EXHIBIT I

DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES

SUBJECT: The Provider-Led Arkansas Shared Savings Entity Program – Phase I

DESCRIPTION: DHS is promulgating (1) the 1915(b) Waiver Application for the PASSE program; and (2) the PASSE Provider Manual. The 1915(b) Waiver and accompanying Provider Manual will implement Phase I of the Provider-Led Arkansas Shared Savings (PASSE) Program. Under this Waiver, PASSEs will provide care coordination for attributed beneficiaries with behavioral health and developmental disabilities services needs who are experiencing complex medical, behavioral, and social issues.

PUBLIC COMMENT: A public hearing was held on August 8, 2017. The public comment period expired on August 11, 2017. The Department provided the following summary of the public comments that it received:

Comment: Section 213.100, A. – Does this mean, based on the methodology, ANY specialty service provider could be responsible for the Care Coordination – It appears to be more appropriate for this fall to only BH and DD providers? If that is the intent, please clarify in the language.
Response: The provision of care coordination is the responsibility of the PASSE.

Comment: Section 213.110, B. – The visit point methodology appears confusing and is lacking usable information for just one month. Could you consider looking at all services, per provider, in the 12-month period? It would allow an analysis of where the majority of services are being performed.
Response: All services will be looked at per provider over a 12-month period.

Comment: Will this be "cumulative" scoring? Example, if a recipient fell into
Provider class 5
i. Certified Behavioral Health Provider, also
Provider class 4
i. Physician – Primary Care Physician
ii. Pharmacy
Would Specialty points be added as – 5 points for Provider Class 5, yet 4 points each for Provider Class 4? That would give the BH or DD provider only 5 points, while giving Providers in Class 4 – 8 points (4 points each). Or, if the individual saw two or more providers in One Provider Class, would that only count as one point for that Provider Class (EG – if they saw a PCP and Pharmacy, would that count as only 4 points TOTAL)? It is very difficult to follow this system – Is there a way to clarify and simplify?
Response: Points are calculated by provider within each class. A visit to 2 different providers within the same class would count as separate visit points.

Comment: What relevance will Pharmacy costs play in this equation? Are you anticipating evaluating all service and pharmacy costs together? How do you explain or account for the inequitable difference between pharmacy costs versus the cost and service intensity of BH and DD service/costs.
Response: All service and pharmacy costs will be evaluated together. Behavioral Health and Developmental Disability service providers are in Service Class 5 while Pharmacy providers are in Service Class 4.

Comment: 213.100 – While we appreciate that a lot of thought and effort went into developing this proposed methodology, it does not achieve the policy goals the Department has articulated to us as:

1. Incentivize participation by providers in more than one PASSE.
2. Maintain the relationship between beneficiaries and their primary BH or DD provider.
3. Promote the success of the PASSE model.

The proposed methodology would do just the opposite. As soon as it came out, providers "locked down" because they realized that under this formula if they sign as a participating provider with another PASSE it will split the attribution of their clients, sending a large portion of them to other PASSEs. This is not just our PASSE – as soon as the methodology came out we received a notice from a big provider in another PASSE that in light of the proposed methodology they were withdrawing their earlier agreement to participate in our network.

Our providers want to be able to participate in more than one PASSE, but they believe strongly that their clients should be attributed to the PASSE in which they are part of the 51% ownership. Throughout the development of this model, we have been repeatedly assured that attribution would be based primarily on the BH or DD provider. This is in keeping with the Patient-Centered Medical Home model. The attached paper details our analysis of the methodology and its problems in this context. Our suggestion on how to improve it:

a. If an individual has an established outpatient BH provider or DD waiver provider, then that individual gets attributed to a PASSE in which that provider is a member ("member" meaning part of the 51% ownership, not mere participating provider).

b. If a DD wait list individual has a DDTCS provider, then that individual is attributed to a PASSE in which that provider is a member.

c. For wait list individuals who are not receiving any DD services, we would recommend use of an informed decision-making process for those beneficiaries and families rather than a random assignment, which could result in establishment of a provider and service plan only to be disrupted during the 90-day choice period.

d. Only in the rare cases where a Tier 2 or Tier 3 individual has no established core provider relationship would random assignment to PASSEs be utilized.

Response: We are not making changes to the attribution methodology.

Comment: Section 214.000 – What allowance will be made for the recipients of services whom due to their illness might not be able to even "understand" this concept? Will the BH or DD provider and/or Care Coordinator be able to assist severely disabled BH and or DD recipients with this request? Please clarify how this will be accomplished for the severely disabled client. Same issue as listed above. Chronically mentally-ill individuals will have "no concept" of how to, or if they even need to, do this. How can they be assisted?
Response: DHS choice counselors will assist beneficiaries understanding their participation in PASSEs.

Comment: Section 231.000 – There is currently a restricted number of SA providers in the state. Is there a possibility of extending the network requirements until there are a sufficient number of SA providers in Arkansas? If not – How will this requirement be accomplished?
Response: DHS may allow a variance in standards in geographic areas of the state. With the allowance of Substance Abuse treatment services within the Outpatient Behavioral Health Services (OBHS) program, DHS expects to have more Medicaid enrolled Substance Abuse treatment providers.

Comment: Section 241.000 – The one to 25 ratio may be an ideal practice goal for a care coordinator. However, this will translate into an estimated 4,000 care coordinators required to meet the care coordination needs of projected 30,000 individuals who are projected to be attributed to a PASSE.

This work ratio coupled with the care coordinator qualifications below appears completely unfeasible in the current Arkansas work force environment. How do you anticipate increasing the workforce capacity?

Comment: The rates being offered to PASSEs for care coordination do not reflect any dollars for any service beyond standard service coordination for providers. There are no admin dollars for PASSE operations of functionality, admin staffing, etc. Again, this seems to more closely align with having providers provide care coordination services until January 1, 2019.

Comment: Section 251 Quality Metrics – Section A states caseloads "must be 25 or less." We would recommend enabling the PASSE to determine caseloads, particularly based on prior experience with stratification and caseloads. Caseloads can vary by severity and individual patient needs. This should be determined by the PASSE who will in very short order be at risk for the population and should best determine appropriate ratios in order to achieve quality outcomes.
Response: DHS has clarified the ratio to no greater than 1 care coordinator to 50 client ratio.

Comment: G. The ratio of 1:25 is too small for this rate. An individual care coordinator may justify a smaller or larger caseload, depending on the care coordinator's experience and the needs of the clients.

Please make it an average of 1:35 so that we can adjust based on client acuity, employee capability, family supports and other circumstances – or more desirable, eliminate the ratio requirement altogether and allow us to manage care coordination as needed to provide the service in the manner prescribed by DHS. A 1/25 ratio for the rate established exaggerates the fact that there not sufficient funds for administrative support funds. Both the rate and the ratio need to be revised to promote care coordination as envisioned in the manual.
Response: DHS has amended the ratio to no greater than 1 care coordinator to 50 client ratio.

Comment: Section 241.000, H – This is an ideal practice concept – but, likely difficult if not impossible to accomplish. Can technology assisted contact be utilized for monthly contact?
Response: After the initial in person face-to-face contact, video conferencing can be utilized to achieve monthly contact with clients for care coordination.

Comment: PASSE APPLICANT recommends face-to-face contact be driven by individualized needs and levels of care coordination.
Response: After the initial in person face-to-face contact, video conferencing can be utilized to achieve monthly contact with clients for care coordination.

Comment: This definition does not align with Act 203 of 2017. The definition should track the Act's language at Ark. Code Ann. § 17-80-402(7), and then later in the manual say how it can be used. Act 203 requires Medicaid and private insurers to "provide coverage and reimbursement for healthcare services provided through telemedicine on the same basis as the health benefit plan provides coverage and reimbursement for healthcare services provided in person." (The service provided via telemedicine must be "comparable" to the same service provided in person.) Ark. Code Ann. § 23-79-1602. Thus, while we commend the Department for recognizing the value of telemedicine for care coordination, it cannot be limited to that use only.
Comment: H – This does not match the CES Waiver for DD which says that "contact" must be made monthly, but "face-to-face" must be made at least quarterly. Please clarify if "face-to-face" can be telemedicine.
Response: Within the context of care coordination, we have clarified that the use of video conferencing for the purpose of required contacts is allowable after the initial face-to-face visit. Telemedicine is still allowable under the Medicaid State plan in order to deliver a medical service.

Comment: What is the State's specific definition of telemedicine in this context?
Response: Telemedicine was not used in the proposed manual as a term of art and this term is being clarified.

Comment: PASSE APPLICANT recommends the State provide additional definition around beneficiary contact requirements, which may include: Follow-up must make contact with the beneficiary either telephonically, via telemedicine or in-person. If the beneficiary is unreachable, the Care Coordinator must document their attempts to contact the member, which must include contacting the beneficiary's natural supports and an in-person attempt to the member's last known location before the care coordinator may start the 45-day timeline to classify the member in abeyance.
Response: Within the context of care coordination, we have clarified that the use of video conferencing for the purpose of required contacts is allowable after the initial face-to-face visit. Telemedicine is still allowable under the Medicaid State plan in order to deliver a medical service.

Comment: PASSE APPLICANT recommends the State consider caseload ratios based on the tier of care coordination the beneficiary is receiving and clinical need. Current evidence-based, and best practice models including:
Tier II - Connective – 1: 70 to 100
Tier II & Tier III – Supportive – 1: 30 to 50
Tier III - High Needs Case Management (children) – 1: 20 to 25
Tier III - Assertive Community Treatment – 1: 12
Response: DHS has clarified the ratio to no greater than 1 care coordinator to 50 client ratio.

Comment: Section 242.000 – It will be difficult to find enough individuals who meet the qualifications in this section.
Response: In response to public comments, DHS is clarifying the qualifications of a Care Coordinator.

Comment: Please note that Care Coordinator Qualifications are very different from case manager qualifications. Existing case managers who do not have a bachelor or RN degree should be grandfathered in as care coordinators. As we understand it, we will need some 1200 additional employees to serve as care coordinators in addition to the existing case managers. Please consider removing the bachelor degree requirement to address workforce realities.

This is another reason not to move forward with care coordination. In a fully capitated program, we will have a care management team, which will provide clinical care management oversight of care coordination. Care coordination shouldn't be defined as a single person, but rather a whole team approach. There is a gulf of a difference in the level of training and skills a person needs to be in an individual's home providing case management support and communicating back to care management team.
Response: In response to public comments, DHS is clarifying the qualifications of a Care Coordinator.

Comment: PASSE APPLICANT's proposed model of care includes high-touch tiered care coordination in the community, at the provider and at the health plan level that is driven by beneficiary choice and needs. We seek to utilize peer and family supports in addition to a continuum of care navigation, coordination, and management professionals with expertise in mental health, substance use, intellectual and developmental disabilities, chronic disease, etc. To do this, PASSE APPLICANT requests that State allow for a greater variety of care coordination professionals to support the PASSE model of care, including non-degree holding professionals to ensure members get the right care, at the right time, in the right location – expanding Care Coordination definition to separate Care Navigations to enable Community Health Worker or peer support navigator.
Response: In response to public comments, DHS is clarifying the qualifications of a Care Coordinator.

Comment: PASSE APPLICANT recommends the State allow PASSEs to develop qualification requirements based on the role the staff person is filling (care navigation, case management, care coordination, care management, etc.). PASSE APPLICANT is concerned about the availability of a skilled workforce at the levels included in this requirement, in addition to these requirements being overqualified for the roles and functions required by this program – especially in Phase I.

PASSE APPLICANT recommends the State allow non-licensed technicians with an associate's degree and multiple years' experience. PASSE APPLICANT additionally recommends and advocates that the State push for the intentional use of peers and family members where applicable.
Response: In response to public comments, DHS is clarifying the qualifications of a Care Coordinator.

Comment: Will the PASSE be required to meet the same suggested caseload standard of 25 beneficiaries per care coordinator for Tier I beneficiaries?
Response: In response to public comments, DHS is clarifying the qualifications of a Care Coordinator. Tier 1 beneficiaries will not be able to join a PASSE until January 2019.

Comment: For recipients with lower level need – would the use of a telephone contact be permitted?
Response: Telephone contact is permitted and encouraged, but does not count towards the required monthly contact.

Comment: The October 1 start date is not realistic, and the state is providing no money for anything beyond traditional case management. Phase I is not necessary to the success of the program – focus on full capitation go live date.
Response: The October 1 start date is only for care coordination provided by the PASSE. Phase I of the PASSE includes initial attribution of beneficiaries to a PASSE, which is vital to the successful implementation of the program.

Comment: PASSEs have not been given any guidance in terms of what IT capabilities they should have. There has been no mention of member file formats, utilization data type and frequency, etc. and how data would flow from the state to the PASSE.
Response: An agreed upon time frame of data transfer will be discussed with each PASSE. Quarterly quality measure reporting expectations (for instance, file formats) will be discussed with each PASSE.

