proposed at this time (in the year 2018, mind you!). By going against current best practice, this rule invites clinicians to operate outside of their professional integrity by submitting to practices that have been outdated for years… and of most harm, discourages families of children with special needs (and the children themselves!) by halting the opportunity to continue growth in language areas with the support of trained clinicians.

To review: Currently, the Medicaid Provider Manual (of which the PASSES will be required to follow) is supporting cognitive referencing for children 10 years old and above. As of a child's 10th birthday, in order for the child to continue to receive language services, the child's I.Q. must be higher than their language standard scores. Essentially, cognitive referencing assumes the child cannot acquire more language (functional or otherwise) because the "IQ" says the child isn't smart enough to! While this was considered evidenced-based practice in the 1970's, it is not now and is flawed on so many levels!

First of all, let's just say that this WAS still "evidenced-based practice" (which, it is not! Neither is "bleeding" patients for infections, but I don't see Medicaid requiring physicians to do it in 2018!) On the contrary, it has been quite disproven. But, let's just use the existing assumption, shall we? How unfortunate is it when a child does not have access to an examiner that is qualified in that child's particular diagnosis or an examiner who has any interest in establishing rapport with that child or finding a test that that child responds to? Some examiners are only willing to purchase just enough test kits to meet the Medicaid requirements for the bulk of the kids they see. Are you aware of that? Do you even understand what these I.Q. tests look like? Because here is an example of a typical stimulus item on a Medicaid accepted "non-verbal" IQ test:

Now, looking at this one isolated page from one of the most well-known "non-verbal" IQ tests on the Medicaid list, you are assuming that a) the child can point, b) the testing area

is calm and quiet, and c) the examiner is able to establish trust and rapport with the child and can handle aversive behaviors that prevent some children from showing their intelligence in traditional settings and/or with novel examiners.

Please look at that test plate example in Appendix A again. What on EARTH does that stimulus item has to do with learning to ask for desired items/activities, comment on things seen in the environment, asking for help or a break from activities, learning how to tell if someone hurt them or if they have a body part that is aching? etc.? That is simply a spatial analytical reasoning task! And that is what the entire test is made up of! Are you, Medicaid, going to continue to tell parents that you no longer support their children learning to do these things once they turn 10 years old if they cannot answer ridiculous questions such as seen in Appendix A? A child's 10th birthday should be a happy occasion…not the moment a parent realizes therapy will now be allowed from generous clinicians only. Ones who are willing to get audited and have to pay back all the therapies since the child turns 10!

At age 10, my son was disqualified from therapies because his I.Q. was not above his language scores. I was devastated. He had been making progress with The Picture Exchange Communication System© and I wanted continued support of a Speech-Language Pathologist! Well, guess what? No one would see him because of this rule! Fortunately for my son, he had a mom who was studying to be a Speech-Language Pathologist who kept working with him and recruiting friends and family and staff to work with him on functional communication skills. But, that is NOT the case for most children in our state! Ironically, at the bottom of every page of DHS paperwork is this:

- humanservices.arkansas.gov
- Protecting the vulnerable, fostering independence and promoting better health

Well? How is cutting a child off help at 10 years old from continuing language training "protecting the vulnerable" or "Fostering Independence"?

When we look at a child's developmental skill level and knowledge in decontextualized situations, it is clear that standardized I.Q. testing for the child's chronological age is inappropriate and ineffective methodology for determining specific deficits and strengths. Clinical observation skills and evidence of progress in treatment should be the determinant for continued treatment, not I.Q.! Occupational Therapists and Physical Therapists are not held to this same standard at all and what is a more basic need in this life than communication? Functional communication and language development goals are very measurable. Outcome can be easily documented with data, video, and family report in the community and when guided by a skilled speech-language pathologist, the results can be phenomenal! I have over two decades of proof in video (of my son and many other clients!) and I am certain that others do, as well!

I realize that perhaps this I.Q. issue may not seem relevant to the sections in the public comment areas. But, look! It is!

For instance, look at this section of the proposed PASSE manual:

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

A. Appropriate level of care or coding,
B. Medical necessity,
F. Least restrictive setting,

How can denying therapy at age 10, even when progress is being made, NOT be adversely affecting the client? How is appropriate level of care being addressed when current best practices and research are being kicked to the curb? How is it not medically necessary to a child to not be taught how to label pain or abuse in some manner? These things take time!

Example: My son was finally able to tell a teacher his JUNIOR YEAR OF HIGH SCHOOL via his communication app on his iPad, "I hurt foot." He had been breaking our hearts for days and crying and having tantrums we couldn't figure out and after days of this, he said that to his teacher via his app "I hurt foot" …she took off his shoe and guess what! He had a blister that I had not seen! I had looked, but it was not super noticeable. What saved that blister from becoming worse and requiring antibiotics and doctor's visits or continued pain? COMMUNICATION!
Guess what? He learned that after the age of 10! And it saved the cost of a PCP visit and Rx! That was after 17 years of hard work, folks! And most of that since he was 10 UNFUNDED by Medicaid because of cognitive referencing. I can't help but wonder if he could have told me sooner if I'd had more help by getting those therapies funded! As a single mom, I could NOT pay out of pocket in those years! I will say, in his later teen years, I found a clinician who would see him and take a chance…but, it was because I worked with her and she was kind when I begged. She took a chance she'd have to pay back every single session if she got audited. How is that not a decision that adversely affects a Medicaid Provider?

Listen, I am in that same position constantly with the children I serve. How could I not be after what I've seen with my own child? How can I not take the chance I'll go broke treating those 10 and over whose families are working so hard for them? Especially when I KNOW how positive outcomes can be for these kids when given intensive and appropriate EVIDENCED-BASED intervention? Intervention?

Finally, how is denying the opportunity to learn language and functional communication skills preparing these children for a lifetime of least restrictive setting? No, dear sirs and madams… this archaic means of discriminating against children is quite the opposite. And if you want to look at it from a fiscal perspective, costing your system way more money on the other end when their poor parents die or poop out!

I see so many amazing young people whose conditions do truly make it difficult to obtain typical communication abilities. HOWEVER, it does NOT prevent them from learning functional communication skills and improve their functional vocabulary! On the contrary, these things improve their levels of independence, which ultimately reduces

Medicaid's cost over the course of a lifetime! I can use my son as an example, freely and have parents who would be willing to share their children's similar successes at older ages should you be interested in speaking with them. But, let me share just one example from last week with my own son with autism. Look at Appendix B. Last week, he was missing his little sister. She graduated from college last year and moved from Savannah, GA to Salt Lake City, Utah. We haven't visited her in Utah yet, so he doesn't have a tangible experience about her being in a different place. Well, look what he brought me with his ProLoQuo2Go Communication app on his iPad! I have NEVER taught him state icons! This was all him! At age 25! He is growing all the time! But, Medicaid, at age 10 years old, told me by cutting him off of therapies because of his I.Q.score, that he would never progress! If you don't think this is amazing, let me take this a little deeper. We are a family that eats at home most every night (Like I said, we are frugal). It is a RARE treat for us to go out to eat. Exception? When we go see his sister or other family on road trips. Are you following me here? Chances are, he wanted to go out to eat and perhaps didn't even really want to see his sister, but the only way he could figure out how to do so was to request to go see her the last place we ever got to eat out with her…GEORGIA! Now, if that's not high level reasoning that could not possibly be shown on some ridiculous I.Q. stimulus item as in Appendix A…I don't know what is! Can you imagine what he could be doing if he'd been able to receive services all those years?

Let's look at another section of the PASSE manual:
Person-Centered Service Plan (PCSP)
The total plan of care made in accordance with person centered service planning as described in 42 CFR 441.301(c)(1) that indicates the following:

A. Services necessary for the member;
B. Any specific needs the member has;
C. The member's strength and needs; and,
D. A crisis plan for the member.

