

_750, Form 2 or DOM 400, Form 3), with audit adjustments, is presented fairly and in compliance with program policy and regulations.

1-9 Unauditable Situations

If a facility is unable or unwilling to provide necessary documentation to support the financial or statistical records contained in their cost report, the auditors will issue a “disclaimer” report signifying that the audit could not be accomplished. The Office of Long Term Care will advise the facility of the disclaimer in writing. A period of 90 days from the date of the letter of notification will be allowed to permit the facility to accumulate necessary documentation. A follow-up audit will be attempted upon expiration of the 90 day period or sooner if requested by the facility. If the audit can not be completed on the second attempt, the facility will be advised, in writing, that their agreement to participate in the Medicaid program will be terminated effective immediately. A period of 30 days from the date of such notification will be allowed to permit the orderly relocation of Medicaid recipients. The appeals procedures specified in Section 1-10 of this Manual are available to providers.

1-10 Appeal Procedures

A. Time Limit for Appeals

1. Any ~~Long Term~~Long-Term Care Facility may appeal the facility’s reimbursement rate, ~~a recoupment, a cost disallowance, a fine, a sanction, the imposition of a civil money penalty, or suspension or termination from the program,~~ by submitting a written notice of appeal to the Director of the Department of Human Services within ~~thirty calendar days~~sixty-five (65) calendar days ~~or subsequently, the timeframe allowed in (state statute)~~ or subsequently, the timeframe allowed in ~~appealed action~~notice from DHS regarding a final reimbursement rate. The appeal must clearly state the basis for appeal and must be accompanied by supporting documentation. If the facility wishes to utilize the “MEDIATION PROCESS” as contained in this section, it must so state in its written Notice of Appeal.
2. If an appeal is filed, the DHS Director or ~~his~~ designee will appoint an independent hearing officer to hear the appeal. The hearing officer will schedule all appeals within sixty (60) calendar days of receipt of written notice of appeal by the Division and will notify the parties in writing of the hearing schedule. ~~Provided that~~ If the appealing facility states in its written Notice of Appeal that it wishes to utilize the “MEDIATION PROCESSES” and the department agrees, then the time for the DHS Director or ~~his~~ designee to appoint a Hearing Officer is waived. ~~However,~~ The appealing facility and the DHS Director or ~~his~~ designee shall implement the mediation process within the sixty (60) days. Upon the

termination of the mediation process, if any dispute stated in the notice of appeal remains unresolved,

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750, Form 2 or DOM 400, Form 3), with audit adjustments, is presented fairly and in compliance with program policy and regulations.

1-9 Unauditable Situations

If a facility is unable or unwilling to provide necessary documentation to support the financial or statistical records contained in their cost report, the auditors will issue a “disclaimer” report signifying that the audit could not be accomplished. The Office of Long Term Care will advise the facility of the disclaimer in writing. A period of 90 days from the date of the letter of notification will be allowed to permit the facility to accumulate necessary documentation. A follow-up audit will be attempted upon expiration of the 90 day period or sooner if requested by the facility. If the audit can not be completed on the second attempt, the facility will be advised, in writing, that their agreement to participate in the Medicaid program will be terminated effective immediately. A period of 30 days from the date of such notification will be allowed to permit the orderly relocation of Medicaid recipients. The appeals procedures specified in Section 1-10 of this Manual are available to providers.

1-10 Appeal Procedures

A. Time Limit for Appeals

1. Any Long-Term Care Facility may appeal the facility’s reimbursement rate, by submitting a written notice of appeal to the Director of the Department of Human Services within sixty-five (65) calendar days following the date of the notice from DHS regarding a final reimbursement rate. The appeal must clearly state the basis for appeal and must be accompanied by supporting documentation. If the facility wishes to utilize the “MEDIATION PROCESS” as contained in this section, it must so state in its written Notice of Appeal.
2. If an appeal is filed, the DHS Director or designee will appoint an independent hearing officer to hear the appeal. The hearing officer will schedule all appeals within sixty (60) calendar days of receipt of written notice of appeal by the Division and will notify the parties in writing of the hearing schedule. If the appealing facility states in its written Notice of Appeal that it wishes to utilize the “MEDIATION PROCESS” and the department agrees, then the time for the DHS Director or designee to appoint a Hearing Officer is waived. The appealing facility and the DHS Director or designee shall implement the mediation process within the sixty (60) days. Upon the termination of the mediation process, if any dispute stated in the notice of appeal remains unresolved,

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100.100 Introduction

9-15-096-1-
26

Section I ~~imparts-gives~~ general program information about the Arkansas Medicaid Program. -It includes information about beneficiary eligibility and explains the provider's role and responsibilities. -The intent is to provide users with an understanding of Medicaid Program objectives and regulations. ~~-Additionally, it~~ contains details providers may need to answer questions often asked about the Medicaid Program. -Seven (7) major areas are covered in Section I.

- A. General information ~~about the program~~ - ~~Contains information regarding~~ Describes the background, history, and scope of the Medicaid Program, including information about Medicaid waivers and ~~or other~~ programs administered by ~~the Department~~ division of Medical Human Services (DHS).
- B. Beneficiary eligibility - ~~Contains information about~~ Explains Medicaid beneficiary aid categories, ~~beneficiaries'~~ eligibility for benefits, responsibilities, and ~~an explanation of the~~ Medicaid identification card, ~~the beneficiaries' responsibilities~~ and additional beneficiary information.
- C. Provider participation - Specifies the provider enrollment procedures, ~~the~~ general conditions that must be met by providers to begin and ~~to~~ maintain program participation, and remedies and sanctions ~~that the Division of Medical Services~~ DHS may employ in the administration and regulation of the Arkansas Medicaid Program.
- D. Administrative remedies and sanctions - Describes the rules for imposing sanctions.
- E. Provider due process - ~~Describes~~ Explains how a provider may request an administrative reconsideration or appeal of an adverse decision ~~/action within 30 calendar days after the notice of the decision/action or sanctions~~.
- F. Beneficiary due process - Describes how a beneficiary may request an administrative reconsideration appeal of an adverse decision ~~/action within 30 calendar days after the notice of the decision/action~~.
- G. Managed Care due process – Describes how a managed care organization must develop a grievance and appeals process and how a member of a managed care organization can utilize the grievance and appeals process and request a state fair hearing.
- H. Primary Care Case Management Program (PCCM) - Defines the scope of the Primary Care Case Management Program (PCCM) and regulations regarding provider and enrollee participation. -It lists the categories of eligibility that are exempt from primary care ~~physician-provider~~ (PCP) referral requirements and ~~it~~ itemizes the services that do not require PCP referral. -PCP enrollment and enrollment transfer procedures are explained, as are PCP referral requirements and procedures.

106.000 Limitations on Coverage for Certain Organ Transplants6-1-26

The Arkansas Medicaid Program will comply with Ark. Code Ann. § 23-79-169 in providing coverage for human organ transplants.

110.700 Medicaid Fraud Detection and Investigation Program

4-1-166-1-
26

Federal Regulations require the implementation of a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate utilization of care and services and excess reimbursements by the Medicaid program. -The purpose of the Office of the Medicaid Inspector General (OMIG) is to investigate fraud allegations and ensure Arkansas' Medicaid's compliance. -[Title XIX of the Social Security Act, Arkansas Code Annotated, 42 C.F.R. §455 and the Arkansas State Plan].

The goal of the unit is to verify the nature and extent of services reimbursed by the Medicaid program, while ensuring reimbursements made are consistent with the quality of care being provided, and protecting the integrity of both state and federal funds.

Responsibilities of the unit include the following:

- A. Verifying medical services meet an accepted standard of care and are rendered as billed;
- B. Verifying services are provided by qualified providers to eligible beneficiaries;
- C. Verifying reimbursement for services is correct and that all funds identified for collection prior to Medicaid reimbursement are pursued.

The OMIG Section is responsible for conducting on-site medical reviews for the purpose of to verifying the above tasks, as well as record keeping, and other specified information. -Providers selected for an on-site review will not be notified in advance. -Review analysts may request additional information regarding the provider's medical practice. -[View or print Office of Medicaid Inspector General contact information.](#)

Additionally When warranted, the OMIG Section is responsible for the identifying and recovering of questioned costs claimed for reimbursement from Medicaid funds when warranted. -Situations resulting in recoupment include such things as, but are not limited to, the following:

- A. When duplicate payments are made;
- B. When the Quality Improvement Organization (QIO) denies all or part of a hospital admission;
- C. When medical consultants to the Medicaid Program determine lack of medical necessity;
- D. When Medicaid, Medicare, or the Attorney General's Medicaid Fraud Unit discovers evidence of overpayment;
- E. When a provider has been assessed a monetary penalty for failure to follow a corrective action plan which was developed to correct a pattern of non-compliance as provided in [\(See Sections 151.000 and 190.005\)](#)

When a review is completed, ~~Office of Medicaid Inspector General~~ OMIG will forward a findings report to the provider. -If questioned costs are identified through the review, a "Notice of Decision/Action" will be forwarded sent to the provider. -The notice must comply with [Section 190.006 of this manual required explanations of adverse decisions](#) and must include the name(s) of the patient(s), date(s) of service, date(s) of payment, and the reason(s) for the recoupment decision.

Upon receipt of the notice, the provider has ~~thirtysixty~~ thirty-five (35) calendar days in which to pursue one of the following actions:

- A. Forward a check for the indicated recoupment amount;
- B. Request administrative reconsideration;

C. Appeal.

~~See Sections 160.000 through 169.000 for r~~Rules, timelines, and procedures related to administrative reconsideration and appeals are further explained in ensuing sections of this manual.

161.200 Administrative Reconsideration6-1-2~~65~~

A. Within ~~thirty (30)~~sixty-five (65) calendar days after notice of an adverse decision or/ action, the provider may request administrative reconsideration. -Requests must be in writing and include:

1. A copy of the letter or notice of adverse decision or/ action; and
2. Additional documentation that supports medical necessity.

Administrative reconsideration does not postpone any adverse action that may be imposed pending appeal.

B. Requests for reconsideration must be submitted as follows:

1. In situations where the adverse decision or/ action has been taken by a reviewing agent, the request must be directed to that reviewing agent. -Contact information for the department's reviewing agents can be found in Section V of this manual.
2. When an adverse decision or/ action has been taken by the Office of Medicaid Inspector General (OMIG) on behalf of Division of Medical Services (DMS), the request for reconsideration must be directed to ~~Office of Medicaid Inspector General (OMIG)~~.- View or print the Office of Medicaid Inspector General contact information.- Within twenty (20) calendar days of receiving a timely and complete request for administrative reconsideration, OMIG will designate a reviewer and proceed according to its own procedures. When an adverse decision or/ action has been taken by the Utilization Review (UR) Section of DMS, the request for reconsideration must be directed to UR. View or print the Utilization Review contact information.

The ~~30-sixty-five~~-day time period to request a reconsideration begins to run five (5) days after the date of the written notice.

No administrative reconsideration is allowed if the adverse decision or/ action is due to loss of licensure, accreditation, or certification.

161.300 Administrative Appeals of Adverse Actions that are not Sanctions6-1-2~~65~~

In addition to sanction reconsiderations and appeal procedures set forth in Sections 160.000-169.000, providers may appeal any other decision of the Department of Human Services, its reviewers, or contractors if that decision adversely affects a Medicaid provider or beneficiary with regard to receipt or payment of Medicaid-covered services. -Such decisions and consequent actions are "non-sanction adverse actions."

Within ~~thirty-sixty-five (3065)~~ calendar days of receiving notice of non-sanction adverse action, or ~~ten (10)~~sixty-five (65) calendar days of receiving an administrative reconsideration decision that upholds all or part of any adverse decision or/ action, whichever is later, the provider may appeal.- The time period for filing an appeal shall begin to run five (5) days after the date of the written notice of non-sanction adverse action or administrative reconsideration decision. An appeal must be in writing and must specify in detail all findings, determinations, and adverse decisions or/ actions that the provider alleges are not supported by applicable laws, including state and federal laws and rules, applicable professional standards, or both.- Providers shall mail or deliver the appeal to the Arkansas Department of Health, Office of Medicaid Provider Appeals.