Comment: There will be a lot of chaos and confusion once an individual is attributed to a PASSE and has to change service coordinators. We do not feel this aspect of the program has been adequately communicated to the individuals and lessons from other states have shown us that this has the potential to be significantly disruptive to individuals, families, and their services and has the potential to start the program off on a negative foot, putting the program at risk. Again, the state should consider delaying or canceling PASSE participation in care coordination and focus on the transition to January 1, 2019.
Response: The next 14 months will be a transition period. Care coordination under the 1915(c) or under the 1915(b) PASSE model includes identical services for this reason. We believe this will offer beneficiaries a seamless transition regardless of the Waiver under which they receive the service.

Comment: We are not opposed to conflict-free case management – when properly interpreted and applied. We believe the draft rules are well-intentioned but have lost sight of the policy rationale underlying "conflict-free case management." "Case management" is a nebulous term that can mean all sorts of things. You cannot simply go into the manual and try to remove everything that you used to define as "case management." We believe the goal of "conflict free case management" should be to ensure that direct care providers do not control decisions of resource allocation that should be handled by an independent party. Beyond that, direct care providers are not only suitable but they are in the best position to effect better care coordination because they are the ones who see the clients on a regular basis and have the closest relationships with the clients and their families. We strongly recommend starting over, focusing on those tasks that pose actual conflicts, i.e., resource allocation, by assigning them to a third party (the independent assessor, DDS, or the PASSE MCO), and then allow the direct care providers to provide the rest of the care by whatever name. This is not only easier to administer, it is in the best interests of clients and what they have overwhelmingly demonstrated that they want when offered a choice.
Response: Based on public comment, DHS has clarified that it is the responsibility of the PASSE to comply with Conflict Free Case Management rules.

Comment: C. This section states: The care coordinator for attributed beneficiaries who are also CES Waiver participants cannot be affiliated with the direct service provider for that beneficiary. We strongly oppose this overly broad approach. See discussion above. A more nuanced approach is needed.
Response: Based on public comment, DHS has clarified that it is the responsibility of the PASSE to comply with Conflict Free Case Management rules.

Comment: PASSE APPLICANT seeks clarification on the requirement that "the care coordinator for attributed beneficiaries who are also CES Waiver participants cannot be affiliated with the direct service provider for that beneficiary." Can the State clarify how 'the direct service provider' is defined and identified for a beneficiary?
Response: Based on public comment, DHS has clarified that it is the responsibility of the PASSE to comply with Conflict Free Case Management rules.

Comment: Section 241 details the "Definition of Care Coordination"; however, it does not provide expectations on the separation of responsibilities of Care Coordinators at the PASSE level and those working for DD providers. Further clarification on the expectations/roles of these positions at the different entities should be provided.
Response: Based on public comment, DHS has clarified that it is the responsibility of the PASSE to comply with Conflict Free Case Management rules.

Comment: The attribution model as it is defined today does not create a structure whereby a provider investing in a particular PASSE would be inclined to join the network of another PASSE until after attribution. This has created a scenario where, seven weeks out from go-live, no PASSE will have an adequate network as outlined by care coordination referral network access standards. We would advise adjusting the attribution methodology to reflect a scoring enhancement if an individual's majority service provider is also an owner/investor in a particular PASSE. This would provide needed certainty that providers joining other PASSE networks would not dilute attributed membership, thereby impacting their investment in a PASSE. Act 775 requires providers to have 51% ownership, and providers are taking this seriously. Additionally, because of the nature of the individuals participating in this program and the types of services most primarily access, there should be an increased emphasis in attribution towards core BH/IDD providers. The scoring methodology as currently outlined does not create a substantial enough variance between core DD/BH providers of service and other, less intensive services (i.e. pharmacy). As referenced above in care coordination, we do not feel individuals are getting a clear picture of the PASSE entity they are being attributed to, because much of the design work for the full-risk program has not been completed. This puts members at a disadvantage when deciding whether or not to retain a particular PASSE with which they have been attributed to.
Response: The success of this coordinated care model is contingent upon the development of robust provider networks for each of the PASSEs. DHS encourages all direct service providers to join all PASSE networks. Behavioral Health and Developmental Disability service providers are in Service Class 5, which means that they have the greatest impact on attribution to a PASSE. A beneficiary has 90 days to transition to a different PASSE upon initial attribution and then has 30 days on the beneficiary's annual anniversary of attribution to a PASSE to transition to a different PASSE. The proposed manual is for Phase I of the PASSE, which includes the provision of care coordination.

Comment: We believe the Department should develop more specific criteria that will enable it to narrow the qualified PASSE applicants to no more than two or three PASSEs. The market will not support five, and it is not fair to consumers and providers to have churn and chaos as this is worked out over many months.

Response: If a prospective PASSE meets the requirements as specified in Act 775 of the Arkansas Regular Session of 2017, the Arkansas Insurance Department Rule 117, and the network adequacy requirements within the PASSE Arkansas Medicaid Provider Manual, the PASSE will be allowed to enroll as a Medicaid provider.

Comment: We request the Department to include rules regarding tax-payer supported, essential providers, i.e., the state's only teaching hospital and the state's only children's hospital. Specifically, they should be required to participate in all PASSEs and should provide transparency as to the amount and source of their investment interests and their role in governance of any particular PASSE. There are also concerns around (IGT) and other special source of revenue not available to providers in competing PASSEs. We are requesting a meeting to discuss in more detail.
Response: Act 775 of the Arkansas Regular Session of 2017 does not identify these providers as unique.

Comment: "Participating Provider" is defined as "an organization or individual that is a member or has an ownership interest in a PASSE and delivers healthcare services to beneficiaries attributed to a PASSE." In health plans, participating provider status is not linked to membership or ownership. Please revise along the following lines: "A participating provider is an organization or individual that agrees to deliver healthcare services to beneficiaries attributed to a PASSE as part of that PASSE's provider network." "Direct Service Provider" is defined as "an organization or individual that delivers healthcare services to beneficiaries attributed to a PASSE. Participating providers can be direct service providers." This is confusing because it mixes direct service delivery with participating provider status. Suggest delete last sentence.
Response: These definitions are consistent with the enabling legislation (Act 775). A provider can be characterized in both ways.

Comment: We do not understand why the PASSE will be required to stop delivering services because someone has not communicated with the PASSE in 45 days. Do we send them a notice or what happens?
Response: Based upon public comment, DHS has clarified the language to reflect the intent of abeyance. The PASSE as well as the beneficiary or guardian will have the responsibility of regular contact.

Comment: PASSE APPLICANT acknowledges the functional capacity of individuals assigned to Tier II and Tier III levels of care and advocates the State shift responsibility from members and their guardians to maintain contact with the PASSE and share responsibility between the beneficiary and the PASSE to engage beneficiaries. We suggest neutral language such as: "Loss of contact with the beneficiary or guardian for more than 45 days" with beneficiary contact requirements delineated in section 240.000 Care Coordination Requirements.

Response: Based upon public comment, DHS has clarified the language to reflect the intent of abeyance. The PASSE as well as the beneficiary or guardian will have the responsibility of regular contact.

Comment: PASSE APPLICANT recommends language that defines beneficiary contact requirements, for example: "if the beneficiary is unreachable, the Care Coordinator must document their attempts to contact the member, which must include contacting the beneficiary's natural supports and an in-person attempt to the member's last known location before the care coordinator may start the 45-day timeline to classify the member in abeyance."

Response: Based upon public comment, DHS has clarified the language to reflect the intent of abeyance. The PASSE as well as the beneficiary or guardian will have the responsibility of regular contact.

Comment: The proposed definition is "The Direct Service Providers that join the PASSE." The word "join" is confusing people. Please revise to say: "The Direct Service Providers that have agreed to provide healthcare services to beneficiaries as participating providers of a PASSE."

Response: Based on public comment, DHS has clarified the PASSE Provider Manual to read, "The Direct Service Providers that have agreed to provide healthcare services to beneficiaries enrolled in the PASSE."

Comment: This section makes no distinction between conditional and full licensure. Section 7 of Act 775 contains a timeline that provides initially for conditional licensure with various milestones to achieve full licensure. The PASSE enrollment and licensure process should follow that timeline established in the statute. This is an important distinction under Act 775 and ignoring that distinction is causing the Insurance Department to force PASSE applicants to meet standards prematurely and without sufficient information from DHS. The PASSEs will not be operating as risk-bearing entities until January 1, 2019. Between October 1, 2017, and January 1, 2019, the PASSE/RBPOs will not even be TPAs or ASOs—they will be providing a single service (care coordination) on a rate paid per client by Medicaid. None of the PASSEs will meet the risk-bearing, global capitation part of the definition prior to January 1, 2019. There really is no practical reason to even require PASSEs to enroll anyone until they actually begin operating under the risk-based global capitation model.

Response: Licensure is issued by the Arkansas Insurance Department and is addressed within Rule 117 of the Arkansas Insurance Department. The PASSE enrollment and licensure process is following the timelines established within the statute and as directed by the Arkansas Insurance Commissioner.

Comment: In the third paragraph, it says the PASSE must have the ability to provide care coordination beginning October 1. DHS is providing no funding for the PASSEs to do anything October 1. See above for the other reasons this is not feasible. The fourth paragraph requires the PASSE to sign the "PASSE Agreement." We have not seen the agreement, which is yet another reason this is not ready for October 1.

Response: DHS will provide a one-time foundation payment to the PASSE upon the beneficiary's initial attribution to the PASSE. This one-time payment will be provided when beneficiaries are attributed to the PASSE. Subsequent monthly care coordination payments will be made for each attributed beneficiary. These prospective payments reimbursed by Arkansas Medicaid will be provided to the PASSE for the provision of care coordination. The PASSE agreement will be between the PASSE and DHS. The PASSE agreement cannot be signed until the PASSE is licensed by the Arkansas Insurance Department.

Comment: While we agree with and definitely need the "foundation payment," it should be in addition to, NOT "in lieu of" the care coordination fee. Otherwise, it is only $35 more than the care coordination fee.
Response: The proposed rates have been established and will not be amended at this time.

Comment: Section 213.000 – Without revision, providers will be disincentivized to participate in other PASSEs. See comments above. Because a primary intent of the PASSE is to offer options to the consumer, it is important for them to understand the same DD program may provide services in different ways depending on which PASSE the service is through. How will DHS assist in conveying this information?
Response: The Department continues to encourage Providers to join the network of all PASSEs. As the PASSE is forming its network, it may offer incentives to Providers to join. Only care coordination will be provided by the PASSE during Phase I. Existing provider relationships will continue in Phase I as those providers will continue being reimbursed on a fee-for-service basis by Arkansas Medicaid until January 1, 2019.

Comment: Section 214.000 – Item "C" says that a beneficiary may transition when a PASSE has been sanctioned. That should be qualified in some way. What if the sanction has nothing to do with beneficiary care, but instead relates to reporting requirements. This is too broad as written.

Item "D" says "Other reasons, including poor quality of care, lack of access to services covered under the PASSE agreement, or lack of access to providers experienced in dealing with the beneficiary's care needs." We understand the federal rule allows "other reasons," but the state needs to say what they are – they should be limited to the ones stated or described more specifically as to what other reasons will suffice.

Please state that DHS will first give the PASSE time to remedy the alleged problem (poor quality, access, experienced providers) the beneficiary is asserting.
Response: DHS has clarified this section, the PASSE for which the beneficiary is attributed may be sanctioned in accordance with Section 152.000 of the PASSE Medicaid Provider Manual.

Comment: Section 221.000, E. – Please provide more detail regarding specificity making auxiliary aids and services available upon request of the potential beneficiary or beneficiary at no cost.
Response: In reference to enrollment into a PASSE, information must be provided to the beneficiary in a manner and format that is easily understood and is readily accessible by beneficiary. This manual does not address auxiliary aids and services as medical services.

Comment: 224.000 – This section states: "The PASSE may only market to potential beneficiaries through its website or printed material distributed by DHS's choice counselors. All marketing materials and activities must be approved by DHS in advance of use." This is far too restrictive. We have no problem with DHS reviewing and approving our materials, but we should be able to distribute them ourselves within defined parameters and guidelines. Otherwise, it puts us in the awkward position of telling beneficiaries we can't put something in writing or give them information they need, that they must go ask DHS. We will be blamed for giving them excuses and "the run-around." Rules like this go against the intended goal of greater efficiency. The language as written is not workable. Please follow the same Solicitation and Marketing language that has been used for years for other programs managed by DHS. Please provide more detail regarding role of DHS "choice counselors." What is their relationship to the attribution process?
Response: Information can and is expected to be provided to attributed beneficiaries. Once the beneficiary is attributed to a PASSE, the DHS choice counselors will assist the beneficiary.

