Division of Medical Services
P.O. Box 1437, Slot S295, Little Rock, AR 72203-1437
P: 501.682.8292 F: 501.682.1197

MEMORANDUM

TO: Interested Persons and Providers

FROM: Elizabeth Pitman, Director, Division of Medical Services

DATE: May 11, 2021

SUBJ: Notice of DMS Managed Care Quality Strategy

As a part of the federal regulations requirements at 42 CFR § 438.340, attached for your review and comment is proposed DMS Managed Care Quality Strategy.

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you have any comments, please submit those comments in writing, no later than June 12, 2021.

NOTICE OF DMS MANAGED CARE QUALITY STRATEGY

Pursuant to 42 CFR § 438.340, the Director of the Division of Medical Services (DMS) of the Department of Human Services (DHS) issues the following Notice for public comment of the DMS Managed Care Quality Strategy.

This Quality Strategy (QS) document meets the federal requirements of 42 CFR § 438.340 to describe the strategies for assessing and improving the quality of health care and services offered to Arkansas Medicaid clients served by managed care programs. The QS defines network adequacy and availability standards. It provides the State's goals and objectives for continuous quality improvement which are measurable and take into consideration the health status of all populations in the State. The QS contains a description of the quality metrics and performance targets used in measuring the performance and improvement of each described entity as well as performance improvement projects to be implemented. The QS outlines arrangements for annual, external independent reviews of the quality outcomes and timeliness, and access to services covered. The QS also contains the plan to identify, evaluate, and reduce health disparities based on statutory criteria. Also, the QS creates the definition of a "significant change" for the purpose of requiring future revisions.

The DMS Managed Care Quality Strategy is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download this notice and the full QS on the DHS website at: https://humanservices.arkansas.gov/do-business-with-dhs/proposed -rules/.

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than June 12, 2021. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-320-6266.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4501960528

Elizabeth Pitman, Director
Division of Medical Services

ARKANSAS DIVISION OF MEDICAL SERVICES
QUALITY STRATEGY 2021

DRAFT

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INTRODUCTION

The Arkansas Department of Human Services (DHS) Division of Medical Services (DMS) offers high-quality, person-centered managed care in two programs: Provider-led Arkansas Shared Savings Entities (PASSE) that provides all services to Medicaid clients with high behavior health and intellectual or developmental disability needs and Healthy Smiles that provides dental services to the majority of Arkansas Medicaid clients.

1. Purpose and Scope

This document meets the federal requirements of 42 CFR § 438.340 to describe the strategies for assessing and improving the quality of health care and services offered to Arkansas Medicaid clients. It includes specific strategies Arkansas will use to align programs to best meet the needs of managed care members and continually improve their health.

This Quality Strategy is specifically focused on members of the PASSE and Healthy Smiles programs and sets a three-year vision for DMS to accomplish its quality goals and objectives. This Quality Strategy is intended to evolve over time.

Although there is some alignment and overlap between the PASSE and Healthy Smiles programs' goals, objectives, and strategies; some divergence is necessary to address the specific needs of the members served in each program.

2. Overview of Arkansas Managed Care Programs

A. The Provider-led Arkansas Shared Savings Entities (PASSE)

History

The PASSE program is an innovative approach to organizing and managing the delivery of services for Medicaid clients with high behavioral health and intellectual or developmental disability needs. PASSE was created in the 2017 Arkansas General Session and codified as ACA 20-77-2701 et seq. Under this model of organized care, the PASSEs are responsible for integrating the physical health services, behavioral health services, and specialized developmental disabilities services for approximately 40,000 individuals who have intensive levels of treatment or care needs due to mental illness, substance abuse, or intellectual or developmental disability.

The PASSE program was implemented in two phases. The first phase, which began on February 1, 2018, was known as the "Arkansas Provider-led Care Coordination Program." In that Phase, Medicaid clients who were identified as receiving high levels of services due to a mental illness, substance abuse, or intellectual or developmental disability were attributed to a PASSE based on provider relationships. The PASSE began providing care coordination to that member, while all other services continued to be paid on a fee-for-service basis. The purpose of Phase I was to

allow the PASSEs time to build their infrastructure and become more familiar with the population they serve and their unique needs.