I would think that EVERY human's necessary services should include how to communicate need better. I would think that specific needs of any client would be to be able to communicate, and the means to communicate how to do that could include the individual's STRENGTHS and needs, not just a deficit in an intellectual quotient that in no way represents those very strengths and needs. And as the mother of a young man who was attacked by a waiver care-giver in 2016 and the only thing that withheld the monster from having criminal charges brought against him was my son's lack of ability to describe exactly what had transpired… I would say, communication is absolutely proactively planning against having to make a crisis plan for the member. Please note: This is the first I have spoken about an incident that broke my entire family's heart. I'm shaking as I type this, as I will never stop aching to think someone could try to hurt my baby (and then went unpunished because my son couldn't follow through with testimony). BUT, I am only speaking of this now in hopes to protect children in the future who are being denied the opportunity to develop functional communication skills that could protect them! This is VERY difficult for me to write about.

MORE PASSE MANUAL AREAS THAT SUPPORT THIS:
Quality Improvement

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

A. Improve health quality;

B. Meet specified quality performance measures;

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

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

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

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

I feel like I'm being redundant here, but should we talk about the idea that the PASSES will be grounded in evidenced based medicine, widely accepted best clinical practice, or criteria issues by recognized professional medical associations, accreditation bodies?

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

Well, here you go. I am concerned that I am being asked by Medicaid to operate outside of The Code of Ethics as put forth in The Ethics Session of the American Speech/Language/Hearing Association (ASHA). ASHA is our national accreditation agency that Arkansas Medicaid requires to reimburse SLPs in the state and is considered the utmost authority regarding current evidenced-based practice for our discipline. So, not only does ASHA not recognize IQ scores as a determinant of whether a child will benefit from Speech/Language services and supports, (for the record, neither does The Department of Education) …but, as speech-language pathologist who is very proud of her chosen field and who strives to operate within the scope of her credential's CODE OF ETHICS, I feel Arkansas Medicaid is trying to force me to operate outside of my own personal integrity and turn clients of a certain age away or see them for free (which I do! Lots!!) I feel that Medicaid does not support me providing care based on current evidenced-based practices. Note, this stance was put in force in 2003…that is FIFTEEN YEARS AGO! The same time my own beautiful child was first denied services. How many more children were unfairly denied treatment during that time… and where are they now?

In addition to asking the speech-language pathologists to adhere to this rule, Medicaid is thusly holding the RN, SLP, and MD on the auditing teams to the same standard… jeopardizing each of their licensures, as well, should a lawsuit commence. This is haphazard care of your providers and again, in direct violation of the standards you are proposing.

Again, here in the proposals, it sounds like discrimination will not be allowed in the PASSES. If this is true, how can this antiquated cognitive referencing method not be discrimination or arbitrary denials of services? Is it not, in fact, basing a decision solely on a diagnosis of intellectual disability (formerly labeled mental retardation?)

B. 221.200 Covered Services

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

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

And will DHS not withhold patient outcomes, quality measures, and implementation of Person-Centered Services by insuring that children age 10 and over have access to this much-needed service?

259.100 DHS Review of Outcomes 1-1-19

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

F. A. Delivery of services;

G. B. Patient outcomes;

H. C. Efficiencies achieved; and

I. D. Quality measures, which include:

J. 1. Reduction in unnecessary hospital emergency department utilization;

K. 2. Adherence to prescribed medication regimens;

L. 3. Reduction in avoidable hospitalizations for ambulatory-sensitive conditions; and

M. 4. Reduction in hospital readmissions.

N. E. Implementation of Person-Centered Service Plan.

You have now heard my concerns as a mother and provider of children with delayed language development who truly believes in her life's work with speech and language impairments.

Now, I will attend to the lesser of my concerns, albeit important ones.

As a clinician who is a small, private clinic owner and dual breadwinner for my family, I have personally opted to keep my clinic small and simple, so that I can focus on my patients and their needs without generating costly overhead. My personal family lives simply and frugally and even the way it is right now (I bill on Fridays to Medicaid, call in on Saturdays to see what my next Friday's paycheck will be) and repeat that weekly. That is uncertainty enough, right? With insurance companies, I never know when or what I will get paid. Sometimes, insurance companies pay less than minimum wage! And I just have to sit and wait, as they do not have a timely paying system like Medicaid's current one. From everything I see in writing in this PASSE manual, as well as the individual PASSE's information that is currently available to us, it appears we will not have any

predictable pay pattern and each PASSE will be different in how they execute this. How are clinics supposed to survive this? From what I read below, the PASSES have 30 days to reimburse. Is that correct? When I was reading the intro packet to one of the PASSES, it said 45 days! How do you think ANY clinic, large or small, can afford this? AND, going back to Any decision or action by the PASSE or DHS that adversely affects a Medicaid provider how do DHS and the PASSES justify this lack of commitment to keeping our paydays consistent and reliable? We accept in this field, that if a patient doesn't show up or is late or we/they cancel…we don't get paid. But, I do not believe not knowing exactly WHEN we're getting paid each week or month is acceptable at all! Even employees in fast food chains know when they are getting paid, why do licensed professionals with Master's and Doctorate degrees and hundreds of thousands of dollars in student loan debt not have that right? IN FACT, I imagine that the very decision makers who developed this have a regular pay check to count on for THEIR families. Am I right?

This lack of commitment to timely and predictable reimbursement rates to providers is in direct defiance of the commitment to not adversely affect Medicaid providers. We already know we are each getting pay reductions (of course, we don't know how much, because no PASSE is being required to tell us yet! And it is September and this goes into effect January 1st! Sorry kids, it's poetry again for you for Christmas this year, to be certain we have groceries in January!). This is such absolute nonsense. Providers can't even make a clinic or personal budget for 4 months from now! How is that promoting fiscal responsibility? Here is what I believe you will see as a result of this lack of concern for Medicaid Providers:

- More clinics refusing to see Tier 2 and Tier 3 individuals…the very ones who need care the most
- Bankrupted clinics and providers
- Increased Fraudulent Practices as clinics panic about the situation and scramble to figure out how to pay their staff and keep the doors open
- Layoffs of providers, forcing them to change career paths, relocate, etc. worsening waiting lists and increasing need
- Decreased services to PASSE members, in general
- More dependence on the system, long term, from the clients who lost services because of this
- Perhaps even, death, for the fragile children who will sit on waiting lists

Claims Payment Process

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

211.200 Standard Contract Requirements 1-1-19

The Centers for Medicare & Medicaid Services (CMS) must review and approve the PASSE Provider agreement. The proposed final PASSE Provider Agreement must be submitted in the form and manner established by CMS. The proposed final PASSE

Provider Agreement must be submitted to CMS for review no later than 90 days prior to the effective date of the contract.

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

A. Specific terms and conditions,
B. Capitation rate sheet;
C. Termination provision;
D. Notices and reporting provisions;
E. Performance period;
F. Dispute resolution;
G. Indemnity provisions; and,
H. And any other relevant information regarding the agreement between DHS and the PASSE.