Comment: Please reconsider your use of the term "Referral Network" in the manual since that is confusing. Health plans have participating providers and non-participating providers. This section should be addressing all participating providers, regardless of whether they are in the core BH/DD or they are in the referral "halo."
Response: A PASSE must meet network adequacy requirements of all types of providers regardless of ownership status.

Comment: Section 250.000 – This section states: "Care Coordinators must initiate contact within 15 days of attribution to a PASSE." We don't even know the manner and mechanism the state plans to notify us an individual has been attributed. For now, until we have more information, please change to say the coordinator will contact the individual within 15 days of attribution, but that they would have 60 days to initiate care coordination. But, again, the October 1 date is not realistic.
Response: Notification of beneficiary attribution will be sent weekly to the PASSE via electronic mail. Care coordinators must initiate contact within 15 days of attribution to a PASSE.

Comment: There should be some severity scale applied, so that the state cannot terminate a PASSE for failure to meet quality metrics unless the failure is egregious. (This will be more of an issue going forward with metrics that are more difficult to meet, but we don't want to see the language embedded.) We don't know what the quality metrics are going to be. The funding does not allow for a comprehensive care management approach, which is prohibitive to the success of the program.
Response: DHS may take action to correct the failure or impose penalties on the PASSE if the PASSE fails to meet 2 of the 5 quality metrics for care coordination.

Comment: Please explain in more detail how the grievance process will work between the PASSE level and the state fair hearing process. Similarly, please explain how the PASSE will interface with provider appeal in light of the Arkansas Medicaid Fairness Act.
Response: Please see DHS Policy 1098 regarding the grievance process. Medicaid Fairness is still applicable and provider appeals will go to the Department of Health.

Comment: Based on the review of the proposed PASSE rules by our partners, it is important to clarify what services of the policy manual apply to Phase I (2017 to 2018) of the PASSE implementation ONLY. It is our key assumption that prior to the PASSE assuming risk in 2019, there would be updates to the policy manual (Phase II), contract, and a second readiness review. PASSE APPLICANT seeks verification from the State that this key assumption is accurate.
Response: Yes, these rules apply to Phase I.

Comment: PASSE APPLICANT agrees with the State that the payment model and rates should reflect the resources and activities needed to assess beneficiaries, develop their total care plan and support high quality 24/7 care coordination at the right time and in the right place. We know that high quality, 24/7 care coordination requires a skilled workforce, adequate network, advanced technological infrastructure. Thus, PASSE APPLICANT requests the State ensure an equal and equitable distribution of attributed members to provide an economy of scale, in addition to utilizing a per member, per month rate of $208. This rate is based on the Phase I scope requirements of the PASSE in acknowledgement of the robust technology infrastructure, provider network development, workforce development, and innovations PASSE APPLICANT seeks to offer the State through our program.
Response: The proposed rates have been established and will not be amended at this time, nor will the attribution methodology.

Comment: Request the per-member, per-month rate be $208 due to the administrative lift to establish technology and resources to provide outlined services.
Response: The proposed rates have been established and will not be amended at this time.

Comment: PASSE APPLICANT wishes to express its concern that the individuals who are completing the independent assessment are unlicensed, non-clinical professionals. Based on the information provided, this role includes making a clinical determination of the level of care a member will be assigned to, including whether or not the member will receive case management, whether they meet institution level of care criteria and whether they require 24-hour care. PASSE APPLICANT believes these are clinical decisions that should be made by licensed clinical professionals who are credentialed and in good standing with the State or for ease of member access needs by key providers throughout the state with follow up audit for compliance. This will allow for the immediate intervention for more complex members; right care, right location, right time.
Response: The Independent Assessment is a functional needs assessment not a diagnostic assessment.

Comment: PASSE APPLICANT appreciates the State's dedication to ensuring beneficiaries have choice and remain connected to the providers with which they have the strongest relationship. PASSE APPLICANT requests clarification on the implications of the attribution methodology, given the expectation that all PASSEs operate statewide and will contract will all providers; it is understood that a beneficiary would continue to see their preferred providers regardless of what PASSE they are assigned to. While assignment to a PASSE would not impact the beneficiary's choice in from whom they get their care, it will however impact the distribution of attributed members. This may skew the attribution process, leading to inequitable and uneven distribution across the PASSEs, which has potentially deleterious clinical, operational and financial implications for the success of the PASSE program for Arkansas. PASSE APPLICANT recommends the State implement an even distribution methodology for beneficiary attribution.
Response: The proposed attribution methodology has been established and is not being changed at this time.

Comment: PASSE APPLICANT knows that in order to mitigate actuarial risk and maintain a solvent organization, the risk pool we assume must include an appropriate blend of high, medium and low risk membership. To ensure the PASSE program will be stable and solvent by 2019, PASSE APPLICANT recommends that DHS allow Tier I individuals begin to request voluntary attribution no later than January 1, 2018. This will allow PASSEs to assume a solvent risk pool by the time risk is assumed on January 1, 2019.
Response: Voluntary enrollment into a PASSE will not be allowed until January 1, 2019. A rate for Care Coordination for individuals assessed to not be eligible for Tier II and Tier III services was not established.

Comment: Given that the PASSE will not be traditionally contracting with the provider network in Phase I (2017 – 2018), PASSE APPLICANT is requesting the Department of Human Services share member data for the beneficiaries attributed to each PASSE, including: demographic, eligibility, independent assessment, claims history and that the PASSE be included in all prior authorizations, concurrent reviews and retrospective reviews for assigned members. Further, PASSE APPLICANT requests the State define requirements that will be placed on the provider network to collaborate with each PASSE for care coordination, including beneficiary consents, releases of information,

collaborative care planning, notification of unexpected changes in care such as urgent care and emergency department utilization, jail booking, disruptions in foster care placements, etc.

Response: DHS has the ability to report on claims filed by providers, procedure codes bill for and paid, dollar amounts paid, units paid, etc. that can be shared with the PASSE. An agreed upon time frame of data transfer will be discussed with each PASSE.

Comment: PASSE APPLICANT seeks clarification on the term 'network' in this requirement for Phase I; does it reference a provider network or a referral network? Given the limited scope of care coordination, prior to assuming full risk in 2019, the provider network will be limited to care coordinators, while the referral network will include all Medicaid providers in the State, plus community-service organizations that provide non-covered services to address the social determinants of health (i.e. housing, employment, food boxes, etc.). Further, PASSE APPLICANT recommends the State Phase II include in its definition of 'network' not just behavioral health and ID/DD providers, but also hospitals, pharmacy, physicians to ensure statewide coverage of healthcare and access to services.

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

Comment: PASSE APPLICANT appreciates the collaborative process the State has proposed throughout the development of the PASSE program and the critical importance of a readiness review prior to go-live of PASSEs. PASSE APPLICANT is in full support and is prepared to meet the requirements of the State's readiness review. In order to fully execute the Phase I scope of the PASSE program, PASSE APPLICANT encourages the State to expand the scope of the readiness review to additionally include:

– Cover letter which includes: applicant name, physical address(s) for all locations in Arkansas, tax ID number
– Verification the applicant is licensed or otherwise authorized to transact health insurance as an insurance company under § 23-62-103
– Verification the applicant is authorized to provide healthcare plans under § 23-76-108
– A qualified organization that is capable of accepting and maintaining risk
– Authorized to issue hospital service or medical service plans as a hospital medical service corporation under § 23-75-108
– License from Arkansas Department of Health Services as a provider
– Care coordination model with supporting policies, workflows, and desktop protocols, specifically detailing coordination between behavioral health and developmental disabilities departments and providers
– Referral network directory by county and provider type

– Quality management plan, including composition of committee(s), which, at a minimum, must include a medical management committee and a consumer advisory council
– Business continuity and disaster recovery plan
– Network development plan
– Cultural competency plan
– Data management plan and a data flow diagram(s) that depict how the PASSE will send and receive data with the State and stakeholders
– Contact information for key staff where they can be reached after business hours
– PASSE Organization job descriptions
– Communications plan, including marketing materials, and beneficiary notices
– Copy of the comprehensive, integrated clinical assessment tool that will be used, if any, to assess and re-assess beneficiary functioning
– Member transition plan with supporting policies, workflows, and desktop protocols
– Agency policies including: beneficiary rights policies
– Provider manual
– Provider contract boiler plate
– Provider scope(s) of work
– Identification of 24/7 psychiatric crisis hotline that will be provided to beneficiaries
– Identification of language access vendor
– Provider performance measures and sample reports
– Professional development training map, to include at a minimum:
    – Fraud, waste, and abuse
    – Privacy and confidentiality
    – Complaints, grievances, and appeals
    – Beneficiary rights
    – Care coordination model
    – Motivational interviewing
    – Psychiatric crisis intervention
– Demonstration of ability to exchange care coordination data electronically with DHS and providers
– Within twelve (12) months of go-live, we encourage the State to require PASSEs to produce written care coordination protocols that discuss roles and responsibilities, timeliness expectations, information sharing, and conflict resolution agreements with multi-sectoral partners that also have contact with or provide services to PASSE attributed beneficiaries, including, but not limited to:
    – Out-of-network direct service providers
    – Psychiatric crisis providers
    – First responders (Fire/EMS)
    – Law enforcement
    – Adult & juvenile corrections
    – Adult & juvenile courts
    – Adult & juvenile probation
    – Veteran's Administration
    – Indian Health Services
    – Child welfare
    – Department of Education

– Emergency departments & hospitals
– Housing providers
– Employment providers

Response: Many of the proposed suggestions are addressed by the Arkansas Insurance Department, will be a part of the PASSE provider agreement with DHS, or will be addressed by Medicaid Provider Enrollment.

Comment: PASSE APPLICANT requests clarification if this methodology is to be used only for the initial attribution of members or if this will be the permanent methodology for attributing beneficiaries in perpetuity?
Response: The proposed attribution methodology has been established and is not being changed at this time.

Comment: Will DDTCS and/or CHMSs receive their points based off of their facility type only, or will they receive additional points when their clients also receive PT/OT/or ST?
Response: Points will be based upon provider type as established in Act 775 of the 2017 Arkansas Regular Session including Early Intervention providers certified by DDS.

Comment: Does the State intend for beneficiaries to only receive care from PASSE partners/providers or will they continue to be able to receive care from any Medicaid contracted provider (as stated in 231.100.B)? If beneficiaries will continue to receive care from any Medicaid contracted provider, this implies that all PASSEs will be required to maintain a state-wide network and contract with all Medicaid contracted providers in Phase II. If these assumptions are correct, is the relationship-score attribution methodology necessary – as there is no reason to assume that attribution will impact where or from whom the beneficiary receives their care?
Response: The State will continue to pay for services on a fee-for-service basis. The manual for Phase II of the PASSE will be released in calendar year 2018.

Comment: PASSE APPLICANT requests the State include an equitable distribution of beneficiaries to this methodology to ensure all PASSEs receive an equal number of beneficiaries that are a diverse blend of risk scores, to ensure they are able to achieve critical mass and sustainable risk pool. Including equity in attribution is critical to the financial viability and sustainability of the PASSE model and to eliminate perverse incentives for PASSEs and provider groups to enter into exclusive agreements or otherwise intentionally or unintentionally sabotage the State's intended program model.
Response: The proposed attribution methodology has been established and is not being changed at this time.

Comment: If the State elects to use the relationship score approach versus the randomized, equitable distribution approach: PASSE APPLICANT recommends the State allow additional points for each visit per month. Many providers see Tier II and Tier III patients routinely, including multiple times per week, in some instances; building and

strengthening their rapport and relationship with the member at each visit. In many cases, PASSE APPLICANT has observed that these frequent contacts result in the member trusting their weekly provider to coordinate their care, seek referrals, and get psychoeducation about their condition. This relationship should be acknowledged and validated in the State's attribution methodology, should it continue to use a relationship score approach.
Response: The proposed attribution methodology has been established and is not being changed at this time.

Comment: PASSE APPLICANT requests clarification on the specialty point weighting methodology for attribution. Will provider class five hold a weight of 5 points compared to provider class one holding a weight of 1 point?
Response: This topic was previously addressed in the white paper released and distributed by DHS on June 27, 2017, see Attachment "A."

Comment: PASSE APPLICANT requests clarification on the definition of an 'outpatient clinic' in this context. Does this align with the outpatient behavioral health clinic, or is there an alternative definition?
Response: In this context, "outpatient clinic" refers to hospital outpatient clinics.

Comment: PASSE APPLICANT seeks clarification if the term 'visits' in this sentence refers to crude/duplicative visits (i.e. if a patient visits the same provider multiple times in a month, are there multiple points, or just a single point assigned) or visit points per the method described in 213.100.B.
Response: If a client visits the same provider multiple times in a month, that will count as one visit point.

Comment: Details regarding the methods for notifying PASSEs that a beneficiary has been attributed, including the frequency/timeliness of notifications.
Response: Notification of beneficiary attribution will be sent weekly to the PASSE via electronic mail.