161.400 Sanction Appeals

6-1-256

Within ~~thirty (30)~~sixty-five (65) calendar days of receiving notice of adverse decision or/ action, or sixty-five (65) calendar days of receiving an administrative reconsideration decision that upholds all or part of any adverse decision/action, whichever is later. the provider may appeal. The ~~thirty (30)~~sixty-five (65) days begins to run five (5) days after the date of the written notice.

An appeal must be in writing and must specify in detail all findings, determinations, and adverse decisions or /actions that the provider alleges are not supported by applicable laws, including state and federal laws and rules, applicable professional standards, or both.- Providers shall mail or deliver the appeal to the **Arkansas Department of Health, Office of Medicaid Provider Appeals**. No appeal is allowed if the adverse decision / or action is due to loss of licensure, accreditation, or certification.

162.000 Notice of the Appeal Hearing

9-15-096-1-26

When an appeal hearing is scheduled, the Office of ~~Hearings and Appeals~~ Medicaid Provider Appeals of the Department of Health shall notify the provider, or if the provider is represented by an attorney, the provider's attorney, in writing, of the date, time, and place of the hearing.- Notice shall be mailed not less than ten (10) calendar days before the scheduled date of the hearing. ~~Hearings shall be conducted in accordance with DHS Policy 1098.~~ The decision of the Office of Medicaid Provider Appeals and Hearings is the final agency determination.

169.100 Recovery of the Costs of Services Continued During the Appeal Process

9-15-096-1-26

42 CFR §431.230 entitled "Maintaining Services," which states in part:

(b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or beneficiary to recoup the cost of any services furnished the beneficiary, to the extent they were furnished solely by reason of this section.

~~Federal regulation does not distinguish between beneficiary filed and provider filed appeals.~~

~~Providers filing appeals shall be subject to the same recovery procedures as beneficiaries. When both the provider and beneficiary appeal, liability shall be joint and several.~~

190.001 The Medicaid Fairness Act

42-15-146-1-26

The Medicaid Fairness Act, Ark. Code Ann. §§ 20-77-1701 ~~–20-77-1716~~et seq., requires that the Department of Human Services and its outside contractors treat providers with fairness and due process.

190.002 Definitions

9-15-096-1-26

A. Adverse decision or/ adverse action: any decision or action by the Department of Human Services or its reviewers or contractors that adversely affects a Medicaid provider or beneficiary in regard to:

1. Rceipt of and payment for Medicaid claims and services including but not limited to decisions as to:

- 1a. Appropriate level of care or coding;
- 2b. Medical necessity;
- 3c. Prior authorization;
- 4d. Concurrent reviews;

- 5e. Retrospective reviews;₁₇
- 6f. Least restrictive setting;₁₇
- 7g. Desk audits;₁₇
- 8h. Field audits and onsite audits;₁₇ and
- 9j. Inspections or surveys;₁
- j. Payment amounts due to or from a particular provider resulting from gain sharing, risk sharing, incentive payments, or another reimbursement mechanism or methodology, including calculations that affect or have the potential to affect payment; and
- k. Imposition of corrective action plans.
- 2. To constitute an adverse decision, an agency decision need not have a monetary penalty attached or a direct monetary consequence to the provider.
- 3. “Adverse decision” does not include the design of or changes to an element of a reimbursement methodology or payment system that is of general applicability and implemented through the rulemaking process.
- B. Appeal: an appeal under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 ~~–25-15-218~~et seq.
- C. Claim: a request for payment of services.
- D. Concurrent review or concurrent authorization: a review to determine whether a specified beneficiary currently receiving specific services may continue to receive services.
- E. Denial: denial or partial denial of a claim or authorization of services.
- F. Department:
 1. The ~~Arkansas~~ Department of Human Services;₁₇
 2. All of the divisions and programs of the ~~Arkansas~~ Department of Human Services, including the ~~state-Arkansas~~ Medicaid Program;₁₇ and
 3. All of the ~~Arkansas~~ Department of Human Services' contractors, fiscal agents, and other designees and agents.
- G. Medicaid: the medical assistance program under Title XIX of the Social Security Act that is operated by the ~~Arkansas~~ Department of Human Services and its contractors, fiscal agents, and all other designees and agents.
- H. Person: any individual, company, firm, organization, association, corporation, or other legal entity.
- I. Primary care physician: a physician whom the department has designated as responsible for the referral or management, or both, of a Medicaid beneficiary's health care.
- J. Prior authorization: the approval by the ~~state-Arkansas~~ Medicaid Program for specified services for a specified Medicaid beneficiary before the requested services may be performed and before payment will be made by the ~~state-Arkansas~~ Medicaid Program.
- K. Provider: a person enrolled to provide health or medical care services or goods authorized under the ~~state-Arkansas~~ Medicaid Program.
- L. Recoupment: any action or attempt by the Department of Human Services to recover or collect Medicaid payments already made to a provider with respect to a claim by:
 1. Reducing, withholding or affecting in any other manner current or future payments to a provider;₁ or

2. Demanding payment back from a provider for a claim already paid.
- M. Retrospective review: the review of services or practice patterns after payment, including, but not limited to:
1. Utilization reviews;
 2. Medical necessity reviews;
 3. Professional reviews;
 4. Field audits and onsite audits; and
 5. Desk audits.
- N. Reviewer: any person, including reviewers, auditors, inspectors, surveyors and others who, in reviewing a provider or a provider's provision of services and goods, perform review actions, including, but not limited to:
1. Reviews for quality;
 2. Reviews for quantity;
 3. Utilization;
 4. Practice patterns;
 5. Medical necessity;
 6. Peer review; and
 7. Compliance with Medicaid standards.
- O. Technical deficiency: an error or omission in documentation by a provider that does not affect direct patient care of the beneficiary. -Technical deficiency does not include:
1. Lack of medical necessity or failure to document medical necessity in a manner that meets professionally recognized applicable standards of care;
 2. Failure to provide care of a quality that meets professionally recognized local standards of care;
 3. Failure to obtain prior, concurrent, or mandatory authorization if required by regulation;
 4. Fraud;
 5. A pattern of abusive billing;
 6. A pattern of noncompliance; or
 7. A gross and flagrant violation.

190.003 Administrative Appeals

42-1-056-1-
26

- A. The following appeals are available in response to an adverse decision:
1. A beneficiary may appeal on his or her own behalf;
 2. A provider of medical assistance that is the subject of the adverse action may appeal on the beneficiary's behalf; and
 3. If the adverse action denies a claim for covered medical assistance that was previously provided to a Medicaid-eligible beneficiary, the provider of such medical assistance may appeal on the provider's behalf. -The provider does not have standing to appeal a non-payment decision if the provider has not furnished any service for which payment has been denied.

- B. All appeals shall conform to the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ ~~25-15-201~~ ~~—25-15-218~~ et seq.
- C. Providers may appear in person, through a corporate representative or, with prior notice to the Department of Human Services, through legal counsel.
- D. Beneficiaries may represent themselves or they may be represented by a friend, by any other spokesperson except a corporation, or by legal counsel.
- E. A Medicaid beneficiary may attend any hearing related to his or her care, but the department may not make his or her participation a requirement for provider appeals. The department may compel the beneficiary's presence via subpoena, but failure of the beneficiary to appear shall not preclude the provider's appeal.
- F. If an administrative appeal is filed by both a provider and beneficiary concerning the same subject matter, the department may consolidate the appeals.
- G. Any person who considers himself or herself injured in his or her person, business, or property by the decision rendered in the administrative appeal is entitled to judicial review of the decision under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ ~~25-15-201~~ ~~—25-15-218~~ et seq.
- H. This rule shall apply to all pending and subsequent appeals that have not been finally resolved at the administrative or judicial level as of April 5, 2005.

191.001 Definitions

~~9-15-096-1-~~
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- A. Adverse decision/ or adverse action: means any decision or action by the Department of Human Services or its reviewers or contractors that adversely affects a Medicaid provider or beneficiary in regard to receipt of and payment for Medicaid claims and services by limiting, terminating, suspending, or reducing Medicaid eligibility or covered services in connection with, but not limited to:
1. A termination, suspension of, or reduction in covered benefits or services, including benefits or services for which there is a current approved prior authorization;
 2. A termination, suspension of, or reduction in Medicaid eligibility, or an increase in beneficiary liability, including a determination that a beneficiary must incur a greater amount of medical expenses to establish income eligibility in accordance with 42 CFR § 435.121(e)(4) or 42 CFR § 435.831;
 3. A determination that a beneficiary is subject to an increase in premiums or cost-sharing charges under 42 CFR part 447, subpart A; or
 4. A determination by a skilled nursing facility or nursing facility to transfer or discharge a resident and an adverse determination by a State regarding the preadmission screening and resident review requirements of section 1919(e)(7) of the Social Security Act. ~~Appropriate level of care or coding,~~
 2. ~~Medical necessity,~~
 3. ~~Prior authorization,~~
 4. ~~Concurrent reviews,~~
 5. ~~Retrospective reviews,~~
 6. ~~Least restrictive setting,~~
 7. ~~Desk audits,~~
 8. ~~Field audits and onsite audits, and~~
 9. ~~Inspections.~~

- B. Beneficiary:
1. A person who has applied for medical assistance under the Arkansas Medicaid Program;¹⁷ or
 2. A person who is a beneficiary of medical assistance under the Arkansas Medicaid Program.
- C. Department: The Department of Human Services.

191.002 Notice

~~42-1-056-1-~~
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- A. If an application or claim for medical assistance is denied in whole or in part or is not acted upon with reasonable promptness, the ~~d~~Department of Human Services shall provide written notice:
1. Of the beneficiary's right and opportunity for a fair hearing under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 ~~—25-15-218, et seq.:~~
 2. Of the method by which the beneficiary may obtain a fair hearing;¹⁷ and
 3. Of the beneficiary's right to:
 - a. Represent himself or herself;¹⁷ or
 - b. Be represented by legal counsel, a friend, or any other spokesperson except a corporation.
- B. A notice required under this rule shall include but not be limited to:
1. A statement detailing the type and amount of medical assistance that the beneficiary has requested;¹⁷
 2. A statement of the adverse action that the department has taken or proposes to take;¹⁷
 3. The reasons for the adverse action,¹⁷ which shall include but not be limited to:
 - a. The specific facts regarding the individual beneficiary that support the action;¹⁷ and
 - b. The sources from which the facts were derived;¹⁷
 4. An explanation of the beneficiary's right to request a fair hearing, if available, or in cases of an adverse action based on a change in law:
 - a. The circumstances under which a fair hearing will be granted;¹⁷ and
 - b. An explanation of the circumstances under which medical assistance is provided or continued if a fair hearing is requested.

191.003 Determination of Medical Necessity – Content of Notice

~~42-1-056-1-~~
26

If the adverse action that the ~~d~~Department of Human Services has taken or proposes to take is based on a determination of medical necessity or other clinical decision, the notice required under Rule 191.002 shall include all of the following:

- A. Specification of the medical records upon which the physician or clinician relied in making the determination;¹⁷
- B. Specification of any portion of the criteria for medical necessity or coverage that is not met by the beneficiary;¹⁷
- C. The specific regulation(s) that support the adverse action, or the change in federal or state law that has occurred since the application was filed that requires adverse action;¹⁷ and

- D. A brief statement of the reasons for the adverse action based upon the individual beneficiary's circumstances.

The department and others acting on behalf of the department may not cite or rely on policies that are inconsistent with federal or state laws and regulations or that were not properly promulgated. -Generic rationales or explanations shall not suffice to meet the requirements of this rule.

191.004 Administrative Appeals

6-1-265

When notice of an adverse decision is received from the Division of Medical Services, the beneficiary may appeal. -The appeal request must be in writing and submitted to the Department of Human Services, [Office of Appeals and Hearings Section](#). -[View or print the Department of Human Services, Office of Appeals and Hearings Section contact information](#). -The appeal request must be received by the [Office of Appeals and Hearings Section](#) no later than thirty (30) days from the date of written notice. The thirty (30) days begins to run five (5) days after the date of written notice.

All appeals shall conform to the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 ~~—25-15-218et seq.~~ -Beneficiaries may represent themselves or they may be represented by a friend, by any other spokesperson except a corporation, or by legal counsel.