Pursuant to 42 CFR § 438.66(d), DHS conducted an on-site readiness review in October 2018 for a total of four entities. Each entity also submitted desk review items to DHS. After a desk review and onsite review, all entities passed the readiness reviews and were provided feedback. At the start of the PASSE go live date of March 1, 2019 (Phase II), there were only three PASSEs that entered into the PASSE Provider Agreement to provide care coordination, home and community-based services, and other medically necessary state plan services and Nonmedical Community Supports and Services (NCSS) to enrolled members.

Phase II began on March 1, 2019. In Phase II, under the authority of a concurrent 1915(b)/(c) Waiver along with a 1915(i) State Plan Amendment, the PASSEs provide all services to members under a "full-risk" Managed Care Organization (MCO) model. The PASSEs continue to provide care coordination to assigned clients and assume responsibility for the development of members' Person-Centered Service Plans (PCSPs) and delivery of all services.

Purpose and Scope

The purpose of the Arkansas PASSE program, pursuant to Title XIX of the Social Security Act (The Act) and Arkansas Act 775, is to organize and manage the delivery of services for certain Medicaid clients who have complex behavioral health, intellectual and developmental disabilities service needs.

According to Act 775 of 2015 of the Arkansas General Assembly, the intent and purpose of the PASSE model of care is to:

- Improve the experience of health care, including without limitation quality of care, access to care, and reliability of care, for enrolled members;
- Enhance the performance of the broader health care system leading to improved overall population health;
- Slow or reverse spending growth for the enrollable population and for covered services while maintaining quality of and access to care;
- Further the objectives of Arkansas payment reforms and the state's ongoing commitment to innovation;
- Discourage excessive use of services;
- Reduce waste, fraud, and abuse;
- Encourage the most efficient use of taxpayer funds; and
- Operate under federal guidelines for patient rights.

The PASSEs are responsible for the provision of comprehensive medically necessary and NCSS services to the following groups:

- Clients who have received the independent assessment for behavioral health services and tiered at a two (2) or a three (3).

- Clients who have received the independent assessment for developmental disabilities services and tiered at a two (2) or a three (3), in the following categories:
    - Community and Employment Supports (CES) Waiver under 1915(c)
    - Waitlist for the CES Waiver
    - Residents of Private Intermediate Care Facility for Individuals with Intellectual Disabilities (IFC/IID)

For individuals served by the Division of Aging, Adult, & Behavioral Health Services, the tiers are as follows:

Tier I: Counseling Level Services (not enrolled)

At this level, the score reflects that is that the individual can continue professional Counseling and Medication Management services but is not eligible for the additional array of services available in Tier 2 or Tier 3.

Tier II: Rehabilitative Level Services (Mandatory Enrollment)

At this level of need, the score reflects difficulties with certain behaviors allowing eligibility for a full array of non-residential services to help the client function in home and community settings and move towards recovery.

Tier III: Intensive Level Services (Mandatory Enrollment)

At this level of need, the score reflects difficulties with certain behaviors allowing eligibility for a full array of services including twenty-four (24) hours a day, seven (7) days a week residential services, to help the client move towards reintegrating back into the community.

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

Tier I: Community Clinic Level of Care (not enrolled)

At this level of need, the individual receives services in a day habilitation setting, i.e., an Early Intervention Day Treatment (EIDT) or Adult Development Day Treatment (ADDT).

Tier II: Institutional Level of Care (Mandatory Enrollment)

This level of need means that the client scored high enough in certain areas to be eligible for paid services and supports.

Tier III: Institutional Level of Care (Mandatory Enrollment)

This level means that the client scored high enough in certain areas to be eligible for the most intensive level of services, including twenty-four (24) hours a day, seven (7) days a week paid supports and services.