Comment: Description of the data set that will be provided to PASSEs upon attribution of a new beneficiary. Despite providers owning 51% of the PASSE, it is a separate legal entity and the beneficiary would need to consent to share medical information (specifically HIV and substance use data); thus, we cannot assume the PASSE will have access to information the direct service providers may have by nature of their relationship with the providers. The State providing this information is additionally pertinent, if the beneficiary sees providers not participating in the particular PASSE to which the member is attributed. PASSE APPLICANT proposes this dataset include at a minimum:
– Demographic information, including clinical information and contact information for the beneficiary, their legal guardian, and an emergency contact.
– Independent assessment tool raw data.
– Prior two-years claim history for the beneficiary.
– Based on the information provided about the Arkansas Medicaid Independent
Response: DHS has the ability to report on claims filed by providers, procedure codes bill for and paid, dollar amounts paid, units paid, etc. that can be shared with the PASSE. An agreed upon time frame of data transfer will be discussed with each PASSE.

Comment: PASSE APPLICANT knows that in order to mitigate actuarial risk and maintain a solvent organization, the risk pool we assume must include an appropriate blend of high, medium, and low risk membership. To ensure the PASSE program will be stable and solvent by 2019, PASSE APPLICANT recommends that DHS allow Tier I individuals begin to request voluntary attribution no later than January 1, 2018. This will allow PASSEs to assume a solvent risk pool by the time risk is assumed on January 1, 2019. PASSE APPLICANT requests clarification of requirements for voluntary attribution. Specifically, what is the process a PASSE should follow in the event a beneficiary contacts a PASSE directly and requests voluntary attribution?
Response: Voluntary enrollment into a PASSE will not be allowed until January 1, 2019.

Comment: PASSE APPLICANT recommends that Emergency Department visits and Psychiatric Residential Treatment Units be considered for attribution. While in Phase I, PASSEs are not risk bearing, these levels of care are high cost and if unevenly attributed to PASSEs, high utilizers of these levels of care may disproportionately distribute financial risk to a PASSE when they assume risk in 2019.
Response: The proposed attribution methodology has been established and is not being changed at this time.

Comment: PASSE APPLICANT recommends the State allow beneficiaries the option to change their PASSE no more than once within a thirty (30) day period to align with the State's mission to offer member choice. We are recommending this to ensure members remain in the driver's seat of their care and are not restricted or bound to a PASSE that may not meet the member's needs.
Response: The timelines established comply with federal Medicaid Managed Care Rules and will not be changed at this time.

Comment: PASSE APPLICANT asks for clarification if PASSEs will be responsible to notify beneficiaries of their anniversary or ability to elect a new PASSE in addition to a definition of a time allotment beneficiaries will have to switch to a new PASSE (i.e. within 30 days before or after their anniversary).
Response: Notification will be provided from DHS or a contractor on the anniversary of the client's attribution to a PASSE. The timelines established comply with federal Medicaid Managed Care Rules and will not be changed at this time.

Comment: PASSE APPLICANT asks for clarification of requirements to notify DHS that a beneficiary has requested a change in their PASSE. Please describe the process, any specific forms, and timeliness requirements.
Response: A beneficiary will be informed of the process to transition to another PASSE in their notification of attribution to a PASSE.

Comment: PASSE APPLICANT requests clarification on the title of this section. This header appears to be an error as this section focuses on communications or language access requirements.
Response: DHS agrees and has clarified this section heading to "General Information."

Comment: PASSE APPLICANT requests clarification on the definition of 'easily understood' and 'readily accessible.'
Response: These terms speak for themselves, and we do not believe they require further explanation.

Comment: PASSE APPLICANT recommends the State require PASSEs to make materials available 'in other languages upon request from beneficiaries or their families.'
Response: The State does require PASSEs to make materials available in other languages upon request from beneficiaries or their families.

Comment: FORVERCARE requests clarification on the definition of 'auxiliary aids' and which aids are classified as covered versus non-covered.

In Phase I, will PASSE APPLICANT be reimbursed for the expense of auxiliary aids?
Response: There will be no additional payments outside of the foundation payment or care coordination payment in Phase I.

Comment: Section 222.000 – PASSE APPLICANT requests clarification on the title of this section. This header appears to be an error as this section focuses on beneficiary rights.
Response: DHS agrees and has clarified the heading of this section to "Beneficiary Policy."

Comment: PASSE APPLICANT recommends the State add a requirement stating the beneficiary has: "the right to file a complaint or grievance with the State at any time and the right to receive assistance filing a complaint or grievance without retaliation."
Response: Please see DHS Policy 1098 regarding the grievance process.

Comment: PASSE APPLICANT requests clarification on the scope of content of the beneficiary handbook that will be provided in Phase I. Covered services offered by a PASSE will be limited to care coordination. Is there an opportunity to update DHS' beneficiary handbook until the PASSE assumes risk in 2019, so as to avoid confusion and multiplication of handbooks beneficiaries must track?
Response: A PASSE is required to have its own beneficiary handbook. DHS must also have a beneficiary handbook as most services will continue to be provided on a fee-for-service basis until January 2019.

Comment: PASSE APPLICANT recommends the State require PASSEs to include "a description of covered services available to the beneficiary" in the beneficiary handbook.
Response: This will be a requirement of the beneficiary handbook.

Comment: PASSE APPLICANT recommends the State add a requirement that the beneficiary handbook include a toll-free number the beneficiary can use in the event of a psychiatric emergency.
Response: Each PASSE may create this number for a beneficiary in the event of a psychiatric emergency for their attributed clients.

Comment: PASSE APPLICANT recommends the State add a requirement that the beneficiary handbook be reviewed/revised no less than annually and that beneficiaries be notified of updates to the beneficiary handbook no less than 30 days prior to their implementation.
Response: A PASSE Provider Manual for Phase II will be available calendar year 2018, which will contain requirements for the beneficiary handbook.

Comment: PASSE APPLICANT recommends the State add a requirement that direct service providers make the beneficiary handbook available in print form free of charge to the beneficiary upon request.
Response: This is an agreement that would be reached between the PASSE and direct service providers, not something that will be mandated upon direct service providers by DHS.

Comment: PASSE APPLICANT requests clarification if there are additional communications requirements that must be followed – for non-marketing purposes. This request includes State requirements regarding approval of provider and member notices, website-copy, and timelines for submission in order to obtain approval and the point of contact at DHS from whom to seek approval, etc.
Response: No, there are not additional communications requirements that must be followed at this time in Phase I.

Comment: PASSE APPLICANT requests clarification on the State's timeline for notification to beneficiaries of their attribution to a PASSE. Specifically, when will beneficiaries be notified, how, and will the PASSEs receive a copy of the notification materials to train our member services department on the information provided to beneficiaries?
Response: Notification of beneficiary attribution will be sent weekly to the PASSE via electronic mail.

Comment: PASSE APPLICANT requests clarification on the use of social media for marketing purposes.
Response: Any marketing materials must be approved by DHS.

Comment: PASSE APPLICANT recommends that State add a requirement that "the PASSE must maintain a network development plan that is submitted to the State no less than annually. At a minimum, the network development plan shall include:
– An assessment of beneficiary needs, including specialists, and non-covered services that address the social determinants of health.

– Geographic and travel time to care analysis of beneficiaries by tier with referral providers identified by type.
– Network sufficiency gap analysis of provider to beneficiary availability and accessibility.
– A summary of network development activities for the previous year.
– Strategies for network development.
Response: A PASSE Provider Manual for Phase II will be available calendar year 2018, which will contain requirements for the beneficiary handbook.

Comment: PASSE APPLICANT requests clarification from the State regarding a PASSE's ability to ensure time and distance requirements based on the scope of work a PASSE will manage in Phase I. It is our understanding that a PASSE will not be contracting with or managing direct service providers until they assume risk in 2019; therefore, a PASSE is not in a position to ensure network sufficiency, determine where direct services providers are located, what their hours may be, or the type of services available. In Phase I, a PASSE can support the State in identifying network gaps and provide consultation on where specific services are needed by type.
Response: The PASSE must meet network adequacy requirements in both Phase I and Phase II.

Comment: PASSE APPLICANT requests a comprehensive list of policies a PASSE is required to maintain (i.e. fraud, waste and abuse, confidentiality, conflict of interest, covered services, etc.).
Response: Many are addressed by the Arkansas Insurance Department, will be a part of the PASSE provider agreement with DHS, or will be addressed by Medicaid Provider Enrollment. Section 1 of the PASSE Medicaid Provider Manual contains all other required policies the PASSE is required to maintain. The PASSE will also be required to meet the federal Medicaid Managed Care rules.

Comment: PASSE APPLICANT requests clarification on the process for requesting a variance of these referral network standards.
Response: Variance requests will be handled on a case-by-case basis by DHS.

Comment: PASSE APPLICANT appreciates the necessity to utilize technology when providing 24/7 high quality, real-time care coordination for vulnerable populations. We request clarification from the State regarding the timeliness of care coordination requirements and use of technology including any State-led targets for implementation or use of technology platforms, such as a health information exchange or other community-based, cloud-based tools for data exchange platforms between Medicaid providers and with external multi-system stakeholders.
Response: Use of technology is an operational issue that will be addressed between successful PASSE applicants and the Department.

Comment: PASSE APPLICANT requests clarification on ultimate ownership for beneficiary care in Phase I. It is clear that the PASSE will assume risk and ultimate responsibility for the beneficiary in 2019. Prior to then, does DHS, the beneficiary's primary care physician, or the PASSE assume ultimate responsibility for their care?

Response: DHS will continue to reimburse direct service providers (including PCPs, PCMHs, Specialty Providers) for the delivery of services to the beneficiary in Phase I. The PASSE is responsible for providing care coordination to the beneficiary in Phase I.

Comment: PASSE APPLICANT requests clarification regarding the operational expectations for case management and care coordination. We recognize there are many models and types of care coordination, including:
– Care navigation
– Case management (including: supportive, connective, and assertive)
– High needs case management
– Care coordination
– Care management
Further, we understand that beneficiaries with behavioral health and substance use eligibility may have a different array of benefits available to them compared to individuals with intellectual or developmental disabilities; further qualified by their level of care needs and tier of eligibility. PASSE APPLICANT is prepared to develop and propose a care coordination model that ensures beneficiaries receive the highest quality care that achieves health outcomes at a cost savings and seeks to ensure our model meets all requirements from the State.
Response: As you point out this is an operational issue, not a policy issue. DHS will engage successful PASSE applicants in these operational issues.

Comment: PASSE APPLICANT requests clarification if PASSE care coordinators must be employed by the PASSE entity. We recommend and request the State allow for a multi-leveled approach to care coordination that includes care navigation, care coordination and care management through different levels of connectedness and coordination based on the beneficiary's individualized needs. Under our proposed model, some care coordination activities will be managed at the provider level, by their staff, with other activities being directly implemented by PASSE employees. PASSE APPLICANT integrated comprehensive continuum of high touch care coordination that is provided in the right place, at the right time, in the right dose to meet member needs.
Response: The PASSE is required to provide care coordination as described in the PASSE manual to attributed beneficiaries. The PASSE may use various arrangements to satisfy this requirement.

Comment: PASSE APPLICANT recommends the State add a requirement that the total care plan be reviewed no less than semi-annually (every six months) in Phase II when at full risk and with the beneficiary updated no less than annually, with tracking of progress towards treatment goals.
Response: This manual only applies to Phase I.

Comment: PASSE APPLICANT requests clarification on the requirements that DHS will place on the beneficiary's providers to work with the PASSE care coordinator, share information, problem solve, etc. during Phase I, when the PASSE does not have oversight of the providers.
Response: It the responsibility of the PASSE to coordinate those efforts. DHS would encourage all providers to cooperate in the delivery of services to beneficiaries.

Comment: PASSE APPLICANT requests clarification if there is a uniform strategy to be used statewide to obtain beneficiary consent and for information sharing across multi-sector partners, specifically, for members additionally protected under 42.C.F.R. Part B with substance use and HIV data in both structured data and unstructured data sections of their care plan(s).
Response: It is the responsibility of the PASSE to determine appropriate methods to obtain consents and authorizations for information sharing across multi-sector partners for the release of essential records.

Comment: PASSE APPLICANT recommends the State add 'booked into jail, disrupts from a foster care placement' to the requirements for seven (7) day follow-up.
Response: We are not making changes to this section of the manual.

Comment: PASSE APPLICANT recommends that requirements be imposed upon emergency departments, hospitals, urgent cares, etc. by DHS to notify the PASSE of a beneficiary's contact, so the PASSE will be able to meet the seven (7) day follow-up requirement. Given the PASSE will not have direct oversight of the provider network in Phase I, a PASSE will need a technology based mechanism in place to be notified of their beneficiaries' contact with these entities; concurrently, these external entities will need a mechanism to identify a beneficiary's attribution to a PASSE in order to notify them. PASSE APPLICANT recommends that State add requirements that the follow-up visit include 'assessing for new needs and identifying any changes to the total care plan.'
Response: Linking to these providers is part of the responsibility of the PASSE.