If an administrative appeal is filed by both a provider and beneficiary concerning the same subject matter, the department may consolidate the appeals.

Any person who considers himself or herself injured in his or her person, business, or property by the decision rendered in the administrative appeal is entitled to judicial review of the decision under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 ~~—25-15-218et seq.~~

191.005 Conducting the Hearing

42-1-056-1-26

If a beneficiary appeals an adverse action under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 ~~—25-15-218et seq.~~, the reviewing authority shall consider only those adverse actions that were included in the written notice to the beneficiary as required under Rules 191.002 and 191.003.

All determinations of the medical necessity of any request for medical assistance shall be based on the individual needs of the beneficiary and on his or her medical history.

192.000 MANAGED CARE DUE PROCESS

192.001 Scope

6-1-26

This section applies to beneficiary appeals to managed care organizations (MCO). A "managed care organization" includes, but is not limited to, a Provider-Led Arkansas Shared Savings Entity (PASSE) or other Risk Based Provider Organization. Provider appeals to MCOs are governed by all applicable state and federal laws and agreements or contracts between the provider and the MCO.

This section does not apply to non-emergency medical transportation Prepaid Ambulatory Health Plans (PAHPs) in accordance with 42 CFR § 438.9. This section also does not apply to Qualified Health Plans in the AR HOME program.

192.002 Definitions

6-1-26

- A. Adverse benefit determination means any of the following:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
 2. The reduction, suspension, or termination of a previously authorized service;
 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at 42 CFR § 447.45(b) is not an adverse benefit determination;
 4. The failure to provide services in a timely manner;
 5. The failure to act within the prescribed timeframes regarding the standard resolution of grievances and appeals;
 6. For a resident of a rural area with only one (1) managed care organization, the denial of a member's request to exercise his or her right to obtain services outside the network; and
 7. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, coinsurance, and other member financial liabilities.
- B. Appeal means a review of an adverse benefit determination by an MCO.
- C. Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationship such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the MCO, PIHP, or PAHP to make an authorization decision.
- D. Grievance and appeal system means the processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.
- E. Managed Care Organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is:
1. A federally qualified HMO that meets the advance directives requirements of 42 CFR part 489, subpart I; or
 2. Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:
 - a. Makes the services it provides to its members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity; and
 - b. Meets the solvency standards of 42 CFR § 438.116.
- F. Managed Care Program means a managed care delivery system authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act.
- G. Member means a Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program;
- H. Prepaid ambulatory health plan (PAHP) means an entity that:
1. Provides services to members under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates;
 2. Does not provide or arrange for, and is not otherwise responsible for the provision of inpatient hospital or institutional services for its members; and
 3. Does not have a comprehensive risk contract.

- I. Prepaid inpatient health plan (PIHP) means an entity that:
1. Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates;
 2. Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
 3. Does not have a comprehensive risk contract.
- J. Provider-Led Arkansas Shared Savings Entity (PASSE) means a Risk Based Provider Organization (RBPO) in Arkansas that has enrolled in Medicaid and meets the following requirements:
1. Is fifty-one percent (51%) owned by PASSE Equity Partners; and
 2. Has the following Members or Owners:
 - a. An Arkansas licensed or certified direct service provider of Developmental Disabilities (DD) services;
 - b. An Arkansas licensed or certified direct service provider of Behavioral Health (BH) services;
 - c. An Arkansas licensed hospital or hospital services organizations;
 - d. An Arkansas licensed physician's practice; and
 - e. A Pharmacist who is licensed by the Arkansas State Board of Pharmacy.

Among other things, each PASSE must be licensed with the Arkansas Insurance Department, enrolled as a Medicaid provider, and enter into an annual PASSE agreement with DHS.

- K. Risk Based Provider Organization means an entity that:
1. Is licensed by the Insurance Commissioner under the rules established for risk-based provider organizations by the commissioner;
 2. Is obligated to assume the financial risk for the delivery of specifically defined healthcare services to an enrollable Medicaid beneficiary population; and
 3. Is paid by DHS on a capitated basis with a global payment made, whether or not a particular member of an enrollable Medicaid beneficiary population receives services during the period covered by the payment.
- L. State Fair Hearing means an administrative review provided by the State that meets the requirements of 42 CFR part 431, subpart E, and will result in a final agency action in accordance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq.

192.003 Timing and Content in Notice of Adverse Benefit Determination by Managed Care Organizations **6-1-26**

- A. Notice. The MCO must comply with all applicable provisions of 42 CFR 438.210, Coverage and authorization of services, and the Arkansas Prior Authorization Transparency Act, Ark. Code Ann. 23-99-1101 et seq.
- B. The notice must explain the following:
1. The adverse benefit determination the MCO has made or intends to make;
 2. The reasons for the adverse benefit determination, including the right of the member to be provided upon request free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

3. The member's right to request an appeal of the MCO's adverse benefit determination, including information on exhausting the MCO's one level of appeal and the right to request a State fair hearing from the DHS Office of Appeals and Hearings;
4. The procedures for exercising the rights specified in this section;
5. The circumstances under which an appeal process can be expedited and how to request it; and
6. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of these services.

C. Timeframe for decisions. The MCO must provide for the following decisions and notices:

1. Standard (nonurgent healthcare service) authorization decisions
 - a. For standard authorization decisions, provide notice as expeditiously as the member's condition requires and not more than two (2) business days of obtaining all necessary information to make the authorization or adverse benefit determination. Necessary information included the results of any face-to-face clinical evaluation or second opinion that may be required.
 - b. Standard authorization decisions may have an extension of up to 14 additional calendar days if the member or provider requests the extension and the MCO justifies the need for additional information and how the extension is in the enrollee's interest.
2. Expedited (urgent healthcare service) authorization decisions
 - a. For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than one (1) business day after receiving all information needed to completed the review of the requested service.
 - b. Expedited authorization decisions may have an extension of up to 14 additional calendar days if the member or provider requests the extension and the MCO justifies the need for additional information and how the extension is in the enrollee's interest.

192.004 Managed Care Organizations - Appeals

6-1-26

- A. Each Managed Care Organization (MCO), including PASSEs, must have an appeal system in place for members. Non-emergency medical transportation providers are exempt from this section.
- B. Each MCO may have only one level of appeal for members.

C. Filing requirements.

1. **Authority to file.** A member may request an appeal with the MCO. A member may request a State fair hearing with the DHS Office of Appeals and Hearings after receiving notice from the MCO that the adverse action is upheld.
 - a. **Deemed exhaustion of appeals processes.** In the case of an MCO that fails to adhere to the notice and timing requirements in section 192.003 the member is deemed to have exhausted the MCO's appeals process. The member may initiate a State fair hearing.
 - b. With the written consent of the member, a provider or an authorized representative may request an appeal, or request a State fair hearing, on

behalf of a member. This will be considered a member appeal, not a provider appeal under the Medicaid Fairness Act.

2. **Timing.** Following receipt of a notification of an adverse action by an MCO, a member has sixty (60) calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the MCO.
3. **Method.** The member may request an appeal to the MCO either orally or in writing by telephone, via mail, in person, or through other commonly available electronic means.

192.005 MCO Appeal Requirements

6-1-26

- A. Each MCO must provide members any reasonable assistance in completing forms and taking other procedural steps related to an appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY or TTD and interpreter capability.
- B. **Special requirements.** An MCO's process for handling member appeals of adverse benefit determinations must:
 1. Acknowledge receipt of each appeal;
 2. Ensure that the individuals who make decisions on appeals are individuals:
 - a. Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual;
 - b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease:
 - i. An appeal of a denial that is based on lack of medical necessity;
 - ii. A grievance regarding denial of expedited resolution of an appeal; or
 - iii. A grievance or appeal that involves clinical issues; and
 - c. Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination;
 3. Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals;
 4. Provide the member with a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in this manual, including timeframes in the case of expedited resolution;
 5. Provide the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, (or at the direction of the MCO), in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in this manual; and
 6. Include, as parties to the appeal:
 - a. The member and his or her representative; or
 - b. The legal representative of a deceased member's estate.

192.006 Resolution and Notification of Managed Care Organization Appeals

6-1-26

- A. Each MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this manual.
- B. Specific timeframes.**
1. **Standard resolution of grievances.** Grievances must be resolved with notice sent to affected parties within thirty (30) calendar days from the date the MCO receives the grievance.
 2. **Standard resolution of appeals.** Appeals must be resolved with notice sent to affected parties within thirty (30) calendar days from the date the MCO receives the appeal.
 3. **Expedited resolution of appeals.** For expedited resolution of an appeal and notice to affected parties, a timeframe that is no longer than seventy-two (72) hours after the MCO receives the appeal. This timeframe may be extended under subsection C of this section.
- C. Extension of timeframes.**
1. The MCO may extend the timeframes from subsection B of this section by up to fourteen (14) calendar days if:
 - a. The member requests the extension; or
 - b. The MCO shows to the satisfaction of DHS upon request that there is need for additional information and how the delay is in the member's interest.
 2. **Requirements following extension.** If the MCO extends the timeframes not at the request of the member, it must complete all of the following:
 - a. Make reasonable efforts to give the member prompt oral notice of the delay;
 - b. Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and
 - c. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.
 3. **Deemed exhaustion of appeals processes.** In the case of an MCO that fails to adhere to the notice and timing requirements in this section, the member is deemed to have exhausted the MCO's appeals process. The member may initiate a State fair hearing with the DHS Office of Appeals and Hearings.
- D. Format of notice.**
1. For all appeals, the MCO must provide written notice of resolution in a format and language that, at a minimum, meet the standards described in 42 C.F.R. § 438.10.
 2. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.
- E. Content of notice of appeal resolution.** The written notice of the resolution must include the following:
1. The results of the resolution process and the date it was completed; and
 2. For appeals not resolved wholly in favor of the members:
 - a. The right to request a State fair hearing, and how to do so;
 - b. The right to request and receive benefits while the hearing is pending, and how to make the request; and
 - c. That the member may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's adverse action.

192.007 Expedited Resolution of Appeals**6-1-26**

- A. MCOs must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
- B. **Punitive action.** The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.
- C. **Action following denial of a request for expedited resolution.** If the MCO denies a request for expedited resolution of an appeal, it must:
1. Transfer the appeal to the timeframe for standard resolution in accordance with this manual; and
 2. Follow the requirements in section 192.006 above.

192.008 State Fair Hearings**6-1-26**

- A. Requirements for State fair hearings
- Availability.** A member may request a State fair hearing only after receiving notice that the MCO is upholding the adverse benefit determination.
 - a. Deemed exhaustion of appeals processes. In the case of an MCO that fails to adhere to the notice and timing requirements in section 192.003, the member is deemed to have exhausted the MCO's appeals process. The member may initiate a State fair hearing with the DHS Office of Appeals and Hearings.
 - State fair hearing.** The member must have no less than ninety (90) calendar days from the date of the MCO's notice of resolution to request a State fair hearing.
 - Parties.** The parties to the State fair hearing include the MCO, as well as the member and his or her representative or the representative of a deceased member's estate. DHS, by its own motion, may intervene and join as a party to the State fair hearing as determined by DHS to be necessary.
- B. Requests for a State fair hearing shall be sent to the **DHS Office of Appeals and Hearings.**

192.009 Judicial Review**6-1-26**

- A. Adjudication of a State fair hearing will be the final agency action.
- B. In cases of adjudication, any person who considers himself or herself injured in his or her person, business, or property by final agency action shall be entitled to judicial review of the action in accordance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq.
- C. The parties to a judicial review action under the Arkansas Administrative Procedure Act will be those parties that participated in the State fair hearing. If DHS did not intervene and participate at the State fair hearing as a responsive party, then DHS will not be a responsive party during the judicial review proceedings. As a non-responsive party, the only initial obligation of DHS in a judicial review proceeding will be the filing of the administrative record.
- D. **Filing the administrative record.**

1. Within thirty (30) days after service of the petition or within such further time as the court may allow but not exceeding an aggregate of ninety (90) days, the agency shall transmit to the reviewing court the original or a certified copy of the entire record of the proceeding under review.
2. The cost of the preparation of the record shall be borne by the agency.