221.300 Payment 1-1-19

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

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

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

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

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

248.220 Claims Payment and Claims Processing 1-1-19

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

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

1. Medicaid National Correct Coding Initiative (NCCI) for Professional, ASC and Outpatient services,
2. Multiple Procedure/Surgical Reductions, and

3. Global Day E & M Bundling standards.

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

1. Timeliness standards
2. Adherence to DHS payment policies.
3. Provider rate schedules changes

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

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

So, not only will providers be having their reimbursement rates decreased by the PASSES taking what they deem fit out of the rates we have been accustomed to and have planned our budgets around… NOW, providers will also have the following issues to face that take away from attention to our clients:

- There will now be multiple billing systems to attend to weekly. Medicaid, each separate private insurance, and then the PASSES. For me, a single provider who does all my own billing, that is 8 separate billing systems I will be attending to weekly so far, while I attempt to still see my full caseload of clients. My one on one time with them does not count any time spent writing evaluations, planning for their sessions, sending for their prescriptions, visiting on the phone with their parents when they need me, advocating for them in the schools and community, etc. This excessive paperwork and new billing load… long term will only create apathetic providers, much like the school districts caseloads and work requirements have been doing to providers for years! This only hurts our clients!
- Also, we will now have quarterly audits, not just from AFMC, but from each PASSE. That is increased paperwork and reduced attention to clients, as well.
- Then, I'm assuming this will mean waiting on even more 1099's each January at tax time, yes?
- Does DHS just WANT people to stop becoming physicians, pharmacists, therapists, etc? Will ALL of Arkansas become like the rural delta where there aren't enough providers to serve the people and then DHS can say, "Oh well! Can't help it! No one wants to work here!" There's your cost savings right there, right?
- And finally, how are the kickbacks to Providers/PASSE Equity Owners NOT illegal and a conflict of interest? How will this not result in PCP refusal to refer for needed services? It reminds of the early 90's HMOs and I feel like Arkansas has taken a giant leap backwards with this. I see some wording where DHS is trying to cover themselves when the PASSES start punishing physicians for referring when needed, but I don't believe it's enough and I believe this whole situation where providers' "Value Based Payments" are allowed will do nothing short of promote unethical denial of needed services. This is not acceptable.

PASSE Equity Partners
An organization or individual that is a member of or has an ownership interest in a PASSE and delivers healthcare services to beneficiaries attributed to a PASSE.
Value-based Payments
Payments made by a PASSE to its providers to promote efficiency and effectiveness of services, improve quality of care, improve patient experience and access to care, and promote most appropriate utilization in the most appropriate setting. Such payments may be made as part of a PASSE's Quality Assessment and Performance Improvement (QAPI) strategy.

221.200 Covered Services
The PASSE cannot provide an incentive, monetary or otherwise, to Provider for withholding medically necessary services. With the exception of flexible services, all services provided to PASSE members must be medically necessary for each member. The PASSE must ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
The PASSE may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the enrollee. The PASSE may place appropriate limits on a service for utilization control, provided the services furnished can reasonably achieve their purpose.
The PASSE is responsible for the provision of services (except as excluded below) as described in each specific programmatic Medicaid Manual located at https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx. All services described in Section II of the manuals must be made accessible to PASSE members if medically necessary.
245.100 Value-Based Payments 1-1-19
Payments made by a PASSE to its providers to promote efficiency and effectiveness of services, improve quality of care, and promote most appropriate utilization in the most appropriate setting. Such payments may be made as part of a PASSE's Quality Assessment and Performance Improvement (QAPI) strategy.
Provider incentives based on value are allowed and encouraged. Payments based on volume to increase inappropriate utilization (including denial of services) will not be permitted.
The PASSE must disclose any value-based payment arrangement with AID.
Response: Qualifications for therapy are not outlined in the documents currently running through public comment. The established medically necessary criteria for any needed therapy paid by Medicaid is available in the therapy manuals. Additionally, a workgroup of private therapist assists DHS with needed amendments. We do appreciate your comment and will bring it up with the workgroup.

Thomas Nichols
Comment:
1. For the benefit of the beneficiaries & providers who read the rule similarly, can you please explain how the language does not represent a gap for individuals who might have mild behavioral health needs, but require developmental disabilities waiver services?
2. Would the same issue be present for an individual who requires Tier II or Tier III behavioral health services, but who is only eligible for Tier DD Services?

3. What is the timeline for committee consideration?
4. Is this a precursor of a rule that DHS plans to expand?
5. If so, what will be done for dually diagnosed individuals between January 01, 2019 and when the rule regarding the committee is implemented?

Response: Individuals that are currently receiving DD waiver services have been mandatorily attributed to a PASSE. Once assigned to a PASSE, the PASSE will be responsible for all medical care. Individuals with a dual diagnosis have already been enrolled into a PASSE and therefore there will not be a gap in services. These timelines and processes are currently being established by DHS.

Sherri Norwood

Comment: I am writing to comment on the Proposed PASSE-1-18 Provider Manual Update. I am the parent of a ten-year-old child with spina bifida. She currently receives services under DDS Waiver.

Overall, I'm excited about the flexibility the PASSE system hopes to provide and think the care coordination will be helpful.

One thing I am concerned about in this manual is potential conflict of interest for providers who are equity owners in a PASSE. Section 222.000 mentions conflict of interest, but it doesn't address this particular issue. I think that equity owner providers in a PASSE should be mandated to join the all the other PASSEs as a network provider. I've heard about people being told that they must become a member of their particular PASSE or they would no longer receive services from the equity owner provider. This is wrong and a conflict of interest. PASSEs should not require people to become members of their PASSE because the equity owners won't join another PASSE. This is unfair.

Thank you for your hard work on this. I am optimistic.

Response: The number of PASSEs a provider wishes to join is up to them. Additionally, every member has 90 days to switch their PASSE if they so choose.

Charles and Brenda Jamison

Comment: We are grandparents of a 25-year-old severe-profound beautiful young man with autism.

He was denied speech and language therapy at age 10 because his IQ was lower than his speech-language standard scores.

We worked with our daughter, family members, and friends to try to fill in the gaps in his therapy until he was 14 when his mother found someone who dared to help him. We see him advancing in speech and he has a clearer understanding of the world around him. Looking back, we realize that those years are lost forever, and we hold Medicaid to blame.

The decisions made, at this time, will not help our grandson, but it will affect many people in our state.

Response: Qualifications for therapy are not outlined in the documents currently running through public comment. The established medically necessary criteria for any needed therapy paid by Medicaid is available in the therapy manuals. Additionally, a workgroup of private therapist assists DHS with needed amendments. We do appreciate your comment and will bring it up with the workgroup.

Dawn Nichols

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Sarah Jennings

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Carlos Casas

Comment: Hello there,
I'm the step father of a wonderful young man with Autism who was denied for services when he was 10 years of age because of his IQ, I believe that our country, as well with the senate and legislators need to care more for the citizens without a voice, I strongly encourage MEDICAID to re think that IQ's shouldn't be more important than language scores. Hope this get to be heard.
Thank you and have a blessed day!

Response: Qualifications for therapy are not outlined in the documents currently running through public comment. The established medically necessary criteria for any needed therapy paid by Medicaid is available in the therapy manuals. Additionally, a workgroup of private therapist assists DHS with needed amendments. We do appreciate your comment and will bring it up with the workgroup.

Jennifer McWhorter

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Lacey Aimee-Lee Burris

Comment: I am a sibling of an adult with a nonverbal autism. My older brother, who does not communicate through spoken words like most of the general public, has benefitted greatly from the language services he has received in the past. Through speech and occupational therapies, my brother has found new ways of letting others know of his wants and needs, as any individual has a right to. He is now able to find ways to communicate as we all do - like placing an order at a restaurant, tell his family what movie he wants to watch, and ask for help if something is wrong. He has not always had access to these beneficial services, however. When he turned ten almost sixteen years

ago, he was denied language therapies because his IQ could not be proven to be higher than his language scores. Let me reiterate on that: his IQ could not be PROVEN to be higher. With scientific information regarding intelligence and behavior always changing and expanding, how are we to know if it is the child's IQ that isn't high enough or if it is that our testing of that child's IQ isn't adequate enough? Without the language therapy that my brother [eventually] received, he would not be able to ask for the essentials such as food, water, or the location of the bathroom. Just because he was assigned an ambiguous number that determined his intelligence, he was almost completely denied the human need for communication. Before you decide that this policy should remain in effect, imagine living in a life where you were not given the gift of words. Everything you can do right now - making a phone call to your spouse, ordering chocolate ice cream instead of strawberry, crying for help if you are in pain or injured - would not be possible without some help from a speech language pathologists and other speech therapists. Thank you for your time.