Individuals who receive services in a publicly owned Human Development Center, a skilled nursing facility or assisted living facility, through a home and community-based services waiver

for adults with physical disabilities, Program of All-Inclusive Care for the Elderly (PACE), Independent Choices or the Arkansas Autism Waiver are excluded from enrollment in a PASSE, even if their autism meets the needs criteria. If an individual is eligible for Medicaid in Arkansas as a Medically Frail individual or through the Spend-down program, they are also excluded. Arkansas Works is currently excluded, but is being added.

Additionally, the PASSE is not responsible for the following services:

- Nonemergency Medical Transportation (NET)
- Dental Benefits (Dental Managed Care)
- School-based services provided by school employees
- Transplants and post-transplant services (excluding pharmacy) for one (1) year following the date of transplant

In addition to medically necessary and NCSS care and treatment services, the PASSE is responsible for:

- All Case Management activities pursuant to Ark. Code Ann. § 20-77-2703(3), including but not limited to:
    1. Assessment of the member
    2. Development of a PCSP
    3. Referral to services
    4. Monitoring activities
- Ensuring shared decision making with the member and caregiver/family/representative of the availability of services that are responsive to the member's needs regarding service delivery, personal goals, and preferences.
- Integrated care services that support the member to remain in the least restrictive setting possible and access HCBS benefits to prioritize the member's choice of living in their own home or choosing an Alternative HCBS Setting rather than residing in an institution.

The goal of the PASSE model is to organize and coordinate the continuity of care for each enrolled member, and to specifically ensure the following:

- Every enrolled member has a medical home;
- Every enrolled member is receiving care coordination services;
- Every member has a PCSP and it is being met;
- There is an organized formal network of providers to meet the enrolled member's needs;
- Information can be easily shared among health care providers, care coordinators, and family members to facilitate the enrolled member's PCSP;
- Every enrolled member receives all medically necessary and NCSS services; and

- Data is accurately reported to measure performance of each PASSE and hold them accountable to meeting the above goals.

B. Healthy Smiles

History

During the 2015 Arkansas Legislative General Session, the General Assembly passed Act 96 which created the Health Care Reform Legislative Task Force in Arkansas. This task force was created to make Medicaid recommendations. The task force along with the Arkansas Dental Association recommended moving to dental managed care in Arkansas.

DHS transitioned the Medicaid dental program to managed care effective January 1, 2018. Arkansas selected two vendors to provide state-wide dental benefits for over 600,000 clients under the authority of a 1915(b) Waiver.

In early December 2017, all Arkansas Medicaid clients who were eligible for dental benefits were randomly and evenly assigned to one of the two Dental Managed Care Organizations (DMOs). Each DMO sent a welcome packet to members and the members were able to begin accessing services. Members continue to be auto assigned to a DMO however, if a member wishes to switch DMOs, he or she has ninety (90) days from auto assignment to do so.

Purpose and Scope

Both DMOs provide, at a minimum, the same dental services that are covered under the Medicaid fee-for service program. If the member does not have a Primary Care Dentist (PCD), one is assigned to them to encourage members to maintain a dental home. However, members are not locked in to that PCD and can switch at any time.

The goal of the Healthy Smiles program is to properly manage the dental care, improve oral health outcomes, develop robust dental provider networks, and adopt and integrate clinically focused dental care solutions. The DMOs must encourage high risk patients to fully complete treatment plans and help all patients overcome obstacles which create “no shows” in dental offices.

The DMOs serve all members who receive dental services through Medicaid except for those residing in Human Development Centers, individuals enrolled in the Program for All Inclusive Care for the Elderly (PACE), members who reside in a nursing home setting or Intermediate Care Facilities, spenddown population, ARChoices in Homecare of Independent Choices programs, and Medicaid expansion (ARWorks) enrollees.

The dental managed care contractors are defined as Prepaid Ambulatory Health Plans (PAHPs) per Centers for Medicare and Medicaid Services (CMS) regulations and are subject to all regulations and requirements for PAHPs.