192.010 Continuation of Benefits While the MCO Appeal and the State Fair Hearing Are Pending

6-1-26

- A. **Definition.** As used in this section, "timely files" means files for continuation of benefits on or before the later of the following:
1. Within ten (10) calendar days of the MCO sending the notice of adverse benefit determination; or
 2. The intended effective date of the MCO's proposed adverse benefit determination.
- B. **Continuation of benefits.** The MCO must continue the member's benefits if all of the following occur:
1. The member files the request for an appeal timely in accordance with section 192.004(c)(2);
 2. The appeal involves the termination, suspension, or reduction of previously authorized services;
 3. The services were ordered by an authorized provider;
 4. The period covered by the original authorization has not expired; and
 5. The member timely files for continuation of benefits.
- C. Providers cannot request continuation of benefits as specified in section 42 CFR § 438.420(b).
- D. **Duration of continued or reinstated benefits.** If, at the member's request, the MCO continues or reinstates the member's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one (1) of following occurs:
1. The member withdraws the appeal or request for state fair hearing;
 2. The member fails to timely request a state fair hearing after the MCO sends the notice of an adverse resolution to the member's appeal under section 192.008(A)(2) above; or
 3. A State fair hearing officer issues a hearing decision adverse to the member.
- E. Member responsibility for services furnished while the appeal or state fair hearing is pending. If the final resolution of the appeal or state fair hearing is adverse to the member, that is, upholds the MCO's adverse action, the MCO may, consistent with the state's usual policy on recoveries and as specified in the MCO's contract, recover the cost of services furnished to the member while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

TOC required

100.100 Introduction 6-1-26

Section I gives general program information about the Arkansas Medicaid Program. It includes information about beneficiary eligibility and explains the provider's role and responsibilities. The intent is to provide users with an understanding of Medicaid Program objectives and regulations. It contains details providers may need to answer questions often asked about the Medicaid Program. Seven (7) major areas are covered in Section I.

- A. General information - Describes the background, history, and scope of the Medicaid Program, including information about Medicaid waivers and other programs administered by Department of Human Services (DHS).
- B. Beneficiary eligibility - Explains Medicaid beneficiary aid categories, eligibility for benefits, responsibilities, the Medicaid identification card, and additional beneficiary information.
- C. Provider participation - Specifies the provider enrollment procedures, general conditions that must be met by providers to begin and maintain program participation, and remedies and sanctions DHS may employ in the administration and regulation of the Arkansas Medicaid Program.
- D. Administrative remedies and sanctions - Describes the rules for imposing sanctions.
- E. Provider due process - Explains how a provider may request an administrative reconsideration or appeal of an adverse decision or sanctions.
- F. Beneficiary due process - Describes how a beneficiary may request an administrative appeal of an adverse decision.
- G. Managed Care due process – Describes how a managed care organization must develop a grievance and appeals process and how a member of a managed care organization can utilize the grievance and appeals process and request a state fair hearing.
- H. Primary Care Case Management Program (PCCM) - Defines the scope of the Primary Care Case Management Program (PCCM) and regulations regarding provider and enrollee participation. It lists the categories of eligibility that are exempt from primary care provider (PCP) referral requirements and itemizes the services that do not require PCP referral. PCP enrollment and enrollment transfer procedures are explained, as are PCP referral requirements and procedures.

106.000 Limitations on Coverage for Certain Organ Transplants 6-1-26

The Arkansas Medicaid Program will comply with Ark. Code Ann. § 23-79-169 in providing coverage for human organ transplants.

110.700 Medicaid Fraud Detection and Investigation Program 6-1-26

Federal Regulations require the implementation of a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate utilization of care and services and excess reimbursements by the Medicaid program. The purpose of the Office of the Medicaid Inspector General (OMIG) is to investigate fraud allegations and ensure Arkansas Medicaid's compliance. **[Title XIX of the Social Security Act, Arkansas Code Annotated, 42 C.F.R. §455 and the Arkansas State Plan].**

The goal of the unit is to verify the nature and extent of services reimbursed by the Medicaid program, ensure reimbursements are consistent with the quality of care being provided, and protect the integrity of both state and federal funds.

Responsibilities of the unit include the following:

- A. Verify medical services meet an accepted standard of care and are rendered as billed;
- B. Verify services are provided by qualified providers to eligible beneficiaries;
- C. Verify reimbursement for services is correct and all funds identified for collection prior to Medicaid reimbursement are pursued.

OMIG is responsible for conducting on-site medical reviews to verify the above tasks, record keeping, and other specified information. Providers selected for an on-site review will not be notified in advance. Review analysts may request additional information regarding the provider's medical practice. [View or print Office of Medicaid Inspector General contact information.](#)

When warranted, OMIG is responsible for identifying and recovering questioned costs claimed for reimbursement from Medicaid funds. Situations resulting in recoupment include such things as the following:

- A. When duplicate payments are made;
- B. When the Quality Improvement Organization (QIO) denies all or part of a hospital admission;
- C. When medical consultants to the Medicaid Program determine lack of medical necessity;
- D. When Medicaid, Medicare, or the Attorney General's Medicaid Fraud Unit discovers evidence of overpayment;
- E. When a provider has been assessed a monetary penalty for failure to follow a corrective action plan developed to correct a pattern of non-compliance (See Sections 151.000 and 190.005)

When a review is completed, OMIG will forward a findings report to the provider. If questioned costs are identified through the review, a "Notice of Action" will be sent to the provider. The notice must comply with required explanations of adverse decisions and must include the name(s) of the patient(s), date(s) of service, date(s) of payment, and the reason(s) for the recoupment decision.

Upon receipt of the notice, the provider has sixty-five (65) calendar days to pursue one of the following actions:

- A. Forward a check for the indicated recoupment amount;
- B. Request administrative reconsideration;
- C. Appeal,

Rules, timelines, and procedures related to administrative reconsideration and appeals are further explained in ensuing sections of this manual.

161.200 Administrative Reconsideration

6-1-26

- A. Within sixty-five (65) calendar days after notice of an adverse decision or action, the provider may request administrative reconsideration. Requests must be in writing and include:
 - 1. A copy of the letter or notice of adverse decision or action; and

2. Additional documentation that supports medical necessity.

Administrative reconsideration does not postpone any adverse action that may be imposed pending appeal.

- B. Requests for reconsideration must be submitted as follows:
1. In situations where the adverse decision or action has been taken by a reviewing agent, the request must be directed to that reviewing agent. Contact information for the department's reviewing agents can be found in Section V of this manual.
 2. When an adverse decision or action has been taken by the Office of Medicaid Inspector General (OMIG) on behalf of Division of Medical Services (DMS), the request for reconsideration must be directed to OMIG. [View or print the Office of Medicaid Inspector General contact information.](#) Within twenty (20) calendar days of receiving a timely and complete request for administrative reconsideration, OMIG will designate a reviewer and proceed according to its own procedures. When an adverse decision or action has been taken by the Utilization Review (UR) Section of DMS, the request for reconsideration must be directed to UR. [View or print the Utilization Review contact information.](#)

The sixty-five-day time period to request a reconsideration begins to run five (5) days after the date of the written notice.

No administrative reconsideration is allowed if the adverse decision or action is due to loss of licensure, accreditation, or certification.

161.300 Administrative Appeals of Adverse Actions that are not Sanctions 6-1-26

In addition to sanction reconsiderations and appeal procedures set forth in Sections 160.000-169.000, providers may appeal any other decision of the Department of Human Services, its reviewers, or contractors if that decision adversely affects a Medicaid provider or beneficiary with regard to receipt or payment of Medicaid-covered services. Such decisions and consequent actions are "non-sanction adverse actions."

Within sixty-five (65) calendar days of receiving notice of non-sanction adverse action, or sixty-five (65) calendar days of receiving an administrative reconsideration decision that upholds all or part of any adverse decision or action, whichever is later, the provider may appeal. The time period for filing an appeal shall begin to run five (5) days after the date of the written notice of non-sanction adverse action or administrative reconsideration decision. An appeal must be in writing and must specify in detail all findings, determinations, and adverse decisions or actions that the provider alleges are not supported by applicable laws, including state and federal laws and rules, applicable professional standards, or both. Providers shall mail or deliver the appeal to the [Arkansas Department of Health, Office of Medicaid Provider Appeals.](#)

161.400 Sanction Appeals 6-1-26

Within sixty-five (65) calendar days of receiving notice of adverse decision or action, or sixty-five (65) calendar days of receiving an administrative reconsideration decision that upholds all or part of any adverse decision/action, whichever is later, the provider may appeal. The sixty-five (65) days begins to run five (5) days after the date of the written notice.

An appeal must be in writing and must specify in detail all findings, determinations, and adverse decisions or actions that the provider alleges are not supported by applicable laws, including state and federal laws and rules, applicable professional standards, or both. Providers shall mail or deliver the appeal to the [Arkansas Department of Health, Office of Medicaid Provider Appeals.](#) No appeal is allowed if the adverse decision or action is due to loss of licensure, accreditation, or certification.

162.000 Notice of the Appeal Hearing 6-1-26

When an appeal hearing is scheduled, the Office of Medicaid Provider Appeals of the Department of Health shall notify the provider, or if the provider is represented by an attorney, the provider's attorney, in writing, of the date, time, and place of the hearing. Notice shall be mailed not less than ten (10) calendar days before the scheduled date of the hearing. The decision of the Office of Medicaid Provider Appeals is the final agency determination.

169.100 Recovery of the Costs of Services Continued During the Appeal Process 6-1-26

42 CFR §431.230 entitled "Maintaining Services," which states in part:

(b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or beneficiary to recoup the cost of any services furnished the beneficiary, to the extent they were furnished solely by reason of this section.

190.001 The Medicaid Fairness Act 6-1-26

The Medicaid Fairness Act, Ark. Code Ann. § 20-77-1701 et seq., requires that the Department of Human Services and its outside contractors treat providers with fairness and due process.

190.002 Definitions 6-1-26

- A. Adverse decision or adverse action: any decision or action by the Department of Human Services or its reviewers or contractors that adversely affects a Medicaid provider or beneficiary in regard to:
1. Receipt of and payment for Medicaid claims and services including but not limited to decisions as to:
 - a. Appropriate level of care or coding;
 - b. Medical necessity;
 - c. Prior authorization;
 - d. Concurrent reviews;
 - e. Retrospective reviews;
 - f. Least restrictive setting;
 - g. Desk audits;
 - h. Field audits and onsite audits; and
 - i. Inspections or surveys;
 - j. Payment amounts due to or from a particular provider resulting from gain sharing, risk sharing, incentive payments, or another reimbursement mechanism or methodology, including calculations that affect or have the potential to affect payment; and
 - k. Imposition of corrective action plans.
 2. To constitute an adverse decision, an agency decision need not have a monetary penalty attached or a direct monetary consequence to the provider.
 3. "Adverse decision" does not include the design of or changes to an element of a reimbursement methodology or payment system that is of general applicability and implemented through the rulemaking process.
- B. Appeal: an appeal under the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq.