Response: Qualifications for therapy are not outlined in the documents currently running through public comment. The established medically necessary criteria for any needed therapy paid by Medicaid is available in the therapy manuals. Additionally, a workgroup of private therapist assists DHS with needed amendments. We do appreciate your comment and will bring it up with the workgroup.

Cristina Mendez

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Stacy Levering

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Suzette Manen

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Ashley Knowlton

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a

participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Jessica Hayes
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our provider.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Diane Fowler
Comment: 3 sons that have Medicaid waiver and in a PASSE. It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Kluane Billings
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Kim Warren
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Kimberly Bruyere
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers. Please do not limit more of our choices.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Nurse Betsey

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Stacey Torell

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Krista Price

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Caroline Dockery

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Thank you for your attention to this matter.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Megge Woolbright

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Regan Schooler

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Lacy Biram

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Our special needs children rely on us to be their voice!!! Please help!
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Lisa Michelson-Wilburn

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Chelsey Bingham

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary

Yolanda Whitmore

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Lindsey Sabatini

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Thank you
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Abigail Bell

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Shannon McIvor

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups, then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Thank-you for giving this consideration!

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Teresa Pratt

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Kelley Grandy

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Jacqueline Ernst

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Kimberly Cook

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to their PASSE only if they ate one of our providers.

I'm the mother of a special needs child that requires total care.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Megan Phillips

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Susan Roberts

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Nicole Ramirez

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Larry and Kendra Pliler

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Shella Beccard

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Loretta Cochran

Comment: From: Proposed PASSE-1-18 Provider Manual Update
PASSE Equity Partners that are also Providers must be held to a high standard. Medicaid block grant funds have been given to behavioral health providers for decades and any

entity, but especially direct and indirect equity partners, MUST be required to participate in ALL of the PASSE organizations. Those Block Grant dollars were given to organizations to provide services to our most vulnerable groups. It is offensive to learn that now some providers are threating clients with denial of services if they do not join particular PASSES (I'm talking to you EMPOWER and SUMMIT). By Indirect Equity Partners, I mean all the member organizations that belong to Equity Partners like the DDPA that are attempting to hide their ownership. Sunshine laws in Arkansas are obviously not strong enough to compel full disclosure – but the PASSE manual should do this. The language for sanctions against providers and PASSEs that directly market to members of other PASSEs is too weak. There need to be mandatory sanctions and punishments sufficient to stop the bad behaviors that are already taking place.
The PASSE needs to have a way to appeal to DHS/Medicaid for non-preferred drugs so that when clients need drugs that are not on the Arkansas Preferred Drug List. Right now, it is a nightmare and I have to beg Dr. Larry Miller for help with a DD client needs a non-formulary drug. The appeal and approval process is so onerous that I maintain private health insurance on my son just to pay for the medication he needs that Medicaid will not cover.
Care coordinators must follow up with members within seven (7) business days of visit to Emergency Room or Urgent Care Clinic, or discharge from Hospital or In-Patient Psychiatric Unit/Facility. Care coordinators should be contacting the client or the family WHILE the client is in the ER or in the Hospital. A week after discharge is waaay too late.
284.005 Consultation – Peer/Family Support should be here as a licensed/certified service as well as Dr. Ross Greene's Live in the Balance/Collaborative Problem Solving Consulting. I am very encouraged to see Peer and Family Support provided for in the PASSE manual. These are tremendous opportunities to improve quality of life of clients as well as their health outcomes.
Response: There are multiple sanctions that may be imposed upon the PASSE entity itself as well as against individual providers as all providers must be enrolled in Arkansas Medicaid. Each PASSE must disclose ownership to the Arkansas Insurance Department as well as to Arkansas Medicaid when enrolling as a PASSE provider.
The PASSE will be responsible for reviewing and approving non-preferred drugs based on medical necessity. They will also have an appeal process. The prior authorization criteria cannot be more stringent than the State but can be less stringent.
Seven (7) business is the high end of the limit. The PASSE has the ability to conduct follow up visits/contacts in a shorter time frame.
Thank you for your comment.

Mardee Clive
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Shannon Torell

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Robert Baratta and Bill Philips

Comment: The Department of Human Resources, Division of Medical Services, has proposed a new rule to update its PASSE Manual that includes a faulty definition of telemedicine that does not follow the current statute. Note the highlighted section below in the definition section. Act 203 of the 2017 Regular Session amended the previous telemedicine statute. The definition of the telemedicine included in the proposed rule tracks with the current statute in §17-80-402(7)(A) & (B). However, the prohibitions listed apply only to the establishment of a professional relationship and not telemedicine in general. §17-80-403(c) states that "Professional relationship" does not include a relationship between a healthcare professional and a patient established only by the following: (1) An internet questionnaire; (2) An email message; (3) Patient-generated medical history; (4) Audio-only communication, including without limitation interactive audio; (5) Text messaging; (6) A facsimile machine; or (7) Any combination thereof;

The Department is confused. In its proposed rule it is mixing what are acceptable technologies to diagnose and treat with those acceptable to establish the professional relationship (or first virtual visit).

Moreover, the current statute at §17-80-404(a)(2) states "Once a professional relationship is established, a healthcare professional may provide healthcare services through telemedicine, including interactive audio, if the healthcare services are within the scope of practice for which the healthcare professional is licensed or certified and the healthcare services otherwise meet the requirements of this subchapter."

Accordingly, the proposed rule will put in place regulations on telemedicine for this state program that are more restrictive than both the current state telemedicine statute and governing Board of Medicine regulations.

While this proposed regulation is for a line of business we do not yet participate in, Teladoc Health should at a minimum raise the issue with of statutory conflict with the Department. Comments?

Response: Exclusion from reimbursement in Act 203 does not prevent the PASSE from using those methods of communication, but it is not considered a medical service delivered via telemedicine.

Mark George

Comment:

200.000 Definitions

1. Adverse Decision/Adverse Action. This is not exactly the best recitation of the Medicaid definition of what constitutes an adverse action. In any event, the second sentence should probably read, " ... receipt of OR payment for claims OR services..." A denial of a request for a service is an adverse action whether or not it has been received, paid for, or a claim for payment has been made. I would suggest incorporating the

definitions found in 42 CFR 438.400(b). The examples of "including but not limited to decisions or findings related to" can be included in a separate section.

2. Independent Assessment. The first paragraph references a "Tier 2" or a "Tier III" level of care. The Tiers should be presented consistently ... either as Tier I, 2 or 3, or as Tier I, II or III. This lack of consistency is evident in all of the various documents being submitted for comment.

3. 211.200.H

The use of the word "and" at the beginning of the sentence and at the end of the sentence above is redundant.

4. 212.000

To be consistent with how citations are presented elsewhere in the document, "42 CFR" should be included before each citation to a specific section in the federal rules.

5. 212.000E

This sentence does not read smoothly. Even correcting the "for" to "from" in the part of the sentence that reads, " ... cross-subsidized by payments for any other rate cell" doesn't make the sentence any clearer.

6. 221.200 Covered services CES waiver services is not a term previously defined.