3. Mission of the Department of Human Services

The Mission of the Arkansas Department of Human Services (DHS) is to "improve the quality of life of all Arkansans by protecting the vulnerable, fostering independence, and promoting better healthcare." In support of this Mission, DHS has developed the following core beliefs:

1) Every person matters
2) Families matter
3) Empowered people help themselves
4) People deserve access to good health care
5) We have a responsibility to provide knowledge and services that work
6) Partnering with families and communities is essential to the health and well-being of Arkansans
7) The quality of our services depends upon a knowledgeable, accessible, and motivated workforce

The PASSE and Healthy Smiles programs are person-centered approaches to coordinated care and outreach that aligns with the mission and belief of DHS that each person should be at the center of and involved in the direction of his or her health care.

4. Quality Strategy Development and Public Input

DMS along with a core team of DHS employees from the respective divisions, specifically the Division of Developmental Disabilities Services (DDS) and the Division of Aging, Adult, and Behavioral Health Services (DAABHS), came together to write the initial draft of the quality strategy. The goal of this strategy is to lay out the goals and objectives of the PASSE and Healthy Smiles program and a strategy for meeting those goals. After this group finalized an initial draft, it was sent through the internal DHS approval process and then approved by the Arkansas Governor's Office on _____.

The Quality Strategy will be put out for public comment from DATE, through DATE. To ensure the public is aware of the written quality strategy, DHS will place an advertisement in the Arkansas Democrat-Gazette, a paper with statewide circulation, as well as post the document on the DHS webpage. Links will be placed on the DHS Facebook page. It will also be sent to the major provider organizations, family and client organizations, and each PASSE and Healthy Smiles DMO. Comments will be summarized and responded to in Appendix 2 of this document.

QUALITY IMPROVEMENTS & INTERVENTIONS

1. Areas of Focus

This document is the written quality strategy for assessing and improving the quality of health care and services furnished by the PASSE and DMOs in accordance with 42 CFR § 438.340. With the purpose of each program in mind, Arkansas chose to focus its efforts in three key areas:

1) Network and access standards;
2) Person-centered care, care coordination, and outreach; and
3) Quality metrics and encounter data

Each of the goals and their respective objectives are designed to further one of these three areas.

2. Goals and Objectives: §438.340(b)(2)

The listed goals have been carefully considered by all stakeholders, including state staff, the PASSEs/DMOs, providers, and families.

The DMS quality goals align with and support the DHS missions and core beliefs. The goals and objectives fall under four areas with specific objectives in each:

Goal 1: Focus on person-centered, coordinated care, and outreach.			
PASSE		**Healthy Smiles**	
Objective 1.1	Provide qualified and trained care coordinators. • Must provide health education and coaching; coordination with healthcare providers for diagnostic, ambulatory care, and hospital services; assistance with social determinants of health; promotion of activities focused on the health of a patient and their community.	**Objective 1.1**	Make sure every enrolled member has a Primary Care Dentist (PCD).
Objective 1.2	Develop care coordinator relationships with enrolled members.	**Objective 1.2**	Take a proactive role in reaching out to clients to ensure that each client has the information necessary to receive Medically Necessary dental services.
Objective 1.3	Improve PCSP development for enrolled members.	**Objective 1.3**	Shall identify targeted populations and/or service areas

	• Must adhere to 42 CFR § 441.540. • Include members outlined treatment goals and objectives. • Contain medical and NCSS services necessary for the member as identified through the assessment of functional need, and crisis plan.		for outreach and education activities.
Goal 2: Improve access to needed services and safety for all enrolled members.			
PASSE		Healthy Smiles	
Objective 2.1	Improve access to appropriate care through network adequacy. • Specific provider must be within forty (40) miles in urban county and ninety (90) miles in a rural county. • Must have at least one Provider Type 05 (Acute Inpatient Hospital) within thirty (30) miles in an urban county and sixty (60) miles in a rural county.	**Objective 2.1**	Improve access to appropriate dental services through network adequacy.
Objective 2.2	Encourage development of innovative and value-added service models that cross service divisions.	**Objective 2.2**	Improve prevention among clients.
Objective 2.3	Ensure safety by monitoring compliance with incident and accident reporting requirements.	**Objective 2.3**	Decrease per capita emergency room (due to dental emergencies) visits.
		Objective 2.4	Internal quality assurance and improvement program that is comprehensive and routinely and systematically monitors access, availability and utilization of services, network adequacy, and customer satisfaction.
Goal 3: Continuously increase member satisfaction with Services.			