Comment: PASSE APPLICANT recommends the State require that care coordinators report directly or indirectly to the Medical Director.
Response: This is the responsibility of the PASSE.

Comment: PASSE APPLICANT requests clarifications on the claims submission requirements during Phase I and requests the State to provide an allowable procedures code book for the PASSEs to utilize, including any modifiers.
Response: PASSEs will be paid prospectively on a PMPM basis based upon beneficiaries attributed. There are no claims submission requirements because the PASSE will not have any claims to file.

Comment: PASSE APPLICANT acknowledges the importance of the foundation payment and applauds the State's recognition of the volume of work required to successfully establish a new beneficiary into the PASSE program. PASSE APPLICANT recommends the State consider the workload implications of evolving program requirements and provide a more flexible payment model that includes additional payment mechanisms for annual re-assessment and total care plan development in addition to value-based payments for achievement of quality metrics.

Specifically, the provided definition states the foundation payment is to be used to conduct initial assessment and begin collecting health information from providers; given the requirements that the assessment to review/revise no less than annually, this payment should be available as an allowable procedure code to allow for appropriate compensation for reassessment on an annual basis. Further, PASSE APPLICANT wishes to reinforce the importance of randomized and equal attribution of members to ensure that PASSEs are able to achieve an economy of scale with a blended risk-pool to ensure the solvency of the PASSE program in Arkansas.
Response: PASSEs will be paid prospectively on a PMPM basis based upon beneficiaries attributed. There are no claims submission requirements because the PASSE will not have any claims to file.

Comment: PASSE APPLICANT is concerned this requirement does not accurately reflect the nature of the target population, taking into account the transient nature of this population, their ability to maintain consistent housing, keep their phones connected, and maintain contact with natural supports that can help locate them. PASSE APPLICANT recommends the State allow for: 100% of care coordinators will make monthly face to face contacts with 90% to 95% of their assigned case load.
Response: Our requirements on providing care coordination are clear.

Comment: PASSE APPLICANT recommends the State strengthen this requirement to state "care coordinators must initiate a total care plan within 30 days of attribution" to ensure beneficiaries are not just contacted, but engaged in assessment and treatment planning and access highly coordinated care in a timely fashion.
Response: Our requirements on providing care coordination are clear.

Comment: PASSE APPLICANT recommends the State add 'booked into jail, disrupts from a foster care placement' to this requirement.
Response: Our requirements on providing care coordination are clear.

Comment: PASSE APPLICANT recommends that State remove the requirement that PASSEs must fail to meet '2 of the 5' quality metrics before DHS may take action. PASSE APPLICANT supports the State in monitoring PASSE performance and is willing to be held accountable for failure to meet any of the required quality metrics.
Response: We will not make this change.

Comment: PASSE APPLICANT is committed to and prepared to detect under and over utilization of services and seeks verification from the State that the State will submit claims, pharmacy, and other utilization data to PASSE APPLICANT during Phase I, as the PASSE will not be receiving or processing claims from providers during this initial phase.
Response: DHS has the ability to report on claims filed by providers, procedure codes bill for and paid, dollar amounts paid, units paid, etc. that can be shared with the PASSE. An agreed upon time frame of data transfer will be discussed with each successful PASSE applicant.

Comment: PASSE APPLICANT requests clarification from the State regarding the State's monitoring of 'delivery of services.' In Phase I, the PASSE will not be responsible for provision of services. PASSE APPLICANT seeks clarification from the State regarding how the State will measure the PASSEs' performance for patient outcomes. In Phase I, the PASSE is not managing patient care and thus, cannot be responsible for the oversight or achievement of patient outcomes. The PASSE can only be accountable for coordination of care. PASSE APPLICANT requests the State define the specific outcomes to be monitored to ensure the PASSE has the data needed to monitor the outcomes when we assume risk in 2019. PASSE APPLICANT requests clarification on the specific efficiencies the system seeks to achieve and measure.
Response: All outcome measures refer to the provision of care coordination. This manual is for Phase I of care coordination.

Comment: PASSE APPLICANT requests clarification on the specific efficiencies the system seeks to achieve and measure.
Response: This topic was previously addressed in the white paper released and distributed by DHS on June 27, 2017. See Attachment "A."

Comment: PASSE APPLICANT recommends beneficiaries are allowed up to 90 days at a minimum from the date of the action to file a grievance.
Response: The federal managed care rule allows up to 90 days for a beneficiary to file a grievance. DHS has chosen a shorter timeframe due to the specialty needs of the covered population, to permit a faster resolution for the beneficiary.

Comment: PASSE APPLICANT recommends that State add requirements that:
– The PASSE shall include information about their complaint, grievance, and appeals process in the beneficiary handbook, on their website, and must make this information publically available upon request.
– The PASSE shall offer beneficiaries assistance submitting a complaint, grievance, or appeal without retaliation.
Response: The PASSE is required to have a beneficiary handbook.

Comment: PASSE APPLICANT recommends the State add requirements that:
– The consumer advisory council include at least one (1) parent/caregiver of a child in care.
– The consumer advisory council must meet no less than annually; must be provided information about the PASSE's performance, beneficiary outcomes, complaints, grievances, and appeals; and be provided opportunities to provide recommendations to the PASSE's executive leadership.
– Consumer advisory council meeting minutes shall be kept on record and made available to DHS upon request.
Response: Act 775 addresses this issue.

Comment: Beacon Health Options Conflict of Interest
Response: DHS is aware of this potential conflict and has put measures in place to avoid any misuse of data or non-private information. A Mitigation Plan is in place, subject to amendment as needed that will be monitored. Any potential conflict will not exist for Phase II of the PASSE program. Any knowledge of any impropriety should be reported to DHS.

Question: Please clarify dates and timeline.
Response: Phase I of the PASSE model will be implemented on October 1, 2019. This includes the beginning of Independent Assessments and people being attributed to a PASSE to receive care coordination. The PASSE will take full risk and provide *all services* to attributed beneficiaries in Phase II, beginning on January 1, 2019.

Questions: Regarding conflict free case management, who is the care coordinator? What is the role of the direct care supervisor? Are they care coordinators? What separates the current case manager from the future care coordinator?
Response: Under the PASSE care coordination model, all case management/care coordination activities will be done by the PASSE care coordinator. To ensure continuity of service and consistency, we have changed the definition of case management in the CES waiver and changed the name of it to care coordination. The current case managers will provide care coordination as it is defined in the CES waiver to their clients until such time as those clients are attributed to a PASSE. Then the PASSE will take over providing care coordination.

Question: How do we handle medical care in South Arkansas if what few doctors we have don't/won't sign up on PASSE?
Response: Under Phase I, which is going into effect on October 1, 2017, all services remain fee-for-service. So, you do not have to see a PASSE network provider under this model. The PASSE will have to have the ability to provide referrals and make connections between beneficiaries and providers for needed services. We are anticipating that PASSEs will use the time until January 1, 2019, to build their network so that they can provide statewide coverage for all services to all beneficiaries.

Question: What kind of supervision will the State be utilizing to oversee PASSE units?
Response: DMS is creating a new Office which will oversee the PASSE, as well as other organized care models. This office will review all quarterly reports provided by the PASSE office to ensure that quality metrics are being met.

Question: When a client has been assessed tier 2, does every tier 2 client get the same annual amount of money or are the dollars still individualized to clients' varying levels of need? Will it just be an annual figure or will we bill on a daily rate, as now? Will the dollars be assigned as now, with the amount calculated for hours/week of one-on-one care with staff and another dollar amount for shared staff time?

Response: A rate study will be conducted to determine what amount should be assigned to the tiers and to the clients within those tiers. This will be part of Phase II of the PASSE model and the rates and methods for determining the individual's plan will be put out for public comment in that Phase.

Question: Will each PASSE do business with providers in the same, standardized way, or will providers have to use different case notes, plans of care forms and billing approaches depending on what each PASSE requires? If the latter, then how does the provider interact with the annual DDS auditors based on non-standardized paperwork and structure of info?
Response: These issues will be specifically addressed in Phase II of the PASSE model, which will be put out for public comment before taking effect in January 2019.

Question: How are projected Medicaid savings impacted by people who are dually eligible for Medicare and Medicaid, since Medicare will pay most of the medical costs?
Response: Services paid for by Medicare are excluded in the global payment amount; therefore, the PASSE will not be accountable for those costs and they will not factor into the State's savings numbers.

Question: How does DHS plan to educate the insurance companies, doctors, hospitals, pharmacist partners in each PASSE about housing and employment?
Response: DHS has several training contracts that will be utilized to educate providers and consumers about the new PASSE model and independent assessments, as well as other transformation efforts.

Question: Will I have money to pay for my services?
Response: Yes. Under Phase I, starting on Oct. 1, 2017, the services on the case plan will still be paid the same way they are now, through fee for service billing. In Phase II, starting on Jan. 1, 2019, Medicaid will still pay money for the services on your case plan, but it will be a global payment to a PASSE, who will ensure you get the services on your case plan.

Question: How will this affect my work and living arrangements?
Response: Under Phase I, the only service moving into the PASSE is care coordination. Therefore, work and living arrangements will not be affected by your enrollment into a PASSE. The PASSE care coordinator will be responsible for coordinating work and living services, if you need them and do not already have them provided.

Question: Will we be able to get Medicare and Medicaid?
Response: Yes. But, all Medicare paid services are excluded from the PASSE.

Question: What role will the PASSE Stakeholder Advisory Council play? Real input or just be advised of decisions?

Response: According to Act 775 of 2017, each PASSE must ensure that they have a Consumer Advisory Council. The role of the Consumer Advisory Council will be left up to each PASSE.

Question: What is Medicaid prepared to do and support with money and training (and DDS) to change things for improvement in quality of life, health care savings (no ER), and how do we not interfere with client choice and independence in setting goals and staff working them to change their choices?

Response: The care coordination fee that will be paid to the PASSE or Waiver care coordinator each month is designed for many of the purposes listed in this question. For example, the care coordinator is responsible for conducting follow up visits after a client goes to an ER. The care coordinator is also responsible for assisting the client when they have a service need they are not able to meet and for identifying health education and health coaching needs for their clients and making sure those needs are met. Each client will get a 90 day choice period after attribution, so that if they are not happy with their PASSE, they may change. After that, the client will be able to change PASSEs once per year on their annual attribution date for any reason, or anytime for cause. Under Phase I of the PASSE model, all services other than care coordination remain fee for service, and the client is not limited to any particular service provider by the PASSE. Under Phase II, beginning on Jan. 1, 2019, the client will have to choose a service provider within their PASSE. However, to avoid change of providers, DHS is basing attribution on the client's existing provider relationships. DHS is also encouraging all providers to join all PASSEs.

Question: How is the eligibility determination discussed in Section 241.000(C)(9) different from the independent assessment, and/or is this a prior authorization?

Response: Section 241.000(C) describes what functions a care coordinator will be required to perform for a DD Waiver client. One of those functions is assisting with the ICF/IID Level of care redetermination every year. A DD Waiver client will only have to undergo the Independent Assessment (IA) once every three (3) years unless there is a change in condition and another IA is requested. The IA will not be used to determine whether a client is eligible to receive waiver services; that will be determined by DDS's intake and eligibility unit. The IA is a functional assessment that helps determine the individual client's service need.

Question: Providers are currently reimbursed $217.00 for case management, plan of care, and related supports. The proposed rate is $173.33 (along with a $208.00 one-time assessment fee for a PASSE and a $90.00 care plan fee for a DD Waiver provider). Please explain the reduction in fee and the plan for how assessment, care planning, and care coordination will be administered with current providers and PASSEs. For instance, how does DHS envision the user change to case managers, DCS, and PASSE integrated, whole-person care management?

Response: Providers are currently reimbursed $117.00 for case management and $100.00 for care coordination. "Whole-person" case management is the premise behind the PASSE model. Having a single care coordinator will allow a global view of each client's needs and ensure all health needs are addressed.

Question: Once a tier 2/3 client is in a PASSE and the PASSE takes over in 2019, will the PASSE be developing the programming goals/objectives for adult day programs?
Response: Once the PASSE takes over full risk of Tier 2 and Tier 3 DD and BH clients, beginning on January 1, 2019, the PASSE will be responsible for developing the consumer's overall plan of care. This will include any billable Medicaid service.