7. 221.540 and 221.600

Both end with the same paragraph. It appears that it is applicable only to Section 221.600

8. 221.700 Transitioning to Different PASSE

Subsection A. Although 42 CFR 438.56 speaks of "disenrollment," I can see where disenrollment from one PASSE will be needed before enrolling in a new PASSE. As such, "the member moves out of state" is wrong. If a member moves out of state, they are no longer eligible for Arkansas Medicaid, making PASSE disenrollment automatic. What the rigs reference is when a member moves to an area of the state not covered by a PASSE. Since every PASSE covers the entire state, this section is not applicable, and should be deleted.

Subsections A through D purport to list the reasons why a member can request a transition. The reasons are specified in 42 CFR 438.56(d)(2). This list in this document is not inclusive, and should be amended to include each rationale specified in the regulations.

9. 247.000 PASSE Grievance System

42 CFR 438.400 to 438.424 covers managed care grievances and appeals. Within the regs, there are different definitions for grievances and appeals. This section in the document appears to treat them as the same, or as being interchangeable. For grievances, 438.402(c)(2)(i) says a "grievance may be filed at any time, and must be resolved with 90 days." For appeals, 438.402(c)(2)(ii) states that appeals be filed with 60 days (not 45), with a resolution within 30 days. This entire section needs to be rewritten. There should be one section covering grievances, with the applicable, procedures and resolution timeframe, including information on how to appeal an unfavorable decision. There should be a separate section covering appeals and state fair hearing requests, with the applicable timeframes and procedures.

10. 247.200.D

This section is generally correct but is incomplete. It should be made clear that, pursuant to 42 CFR 438.420(c), benefits will be continued if the member requests a state fair hearing and continuation of benefits within 10 days of a notice of an adverse resolution by the PASSE. Failure by this section to track, and incorporate, the specific requirements

in 438.420 will likely lead to inconsistent provisions within the member handbooks of the different PASSEs, resulting in violations by a PASSE in complying with a member's due process rights.

Subsection D.3 is not an "unless" condition. It should be a separate subsection. How will the PASSE determine what "the cost of any services furnished the member" were? Will it be based on specifically identified charges, or a part of the capitation payment received? Under a Medicaid FFS system, a provider might be required to repay Medicaid for payments received during the pendency of an appeal that is upheld against the client. In such a case, seeking recoupment from the client might make sense. In a managed care system, the PASSE will receive the same payment per member per month, regardless of services being actually furnished or paid for. As such, neither the PASSE nor the provider are out any money, and the client should not have to repay the cost of services received. Given the critical importance of services provided to the PASSE members, and the fact that members are essentially indigent to start with, recoveries should be waived as a matter of policy. In addition, if an adverse action involves the termination, suspension or reduction of a previously authorized service, the PASSE should be required to document that such termination, suspension or reduction in a service will not have a negative impact on the current, or future, health and safety of the member.

11. 283.003 Planned Respite

In that Section 211.000.C references services are to be provided in the least restrictive setting, should an HOC be an approved respite care provider?

Responses:

1. Adverse action is defined within existing Medicaid Manuals (Section 190.002). The PASSE manual utilizes the same definition to ensure consistency.
2. This will be corrected.
3. This will be corrected.
4. This will be corrected.
5. This language is taken directly from 42 CFR § 438.4.
6. CES will be clarified in this section of the manual.
7. For purposes of the PASSE manual, the sentence "The PASSE cannot transition any assigned member and is responsible for all eligible services provided to that member during the time the member is eligible and a member of that PASSE." applies to both enrollment discrimination protection as well as disenrollment limitations.
8. All federal requirements must be met and are incorporated by reference. Therefore, DHS does not believe changes to the manual are necessary.
9. Section 247.000 is for Grievances, Section 247.100 is for DHS Appeal Rights, and Section 247.200 is for PASSE Appeal rights. All federal requirements must be met and are incorporated by reference. Therefore, DHS does not believe changes to the manual are necessary.
10. Section 247.200.D does make it clear that the member can appeal within 10 days (before the date of the action on a 10-day notice) and request that services continue pending the outcome of the appeal. Part D.3 will be renumbered. The rule cited (42 CFR § 438.20) is from those governing managed care, so any arguments that unless you're in a FFS system you cannot determine the price of a service to then recover from the member who lost an appeal are misplaced. Most (virtually all) managed care systems use capitated payments; that's where the element of risk comes in.
11. An HDC can be considered "a least restrictive setting" if in fact, it is so.

Gabe Freyaldenhoven

Comment: As we are approaching the final rules being put into place for Arkansas Medicaid PASSE providers, I would like to express my concern for the lack of an Any Willing Provider provision in the manual.

Throughout the legislative process of creating Act 775, legislative intent was expressed to make sure that patients could keep their providers of choice and that patients would not be forced to change providers.

As Phase I of this program has rolled out, there have been many instances of individual PASSE's encouraging their equity owner providers not to sign with other PASSE's. This atmosphere of exclusion has the potential for PASSE's to close their networks once network adequacy standards have been met, preventing Medicaid patients from seeing the very providers they wish to see. This atmosphere will only be made worse moving forward without an Any Willing Provider provision to protect providers seeking to join a PASSE and support access to care.

Without an Any Willing Provider provision, patients will struggle with access to care provided by the license professionals that these patients are comfortable working with. This will allow a PASSE to exclude providers when the provider is willing to accept the standard contract. This creates a one-sided negotiation if the proposed rule for an out of network provider receiving 80% of the allowable also goes into effect.

I appreciate having had the opportunity to provide my comments and am asking to see protections consistent with Arkansas' Any Willing Provider statute. This would include a regulation that does not give exclusions based on network adequacy.

Response: PASSEs must comply with all applicable federal, state regulations including any willing provider act as DHS has consistently indicated throughout the development of the PASSE program.

Seth Coulter

Comment: Including Any Willing Provider provisions in the final rules for PASSE Providers:

"I appreciate having the opportunity to provide comments and am asking for protections consistent with Arkansas Willing Provider Statute. This would provide regulation that does not give exclusions based on network adequacy"

Response: PASSEs must comply with all applicable federal, state regulations including any willing provider act as DHS has consistently indicated throughout the development of the PASSE program.

Melissa Foster

Comment: My name is Melissa Foster. I am an occupational therapist in Fayetteville, Arkansas. My primary focus for the past 14 years of practice has been children with Autism, whom I love, and think of as "my babies" as well as my own biological children.

Though I realize that there are a variety of PASSE concerns from both parents and practitioners, pertaining to individuals with a variety of disabilities, I will focus my comments on my concerns for children with Autism as well as my own practice.

1. Eliminate the IQ test for Speech Therapy services for clients over 10 years old. Many times it takes a child/therapists years of trial and error to determine a communication

alternative for a client that will be successful. Combine this with the delayed ability we have here in the state of Arkansas for a child to be identified as needing services, this need for trial & error, and resulting progress can occur much past the 10-year mark. As long as a child is making documentable and meaningful progress past the age of 10, he/she should be allowed to continue to benefit from these services. In addition, I typically specialize in behavior problems among individuals with Autism. The hallmark of working on these "bad" behaviors is to replace them with more appropriate means for communication. When a child is deprived of the collaborative effects of a caring OT & ST combination, it forces me, the OT, to try to pretend to be a speech therapist in our sessions in order to best serve the needs of my client. This is definitely not where my training lies, therefore, not making the most effective use of taxpayer dollars.

2. Reduce payment time for services provided. From what I am reading, it may take 30-45 days for reimbursement. Therapy providers are largely NOT associated with huge medical systems. We are overwhelmingly small business owners of 3-10 employees. Expecting such small businesses to consistently wait 1-2 months for reimbursement will create undue hardship on these tiny organizations that are simply trying to help kids and stay afloat.