PASSE		Healthy Smiles	
Objective 3.1	Increase satisfaction with the PASSE as reflected on the member surveys.	**Objective 3.1**	Increase satisfaction with Healthy Smiles.
Goal 4: Continuously advance plan models to improve the health of enrolled members.			
Objective 4.1	Monitor implementation of performance improvement projects by the PASSEs.	**Objective 4.1**	Monitor implementation of performance improvement projects by the DMOs.
Objective 4.2	Develop strategies to increase the number of value-added services being provided to enrolled members.	**Objective 4.2**	Encourage value added services offered by the DMOs at no cost to the member.
Objective 4.3	Encourage innovative models of value-based services.		

By striving to reach the goals listed above, the Arkansas managed care models aim to improve the health care delivery system for individuals enrolled in the PASSE and Healthy Smiles programs. These goals will ensure better access, decrease service barriers, and focus on person-centered and individualized care for enrolled individuals. This shift in focus to better person-centered, coordinated care and outreach will result in smarter spending by the Medicaid program overall. These programs encourage the services to be designed specifically to target each enrolled members' health needs and goals. Additionally, providers will be able to reach across historical service divides to ensure the correct services are being provided to the member. For example, in the PASSSE model a dually diagnosed client who has historically been served in a developmental disabilities setting will be able to receive behavioral health therapies and treatments in that setting as well.

DHS has set out specific quality metrics and monitoring activities designed to meet these goals and objectives. This written strategy describes the different planned activities and creates a cohesive picture of how the quality assurance and improvement of the PASSEs and DMOs system of care will be achieved.

3. Quality Metrics and Performance Targets §438.340(b)(3)(i)

Below are the quality metrics and performance targets used to measure the performance and improvement of each PASSE and DMO.

A. PASSE

Component	Performance Standard	Damages	Area of Focus	Goal
Out-of-Network Provider Payment	Starting on January 1, 2020, no greater than 20% percent of the total dollars paid to the PASSE shall be paid for services billed by out-of-network providers.	$1000 for each percentage point over 20% paid for services by out-of-network providers per quarter. The percentage point must be rounded up to the next whole number (e.g. 20.01% must be treated as 21%). In no event must the damages assessed for this performance metric exceed $20,000 per quarter.	1	2
Call Center Answer and Abandonment Rates	i. 95% of all calls answered within 3 rings or 15 seconds; ii. Number of busy signals not exceeding 5% of the total incoming calls; iii. The wait time in queue not longer than 2 minutes for 95% of the incoming calls; iv. The abandoned call rate not to exceed 5% for any month.	$500.00 for each percentage point for each criteria (i, ii, iii, or iv) that falls below the standard during each one-month reporting period.	2	1
			2	1

Call Center Return Calls	i. All calls requiring a call back to the Beneficiary or Provider returned within one business day of receipt; ii. For calls received during non-business hours, return calls to Beneficiaries and Providers made on the next business day.	$500 per telephone call that the PASSE fails to return in accordance with standards (i or ii) during each one-month reporting period.		
Website and Portal Availability	Contractor's website is online at least 99% of the time each month, except that Contractor may take the website and portals down from 1:00 am to 5:00 am each Saturday for necessary maintenance.	$250 for each tenth of a percentage point below 99% (excluding maintenance time during the specified window) during the month.	2 & 3	1
Investigation and Resolution of Grievances	Investigate and resolve all Grievances within the following time frames: i. Acknowledgement in writing within five (5) business days of receipt of each grievance. ii. All grievances must be completed and resolved within 30 days of the filing date, unless an extension is granted in accordance with 4.9.19.c.iii of the PASSE Provider Agreement. iii. The PASSE must submit a grievance log with their quarterly report.	$500 for each Grievance or report the Contractor fails to administer in accordance with the standards (i, ii or iii) during each reporting period.	2 & 3	2 & 3
Claims Processing **Denial, Approval, and**	Process, which means deny or approve and submit for payment claims within the following time frames:	$250.00 for each percentage point (I, ii, iii, or iv.) that falls below the standard for each criteria	3	2 & 3