- C. Claim: a request for payment of services.
- D. Concurrent review or concurrent authorization: a review to determine whether a specified beneficiary currently receiving specific services may continue to receive services.
- E. Denial: denial or partial denial of a claim or authorization of services.
- F. Department:
1. The Department of Human Services;
 2. All of the divisions and programs of the Department of Human Services, including the Arkansas Medicaid Program; and
 3. All of the Department of Human Services' contractors, fiscal agents, and other designees and agents.
- G. Medicaid: the medical assistance program under Title XIX of the Social Security Act that is operated by the Department of Human Services and its contractors, fiscal agents, and all other designees and agents.
- H. Person: any individual, company, firm, organization, association, corporation, or other legal entity.
- I. Primary care physician: a physician whom the department has designated as responsible for the referral or management, or both, of a Medicaid beneficiary's health care.
- J. Prior authorization: the approval by the Arkansas Medicaid Program for specified services for a specified Medicaid beneficiary before the requested services may be performed and before payment will be made by the Arkansas Medicaid Program.
- K. Provider: a person enrolled to provide health or medical care services or goods authorized under the Arkansas Medicaid Program.
- L. Recoupment: any action or attempt by the Department of Human Services to recover or collect Medicaid payments already made to a provider with respect to a claim by:
1. Reducing, withholding or affecting in any other manner current or future payments to a provider; or
 2. Demanding payment back from a provider for a claim already paid.
- M. Retrospective review: the review of services or practice patterns after payment, including, but not limited to:
1. Utilization reviews;
 2. Medical necessity reviews;
 3. Professional reviews;
 4. Field audits and onsite audits; and
 5. Desk audits.
- N. Reviewer: any person, including reviewers, auditors, inspectors, surveyors and others who, in reviewing a provider or a provider's provision of services and goods, perform review actions, including, but not limited to:
1. Reviews for quality;
 2. Reviews for quantity;
 3. Utilization;
 4. Practice patterns;

5. Medical necessity;
 6. Peer review; and
 7. Compliance with Medicaid standards.
- O. Technical deficiency: an error or omission in documentation by a provider that does not affect direct patient care of the beneficiary. Technical deficiency does not include:
1. Lack of medical necessity or failure to document medical necessity in a manner that meets professionally recognized applicable standards of care;
 2. Failure to provide care of a quality that meets professionally recognized local standards of care;
 3. Failure to obtain prior, concurrent, or mandatory authorization if required by regulation;
 4. Fraud;
 5. A pattern of abusive billing;
 6. A pattern of noncompliance; or
 7. A gross and flagrant violation.

190.003 Administrative Appeals

6-1-26

- A. The following appeals are available in response to an adverse decision:
1. A beneficiary may appeal on his or her own behalf;
 2. A provider of medical assistance that is the subject of the adverse action may appeal on the beneficiary's behalf; and
 3. If the adverse action denies a claim for covered medical assistance that was previously provided to a Medicaid-eligible beneficiary, the provider of such medical assistance may appeal on the provider's behalf. The provider does not have standing to appeal a non-payment decision if the provider has not furnished any service for which payment has been denied.
- B. All appeals shall conform to the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq.
- C. Providers may appear in person, through a corporate representative or, with prior notice to the Department of Human Services, through legal counsel.
- D. Beneficiaries may represent themselves or they may be represented by a friend, by any other spokesperson except a corporation, or by legal counsel.
- E. A Medicaid beneficiary may attend any hearing related to his or her care, but the department may not make his or her participation a requirement for provider appeals. The department may compel the beneficiary's presence via subpoena, but failure of the beneficiary to appear shall not preclude the provider's appeal.
- F. If an administrative appeal is filed by both a provider and beneficiary concerning the same subject matter, the department may consolidate the appeals.
- G. Any person who considers himself or herself injured in his or her person, business, or property by the decision rendered in the administrative appeal is entitled to judicial review of the decision under the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq.
- H. This rule shall apply to all pending and subsequent appeals that have not been finally resolved at the administrative or judicial level as of April 5, 2005.

191.001 Definitions

6-1-26

- A. Adverse decision or adverse action means any decision or action by the Department of Human Services or its reviewers or contractors that adversely affects a Medicaid provider or beneficiary in regard to receipt of and payment for Medicaid claims and services by limiting, terminating, suspending, or reducing Medicaid eligibility or covered services in connection with, but not limited to:
1. A termination, suspension of, or reduction in covered benefits or services, including benefits or services for which there is a current approved prior authorization;
 2. A termination, suspension of, or reduction in Medicaid eligibility, or an increase in beneficiary liability, including a determination that a beneficiary must incur a greater amount of medical expenses to establish income eligibility in accordance with 42 CFR § 435.121(e)(4) or 42 CFR § 435.831;
 3. A determination that a beneficiary is subject to an increase in premiums or cost-sharing charges under 42 CFR part 447, subpart A; or
 4. A determination by a skilled nursing facility or nursing facility to transfer or discharge a resident and an adverse determination by a State regarding the preadmission screening and resident review requirements of section 1919(e)(7) of the Social Security Act.
- B. Beneficiary:
1. A person who has applied for medical assistance under the Arkansas Medicaid Program; or
 2. A person who is a beneficiary of medical assistance under the Arkansas Medicaid Program.
- C. Department: The Department of Human Services.

191.002 Notice

6-1-26

- A. If an application or claim for medical assistance is denied in whole or in part or is not acted upon with reasonable promptness, the Department of Human Services shall provide written notice:
1. Of the beneficiary's right and opportunity for a fair hearing under the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq.;
 2. Of the method by which the beneficiary may obtain a fair hearing; and
 3. Of the beneficiary's right to:
 - a. Represent himself or herself; or
 - b. Be represented by legal counsel, a friend, or any other spokesperson except a corporation.
- B. A notice required under this rule shall include but not be limited to:
1. A statement detailing the type and amount of medical assistance that the beneficiary has requested;
 2. A statement of the adverse action that the department has taken or proposes to take;
 3. The reasons for the adverse action, which shall include but not be limited to:
 - a. The specific facts regarding the individual beneficiary that support the action; and
 - b. The sources from which the facts were derived;

4. An explanation of the beneficiary's right to request a fair hearing, if available, or in cases of an adverse action based on a change in law:
 - a. The circumstances under which a fair hearing will be granted; and
 - b. An explanation of the circumstances under which medical assistance is provided or continued if a fair hearing is requested.

191.003 Determination of Medical Necessity – Content of Notice

6-1-26

If the adverse action that the Department of Human Services has taken or proposes to take is based on a determination of medical necessity or other clinical decision, the notice required under Rule 191.002 shall include all of the following:

- A. Specification of the medical records upon which the physician or clinician relied in making the determination;
- B. Specification of any portion of the criteria for medical necessity or coverage that is not met by the beneficiary;
- C. The specific regulation(s) that support the adverse action, or the change in federal or state law that has occurred since the application was filed that requires adverse action; and
- D. A brief statement of the reasons for the adverse action based upon the individual beneficiary's circumstances.

The department and others acting on behalf of the department may not cite or rely on policies that are inconsistent with federal or state laws and regulations or that were not properly promulgated. Generic rationales or explanations shall not suffice to meet the requirements of this rule.

191.004 Administrative Appeals

6-1-26

When notice of an adverse decision is received from the Division of Medical Services, the beneficiary may appeal. The appeal request must be in writing and submitted to the Department of Human Services, Office of Appeals and Hearings. [View or print the Department of Human Services, Office of Appeals and Hearings contact information.](#) The appeal request must be received by the Office of Appeals and Hearings no later than thirty (30) days from the date of written notice. The thirty (30) days begins to run five (5) days after the date of written notice.

All appeals shall conform to the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq. Beneficiaries may represent themselves or they may be represented by a friend, by any other spokesperson except a corporation, or by legal counsel.

If an administrative appeal is filed by both a provider and beneficiary concerning the same subject matter, the department may consolidate the appeals.

Any person who considers himself or herself injured in his or her person, business, or property by the decision rendered in the administrative appeal is entitled to judicial review of the decision under the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq.

191.005 Conducting the Hearing

6-1-26

If a beneficiary appeals an adverse action under the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq., the reviewing authority shall consider only those adverse actions that were included in the written notice to the beneficiary as required under Rules 191.002 and 191.003.

All determinations of the medical necessity of any request for medical assistance shall be based on the individual needs of the beneficiary and on his or her medical history.

192.000 MANAGED CARE DUE PROCESS

192.001 Scope

6-1-26

This section applies to beneficiary appeals to managed care organizations (MCO). A “managed care organization” includes, but is not limited to, a Provider-Led Arkansas Shared Savings Entity (PASSE) or other Risk Based Provider Organization. Provider appeals to MCOs are governed by all applicable state and federal laws and agreements or contracts between the provider and the MCO.

This section does not apply to non-emergency medical transportation Prepaid Ambulatory Health Plans (PAHPs) in accordance with 42 CFR § 438.9. This section also does not apply to Qualified Health Plans in the AR HOME program.

192.002 Definitions

6-1-26

- A. Adverse benefit determination means any of the following:
1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
 2. The reduction, suspension, or termination of a previously authorized service;
 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” at 42 CFR § 447.45(b) is not an adverse benefit determination;
 4. The failure to provide services in a timely manner;
 5. The failure to act within the prescribed timeframes regarding the standard resolution of grievances and appeals;
 6. For a resident of a rural area with only one (1) managed care organization, the denial of a member’s request to exercise his or her right to obtain services outside the network; and
 7. The denial of a member’s request to dispute a financial liability, including cost sharing, copayments, coinsurance, and other member financial liabilities.
- B. Appeal means a review of an adverse benefit determination by an MCO.
- C. Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationship such as rudeness of a provider or employee, or failure to respect the member’s rights regardless of whether remedial action is requested. Grievance includes a member’s right to dispute an extension of time proposed by the MCO, PIHP, or PAHP to make an authorization decision.
- D. Grievance and appeal system means the processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.
- E. Managed Care Organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is:
1. A federally qualified HMO that meets the advance directives requirements of 42 CFR part 489, subpart I; or
 2. Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:
 - a. Makes the services it provides to its members as accessible (in terms of

timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity; and

- b. Meets the solvency standards of 42 CFR § 438.116.
- F. Managed Care Program means a managed care delivery system authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act.
- G. Member means a Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program;
- H. Prepaid ambulatory health plan (PAHP) means an entity that:
1. Provides services to members under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates;
 2. Does not provide or arrange for, and is not otherwise responsible for the provision of inpatient hospital or institutional services for its members; and
 3. Does not have a comprehensive risk contract.
- I. Prepaid inpatient health plan (PIHP) means an entity that:
1. Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates;
 2. Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
 3. Does not have a comprehensive risk contract.
- J. Provider-Led Arkansas Shared Savings Entity (PASSE) means a Risk Based Provider Organization (RBPO) in Arkansas that has enrolled in Medicaid and meets the following requirements:
1. Is fifty-one percent (51%) owned by PASSE Equity Partners; and
 2. Has the following Members or Owners:
 - a. An Arkansas licensed or certified direct service provider of Developmental Disabilities (DD) services;
 - b. An Arkansas licensed or certified direct service provider of Behavioral Health (BH) services;
 - c. An Arkansas licensed hospital or hospital services organizations;
 - d. An Arkansas licensed physician's practice; and
 - e. A Pharmacist who is licensed by the Arkansas State Board of Pharmacy.

Among other things, each PASSE must be licensed with the Arkansas Insurance Department, enrolled as a Medicaid provider, and enter into an annual PASSE agreement with DHS.

- K. Risk Based Provider Organization means an entity that:
1. Is licensed by the Insurance Commissioner under the rules established for risk-based provider organizations by the commissioner;
 2. Is obligated to assume the financial risk for the delivery of specifically defined healthcare services to an enrollable Medicaid beneficiary population; and
 3. Is paid by DHS on a capitated basis with a global payment made, whether or not a particular member of an enrollable Medicaid beneficiary population receives services during the period covered by the payment.

- L. State Fair Hearing means an administrative review provided by the State that meets the requirements of 42 CFR part 431, subpart E, and will result in a final agency action in accordance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq.

192.003 **Timing and Content in Notice of Adverse Benefit Determination by Managed Care Organizations** **6-1-26**

- A. **Notice.** The MCO must comply with all applicable provisions of 42 CFR 438.210, Coverage and authorization of services, and the Arkansas Prior Authorization Transparency Act, Ark. Code Ann. 23-99-1101 et seq.
- B. The notice must explain the following:
1. The adverse benefit determination the MCO has made or intends to make;
 2. The reasons for the adverse benefit determination, including the right of the member to be provided upon request free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;
 3. The member's right to request an appeal of the MCO's adverse benefit determination, including information on exhausting the MCO's one level of appeal and the right to request a State fair hearing from the DHS Office of Appeals and Hearings;
 4. The procedures for exercising the rights specified in this section;
 5. The circumstances under which an appeal process can be expedited and how to request it; and
 6. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of these services.
- C. **Timeframe for decisions.** The MCO must provide for the following decisions and notices:
1. Standard (nonurgent healthcare service) authorization decisions
 - a. For standard authorization decisions, provide notice as expeditiously as the member's condition requires and not more than two (2) business days of obtaining all necessary information to make the authorization or adverse benefit determination. Necessary information included the results of any face-to-face clinical evaluation or second opinion that may be required.
 - b. Standard authorization decisions may have an extension of up to 14 additional calendar days if the member or provider requests the extension and the MCO justifies the need for additional information and how the extension is in the enrollee's interest.
 2. Expedited (urgent healthcare service) authorization decisions
 - a. For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than one (1) business day after receiving all information needed to completed the review of the requested service.
 - b. Expedited authorization decisions may have an extension of up to 14 additional calendar days if the member or provider requests the extension and the MCO justifies the need for additional information and how the extension is in the

enrollee's interest.