3. Transparency for reimbursement. Again, the therapy community as a whole is made of small business owners, with limited reimbursement opportunities. The vast majority of our clients depend on Medicaid, and therefore, we therapists also depend on Medicaid in order to best serve or clients. It is impossible for these small businesses to budget for the upcoming year when we have no idea what reimbursement rates will be, and the time frame in which we will be reimbursed. We therapists are in this business because we LOVE to serve our clients, but we must also serve our own families/children and stick to our own family & clinic budgets. Again, it is impossible to create responsible family/clinic budgets if we are kept in the dark as to reimbursement rates.

I thank you for taking the time to take public comments, and to read this letter.

Best regards,

Occupational Therapist

Response:

1. Rules surrounding the medically necessary criteria to determine the need for therapy services is not in this public comment period.
2. This issue is between the provider and the PASSE.
3. Reimbursement is handled contractually between the PASSE and the Provider.

Bo Renshaw

Comment: Without the Any Willing Provider provision, patients will have limited access to care provided by licensed healthcare professionals of their choice. This will give a PASSE entity the ability to intently exclude providers despite their willingness to agree to the PASSE contract. This creates a one-sided negotiation if the proposed rule for an out of network provider receiving 80% of the allowable also goes into effect.

Response: PASSEs must comply with all applicable federal, state regulations including the "Any Willing Provider" Act as DHS has consistently indicated throughout the development of the PASSE program.

Arkansas Hospital Association

Comment: We offer our comments to these existing manual provisions in order to highlight a fundamental problem with the approach DHS has taken to implementing the PASSE initiative. In its original 2017 promulgation, DHS focused primarily on nonhospital outpatient care. In this manual, we expected to see reflected a comprehensive managed care program, which must include both inpatient and outpatient care (including emergency department care) at hospitals. It is imperative to ensure access to and availability of hospital care in the implementation of a managed care program because hospital services are essential for good patient care for this and every patient population.
Response: DHS agrees with the comments that all hospital-based services are critical to the PASSE model and are essential for good patient care and for every patient population. Hospitals are represented on every PASSE board because of their special role in providing care.

Comment: Across Arkansas, hospitals are the constant in our communities. Our facilities and care teams are the foundation of the healthcare system, and in fact, for many rural areas, hospitals are the sole available provider of care for all patients. Given the complexities of care for the vulnerable patient population being served by the PASSEs, hospitals, as the backbone of the Arkansas healthcare system, should not only be included as essential providers, but they also should play a central role in the new program's implementation.
Response: DHS agrees with the comments and fully understands the essential roles that hospitals provide care to our most vulnerable populations.

Comment: We applaud DHS for recognizing that hospitals must be part of the governance structure of a successful PASSE; however, representation in the boardroom alone is not enough. The hands-on patient care that our hospital personnel provide day-to-day is crucial and must be recognized in the rulemaking and expressly protected in this new system.
Response: DHS appreciates the support expressed in the comment. We understand that the essential role of hospital personnel runs throughout the fabric of the PASSE Program. We will ensure that the access to quality hospital services are maintained through our monitoring processes and therefore do not believe additional changes to the manual itself are necessary.

Comment: Virtual and Home Visit Provider Services
Virtual and Home Visit Provider Services are defined as "telemedicine, telehealth, e-consulting, and provider home visits" that include "clinical provider care, behavioral health therapies, and treatment provided to an individual at their residence." AHA requests that this definition specifically include speech, occupational, and physical therapy services, which are important components of many care plans. In-home and virtual therapy services are extremely useful, especially for rural, remote, and mobility-impaired participants who may otherwise lack access; therefore, they should be allowed and encouraged.
Response: DHS agrees, and we are making this change.

Comment: Pharmacy (and Other) Requirements
Although PASSEs are designed to manage the entire healthcare and specialty needs of patients, the pharmacy requirements (and in fact, other sections of the manual) are written as if only outpatient nonhospital care will be required by the individuals whose care is being managed by the PASSEs. For example, sections 221.220 and 221.230 address only outpatient and physician-administered drugs. These sections also should specify that PASSEs must ensure that members have the same or better access to inpatient drugs as they would have under Medicaid Fee-for-Service. To safeguard continued high-quality care for participants with inpatient stays, PASSEs should be explicitly required to guarantee access to inpatient drugs at least at the level consistent with existing practice for Medicaid Fee-for-Service patients.
Response: The cost of inpatient drugs has been built into the inpatient hospital rates by the DHS actuaries. We will clarify that PASSEs must guarantee access to inpatient drugs at least at the level consistent with Medicaid fee for service.

Comment: State Monitoring
Under section 225.000 of the manual (a current manual provision), DHS will analyze timely access to care at the end of the first year and at least every three years thereafter. We applaud the Department for recognizing that timely access to care is critical; however, once again, DHS fails to recognize that access to inpatient and outpatient hospital care is essential. We anticipated that this provision would be broadened in the comprehensive PASSE manual in recognition that the PASSEs are supposed to be managing the entire continuum of care for vulnerable Arkansans.
Yet the analysis in section 225.000 still addresses access to only a specific subset of providers, and hospitals are not included in the list. Hospital inpatient, emergency, and outpatient services are essential services, and access to them is absolutely necessary to guarantee the health of the PASSE populations. Therefore, we respectfully request that DHS actively monitor access to hospital services, both inpatient and outpatient.
Response: DHS agrees that hospital inpatient, outpatient and emergency services are essential services. We assure that DHS will actively monitor access to all of these critical services.

Comment: Provider Selection
We applaud DHS's statement in section 245.000 that PASSEs may not discriminate against providers who "serve high-risk populations or specialize in conditions that require costly treatment." Limiting risk avoidance on the part of the PASSEs is essential to ensuring a strong provider network and continued access to care. As well, we strongly encourage DHS to mirror similar language in section 245.100, Value-Based Payments. Adequate risk adjustment in pay-for-performance methodology may be difficult, but it is essential to avoid punishing providers serving higher-needs or disadvantaged populations. In recognition of the state's "any willing provider" law, we also request that the Department include a requirement that no PASSE may prohibit or limit a healthcare provider that is qualified and willing to accept the plan's operating terms and conditions, schedule of fees, covered expenses, utilization regulations and quality standards from the opportunity to join the PASSE's network. Arkansas law also requires that any measures designed to maintain quality or control costs be imposed equally on all providers in the same class. This statutory provision should be reflected in the PASSE manual.

Response: DHS reiterates that the Arkansas "Any Willing Provider" laws apply in the PASSE Program and are incorporated by reference; therefore, we do not need to make additional changes to the manual.

Comment: Provider Credentialing and Re-Credentialing
The detailed provider credentialing specifications in section 248.300 do not include any information about how providers may appeal a negative credentialing decision by the PASSE. This puts patients' continuity of care at risk if a PASSE makes an unfounded or inappropriate decision and a provider is suddenly deemed out-of-network. Providers whose credentials are denied or revoked should have the opportunity to appeal their case to a committee at the PASSE and, if necessary, the DHS credentialing work group.
Response: Each PASSE must have provider appeal rights. DHS also has appeal rights as specified in the Medicaid Provider Manual.