Submission of Claims	i. The PASSE must process seventy percent (70%) of all clean claims submitted within seven (7) days. iii. The PASSE must process ninety-five percent (95%) of all clean claims submitted within thirty (30) days. iv. The PASSE must process ninety-nine percent (99% of all clean claims submitted within sixty (60) days.)	during each one-month reporting period identified in each quarterly report.		
Accuracy of Encounter Data – Clean Claims	At least ninety-five (95%) of all encounter data must pass through as a clean encounter claim submission to DXC or Magellan (or future contractors responsible for the collection of encounter claims)	$1,000 for each percentage point below the standard during the reporting period.	3	2 & 3
Timeliness of encounter data	All encounter data submitted in accordance with the timeframes established in the Agreement.	$1,000 per each day past the deadline.	3	2 & 4
Report submission	All required monthly, quarterly, bi-annual, and annual reports submitted in accordance with timelines established in the Contract.	$1,000 per day past the deadline.	3	All
Key Personnel Vacancy	In the event of a Key Personnel Vacancy, propose a suitable Replacement to the Contract Monitor within 30 calendar days of the vacancy occurrence or from when the Contractor first knew or should have known the vacancy would be occurring.	$750 per each day after the 30th day that a suitable replacement has not been submitted. The suitability of the replacement is at the sole discretion of the State.	3	1, 2, & 3

Person Centered Service Plans	≥90% of enrolled members will have a PCSP or Interim Plan of Care.	$1,000 for each percentage point below the standard during the reporting period.	2	1
Person Centered Service Plans	≥80% of the 90% of enrolled members will have a PCSP that includes all needed HCBS services.	$1,000 for each percentage point below the standard during the reporting period.	2	1
Care Coordinator to Client Caseload	≥90% of care coordinators will have a caseload of ≤50 members	$1,000 for each percentage point below the standard during the reporting period.	2	1
Initial Contact of Client	≥75% of members will be contacted by a care coordinator or appropriate PASSE team member within 15 business days after assignment to PASSE	$1,000 for each percentage point below the standard during the reporting period.	2	1
Monthly Contact of Client	≥75% of members are contacted monthly and in person quarterly by a care coordinator.	$1,000 for each percentage point below the standard during the reporting period.	2	1
Follow-Up Care	≥50% of members with a visit to Emergency room or discharge from hospital or Inpatient Psychiatric Unit/Facility will have a follow up from a PASSE care coordinator or appropriate PASSE team member within seven (7) business days.	$1,000 for each percentage point below the standard during the reporting period.	2	1
Primary Care Physician Assignment	≥80% of members will have selected a PCP and will be on a PCP's caseload.	$1,000 for each percentage point below the standard during the reporting period.	2	1
Appeals	1. Unless it is an expedited appeal request, an oral appeal request must be followed with a written, signed appeal within ten (10) calendar days of the oral filing, unless the appellant requests an expedited resolution. 2. The PASSE must acknowledge each PASSE appeal	$1,000 per day past the deadline.	3	2 & 3

	in writing within five (5) business days of receipt of each PASSE appeal, unless the appellant requests an expedited resolution. 3. Unless the appellant requests expedited resolution, an appeal must be heard and notice of appeal resolution sent to the member no later than thirty (30) calendar days from the date of receipt of the appeal.			