Comment: Please clarify 'current state,' 'future state,' and changes for 1) care coordination staffing including case managers, direct care supervisor (DCS), 2) related fees for the services, and 3) responsibility for plan of care between current providers such as DD waiver case management, DCSs, and PASSEs.
Response: Under the PASSE care coordination model, all case management/care coordination activities will be done by the PASSE care coordinator. To ensure continuity of service and consistency, we have changed the definition of case management in the CES waiver and changed the name of it to care coordination. The current case managers will provide care coordination as it is defined in the CES waiver to their clients until such time as those clients are attributed to a PASSE. Then the PASSE will take over providing care coordination.

Comment: We strongly believe this section loses sight of what the purpose of "conflict-free case management" is. It is not supposed to be an attempt to separate every possible "case management" or "care coordination" function from "direct care." As the sections above indicate, this is not even possible, e.g., where the roles are assigned to either direct care or care coordinator, that person is then required to cooperate with or monitor the other person, to the point it is not clear who is in charge.) That does not promote integrated, whole-person care. Instead, the issue would be more appropriately addressed in program policy through the Medicaid Provider Manual. We believe the goal of "conflict free case management" should simply be to ensure that direct care providers do not control decisions of resource allocation that should be handled by the Independent Assessment or DDS or the PASSE. Beyond that, direct care providers are not only suitable but they are in the best position to effect better care coordination because they are the ones who see the clients on a regular basis and have the closest relationships with the clients and their families. That is the very premise of "health homes," dozens of which have been promoted and approved by CMS over the years, and which underlie the work we have done with DHS for some seven years.
Response: We agree. The language is changed to reflect that the PASSE will comply with conflict free case management, which involves several components: assessment of an eligible individual (42 CFR 440.169(d)(1)), development of a specific care plan (42 CFR 440.169(d)(2)), referral to services (42 CFR 440.169(d)(3)), and monitoring activities (42 CFR 440.169(d)(4)). We have removed the restrictive language and stated that the PASSE entity will comply with the overall federal regulation.

Comment: Section 211.000 – It says that the PASSEs should begin October 1, 2017. I believe that this model is not ready to begin taking on clients for several reasons. Rules like this one still have to be sent through the legislature for their approval. The Insurance Department isn't supposed to approve the PASSEs until mid-September, which will only leave them a couple of weeks before they start managing people's care. We don't know

what the rules will be, and we don't know who the PASSEs will be. On top of that, they are required to prepare resources for their attributed clients like a handbook, and for that handbook, they will need time to develop policies such as an internal appeals policy. If the PASSEs aren't ready and don't do a good job, they could make mistakes. This will hurt people. I want DHS to push the date back and allow us to keep things the way they are until the PASSEs have had adequate time to review all of the finalized rules and to hire and train people who understand the rules.

Comment: Section 214.000 – It says that people can choose another PASSE during the first 90 days and once every year. How will we know what the differences between each PASSE is? I want to pick the best PASSE, but I don't understand all of the rules or what they all offer. (At this point, I have reason to wonder if the PASSEs themselves understand the rules, as they have not been finalized.) It also says "on the beneficiary's annual anniversary of attribution to a PASSE." Is this a single day to respond, or is it a week? You need to define how long that amount of time would be.
Response: Beneficiaries will be attributed to a PASSE that is heavily weighted by their use of a Developmental Disability or Behavior Health provider. After the initial 90 day choice period, beneficiaries will have an annual 30 day PASSE choice period starting on the beneficiary's anniversary date of attribution to a PASSE.

Comment: Section 214.000 D – It says a client can move because of "poor quality of care," but how do we prove that? That is a relative term. Who determines what kind of care is poor? I believe that the patient should determine whether care is poor and what that means in their situation.
Response: DHS will monitor through outcome measures and families will be consulted. We also anticipate that the Consumer Advisory Councils will be involved.

Comment: Section 215.000 – What if the abeyance is due to DHS/Medicaid's fault in paperwork (and the client can prove that)? Will the coordinator help the recipient to know that their Medicaid eligibility is in dispute and help them to figure that out?
Response: Yes.

Comment: Section 222.000 G – "The right to be provided written notice of a change in the beneficiaries care coordination" should be at least 14 days, not 7 days. If you are relying on snail mail, half of the time can be used simply in sending the notification, leaving the receiver very little time to respond or make other arrangements. Why isn't this policy the same as 223.000 B, allowing 30 days from the time it goes into effect?
Response: These are two different types of activities.

Comment: Section 231.000 – The travel times and distances listed need to be cut in half, especially for DD and BH providers who are seen on a more frequent basis. For example, it is not in the best interest of a child or adult to have to travel an hour to and then an hour to return from a location to see a therapist multiple times per week.
Response: Thank you for your comment but we disagree and think the distance is appropriate.

Comment: Section 241 G, 242 A, & 243.000 – DHS needs to give the PASSEs enough money to have a qualified individual available to help me whenever I need them, as many times as I may need them. Many providers seem to be concerned that the amount announced at the AR Waiver Conference (in July 2017) of $177 is not enough. I want them to get what they need so they can give me what I need. After December 31, 2018, they should have a different funding source and should not use any money from recipients' care for administrative funding needs.

Comment: Section 242.000 – It says in the document that care coordinators will be employees of the PASSE (241 B). However, it does not say where the care coordinators should be located. Because Arkansas is so rural, care coordinators located in the communities they serve would be most knowledgeable for their clients.

Comment: Section 254.000 – Will DHS be required to submit the data received from PASSEs, such as data that shows savings or lack thereof, for public viewing? We want to see that data as well.
Response: Beginning in the fall of 2017, DHS will begin reporting on savings targets to the Arkansas General Assembly. Those meetings are open to the public.

Comment: Section 261.000 – This says that grievances must be resolved within 30 days of the filing date. What will happen in the meantime? If a person needs treatment, do they have to wait all that time to receive it?
Response: There is not one standard answer to this question; the response depends upon the nature of the grievance.

Comment: Section 264.000 – This description needs more definition. Who may serve on a Consumer Advisory Council? I believe that beneficiaries or direct consumers should serve, but caregivers who speak in place of beneficiaries who can't speak for themselves should also be able to serve.
Response: The Consumer Advisory Councils are mandated by Arkansas law and there will be one Council per PASSE entity. The potential PASSE entities are forming their council.

Comment: PASSE Phase 1 timeline is unrealistic. The timeframe should be pushed back and committee should be created for implementation transition like what was done for the children's DDTCS rules.
Response: Thank you for your comment. We believe the timeline is realistic and obtainable for Phase I.

Comment: The whole fiscal structure of the PASSE is unrealistic.

Comment: Current case managers that do not have the degree should be grandfathered in.
Response: In response to public comments, DHS is clarifying the qualifications of a Care Coordinator.

Comment: Services should start within 60 days after attribution not 14 days, again an unrealistic timeframe.
Response: Please note that manual states that the care coordinator will initiate contact within 15 days of attribution.

Comment: At the top of the page, as part of the program overview, assurances are made that the State will "ensure" that at least two PASSEs will always remain enrolled in order to provide beneficiaries with a choice. DRA would like to see the steps which would be taken by the State in order to ensure that at least two PASSEs are available to beneficiaries. We are concerned that without at least two functioning PASSEs, the Provider-Led Care model will not operate as intended and cause harm to beneficiaries who will be unable to receive care.
Response: We agree that clients should have a choice. If two PASSE entities do not remain, the State will not move forward with the organized care model.

Comment: Section 241 – subsection E states "Care coordination services must be available to attributed beneficiaries 24 hours a day through a hotline or web-based application." Can you clarify if the expectation is that Care Coordinators be on an on-call rotation or if a call-center is adequate during after-hours or holiday hours? Also, are existing DD provider care managers expected to be available for this 24/7 support? What is the required standard of Arkansas Medicaid today?
Response: These are operational decisions the PASSE will have to make as it meets the requirements of care coordination.

Comment: Section 254 – DHS Review of Outcomes - Subsection B references "Patient outcomes" – can you specify expected outcome measures? National established standardized?
Response: This requirement comes from Act 775 of the 2017 Arkansas Regular Session. An agreed upon time frame of data transfer will be discussed with each PASSE. Quarterly quality measure reporting expectations (for instance, file formats) will be discussed with each approved PASSE applicant.

Comment: What is the process for appeals/grievances? Does the State anticipate appointing an independent Ombudsman?
Response: Please see DHS Policy 1098 regarding the grievance process. DHS has choice counselors who will assist beneficiaries in transitioning between PASSEs.

Comment: Will Sections 260.00 – Grievances and 262.00 – Appeal Rights be required for Oct. 1, 2017, or will this be required when we are at full risk in 2019?
Response: Please see DHS Policy 1098 regarding the grievance process. These requirements in the manual are for Phase I and are required for October 1, 2017.

Comment: Section 224 – Marketing Materials states: "The PASSE may only market to potential beneficiaries through its website or printed material distributed by DHS's choice counselors. All marketing materials and activities must be approved by DHS in advance of use." What is the process for review/approval of materials and what are the maximum response times expected by the Department with an expected 10/1 go-live date?
Response: DHS will review and approve marketing materials in a timely manner once received.

Comment: Will participating providers in the PASSE's network be required to be participating providers with Medicaid in 2019?
Response: Rules for Phase II will be released in calendar year 2018. Medicaid Managed Care regulations require that participating providers be enrolled as Medicaid providers.

Comment: Will Arkansas Medicaid require the PASSE to offer all Medicaid participating providers an opportunity to join the PASSE as a participating provider in 2019? We are assuming that the PASSEs will be subject to Arkansas' Any Willing Provider Statute?
Response: Rules for Phase II will be released in calendar year 2018.

Comment: In assessing network adequacy, who will determine which providers are considered Substance Abuse treatment providers?
Response: DHS.

Comment: Will the Medicaid definition of substance abuse provider be used? If so, can we get the list of providers that already meet the test?

Comment: May the PASSE allow providers who are not recognized by Arkansas Medicaid to join their network in 2019?
Response: Rules for Phase II will be released in calendar year 2018.

Comment: How are we to distinguish between behavioral health and substance abuse providers who are very specific as to the client they serve (family, children, adults, etc.)? How will the adequacy test be measured in this case?
Response: Each provider who joins your network will be able to help assist you in determining what population they serve. Referral network adequacy will be determined by DHS.

Comment: If a provider type is not covered by the 'Any Willing Provider' laws, will the PASSE be required to add them as a participating provider in their network in 2019?
Response: Rules for Phase II will be released in calendar year 2018.

Comment: When will network adequacy be audited for final approval of the PASSE's network, and who will be completing this review?
Response: DHS will be completing this review for Phase I referral network adequacy by October 1, 2017. Rules for Phase II will be released in calendar year 2018.

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Comment: What documentation is required to prove a contract exists between the provider and the PASSE during the network adequacy audit?
Response: Documentation reflecting contracts and agreements will differ by PASSE and potentially by provider. There is no standardized requirement for these.

Comment: What format will enrollment and eligibility data be provided in – 834? What is the frequency of data provided – daily, weekly, etc.? How will this information be delivered to the PASSE STFP, encryption, etc.?
Response: An electronic listing will be provided to the PASSE (see question 1) in a file that is not in 834 format that will simply be a listing of the individuals attributed to the PASSE for Care Coordination.

Comment: Will PASSEs receive an audit file and what is the frequency?
Response: This question needs to be further articulated to ensure that DHS understands what is being asked.

Comment: Readiness review – When would DMS/DHS anticipate this review? Presently the published timeline wouldn't support a review prior to 10/1/17.
Response: Referral network adequacy will be determined by DHS and is required for AID Licensure as well as required by federal Medicaid Managed Care regulations.

Question: Who will manage things like my child's pull-ups and meds? I manage them at present time and do not want someone else to take over. Will I be able to continue to manage these things?
Response: Yes, you will be able to continue to manage those things. The independent assessment will look at what is currently taking place to determine service needs. If you are currently meeting your child's needs the independent assessment will note that and that will be considered when forming the person centered service plan (PCSP).

Question: Can the assessment find someone who is pervasive not eligible for Waiver?
Response: No, the Independent Assessment is a functional needs assessment and is separate from the eligibility determination. So, the assessment will be used to determine the intensity of services a Waiver client needs, not to make them eligible or non-eligible for Waiver.

Question: Will the plan of care with goals (outcomes) be the responsibility of the providers or the care coordinators? If it is done by the care coordinators, how does provider have input on the needs of the client if don't agree with goals set (or not) by care coordinator we think the client needs?
Response: In Phase I, the development of the Person Centered Service Plan (PCSP) will stay the same as it has been in the past.

Question: The DDS Director said that case management and supportive living cannot be done by the same person. How are companies that have done away with case management handling health and safety issues? Including monthly visits? Specifically, for pervasive level of care clients?
Response: The language is clarified to reflect that the PASSE will comply with conflict free case management, which involves several components: assessment of an eligible individual (42 CFR 440.169(d)(1)), development of a specific care plan (42 CFR 440.169(d)(2)), referral to services (42 CFR 440.169(d)(3)), and monitoring activities (42 CFR 440.169(d)(4)). We have stated that the PASSE entity will comply with the overall federal regulation.