Comment: Request for DHS Hearing for Anti-Competitive Practices-
Section 247.300 establishes procedures for providers to engage DHS if they feel a PASSE is not negotiating in good faith and is engaged in anti-competitive practices. To initiate a hearing, the provider must present evidence, which must "include upper and lower payment amounts paid for the same services, except for value-based payments, to other providers." This necessitates that providers have full knowledge of rates paid to other providers, an uncommon practice, but one which AHA welcomes.
Providers do not share their negotiated prices with one another because of the federal antitrust laws, which prohibit price fixing and other alleged conspiracies to manipulate prices. Therefore, we request that a sentence be added to this section requiring the PASSEs to make available to providers the upper and lower payment amounts being paid to other providers in their network. Without this requirement, no provider could access the protections offered in this manual section because they could not meet the initial requirement for requesting a hearing.
Further, this section also states that a PASSE "shall not be required to disclose the methodology for making value-based payments." While AHA understands that PASSEs may not wish to make legitimate trade secrets public, DHS should ensure that providers within a PASSE network have full knowledge of any and all value-based purchasing methodology, procedures and calculations, so that hospitals may critically evaluate clinical decision-making processes with quality goals in mind.
Finally, transparency in the development of value-based purchasing methodology is especially critical given the problems inherent in the process and the lack of scientific consensus that value-based purchasing improves the patient experience. For this reason, we strongly encourage DHS to require PASSEs to disclose their proposed value-based purchasing methodology prior to its implementation and submit the proposal to a committee that includes providers who can weigh in on the potential impact of the proposal on patient care. No such proposal should be implemented without the committee's review and approval. Otherwise, we risk a managed care entity defining "value" as something other than improving the quality of care.
Response: This is a unique feature that DHS has added to encourage both Providers and PASSEs to negotiate in good faith. At this time, we do not have sufficient evidence that this is not occurring and therefore will not make changes to the manual. DHS will

continue to monitor the indicators such as network adequacy to determine whether we should make provisions in the future.

Comment: Out-of-Network and Emergency Care Access-
To ensure that this vulnerable population's access to emergency care is protected, and providers adequately reimbursed for services rendered, the PASSE provider manual should be amended to explicitly guarantee coverage for emergency services provided by out-of-network hospitals. For example, the manual should mirror the language in sections I.F.1.03 - I.F.1.22 42 of the State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval. In summary, these federal regulations state that PASSEs must:
Cover and pay for emergency services regardless of whether the provider has a contract with the PASSE;
Not deny payment when an enrollee has an emergency medical condition;
Allow enrollees to obtain emergency service outside the primary care case management system;
Not limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms;
Not refuse to cover emergency services based on the provider not notifying the enrollee's PCP, PASSE, or applicable state entity within 10 calendar days;
Cover services until the attending emergency physician or treating provider determines the enrollee is sufficiently stabilized for transfer and discharge; and
Cover post-stabilization care services within or outside the network if they are pre-approved by a PASSE plan provider or representative, or not-pre-approved but administered to maintain the enrollee's stabilized condition.
Clearly, these are fundamental, basic protections to ensure a patient's ability to receive necessary emergency care from the nearest appropriate provider.
Further, in compliance with CMS regulations and recognizing the already limited Medicaid Fee-for-Service rates, the AHA requests that DHS specify that PASSEs must pay non-contracted providers the maximum allowed by federal law for emergency care services rendered. Currently, this maximum is an amount equal to what would be paid under the Medicaid Fee-for-Service program.
Response: All federal requirements must be met and are incorporated by reference. Therefore, DHS does not believe changes to the manual are necessary.

Public Hearing Darragh Auditorium Little Rock, AR 8-20-18.
Cindy Alberding
Comment: In the 1915(c), abeyance is gone. So for individuals that –it still says that individuals must have a service every month, care coordination is no longer in there, but they must have one service at least every month. So, for people that are in jail or in the hospital, that's what abeyance was used for. So, are those individuals going to lose their waiver space? I also couldn't find any information on the 14-day absentee payments, which right now providers have in the waiver, but people are having a lot of trouble getting that to pay.
Response: Page 7 line 22-25 and page 8 line 1-5 concerning the Abeyance Process. Thank you for your comment and for bringing this to our attention. Additional research and discussion will be held around this issue.

Page 8 lines 6-10 concerning the Retainer Payment. Under the current CES Waiver, retainer payments are allowed. Processing is delayed of the expenditure as it must go through the "red" claim submission process.

DHS and the PASSEs are developing the transition of care policy plans, which must be approved by CMS prior to the implementation of Phase II.

DHS has sought approval from CMS, and formal approval is pending.

The proposed effective date of the rule is January 1, 2019.

FINANCIAL IMPACT: There will be a savings to implement this federal rule in the current fiscal year of $6,915,805 in general revenue and $16,535,552 in federal funds for a total savings of $23,451,357 in the current fiscal year. For the next fiscal year, there will be a savings of $14,177,435 in general revenue and $33,897,964 in federal funds for a total savings in the next fiscal year of $48,075,399.

In the current fiscal year, additional revenue is generated due to premium taxes from PASSE entities - $11,820,950 ($5,910,475 for use to offset general revenue of PASSE payments and $5,910,475 for use to reduce the DDS wait list. In the next fiscal year, additional revenue will be generated due to premium taxes from PASSE entities - $24,232,946 ($12,116,473 for use to offset general revenue of PASSE payments and $12,116,473 for use to reduce DDS wait list).

The amounts reported for this statement are tentative pending final approval of rates for calendar year 2019 and 2020.

The total savings to the state will be $35,272,307 for the current fiscal year and $72,308,345 for the next fiscal year.

Concerning the cost to the regulated entities, the agency reports that PASSE entities will negotiate with providers to set service rates under this model. Therefore, the rule itself does not impose any specific cost on the provider.

LEGAL AUTHORIZATION: DHS is authorized to "make rules and regulations and take actions as are necessary or desirable to carry out the provisions of this chapter [Public Assistance] and that are not inconsistent therewith." Arkansas Code Annotated § 20-76-201(12). DHS may promulgate rules as necessary to conform to federal rules that affect its programs as necessary to receive any federal funds. *See* Ark. Code Ann. § 25-10-129(b).

Act 775 of 2017, sponsored by Representative Aaron Pilkington, required DHS to submit an application for any federal waivers, federal authority, or state plan amendments necessary to implement the Medicaid Provider-Led Organized Care System. The Act authorized DHS to promulgate rules necessary to implement the system. *See* Ark. Code Ann. § 20-77-2708.

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL

DEPARTMENT/AGENCY Department of Human Services
DIVISION Division of Medical Services
DIVISION DIRECTOR Tami Harlan
CONTACT PERSON Robert Nix
ADDRESS

PHONE NO. 501-686-9871 **FAX NO.** **E-MAIL** Robert.nix@dhs.arkansas.gov
NAME OF PRESENTER AT COMMITTEE MEETING Paula Stone
PRESENTER E-MAIL Paula.stone@dhs.arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

****

1. What is the short title of this rule?

Provider-Led Arkansas Shared Savings Entity (PASSE) 1-18 Program Medicaid Provider Manual

2. What is the subject of the proposed rule?

Moves the PASSE program into Phase II, in which the PASSE is responsible for providing all CES Waiver services and State Plan services, including those Home and Community Based Behavioral Health Services contained in the 1915(i) state plan amendment.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☒ No ☐

If yes, please provide the federal rule, regulation, and/or statute citation. Act 775 of 2017, ACA 20-77-2701 et seq.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ☐ No ☒

If yes, what is the effective date of the emergency rule?

When does the emergency rule expire? _____

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act?

Yes ☐ No ☐

5. Is this a new rule? Yes ☐ No ☒
If yes, please provide a brief summary explaining the regulation.

Does this repeal an existing rule? Yes ☐ No ☒
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does.

Is this an amendment to an existing rule? Yes ☒ No ☐
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

This Manual is being promulgated pursuant to Act 775 of 2017. It implements Phase II of the PASSE model, in which the PASSE's begin operating as Managed Care Organizations (MCOs) under CMS's regulations and assume full risk for providing all Home and Community Based Services (HCBS) under the 1915(c) Community and Employment Supports (CES) Waiver and all State Plan Medicaid Services, including HCBS services provided through the 1915(i) State Plan Amendment. The PASSE Manual incorporates requirements of the CES Waiver, the 1915(b) PASSE Waiver, and the 1915(i) State Plan Amendment. This model will allow for more flexibility in the provision of HCBS services to individuals with high behavioral health or developmental disabilities service needs. Under this model the PASSE will be responsible for developing the Person Centered Service Plan (PCSP) and delivery of all needed services.