192.004 Managed Care Organizations - Appeals

6-1-26

- A. Each Managed Care Organization (MCO), including PASSEs, must have an appeal system in place for members. Non-emergency medical transportation providers are exempt from this section.
- B. Each MCO may have only one level of appeal for members.
- C. **Filing requirements.**
 - 1. **Authority to file.** A member may request an appeal with the MCO. A member may request a State fair hearing with the DHS Office of Appeals and Hearings after receiving notice from the MCO that the adverse action is upheld.
 - a. **Deemed exhaustion of appeals processes.** In the case of an MCO that fails to adhere to the notice and timing requirements in section 192.003 the member is deemed to have exhausted the MCO's appeals process. The member may initiate a State fair hearing.
 - b. With the written consent of the member, a provider or an authorized representative may request an appeal, or request a State fair hearing, on behalf of a member. This will be considered a member appeal, not a provider appeal under the Medicaid Fairness Act.
 - 2. **Timing.** Following receipt of a notification of an adverse action by an MCO, a member has sixty (60) calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the MCO.
 - 3. **Method.** The member may request an appeal to the MCO either orally or in writing by telephone, via mail, in person, or through other commonly available electronic means.

192.005 MCO Appeal Requirements

6-1-26

- A. Each MCO must provide members any reasonable assistance in completing forms and taking other procedural steps related to an appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY or TTD and interpreter capability.
- B. **Special requirements.** An MCO's process for handling member appeals of adverse benefit determinations must:
 - 1. Acknowledge receipt of each appeal;
 - 2. Ensure that the individuals who make decisions on appeals are individuals:
 - a. Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual;
 - b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease:
 - i. An appeal of a denial that is based on lack of medical necessity;
 - ii. A grievance regarding denial of expedited resolution of an appeal; or
 - iii. A grievance or appeal that involves clinical issues; and
 - c. Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination;

3. Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals;
4. Provide the member with a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in this manual, including timeframes in the case of expedited resolution;
5. Provide the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, (or at the direction of the MCO), in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in this manual; and
6. Include, as parties to the appeal:
 - a. The member and his or her representative; or
 - b. The legal representative of a deceased member's estate.

192.006 Resolution and Notification of Managed Care Organization Appeals 6-1-26

- A. Each MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this manual.
- B. **Specific timeframes.**
 1. **Standard resolution of grievances.** Grievances must be resolved with notice sent to affected parties within thirty (30) calendar days from the date the MCO receives the grievance.
 2. **Standard resolution of appeals.** Appeals must be resolved with notice sent to affected parties within thirty (30) calendar days from the date the MCO receives the appeal.
 3. **Expedited resolution of appeals.** For expedited resolution of an appeal and notice to affected parties, a timeframe that is no longer than seventy-two (72) hours after the MCO receives the appeal. This timeframe may be extended under subsection C of this section.
- C. **Extension of timeframes.**
 1. The MCO may extend the timeframes from subsection B of this section by up to fourteen (14) calendar days if:
 - a. The member requests the extension; or
 - b. The MCO shows to the satisfaction of DHS upon request that there is need for additional information and how the delay is in the member's interest.
 2. **Requirements following extension.** If the MCO extends the timeframes not at the request of the member, it must complete all of the following:
 - a. Make reasonable efforts to give the member prompt oral notice of the delay;
 - b. Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and
 - c. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.
 3. **Deemed exhaustion of appeals processes.** In the case of an MCO that fails to adhere to the notice and timing requirements in this section, the member is deemed

to have exhausted the MCO's appeals process. The member may initiate a State fair hearing with the DHS Office of Appeals and Hearings.

D. Format of notice.

1. For all appeals, the MCO must provide written notice of resolution in a format and language that, at a minimum, meet the standards described in 42 C.F.R. § 438.10.
2. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.

E. Content of notice of appeal resolution. The written notice of the resolution must include the following:

1. The results of the resolution process and the date it was completed; and
2. For appeals not resolved wholly in favor of the members:
 - a. The right to request a State fair hearing, and how to do so;
 - b. The right to request and receive benefits while the hearing is pending, and how to make the request; and
 - c. That the member may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's adverse action.

192.007 Expedited Resolution of Appeals

6-1-26

- A. MCOs must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
- B. **Punitive action.** The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.
- C. **Action following denial of a request for expedited resolution.** If the MCO denies a request for expedited resolution of an appeal, it must:
 1. Transfer the appeal to the timeframe for standard resolution in accordance with this manual; and
 2. Follow the requirements in section 192.006 above.

192.008 State Fair Hearings

6-1-26

- A. Requirements for State fair hearings
 1. **Availability.** A member may request a State fair hearing only after receiving notice that the MCO is upholding the adverse benefit determination.
 - a. Deemed exhaustion of appeals processes. In the case of an MCO that fails to adhere to the notice and timing requirements in section 192.003, the member is deemed to have exhausted the MCO's appeals process. The member may initiate a State fair hearing with the DHS Office of Appeals and Hearings.
 2. **State fair hearing.** The member must have no less than ninety (90) calendar days from the date of the MCO's notice of resolution to request a State fair hearing.
 3. **Parties.** The parties to the State fair hearing include the MCO, as well as the member and his or her representative or the representative of a deceased member's estate. DHS, by its own motion, may intervene and join as a party to the State fair hearing as determined by DHS to be necessary.

- B. Requests for a State fair hearing shall be sent to the [DHS Office of Appeals and Hearings](#).

192.009 Judicial Review

6-1-26

- A. Adjudication of a State fair hearing will be the final agency action.
- B. In cases of adjudication, any person who considers himself or herself injured in his or her person, business, or property by final agency action shall be entitled to judicial review of the action in accordance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq.
- C. The parties to a judicial review action under the Arkansas Administrative Procedure Act will be those parties that participated in the State fair hearing. If DHS did not intervene and participate at the State fair hearing as a responsive party, then DHS will not be a responsive party during the judicial review proceedings. As a non-responsive party, the only initial obligation of DHS in a judicial review proceeding will be the filing of the administrative record.
- D. **Filing the administrative record.**
1. Within thirty (30) days after service of the petition or within such further time as the court may allow but not exceeding an aggregate of ninety (90) days, the agency shall transmit to the reviewing court the original or a certified copy of the entire record of the proceeding under review.
 2. The cost of the preparation of the record shall be borne by the agency.

192.010 Continuation of Benefits While the MCO Appeal and the State Fair Hearing Are Pending

6-1-26

- A. **Definition.** As used in this section, “timely files” means files for continuation of benefits on or before the later of the following:
1. Within ten (10) calendar days of the MCO sending the notice of adverse benefit determination; or
 2. The intended effective date of the MCO's proposed adverse benefit determination.
- B. **Continuation of benefits.** The MCO must continue the member's benefits if all of the following occur:
1. The member files the request for an appeal timely in accordance with section 192.004(c)(2);
 2. The appeal involves the termination, suspension, or reduction of previously authorized services;
 3. The services were ordered by an authorized provider;
 4. The period covered by the original authorization has not expired; and
 5. The member timely files for continuation of benefits.
- C. Providers cannot request continuation of benefits as specified in section 42 CFR § 438.420(b).
- D. **Duration of continued or reinstated benefits.** If, at the member's request, the MCO continues or reinstates the member's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one (1) of following occurs:
1. The member withdraws the appeal or request for state fair hearing;

2. The member fails to timely request a state fair hearing after the MCO sends the notice of an adverse resolution to the member's appeal under section 192.008(A)(2) above; or
 3. A State fair hearing officer issues a hearing decision adverse to the member.
- E. Member responsibility for services furnished while the appeal or state fair hearing is pending. If the final resolution of the appeal or state fair hearing is adverse to the member, that is, upholds the MCO's adverse action, the MCO may, consistent with the state's usual policy on recoveries and as specified in the MCO's contract, recover the cost of services furnished to the member while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

PROPOSED

TOC required**200.000 DEFINITIONS****Adjusted Premium Revenue**

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

Administrative Cost Ratio

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

Adverse Decision/Adverse ActionBenefit Determination

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

- A. Appropriate level of care or coding,
- B. Medical necessity,
- C. Prior authorization,
- D. Concurrent reviews,
- E. Retrospective reviews,
- F. Least restrictive setting,
- G. Desk audits,
- H. Field audits and onsite audits
- I. Inspections, and
- J. Payment amounts due to or from a particular provider resulting from gain sharing, risk sharing, incentive payments or another reimbursement mechanism or methodology.

Arkansas Department of Human Services (DHS)

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

Arkansas Insurance Department (AID)

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

Assignment

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

Benefit Expenditure Report (BER)

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

Care Coordination

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

Case Management

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

Centers for Medicare & Medicaid Services (CMS)

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

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

Claims Payment

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

Claims Payment Process

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

Direct Service Provider

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

Disenrollment

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

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

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

Flexible Supports

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

Fraud Prevention Activities

Fraud Prevention Activities are as defined in 42 CFR § 438.8

Incurred Claims

Incurred claims are as defined in 42 CFR § 438.8

Independent Assessment

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

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

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

Medical/Quality Management Committee

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

Medical Loss Ratio

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

Member

A Medicaid beneficiary who is enrolled in a PASSE.

Network Provider

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

Open Enrollment Period

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

Out-of-Network Provider

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

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

PASSE Equity Partners

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

Person-Centered Service Plan (PCSP)

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

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

Performing Provider

Individual who is the rendering provider of a particular service.

Premium Revenue

Premium revenue is as defined in 42 CFR §438.8.

Provider-Led Arkansas Shared Savings Entity (PASSE)

A Risk Based Provider Organization (RBPO) in Arkansas that has enrolled in Medicaid and meets the following requirements:

- A. Is 51% owned by PASSE Equity Partners; and
- B. Has the following Members or Owners:
 - 1. An Arkansas licensed or certified direct service provider of Developmental Disabilities (DD) services;
 - 2. An Arkansas licensed or certified direct service provider of Behavioral Health (BH) services;
 - 3. An Arkansas licensed hospital or hospital services organizations;
 - 4. An Arkansas licensed physician's practice; and
 - 5. A Pharmacist who is licensed by the Arkansas State Board of Pharmacy.

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

Provider Network

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

Quality Improvement

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

- A. Improve health quality;

- B. Meet specified quality performance measures;
- C. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and or producing verifiable results and achievements;
- D. Be directed toward individual members incurred for the benefit of specified segments of members or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-members; and
- E. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

Risk-Based Comprehensive Global Payment

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

Risk-based Provider Organization (RBPO)

An entity that

- A. Is licensed by the Insurance Commissioner under [Act 775 of 2017 and the risk-based provider organization rules, the rules established for risk-based provider organizations by the Arkansas Insurance Commissioner](#);
- B. Is obligated to assume the financial risk for the delivery of specifically defined healthcare services to an enrollable Medicaid beneficiary population; and
- C. Is paid by DHS on a capitated basis with a global payment made, whether or not a particular member of an enrollable Medicaid beneficiary population receives service during the period covered by the payment.

Service Encounter

A standardized record of a health care-related service, procedure, treatment, or therapy rendered by a licensed provider or providers to a PASSE member. There are two types of service encounters, paid claim encounter and non-paid encounters that were performed but are not reimbursable.

Telemedicine

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

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

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

- C. Text messaging; or
- D. Electronic mail systems.

The Act

Title XIX of the Social Security Act.