Question: If a consumer is pervasive level of care with inclusive opportunities for independence, how will that affect the change within the PASSE?
Response: Under the PASSE model, individuals currently classified as Pervasive level of care are until they are assessed being assigned Tier 2, which is the highest level of need (24 hour paid services and supports). This does not negate the ability for services and supports being provided in inclusive settings that offer maximum opportunities for independence.

Question: Arkansas Medicaid is pushing supported employment. How is DDS proposing to actually provide licensing, training, and money to providers in order to serve our clients in this way? We're in a small town, have taken client with 20+ years dishwasher experience to apply several times for this job, last time, employer said had 200 people applying for 1 dishwasher job.
Response: DDS continues to promote supported employment options for individuals with disabilities. As part of our initiatives, DDS has worked with providers on a voluntary basis to provide assistance as providers transformed service delivery system in the employment arena. This assistance has included technical assistance through Consultants knowledgeable in the field who work directly with providers in their communities to develop provider/community specific planning; Inter/intra agency agreements to stabilize funding for Supported Employment; and other activities. Through the implementation of the revised SE definition, greater flexibility in utilization of funding to better need employment support needs are being offered.

Question: Do you get another Plan of Care development fee of $90.00 for revisions?
Response: Yes, with an approved Prior Authorization.

Question: Who approves the plan of care?
Response: In Phase I, DDS will continue to approve.

Comment: Policy 602. B (in the Certification Standards for CES Waiver Services), which outlines requirements for Direct Care Staff, requires DSPs to have "One (1) year of relevant, supervised work experience with a public health, human services, or other community service agency; OR Two (2) years' verifiable successful experience working with individuals with developmental disabilities."

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Given the low rates of unemployment in many areas of the state and the workforce crisis in the field of direct services, coupled with low wage reimbursements, requiring applicants to have previous experience will be a significant hardship for providers who already experience notable challenges in maintaining an adequate workforce.
Response: The cited section has been changed to require that a DSP has either (1) a high school diploma or GED; (2) one year of relevant work experience with a public health, human services, or other community services agency; OR (3) two years of verifiable experience working with individuals with developmental disabilities. Therefore, experience is no longer a requirement.

Comment: 213.300 – The maximum of $90.00 per plan development is not enough money.
Response: Thank you for your comment.

Comment: 220.000 – Define specialty providers. The entire paragraph is confusing regarding care coordination. The whole 14 month transition time is confusing. Will care coordinators be only employed by the PASSE?
Response: As clients are attributed to a PASSE (if they are DD clients receiving services through the 1915(c) Waiver) the client will only receive care coordination under the PASSE. It will take approximately 14 months to completely transition all DD and BH clients into the PASSE model.

Comment: Will providers be allowed to subcontract with the PASSE with care coordinators?
Response: It will be the decision of each PASSE entity to determine the financial relationship with the care coordinators.

Comment: 405 E – Why is lease supposed to be in the person centered file?
Response: The final rule for HCBS settings requires that individuals in residential settings have a lease, residency agreement, or other form of written agreement that documents protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law. A copy of this document should be maintained in the individual's file for annual licensure review.

Comment: Why is rent expected to be one set fee among all? Consumers receive different amounts; why should one that gets $750 a month have to have a rule that they will pay the same as the one that receives $1200 when they can't afford anything extra as it is now?
Response: DDS does not set rates for rent.

Comment: 501 – Who issues the Interim Service Plan?
Response: DDS will continue to approve interim plans of care.

Comment: Seems like the PCSP Developer does a lot. Who employs the PCSP? How are they reimbursed with all the time and work for which they are completing? Looks like this person gets all the leg work completed and the care coordinator just comes by to collect the completed work or monitor the work. Providers will be doing as much as they are now and more with reimbursement reductions. How?
Response: We disagree and believe the role of the care coordinator under the PASSE model will work in coordination with the supportive living provider and PCSP developer.

Comment: This section of the CES Waiver Standards states that DDS Quality Assurance personnel will review provider compliance with the Certification Standards on an annual basis. Language was removed which required this review to be part of an annual on-site visit. DRA requests that this language be added back into the standards and that an on-site visit be required as an element of oversight of the providers in order to ensure the best care possible for waiver beneficiaries. State oversight, including on-site visits, is important to ensuring safety of beneficiaries.
Response: We have clarified the language.

Comment: This section deals with the requirements for a beneficiary's Person Centered Service Plan (PCSP). It states that "The beneficiary (or, if applicable, their legal guardian) must be an active participant in the PCSP planning and revision process." DRA would like this language revised to state "The beneficiary **(and,** if applicable, their legal guardian)." This will ensure that the beneficiary always is considered a participant, even if they have a guardian. The language as written suggests that a beneficiary with a guardian may not be an active participant. Even a beneficiary with a guardian should have the right and opportunity to be an active participant in this process, which the suggested amended language supports more clearly.

Comment: This section contains the language: "If the beneficiary or their legal guardian objects to the presence of any individual at the PCSP development meeting, then the individual is not permitted to attend." DRA recommends that language be included to address situations where the beneficiary and guardian's wishes are in conflict. For example, the following language could be included: "If the wishes of the beneficiary or guardian are in conflict as to persons attending the meeting, the preferences of the beneficiary will be given primary consideration and take precedence where there is no compelling health and safety reason."
Response: DDS asserts that items regarding guardians will depend on the specifics listed in the actual guardianship order. Because of this, no blanket response can be made.

Comment: This section states that Providers shall not refuse service to beneficiaries unless they cannot ensure the beneficiary's health, safety, or welfare. The stated intent of this policy is "to prevent and prohibit Providers from implementing a selective admission policy based on the perceived 'difficulty' of serving a beneficiary." Determining whether or not a Provider's refusal to serve is legitimate is left to the discretion of DDS. The section contains no mention of consequences for a Provider in the event that it is determined that they are refusing beneficiaries in violation of this policy. DRA requests

that this section be amended to contain sanctions against Providers who violate this policy, and addressing what actions will be taken by DDS in the event that a Provider demonstrates a pattern of improperly refusing to serve beneficiaries.
Response: Currently, Waiver Providers cannot refuse to continue to serve unless they cannot maintain health and safety.

Comment: Section 706(C):
This section discusses the required contact by a care coordinator with a beneficiary while their waiver status is in abeyance. We are concerned about the issue of in-person contact with the beneficiary. When a beneficiary is in the community, the standards require that a care coordinator make monthly contact with the beneficiary, with at least one in-person visit per quarter. However, under the standards, during the period of abeyance when a beneficiary is placed in a licensed or certified facility for up to 90 days (with possible renewal), the care coordinator is required to only "have a minimum of one (1) visit or contact each month." This section does not require any in-person contact as currently written. The language of the abeyance section should be changed to clearly state that even though the beneficiary is institutionalized; the care coordinator is still required to make quarterly in-person visits.
Response: This was the intent and the policy has been clarified to reflect your statement above.

Comment: DRA understands the State's desire to utilize a single instrument to determine beneficiaries' needs for consistency across programs. However, the information provided by the State regarding the move to the new Independent Assessment is vague. For example, the State has not provided access to the planned instrument it will be using for the assessments, only referencing the MnChoices assessment tool utilized in Minnesota. According to the information provided, the State intends to "build upon" that assessment tool and will "customize an Independent Assessment and algorithms and tiering criteria" for use in Arkansas.

There has been no information regarding the algorithms and no information provided regarding what services are available to a beneficiary once categorized into a tier. The tool itself is not included for review or comment. Additionally, there is not enough information included within the proposed document to know how or if the State intends to consider data provided by beneficiaries or their medical providers in determining a beneficiary's level of need.
Response: For DD Clients:
1) DDS will continue to determine institutional level of care eligibility.
2) The independent assessment (IA) is a functional assessment tool, not a diagnostic tool. The client will have a diagnosis before the assessment is conducted.
3) The tool will look at the following domains for purposes of assigning a tier: (a) Neurodevelopmental; (b) Psychosocial; (c) Caregiving/natural supports; (d) Self-preservation; (e) Treatment/monitoring; (f) Activities of Daily Living (ADL); and (g) Instrumental Activities of Daily Living.

4) The assessment tool can also be used to create an individualized PCSP based on the client's needs determined by his or her answers to all applicable areas of the assessment, including mental health, neurological/central nervous system, therapies, geriatric depression screen, suicide screen, CAGE substance abuse questionnaire, mental status, and functional communication.

Comment: Furthermore, the proposed Independent Assessment Manual states it is intended to be used across two divisions within the Arkansas Department of Human Services. Namely, the proposed information states that the Division of Behavioral Health Services and the Division of Developmental Disabilities Services will be utilizing the new Independent Assessment. However, it is our understanding that the current Division of Behavioral Health Services will be merging with the current Division of Adult and Aging Services to form the new Division of Adult and Behavioral Health Services. Therefore, it is unclear whether the Independent Assessment will also be used for the aging and adults with physical disabilities population that is currently being assessed with the ArPath Assessment tool. This needs to be clarified.
Response: The MnCHOICES will be replacing the ArPath Assessment tool beginning calendar year 2018.

Comment: The language is overly broad, does not honor the central premise of a provider-led, risk-bearing model under Act 775, and flies in the face of years of work between providers and DHS, first on health homes and now with the Provider-Led Arkansas Shared Savings Entity (PASSE) model (Act 775). It further fragments an already disjointed service system, and treats individuals with developmental disabilities differently than those receiving treatment for mental health or substance abuse. There is nothing in federal law that requires DHS to take the approach contained in the draft rules.

As currently drafted the PASSE Manual states: "*The care coordinator for attributed beneficiaries who are also CES Waiver participants cannot be affiliated with the direct service provider for that beneficiary.*" (241.000.C.) The draft CES Manual also states: "*Care coordination services may not include the provision of direct services to the beneficiary that are typically or otherwise covered as a service under CES Waiver of State Plan.*" (220.000). Finally, the draft CES Waiver Certification Standards state: "*No beneficiary being paid to provide direct services to a beneficiary may serve as the beneficiary's care coordinator.*" (701).

DHS has indicated verbally that these provisions apply only to Phase I care coordination and will not apply once the PASSE enters Phase II, full risk. However, the promulgated manuals do not make this distinction. If this were the case, there would be no reason to put the conflict-free language into the provider Certification Manual. Moreover, what would be the point of disrupting the entire developmental disability (DD) service system for some 15 months of Phase I, only to revert back to the current system? This is unfair to beneficiaries and confusing to everyone involved.

Additionally, the proposed provisions apply only to DD services. This alone creates a strange anomaly in which behavioral health clients can receive both direct services and care coordination through their chosen provider, but individuals with developmental disabilities cannot. The DD approach is contrary to the whole concept of integrated care.

Practical problems with the proposed rules.

For at least seven years, providers have been working with DHS toward a *provider-led* model of care coordination. At first, we worked toward this model under the authority for DD and BH "health homes." Then, through Act 775, this concept took hold, with our support, under the idea of provider-led organized care. The idea consistently expressed by DHS and its various consultants has been to capitalize on the valuable, long-standing relationships and frequent contact that direct service providers have with their clients as a pathway to successful care coordination by those same providers. All of this is lost if instead of encouraging this approach you actually prohibit it. Indeed, one could wonder what the point would be of a provider-led model.

Under the draft language being promulgated, the PASSEs could contract with DD case managers at Pathfinder, but those case managers would not be able to coordinate care for Pathfinder clients. Instead, they would have to coordinate care for clients at Easter Seals, Friendship, or UCP, etc., with whom they have no relationship. Conversely, case managers from Easter Seals, Friendship, or UCP would have to coordinate care for Pathfinder clients, and vice versa. The same scenario plays out all over the state.

It has been suggested that the PASSE could actually employ all case managers and they could remain housed with their current employers and serve existing clients. This would disrupt many longstanding employer-employee relationships, benefit packages, and other terms incident to employment. It would also be asking a lot of people who have consciously sought out work in the non-profit world to go to work for an insurance company with a different mission and culture.

In our discussions over the years with DHS, the state explained that it wanted to build health homes or PASSEs to capitalize on the success Arkansas has achieved with the patient-centered medical homes (PCMH). Imagine telling PCPs that in order to be a PCMH they would have to allow other physicians' offices to come in and coordinate their patients' care. The whole model would collapse before it started.

We cannot imagine that the state is serious about implementing the conflict-free case management rules as worded in this promulgation, to be effective in less than two months. That type of service disruption and chaos would take many months to address, not mere weeks. We strongly urge the state to modify this extreme version into a more workable, integrated approach discussed in this letter.

The conflict free case management rules do not apply to a 1915(b) PCCM waiver.