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation.

Ark. Code Ann. 20-77-1701 et seq.

7. What is the purpose of this proposed rule? Why is it necessary?
This Provider Manual enacts Phase II of the Provider-Led Arkansas Shared Savings Entity (PASSE) organized care program.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).
https://medicaid.mmis.arkansas.gov/General/Comment/Comment.aspx

9. Will a public hearing be held on this proposed rule? Yes ☒ No ☐
If yes, please complete the following:

Date: August 20, 2018; September 6, 2018

Time: 5:00 PM

Place: Central Library, Darragh Auditorium, 100 Rock Street Little Rock, AR

Hempstead Hall, Blevins Suite, University of Arkansas at Hope

2500 South Main Street
Hope, AR

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
September 12, 2018

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
Jan. 1, 2019

12. Please provide a copy of the notice required under Ark. Code Ann. § 25-15-204(a), and proof of the publication of said notice. *Attached*

13. Please provide proof of filing the rule with the Secretary of State and the Arkansas State Library as required pursuant to Ark. Code Ann. § 25-15-204(e). *Attached*

14. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known. *Position unknown: PASSE entities, current CES Waiver providers, current OBH providers, beneficiaries who are going into the PASSE or their guardians/caregivers.*

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT David McMahon

TELEPHONE 501-396-6421 **FAX** _____ **EMAIL:** David.McMahon@dhs.arkansas.gov

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

SHORT TITLE OF THIS RULE Provider-Led Arkansas Shared Savings Entity (PASSE) 1-18 Program

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

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

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

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

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

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

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

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

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

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	($6,915,805)	General Revenue	($14,177,435)
Federal Funds	($16,535,552)	Federal Funds	($33,897,964)
Cash Funds	0	Cash Funds	0
Special Revenue	0	Special Revenue	0
Other (Identify)	0	Other (Identify)	0
Total	($23,451,357)	Total	($48,075,399)

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

Current Fiscal Year
Additional revenue generated due to premium taxes from PASSE entities - $11,820,950 ($5,910,475 for use to offset General Revenue of PASSE payments and $5,910,475 for use to reduce DDS wait list).

Next Fiscal Year
Additional revenue generated due to premium taxes from PASSE entities - $24,232,946 ($12,116,473 for use to offset General Revenue of PASSE payments and $12,116,473 for use to reduce DDS wait list).

The amounts reported for questions #4 and #5 are tentative pending final approval of rates for calendar year 2019 and 2020.

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

PASSE entities will negotiate with providers to set service rates under this model. Therefore, the rule itself does not impose any specific cost on the provider.

Current Fiscal Year
$ _____

Next Fiscal Year
$ _____

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

Current Fiscal Year
$ (35,272,307)

Next Fiscal Year
$ (72,308,345)

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

Yes ☐ No ☒

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

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

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

(3) a description of the factual evidence that:
  (a) justifies the agency's need for the proposed rule; and
  (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

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

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

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

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
  (a) the rule is achieving the statutory objectives;
  (b) the benefits of the rule continue to justify its costs; and
  (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Supplemental Information

PASSE Fiscal Impact Narrative

Introduction

The costs and savings presented here are based on reasonable assumptions about the current cost of the program and a reasonable level of savings to be achieved in the first year of risk-based capitation rates. The actual cost and savings presented may change from the estimates presented here.

DHS has not negotiated the final rates to be paid to the PASSE which must be approved by the Centers for Medicare and Medicaid Services (CMS). Each PASSE will receive a capitated per member per month (PMPM) payment to reflect all benefits for all covered services and administrative costs. Even after final rates are agreed to by the PASSEs and CMS, actual costs and savings may change. For example, each individual enrolled among the PASSEs has been designated a tier level of care as a result of their Independent Assessment (IA). Currently, there are active appeals for 317 individuals (less than 1% of assessments conducted for these populations).

The rates will be set only for Calendar Year (CY) 2019. DHS will use the experience of CY 2019 to set rates for CY 2020.

Costs

Estimated Medicaid expenditures for CY 2019 and CY 2020 have been projected using actual expenditures from State Fiscal Year (SFY) 2016 and SFY 2017 for the following population groups:

- Behavioral Health (BH) Adult Tier 2
- BH Adult Tier 3
- BH Child Tier 2
- BH Child Tier 3
- Intellectually/Developmentally Disabled (ID/DD) Adult Tier 2
- ID/DD Adult Tier 3
- ID/DD Child Tier 2
- ID/DD Child Tier 3
- Dual Diagnosis Adult Tier 2
- Dual Diagnosis Adult Tier 3
- Dual Diagnosis Child Tier 2
- Dual Diagnosis Child Tier 3

Service category (inpatient hospital, physician, professionals, waiver services, etc.) costs for each of these population groups in SFY 2016 and SFY 2017 have been indexed at variable growth rates based on recent trends.

In addition, DHS has imputed costs for children and adults for services to be provided through the 1915(i) state plan amendment. PASSEs are required to provide all state plan amendment services, which will include the 1915(i) services as well as all waiver services for the ID/DD populations.

Savings

The savings estimates are based on reasonable assumptions about the change in utilization patterns generally experienced in the adoption of managed care models. We expect, in general, an increase in utilization of community-based providers, especially physicians and professionals. Greater access to community services will reduce use of institution-based care. Improvements in organized care will have the greatest impact on the highest cost individuals. For example, individuals with high pharmaceutical costs will benefit from intensive medication management.

DHS estimates savings of approximately $47 million (State and Federal) in CY 2019 net of administrative costs included in the Global Payment. For comparison, in December 2016, the Health Care Task Force (HCTF) estimated that the first year of savings would not occur until SFY 2021. The net savings for SFY 2021 was estimated at $40 million.

Administrative expenses include human capital costs (salaries, wages, benefits, payroll taxes, etc.); operating expenses (equipment, occupancy, etc.); and taxes and fees (premium tax). The administrative component of the PMPM will be comparable with what other states pay for Medicaid managed care. DHS has not assumed net savings to the program in shifting from direct reimbursement to providers (claims processing, member enrollment, provider credentialing, grievances and appeals, etc.) to risk-based payments as each PASSE must perform the same administrative functions.

Revenues—Premium Tax

Each PASSE will pay a 2.5% premium tax. As specified in Act 775, at least 50% of these revenues must be used to reduce the waitlist for individuals with ID/DD. DHS will also use a percentage of revenues to fund a Quality Incentive Pool for the PASSEs. DHS may also use revenues as the nonfederal share to finance the program.

DHS estimates the premium tax will generate approximately $23.1 million in CY 2019. For comparison, the HCTF estimated a premium tax would generate $56 million in revenue in SFY 2021. As the premium tax is based on payments to the PASSEs, the lower revenue amount reflects lower expenditures compared to the HCTF estimates. Spending on the BH and ID/DD populations has decelerated from the HCTF timeframe, due, in part, to the Medicaid transformation initiatives that have been implemented per the HCTF recommendations.

Revenues—Provider Assessments

There is a relationship between supplemental payments to hospital providers and the amount of the assessments they pay. All supplemental payments to hospital providers have been included in the cost of services used to calculate the PMPMs.

There is no fiscal impact on the amount of supplemental payments the hospitals will receive in in SFY 2019, as payments to providers are based on the prior two years. DHS intends to consult with providers on the impact of the PASSE program on provider assessments. DHS estimates that a loss in provider assessment revenues to the General Fund will be offset by the new premium tax.