EXHIBIT B6

In support of the Arkansas Act 575 of 2023 amending Arkansas Administrative Code, Title 23, Subtitle 3, Chapter 99, Subchapter 11, applicable to Arkansas licensed health insurers effective 1/1/2024, Arkansas Total Care (ARTC) has developed a Gold Card program to be implemented on 1/1/25. Key provisions of ARTC's plan are detailed below.

Since the beginning of the PASSE program, ARTC has had the following provisions in place to ensure open access to care for members:

- **No** prior authorization/referrals needed to obtain primary care services.
- **No** prior authorization/referrals needed to obtain specialty provider services.
- **No** prior authorization/referrals needed for physical, occupational, speech and behavioral health therapy services.
- To ensure open access to care, ARTC has removed the following limits, typically applied by Fee for Service Medicaid:
    - Visit limits on physician services.
    - Dollar CAPs on Imaging and DME services.
    - Pharmacy Script Limits
- Expanded services to offer wellness benefits to all adults.
- Continued to perform annual reviews, of the services that require a prior authorization, to determine if a prior authorization is still needed to manage risk.
- Experienced a ~23% reduction in the program rates for since 2019.

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Key provisions of ARTC's Gold Card plan include the following:

- A healthcare provider that received approval for ninety percent (90%) or more of the healthcare provider's prior authorization requests, based on a review of the healthcare provider's utilization of the particular healthcare services, will receive Gold Card status beginning January 1, 2025.
- Authorization data from January 1, 2024 to June 30, 2024 will be reviewed.
- For Gold Card consideration, the healthcare provider must have requested six (6) or more prior authorizations, of a particular healthcare service, in the most recent six-month evaluation period.
- No later than October 1, 2024, ARTC shall submit to each healthcare provider a written statement of:
    - (A) The total number of payable claims submitted by or in connection with the healthcare provider; and

    - (B) The total number of denied and approved prior authorizations between January 1, 2024, through June 30, 2024.
    - The outcome of the Gold Card review and status.
- If a healthcare provider's use, for a particular healthcare service, increases by twenty-five percent (25%) based on a review of the healthcare provider's utilization of the particular healthcare service, ARTC may disallow the exemption from prior authorization requirements.

The PASSE program focuses specifically on a LTSS/Special Need's population, that centers around two Home and Community 1915 waivers, for services only available to PASSE members. ARTC has a fiduciary responsibly to administer the program in a manner that ensures Medicaid spending is controlled, taxpayer dollars are spent efficiently, and members receive the appropriate services to support them in the community. In order to ensure the continued viability of the PASSE program and to support the program requirements, ARTC is excluding the following services from Gold Card consideration:

- 1915(c) and 1915(i) Waiver services
- Residential Treatment Center (RTC) services
- Residential Treatment Unit (RTU) services
- Short-term Skilled Nursing Stays
- Personal Care services
- Home Health services
- Institution of Mental Disease (IMD) services
- Intermediate Care Facility (ICF) services
- Pharmacy Services

Reasons for excluded services:

Per the PASSE agreement, Patient Center Service Plans (PCSP) are required for all members. This plan is developed in collaboration with the member, their providers and ARTC. In order to manage these services, and ensure they are all listed on the PCSP as required by CMS, a prior authorization is required.

1915(c) and 1915(i) waiver services are all home and community-based services that are only available to members in the PASSE. These services make up 48% of the overall spend for this population. Without proper management from a prior authorization perspective, the overall Medicaid program for this population could be jeopardized and impact the member's ability to remain in the community with proper supports.

Residential Treatment Centers/Units (RTC/RTU) are a PASSE-specific residential service for children and adolescents with significant behavioral health needs. Data shows that children/youth in RTCs, for long periods of time, can lead to institutionalization. Removing the prior authorization requirement, may increase the length of stay, and this could be harmful to the members receiving the care. RTC's have limited evidence of benefits beyond what could be offered in home or community-based care. Without the prior authorization, ARTC will be unable to monitor and shape providers around "active treatment" guidelines and ensure discharge planning for members to more successful in the community post discharge.

Short-term Skilled Nursing Stays are intended to be Rehabilitative Skilled Nursing Services but, without prior authorizations, would most likely turn into long-term stays. Long-term stays are not covered by the PASSE and could impact the member's PASSE eligibility status.

Personal Care and Home Health are State Plan Services that are not more restrictive than FFS Medicaid. The PASSEs have received the support of DHS and OMIG in addressing identified overutilization of personal care service through policy change and enhanced oversight through the prior authorization process, as well as, referrals for investigation for potential fraud, waste, and abuse. Home Health service are being added to the Electronic Visit Verification (EVV) process that is already in place for Personal Care service.

Institution of Mental Disease (IMD) is an In Lieu of Service and federal coverage limitations for the PASSEs require prior authorizations remain in place for appropriate monitoring to prevent members from losing PASSE eligibility status.

Intermediate Care Facility (ICF) is a residential treatment facility for individuals with an intellectual or developmental disability level of care that requires an active 704 that is approved by the Office of Long-Term Care. The prior authorization process is for notification purposes only and ensures the proper documentation is in place for this service to be delivered.

Currently, ARTC is required to follow the pharmacy formulary and prior authorization guidelines put in place by Arkansas Medicaid. Removing pharmacy prior authorizations would negatively impact DHS' ability to collect negotiated rebates and may directly impact Arkansas Medicaid's fiscal year budget.