Transition

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

Value-based Payments

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

Virtual and Home Visit Provider Services

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

247.200 Appeal of Adverse Decision/Adverse Action Benefit Determination of a PASSE 6-1-265

When an adverse ~~decision/adverse action~~ benefit determination has been ~~taken made~~ by a PASSE, ~~the following appeals are available in response to that adverse decision/adverse action:~~

- ~~A. A member, or his or her guardian or legal representative may appeal on his or her own behalf; the member may file an appeal in accordance with the procedures found in Section 192.000 of this Manual. A guardian, legal representative, or direct service provider may file an appeal on behalf of the member.~~
- ~~B. A direct service provider of medical assistance that is the subject of the adverse action may appeal on the member's behalf.~~
- ~~C. If the adverse decision/adverse action denies a claim for covered medical assistance that was previously provided to a Medicaid-eligible member, the direct service provider of such medical assistance may appeal on the direct service provider's behalf. The direct service provider does not have standing to appeal a non-payment decision if the direct service provider has not furnished any service for which payment has been denied.~~
- ~~D. When the adverse action denies a claim for previously authorized, covered medical assistance, the PASSE must send the notice of the adverse action no less than ten (10) days before the action will be taken in accordance with 42 CFR 431.211. In all other cases,~~

~~notice must be sent immediately after the adverse decision is made. If the member requests a hearing before the date of action, the PASSE may not terminate or reduce services until a decision is rendered after the hearing unless:~~

- ~~1. It is determined at the hearing that the sole issue is one of Federal or State law or policy; and~~
- ~~2. The PASSE promptly informs the member in writing that services are to be terminated or reduced pending the hearing decision.~~

~~E. If the PASSE's action is sustained by the hearing decision, and the member does not then seek an appeal to DHS, the PASSE may institute recovery procedures against the member to recoup the cost of any services furnished the member, to the extent they were furnished solely by reason of this section.~~

~~F. The appeal process must result in written notice of the resolution being sent to the member. This notice must include the member's right to appeal to the State.~~

~~The PASSE must adhere to the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 *et seq.* in the conduct of appeals and hearings.~~

~~The PASSE appeal process must be approved by DHS. This requires that:~~

~~A. Any proposed changes to the appeals process must be approved by DHS prior to implementation; and~~

~~The PASSE must send written notice to members of significant changes to the appeals process at least thirty (30) days prior to implementation.~~

*TOC required***200.000 DEFINITIONS****Adjusted Premium Revenue**

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

Administrative Cost Ratio

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

Adverse Benefit Determination

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

- A. Appropriate level of care or coding,
- B. Medical necessity,
- C. Prior authorization,
- D. Concurrent reviews,
- E. Retrospective reviews,
- F. Least restrictive setting,
- G. Desk audits,
- H. Field audits and onsite audits
- I. Inspections, and
- J. Payment amounts due to or from a particular provider resulting from gain sharing, risk sharing, incentive payments or another reimbursement mechanism or methodology.

Arkansas Department of Human Services (DHS)

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

Arkansas Insurance Department (AID)

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

Assignment

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

Benefit Expenditure Report (BER)

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

Care Coordination

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

Case Management

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

Centers for Medicare & Medicaid Services (CMS)

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

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

Claims Payment

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

Claims Payment Process

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

Direct Service Provider

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

Disenrollment

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

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

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

Flexible Supports

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

Fraud Prevention Activities

Fraud Prevention Activities are as defined in 42 CFR § 438.8

Incurred Claims

Incurred claims are as defined in 42 CFR § 438.8

Independent Assessment

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

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

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

Medical/Quality Management Committee

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

Medical Loss Ratio

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

Member

A Medicaid beneficiary who is enrolled in a PASSE.

Network Provider

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

Open Enrollment Period

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

Out-of-Network Provider

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

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

PASSE Equity Partners

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

Person-Centered Service Plan (PCSP)

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

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

Performing Provider

Individual who is the rendering provider of a particular service.

Premium Revenue

Premium revenue is as defined in 42 CFR §438.8.

Provider-Led Arkansas Shared Savings Entity (PASSE)

A Risk Based Provider Organization (RBPO) in Arkansas that has enrolled in Medicaid and meets the following requirements:

- A. Is 51% owned by PASSE Equity Partners; and
- B. Has the following Members or Owners:
 1. An Arkansas licensed or certified direct service provider of Developmental Disabilities (DD) services;
 2. An Arkansas licensed or certified direct service provider of Behavioral Health (BH) services;
 3. An Arkansas licensed hospital or hospital services organizations;
 4. An Arkansas licensed physician's practice; and
 5. A Pharmacist who is licensed by the Arkansas State Board of Pharmacy.

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

Provider Network

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

Quality Improvement

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

- A. Improve health quality;

- B. Meet specified quality performance measures;
- C. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and or producing verifiable results and achievements;
- D. Be directed toward individual members incurred for the benefit of specified segments of members or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-members; and
- E. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

Risk-Based Comprehensive Global Payment

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

Risk-based Provider Organization (RBPO)

An entity that

- A. Is licensed by the Insurance Commissioner under the rules established for risk-based provider organizations by the Arkansas Insurance Commissioner;
- B. Is obligated to assume the financial risk for the delivery of specifically defined healthcare services to an enrollable Medicaid beneficiary population; and
- C. Is paid by DHS on a capitated basis with a global payment made, whether or not a particular member of an enrollable Medicaid beneficiary population receives service during the period covered by the payment.

Service Encounter

A standardized record of a health care-related service, procedure, treatment, or therapy rendered by a licensed provider or providers to a PASSE member. There are two types of service encounters, paid claim encounter and non-paid encounters that were performed but are not reimbursable.

Telemedicine

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

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

- A. Audio-only communication, including without-limitation, interactive audio;
- B. A facsimile machine;
- C. Text messaging; or

D. Electronic mail systems.

The Act

Title XIX of the Social Security Act.

Transition

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

Value-based Payments

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

Virtual and Home Visit Provider Services

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

247.200 Appeal of Adverse Benefit Determination of a PASSE

6-1-26

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

1 State of Arkansas
2 95th General Assembly
3 Regular Session, 2025
4

As Engrossed: H3/19/25

A Bill

SENATE BILL 257

5 By: Senator C. Penzo
6 By: Representative Lundstrum
7

For An Act To Be Entitled

9 AN ACT TO AMEND THE MEDICAID FAIRNESS ACT; TO EXTEND
10 THE APPEAL PERIOD FOR PROVIDERS IN THE ARKANSAS
11 MEDICAID PROGRAM; TO REQUIRE COMPREHENSIVE
12 INFORMATION IN NOTICES OF ADVERSE DECISIONS; TO
13 MANDATE PUBLICATION OF ALL POLICIES, PROTOCOLS, AND
14 REQUIREMENTS USED IN MAKING AN ADVERSE DECISION; AND
15 FOR OTHER PURPOSES.
16
17

Subtitle

19 TO AMEND THE MEDICAID FAIRNESS ACT; TO
20 EXTEND THE APPEAL PERIOD FOR PROVIDERS
21 IN THE ARKANSAS MEDICAID PROGRAM; AND TO
22 REQUIRE COMPREHENSIVE INFORMATION IN
23 NOTICES OF ADVERSE DECISIONS.
24

25 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:
26

27 SECTION 1. DO NOT CODIFY. Legislative findings and intent.

28 (a) The General Assembly finds that:

29 (1) The Department of Human Services currently allows providers
30 thirty-five (35) days to appeal an adverse determination before the
31 determination becomes final under 20 CAR § 706-404(a)(5);

32 (2) The thirty-five (35) day period is overly restrictive and
33 does not align with the operational realities of providers' business offices,
34 where adverse determinations arrive via mail and require time to be reviewed,
35 processed, and responded to appropriately;

36 (3) The current notice process lacks necessary details,



1 sometimes failing to include citations to specific policies, protocols, or
2 procedures, which hinders providers from adequately investigating and
3 appealing adverse decisions; and

4 (4) The inefficiency of the current process burdens both the
5 department and its contracted vendors by increasing unnecessary phone calls,
6 claims reopenings, and resubmissions which create additional administrative
7 costs and delays.

8 (b) It is the intent of the General Assembly to improve efficiency and
9 transparency in the Medicaid provider appeals process by:

10 (1) Extending the appeal period for providers;

11 (2) Requiring that notices of adverse decisions contain
12 comprehensive information, including citations to applicable policies and
13 procedures;

14 (3) Mandating the publication of all policies, protocols, and
15 procedural requirements utilized in making adverse decisions; and

16 (4) Ensuring that these requirements apply to the department and
17 any third-party vendors administering portions of the appeals process.

18
19 SECTION 2. Arkansas Code § 20-77-1702, concerning the definitions
20 within the Medicaid Fairness Act, is amended to add an addition subdivision
21 to read as follows:

22 (20) "Third-party entity" means a vendor or other similar entity
23 contracted by the Department of Human Services to administer any part of the
24 Medicaid appeals process.

25
26 SECTION 3. Arkansas Code § 20-77-1705 is amended to read as follows:
27 20-77-1705. Explanations for adverse decisions required.

28 (a) Each denial or other deficiency that the Department of Human
29 Services makes against a Medicaid provider shall be prepared in writing and
30 shall specify:

31 (1) The nature of the adverse decision;

32 (2) The statutory provision or specific rule alleged to have
33 been violated; and

34 (3) The facts and grounds that form the basis for the adverse
35 decision.

36 (b) A notice of an adverse decision sent to a provider shall contain

1 at a minimum:

2 (1) A clear and detailed explanation of the rationale for the
3 adverse decision; and

4 (2) Citations to all specific protocols, procedures, or policy
5 manual references that were relied upon in making the adverse decision.

6
7 SECTION 4. Arkansas Code § 20-77-1712 is amended to read as follows:

8 20-77-1712. Notices.

9 (a) When the Department of Human Services sends letters or other forms
10 of notice with deadlines to providers or recipients, the deadline shall not
11 begin to run before the next business day following the date of the postmark
12 on the envelope, the facsimile transmission confirmation sheet, or the
13 electronic record confirmation, unless otherwise required by federal statute
14 or regulation.

15 (b) The Department of Human Services shall allow a provider no less
16 than sixty-five (65) days from the date of notice to the provider to appeal
17 an adverse decision, whether through administrative reconsideration,
18 administrative appeal, or any equivalent process.

19
20 SECTION 5. Arkansas Code Title 20, Chapter 77, Subchapter 17, is
21 amended to add additional sections to read as follows:

22 20-77-1719. Publication of protocols, procedures, and requirements.

23 (a) The Department of Human Services shall publish and maintain all
24 protocols, procedures, and requirements used in making adverse decisions on
25 the website of the department.

26 (b) The publication shall include:

27 (1) The current version of each protocol, procedure, or
28 requirement;

29 (2) Prior versions of each protocol, manual, or published
30 requirement maintained in an archive for reference for a period equivalent to
31 state law and rule regarding retention of medical records; and

32 (3) An effective date for each version of the protocol, manual,
33 or published requirement to ensure providers have access to historical and
34 current policy requirements.

35 (c)(1) The department shall not use or enforce any policy, protocol,
36 or requirement that is not publicly disclosed and accessible to providers.

1 State of Arkansas
2 95th General Assembly
3 Regular Session, 2025
4

As Engrossed: H3/17/25

A Bill

HOUSE BILL 1622

5 By: Representatives Gramlich, L. Johnson
6 By: Senator J. Boyd
7

For An Act To Be Entitled

9 AN ACT TO AMEND THE MEDICAID FAIRNESS ACT; TO MODIFY
10 THE DEFINITION OF "ADVERSE DECISION" UNDER THE
11 MEDICAID FAIRNESS ACT; TO PROVIDE FOR ADMINISTRATIVE
12 RECONSIDERATION UNDER THE MEDICAID FAIRNESS ACT; AND
13 FOR OTHER PURPOSES.
14
15

Subtitle

16 TO AMEND THE MEDICAID FAIRNESS ACT; TO
17 MODIFY THE DEFINITION OF "ADVERSE
18 DECISION" UNDER THE MEDICAID FAIRNESS
19 ACT; AND TO PROVIDE FOR ADMINISTRATIVE
20 RECONSIDERATION UNDER THE MEDICAID
21 FAIRNESS ACT.
22
23

24 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:
25

26 SECTION 1. Arkansas Code § 20-77-1702(2), concerning the definition of
27 "adverse decision" within the Medicaid Fairness Act, is amended to read as
28 follows:

29 (2)(A) "Adverse decision" means any decision by the Department
30 of Human Services or its reviewers or contractors that adversely affects a
31 Medicaid provider or recipient in regard to:

32 (i) Receipt of and payment for Medicaid claims and
33 services, including, but not limited to, decisions as to:

34 (a) Appropriate level of care or coding;

35 (b) Medical necessity;

36 (c) Prior authorization;



- (d) Concurrent reviews;
- (e) Retrospective reviews;
- (f) Least restrictive setting;
- (g) Desk audits;
- (h) Field audits and onsite audits; and
- (i) Inspections or surveys; ~~and~~

(ii) Payment amounts due to or from a particular provider resulting from gain sharing, risk sharing, incentive payments, or another reimbursement mechanism or methodology, including calculations that affect or have the potential to affect payment; and

(iii) Imposition of corrective action plans.