The conflict free case management rules apply only to case management offered through 1915(c) waiver, Community First Choice, and 1915(i) state plan services. (Refer to CMS Home and Community-Based Services Final Rule, 79 Fed. Reg. 2948-3039 (January 16, 2014), codified at 42 C.F.R. §§ 441.301, 441.555, and 441.730.) The proposed rules remove case management from the Community and Employment Supports (CES) DD 1915(c) waiver in favor of care coordination provided under a 1915(b) waiver. The CMS rule does not apply to 1915(b) waivers for managed care, including "primary care case management" (PCCM), which is the authority being used by Arkansas for Phase I care coordination.

For a number of years now, some states have placed requirements on managed care organizations to deliver case management services without conflict in their state MCO contracts for managed long term services and supports (LTSS). We are not opposed to this type of arrangement; however, it should not be the overly broad approach laid out in these proposed rules. We believe the approach we have designed for our PASSE more than meets the requirements of the law while remaining true to the provider-led nature of Act 775.

Moreover, for purposes of resolving the problem the proposed Arkansas rules create, one need not agree that the conflict-free rule does not apply to 1915(b), whether PCCM or full risk. The state can resolve the issue by addressing the supposed "conflicts" in a more logical manner that preserves the integrated approach we have been working on all these years. (See "Solution" section below.)

Regardless of whether the conflict-free rules apply or not, the proposed language is not in compliance.

One can review the federal regulations at some length and still not be clear exactly what CMS considers the "conflicts" to be when a direct service provider provides case management. "Case management" is a generic term that means many things to many different people. CMS was not consistent in the way it addressed the issue in 1915(c) vs. Community First Choice and 1915(i). Logically, if one parses out the various functions under CMS' historic definition of case management, conflicts arise in **resource allocation**, i.e., **eligibility evaluations**, **needs assessments,** and **care planning**.

Under the proposed Arkansas rules, DHS has resolved the first two "conflicts": It has maintained control of eligibility, and it has contracted with Optum to conduct needs assessments. However, for reasons that are not clear to us, DHS has placed service plan development under Supported Living with the direct care provider, using a newly created title called "Person-Centered Service Plan Developer." If the conflict-free rules were to apply to care coordination under 1915(b), this would be a violation of the 1915(c) rule, which states: "Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management *or develop the person-centered service plan.*" (42 CFR 441.301(c)(vi)).

Response: We agree. The language is clarified to reflect that the PASSE will comply with conflict free case management, which involves several components: assessment of an eligible individual (42 CFR 440.169(d)(1)), development of a specific care plan (42 CFR 440.169(d)(2)), referral to services (42 CFR 440.169(d)(3)), and monitoring activities (42 CFR 440.169(d)(4)). We have stated that the PASSE entity will comply with the overall federal regulation.

We have recommended in the past that the Independent Assessment tool, in this case MnCHOICES, be used to provide a basic plan to fulfill this function, and then the direct service provider would use this tool to provide a more detailed care plan with services, staff, and schedules within the budget approved by DHS. (This appears similar to the approach taken in Minnesota. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_172354. We still believe this is a good approach that will bring the state into compliance. Alternatively, the CMS final Managed Care Rule does not prohibit the MCO/PASSE from performing this function.

On a related note, the draft CES Manual prohibits care coordination by case direct care providers, and it also says that providers may do so as long as they implement certain firewalls, which is the process used today. It is not clear if this language was intended or not, but the firewalls are similar to what we propose under "Solutions."

The draft CES Manual fails to provide a clear distinction between the direct care and care provider and the care coordinator, creating overlapping and confusing responsibilities.

The draft CES Manual reflects the difficulty in trying to separate functions that should not be separated. One glaring example is that it states that the direct care provider is to provide a "PCSP Developer" to develop and implement the person-centered service plan (PCSP), but the Care Coordination section says the person-centered service plan is the responsibility of the care coordinator.

Other examples:

Under 213.000 Supported Living (which is delivered by the direct service provider), the draft Manual charges the direct care provider with the following responsibilities:

C.2 "Serving as liaison between the beneficiary, parents, legal representatives, care coordinator entity and DDS officials." – Isn't this care coordination?
Response: We respectfully disagree.

C.3. "Coordinating schedules for both waiver and generic service categories." – Yet Care Coordination Services Section 220.000 says the care coordinator is responsible for "coordinating and arranging all CES waiver services and other state plan services." It also says the care coordinator is responsible for "generic needs."

C.9 "determine whether the person is receiving appropriate support in the management of medication." – Yet, the Care Coordination section lists "Medication management plan" as a care coordinator responsibility. (It also says the care coordinator is responsible for coordination of medication management. Does this have some meaning different than the direct care providers' "support in the management of medication"?)
Response: The role of the care coordinator will be to work closely with all service providers, including the supportive living provider if applicable to ensure appropriate services and supports are being provided to the beneficiary.

C.9.f. Both the direct care provider and the care coordinator are monitoring the medication management plan.

C.9.g. Both the direct care provider and the care coordinator "are responsible to assure appropriate positive behavior programming is present and in use with programming reviews at least monthly."

C.9.i. Toxicology screenings are the responsibility of the direct care provider "with care coordinator oversight."

C.9.j. Medication administration is monitored by both the direct care supervisor and the care coordinator at least monthly.

The bottom line is that this type of separation of functions is at odds with the whole concept of integrated care. Healthcare is fragmented enough without deliberately creating more fragmentation. What will happen when a direct care provider doesn't "cooperate" or provide information in a timely manner – will the care coordinator still be able to get paid? What will happen when a client experiences an adverse event and the direct care provider wants to immediately respond but can't do anything until the care coordinator signs off? As written, no one understands who is in charge of what. It could result in people working at cross-purposes and finger-pointing when something does not get done or something goes wrong.

This is exactly what happened when Arkansas tried the "conflict-free" approach in 1989 with the initiation of its 1915(c) waiver program for individuals with DD services. The majority of provider organizations chose to be direct care providers, leaving too few case managers in many parts of the state. Some case managers had little or no knowledge of the operational realities of direct care, which led to the creation of unrealistic expectations for clients. Conversely, some direct care providers did not understand the duties of case managers. Also, the state found that some case management functions fit within a third-party approach; but others, particularly day-to-day care coordination, needed the presence of on-site staff. The end result was significant confusion regarding which entity should perform a wide variety of functions and a great deal of frustration for clients. Consequently, Arkansas abandoned this approach around 1995. Consumers are now offered a choice. Tellingly, the vast majority choose the same provider for direct care and case management.

EXHIBIT I

Solution – Assuring Conflict-Free Case Management, Supporting Existing Relationships

We have been working diligently to define roles and relationships to make sure the members of our PASSE receive complete, conflict-free case management and service coordination. Amerigroup will contract with the PASSE to provide care coordination. Amerigroup, in turn, will contract with direct care providers for collaborative activities to enhance overall care management; but Amerigroup and the PASSE, not the direct care provider, will remain ultimately responsible for service coordination.

Amerigroup's Service Coordinators will verify compliance with conflict-free case management standards by providing service coordination with no direct service responsibilities. Amerigroup will contract with local DD and BH direct service providers for the type of case management activities that have been traditionally offered through the DD waiver. We believe the direct care provider is in the best position to develop a detailed care plan, and that Amerigroup's Service Coordinators should retain full accountability for development and implementation of all person-centered service plans and other service coordination functions.

Direct care providers have valuable, longstanding, in-person relationships with PASSE participants. These relationships are key to identifying individual goals, preferences, service barriers, and creating person-centered strategies that support members in leading meaningful lives. Our approach reduces redundant touch points and simplifies processes for PASSE members, while appropriately placing the responsibility for integration and coordination with the Amerigroup Service Coordinator, which fosters conflict-free case management.

We urge the Department to remove the current language in the proposed rules and modify it to require each PASSE to implement conflict-free provisions that address resource allocation, but allow direct care providers to coordinate day-to-day care of their clients.
Response: We agree. The language is clarified to reflect that the PASSE will comply with conflict free case management which, involves several components: assessment of an eligible individual (42 CFR 440.169(d)(1)), development of a specific care plan (42 CFR 440.169(d)(2)), referral to services (42 CFR 440.169(d)(3)), and monitoring activities (42 CFR 440.169(d)(4)). We have stated that the PASSE entity will comply with the overall federal regulation.

Comment: As stated in other comments specifically on the proposed Independent Assessment Manual, the information shared by DHS on the Independent Assessment is vague. Therefore, it is difficult to meaningfully comment on any addition to the use of the Independent Assessment for personal care services, which DHS proposes to amend in multiple manuals, without additional information regarding the tool, algorithms, tier system, service allocation, and population impacted by the use of the new Independent Assessment across differing programs. Though many of the proposed changes direct the public to the Independent Assessment Guide for more information, the Independent

Assessment Manual, as the only "guide" published by DHS directly discussing the Independent Assessment, does not provide the information needed. Consequently, the public is left with little information regarding the process and no way to fully comment on the proposed rule changes.
Response: The independent assessment for the aforementioned population will begin in calendar year 2018. Additional information will be forthcoming.

The agency states that the waiver will require CMS approval; as of August 23, 2017, that approval is pending. The proposed effective date is October 1, 2017.

FINANCIAL IMPACT: The estimated cost to implement the rule is $15,520,632 in the current fiscal year ($4,521,160 in general revenue and $10,999,472 in federal funds) and $12,644,401 in the next fiscal year ($3,683,314 in general revenue and $8,961,087 in federal funds).

Since 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, the agency submitted the following information:

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

This proposed rule implements Act 775.

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

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

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule:

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

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

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

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

N/A

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

N/A

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

N/A

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

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

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

LEGAL AUTHORIZATION: The proposed rule changes incorporate revisions brought about by **Act 775 of 2017**, which created the Medicaid Provider-Led Organized Care Act, to be codified at Arkansas Code Annotated §§ 20-77-2701 through 20-77-2708. Pursuant to Ark. Code Ann. § 20-77-2708, as amended by Act 775, § 1, the Department of Human Services shall submit an application for any federal waivers, federal authority, or state plan amendments necessary to implement the Medicaid Provider-Led Organized Care Act, and it may promulgate rules as necessary to implement the Act. The Department is further required to administer assigned forms of public assistance, supervise agencies and institutions caring for dependent or aged adults or adults with mental or physical disabilities, and administer other welfare activities or services that may be vested in it, and it shall make rules and regulations and take actions as are necessary or desirable to carry out the provisions of Title 20, Chapter 76, Public Assistance Generally, of the Arkansas Code. *See* Ark. Code Ann. § 20-76-201(1), (12).

EXHIBIT I

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 Dawn Stehle

CONTACT PERSON Robbie Nix

ADDRESS PO Box 1437, Slot S295 Little Rock AR.72203

PHONE NO. 501-320-6177 **FAX NO.** 501-404-4619 **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? The Provider-led Arkansas Shared Savings Entity Program—Phase I

2. What is the subject of the proposed rule? This 1915(b) Waiver and accompanying Provider Manual will implement Phase I of the Provider–Led Arkansas Shared Savings (PASSE) Program. Under this Waiver, PASSEs will provide care coordination for beneficiaries with behavioral health and developmental disabilities services needs who are experiencing complex medical, behavioral and social issues.

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 2015 (A.C.A. § 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. Implementation of Phase I of the Provider-Led Arkansas Shared Savings Entity (PASSE) program. Phase I is the care coordination phase.

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."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. AR Statute 20-77-2708

7. What is the purpose of this proposed rule? Why is it necessary? This rule will implement Phase I of the Provider–Led Arkansas Shared Savings (PASSE) Program. Under this Phase, PASSE entities will provide care coordination services to attributed beneficiaries as they prepare to assume full financial risk in January 2019.

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). www.medicaid.state.ar.us/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 8, 2017
Time: 4:30 p.m.
Arkansas Enterprises for the Developmentally Disabled
105 East Roosevelt Road
Place: Little Rock, AR 72206

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
August 11, 2017

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
October 1 , 2017

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. Medicaid Providers (for); Medicaid Participants who will be mandated beneficiaries (unknown).

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Janet Mann

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

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

SHORT TITLE OF THIS RULE PASSE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Current Fiscal Year	Next Fiscal Year
$	$

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

Current Fiscal Year	Next Fiscal Year
$ 15,520,632	$ 12,644,401

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

Yes x No ☐

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

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

This proposed rule implements Act 775.

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

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

(3) a description of the factual evidence that:

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

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

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

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

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

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

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

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

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

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

SUMMARY OF
PROVIDER-LED SHARED SAVINGS ENTITY (PASSE) PROGRAM

DHS is promulgating (1) the 1915(b) Waiver Application for the PASSE program; and (2) the PASSE Provider Manual for the purposes of implementing Phase I of the Provider-led Shared Savings Entity (PASSE) Program. In this phase PASSE entities will begin providing care coordination services to attributed beneficiaries as they prepare to assume full risk in January 2019.