(B) To constitute an adverse decision, an agency decision need not have a monetary penalty attached ~~but must have~~ or a direct monetary consequence to the provider.

(C) "Adverse decision" does not include the design of or changes to an element of a reimbursement methodology or payment system that is of general applicability and implemented through the rulemaking process;

SECTION 2. Arkansas Code § 20-77-1704(a) and (b), concerning the allowance of a provider administrative appeal under the Medicaid Fairness Act, are amended to read as follows:

(a) The General Assembly finds it necessary to:

(1) Clarify its intent that providers have the right to administrative reconsideration and fair and impartial administrative appeals; and

(2) Emphasize that this right of administrative reconsideration and appeal is to be liberally construed and not limited through technical or procedural arguments by the Department of Human Services.

(b)(1)(A) In response to an adverse decision, a provider may request an administrative reconsideration with the Department of Human Services and may appeal to the Office of Medicaid Provider Appeals with the Department of Health on behalf of the recipient or on its own behalf, or both, regardless of whether the provider is an individual or a corporation.

(B)(i) A provider appeal shall be governed by the Arkansas Administrative Procedure Act, § 25-15-201 et seq., except as otherwise provided in this subchapter.

1 (ii) Multiple appeals by the same provider may be
2 consolidated.

3 (C) An administrative law judge employed by the Department
4 of Health shall conduct all Medicaid provider administrative appeals of
5 adverse decisions under this subchapter.

6 (2) The provider may appear:

7 (A) In person or through a corporate representative; or

8 (B) With prior notice to the Department of Health, through
9 legal counsel.

10 (3)(A) A Medicaid recipient may attend any hearing related to
11 his or her care, but the Department of Health may not make his or her
12 participation a requirement for provider appeals.

13 (B) The Department of Health may compel the recipient's
14 presence via subpoena, but failure of the recipient to appear shall not
15 preclude the provider appeal.

16

17 /s/Gramlich

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20 **APPROVED: 4/16/25**

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1 State of Arkansas
2 95th General Assembly
3 Regular Session, 2025
4

As Engrossed: S4/7/25

A Bill

SENATE BILL 311

5 By: Senator C. Penzo
6 By: Representative McAlindon
7

For An Act To Be Entitled

9 AN ACT TO CREATE THE END ORGAN AND GENOMIC
10 HARVESTING ACT; TO PROHIBIT COVERAGE OF CERTAIN HUMAN
11 ORGAN TRANSPLANT OR POST-TRANSPLANT CARE; TO PROHIBIT
12 CERTAIN GENETIC SEQUENCERS AND GENETIC ANALYSIS
13 TECHNOLOGIES; AND FOR OTHER PURPOSES.
14
15

Subtitle

16 TO CREATE THE END ORGAN AND GENOMIC
17 HARVESTING ACT; TO PROHIBIT COVERAGE OF
18 CERTAIN HUMAN ORGAN TRANSPLANT OR POST-
19 TRANSPLANT CARE; AND TO PROHIBIT CERTAIN
20 GENETIC SEQUENCERS AND GENETIC ANALYSIS
21 TECHNOLOGIES.
22
23

24 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:
25

26 SECTION 1. DO NOT CODIFY. Title.

27 This act shall be known and may be cited as the "End Organ and Genomic
28 Harvesting Act".
29

30 SECTION 2. Arkansas Code Title 20, Chapter 9, Subchapter 1, is amended
31 to add an additional section to read as follows:

32 20-9-106. Prohibition on certain genetic sequencers and genetic
33 analysis technologies – Definitions.

34 (a) As used in this section:

35 (1) "Foreign adversary" means the same as the definition of
36 prohibited foreign party under § 18-11-802;



1 (2) "Genetic sequencer" means a device or platform used to
2 conduct genetic analysis, resequencing, isolation, or other genetic research;

3 (3) "Human genome" means deoxyribonucleic acid (DNA) or
4 ribonucleic acid (RNA) found in human cells;

5 (4) "Medical facility" means a facility for the delivery of
6 healthcare services that:

7 (A) Either:

8 (i) Receives state moneys, including interagency
9 pass-through appropriations from the United States Government; or

10 (ii) Is licensed, registered, or permitted in this
11 state to provide healthcare services; and

12 (B) Conducts research or testing on, with, or relating to
13 genetic analysis or the human genome;

14 (5) "Operational and research software" means computer programs
15 used for the operation, control, analysis, or other necessary functions of
16 genetic analysis or genetic sequencers; and

17 (6) "Research facility" means a facility that:

18 (A) Receives state moneys, including interagency pass-
19 through appropriations from the United States Government; and

20 (B) Conducts research on, with, or relating to genetic
21 analysis or the human genome.

22 (b) Beginning on October 1, 2025, a medical facility or research
23 facility in this state shall not put into service within this state any new
24 or additional genetic sequencers or operational and research software used
25 for genetic analysis produced by a foreign adversary, a state-owned
26 enterprise of a foreign adversary, a company domiciled within a foreign
27 adversary, or a company-owned or company-controlled subsidiary of a company
28 domiciled within a foreign adversary for the purpose of conducting genetic
29 analysis.

30 (c) A medical facility or research facility in this state shall report
31 in writing to the Secretary of the Department of Health on all instances of
32 ongoing usage of genetic sequencers and operational and research software
33 used for genetic sequencers produced by a foreign adversary, a state-owned
34 enterprise of a foreign adversary, a company domiciled within a foreign
35 adversary, or a company-owned or company-controlled subsidiary of a company
36 domiciled within a foreign adversary on January 1 of each year until the

1 equipment is no longer in use.

2 (d)(1) A medical facility, research facility, or other company or
3 entity shall store all genetic sequencing data outside of foreign adversary
4 countries.

5 (2) Remote access to data storage, other than open data, from
6 foreign adversary countries is prohibited.

7 (3) If a medical facility, research facility, or other company
8 or entity stores genetic sequencing data, including through contracts with a
9 third-party data storage company, the medical facility, research facility, or
10 other company or entity shall ensure the security of genetic sequencing data
11 using reasonable encryption methods, restrictions on access, and other
12 cybersecurity best practices.

13 (e) On or before December 31 of each year, a medical facility or
14 research facility shall certify in writing to the Attorney General and the
15 Department of Health that the medical facility or research facility is
16 complying with this section.

17 (f)(1) A person or entity determined to be in violation of this
18 section or found guilty of a violation of this section shall be subject to a
19 fine of ten thousand dollars (\$10,000) per violation.

20 (2) Each unique instance of an individual's genome having
21 undergone genetic sequencing or analysis using prohibited genetic sequencers
22 or prohibited operational and research software shall be considered a
23 separate violation.

24 (g)(1) Any person may notify the Attorney General of a violation or
25 potential violation of this section.

26 (2) If the person notifying the Attorney General is an employee
27 of the entity accused of a violation, the person shall be afforded all
28 protections of a whistleblower under the Arkansas Whistle-Blower Act, § 21-1-
29 601 et seq.

30 (3) If the person notifying the Attorney General is a patient or
31 research subject of an entity found guilty of a violation of this section and
32 the person's genetic information was used in violation of this section, the
33 entity shall also be found to have violated the Deceptive Trade Practices
34 Act, § 4-88-101 et seq.

35 (4) The Attorney General may investigate allegations of
36 violations of this section.

1
2 SECTION 3. Arkansas Code Title 23, Chapter 79, Subchapter 1, is
3 amended to add an additional section to read as follows:

4 23-79-169. Insurance coverage of certain human organ transplant or
5 post-transplant care prohibited – Definitions.

6 (a) As used in this section:

7 (1) "Forced organ harvesting" means the removal of one (1) or
8 more organs from a living person, or from a person killed for the purpose of
9 removal of one (1) or more organs, by means of coercion, abduction,
10 deception, fraud, or abuse of power over a position of vulnerability;

11 (2)(A) "Health benefit plan" means:

12 (i) An individual, blanket, or group plan, policy,
13 or contract for healthcare services issued, renewed, or extended in this
14 state by a healthcare insurer, health maintenance organization, hospital
15 medical service corporation, or self-insured governmental or church plan in
16 this state; and

17 (ii) Any health benefit program receiving state or
18 federal appropriations from the State of Arkansas, including the Arkansas
19 Medicaid Program and the Arkansas Health and Opportunity for Me Program
20 established by the Arkansas Health and Opportunity for Me Act of 2021, § 23-
21 61-1001 et seq.

22 (B) "Health benefit plan" includes without limitation
23 indemnity and managed care plans.

24 (C) "Health benefit plan" does not include:

25 (i) A plan that provides only dental benefits or eye
26 and vision care benefits;

27 (ii) A disability income plan;

28 (iii) A credit insurance plan;

29 (iv) Insurance coverage issued as a supplement to
30 liability insurance;

31 (v) Medical payments under an automobile or
32 homeowners insurance plan;

33 (vi) A health benefit plan provided under Arkansas
34 Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et
35 seq., or the Public Employee Workers' Compensation Act, § 21-5-601 et seq.;

36 (vii) A plan that provides only indemnity for

1 hospital confinement;

2 (viii) An accident-only plan;

3 (ix) A specified disease plan; or

4 (x) Plans providing health benefits to state and
5 public school employees under § 21-5-401 et seq.; and

6 (3)(A) "Healthcare insurer" means any insurance company,
7 hospital and medical service corporation, or health maintenance organization
8 that issues or delivers health benefit plans in this state and is subject to
9 any of the following laws:

10 (i) The insurance laws of this state;

11 (ii) Section 23-75-101 et seq., pertaining to
12 hospital and medical service corporations; or

13 (iii) Section 23-76-101 et seq., pertaining to
14 health maintenance organizations.

15 (B) "Healthcare insurer" does not include an entity that
16 provides only dental benefits or eye and vision care benefits.

17 (b) Regardless of a claim filed by a medical facility or provider, a
18 health benefit plan that is offered, issued, or renewed in this state shall
19 not provide coverage for a human organ transplant or post-transplant care if:

20 (1) The transplant operation is performed in the People's
21 Republic of China or another country known to have participated in forced
22 organ harvesting, as designated by rule by the Insurance Commissioner; or

23 (2) The human organ to be transplanted is procured by sale or
24 donation originating in the People's Republic of China or another country
25 known to have participated in forced organ harvesting, as designated by rule
26 by the commissioner.

27 (c)(1) The commissioner may designate by rule any additional country
28 as having participated in forced organ harvesting if the government of that
29 country funds, sponsors, or otherwise facilitates forced organ harvesting.

30 (2) If under subdivision (c)(1) of this section the commissioner
31 designates an additional country as having participated in forced organ
32 harvesting, the commissioner shall provide written notice to healthcare
33 insurers.

34 (d) A healthcare insurer may seek reimbursement or setoff from a
35 medical facility or provider if a claim is submitted and paid in violation of
36 this section.

1 (e) Notwithstanding any other provision of this section, care that is
2 provided to save the life of an individual after the individual receives a
3 prohibited organ transplant shall be covered.

4 (f) The commissioner shall develop and promulgate rules for the
5 implementation and administration of this section.

6
7 SECTION 4. DO NOT CODIFY. SEVERABILITY CLAUSE. If any provision of
8 this act or the application of this act to any person or circumstance is held
9 invalid, the invalidity shall not affect other provisions or applications of
10 this act which can be given effect without the invalid provision or
11 application, and to this end, the provisions of this act are declared
12 severable.

13
14 /s/C. Penzo

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17 **APPROVED: 4/17/25**
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