B. Healthy Smiles

Performance Standards				
Component	**Performance Standard**	**Damages**	**Area of Focus**	**Goal**
Access to Care: Distance	i. At least 90% of Beneficiaries have access to two or more Primary Care Dentists who are accepting new patients within 30 miles of the member's residence in urban counties and 60 miles of the member's residence in rural counties. ii. At least 85% of all members have access to at least one specialty provider within 60 miles of the member's residence. iii. At least 90% of	$1,000 for each percentage point for each criterion (I or ii) that falls below the standard during each one-month reporting period.	1	2

	pediatric members **must** have access to Pediatric Dental Services through two or more Primary Care Dentist who are accepting new patients within 30 miles of the member's residence in Urban counties and 60 miles of the member's residence in Rural counties.			
Access to Care: Time	i. Emergency Care provided within 24 hours. ii. Urgent Care, including urgent specialty care, provided within 48 hours. iii. Therapeutic and diagnostic care provided within 14 days. iv. Primary Care Dentists make referrals for specialty care based on the urgency of the member's dental condition, but no later than 30 days. v. Non-urgent specialty care provided within 60 days of authorization.	$250 for each instance the Contractor fails to meet any of the "Access to Care: Time" performance standard ('i' through 'v') for any member.	1	2

Out-of-Network Provider Billing	No greater than 20% percent of the total dollars billed to the Contractor for outpatient services billed by out-of-network providers.	$1000 for each percentage point over 20% billed for outpatient services by out-of-network providers per quarter, per geographic area. The percentage point shall be rounded up to the next whole number (*e.g.* 20.01% shall be treated as 21%).	1	2
Call Center Answer and Abandonment Rates	i. 95% of all calls answered within 3 rings or 15 seconds; ii. Number of busy signals not exceeding 5% of the total incoming calls; iii. The wait time in queue not longer than 2 minutes for 95% of the incoming calls; iv. The abandoned call rate not to exceed 3% for any month.	$500.00 for each percentage point for each criterion (i, ii, iii, or iv) that falls below the standard during each one- month reporting period.	2 & 3	1
Call Center Return Calls	i. All calls requiring a call back to the member or Provider returned within 1 business day of	$500 per telephone call that the Contractor fails to return in	2 & 3	1

	receipt; ii. For calls received during non-business hours, return calls to members and Providers made on the next business day.	accordance with standards (i or ii) during each one-month reporting period.		
Website and Portal Availability	Contractor's website, member portal, and Provider portal is online at least 99% of the time each month, except that the Contractor may take the website and portals down from 1:00 am to 5:00 am each Saturday for necessary maintenance.	$250 for each tenth of a percentage point below 99% (excluding maintenance time during the specified window) during the month	2 & 3	1
Investigation and Resolution of Grievances	Investigate and resolve all grievances as expeditiously as the member's health condition requires, but not to exceed ninety (90) calendar days. The timeframe may be extended as allowed in Section 4.3.3 of the Appendix, but the extension must be properly documented and shall not exceed fourteen (14) calendar days. i. Written resolution of the grievance must be sent to the member within two (2) business days of making. The written	$500 for each Grievance the Contractor fails to administer in accordance with the standards (i, ii or iii) during each one-month reporting period.	2 & 3	2 & 3

	resolution must conform to the requirements laid out in Section 4.3.3 of the Appendix.			
Denial, Approval, and Submission of Claims	Deny or approve, and submit for payment: i. 100% of clean paper claims within 30 calendar days of receipt ii. 100% of clean electronic claims within 14 calendar days of receipt;	$250.00 for each percentage point for each criteria (i or ii) that falls below the standard during each one-month reporting period identified in each quarterly report.	3	2 & 3
Accuracy of encounter data	At least 99% of all encounter data must be accurate.	$1,000 for each percentage point below the standard during the reporting period.	3	2 & 3
Timeliness of encounter data	All encounter data submitted in accordance with the timeframes established in the contract.	$1,000 per each day past the deadline.	3	2 & 4
Report submission	All required monthly, quarterly, bi-annual, and annual reports submitted in accordance with the timeframes established in the RFP and the provider enrollment agreement.	$2,000 per each day past the deadline for each report.	3	1, 2, 3, & 4

Key Personnel Vacancy	In the event of a Key Personnel vacancy, propose a suitable replacement to DMS within 15 days of the vacancy occurrence or from when the contractor first knew or should have known the vacancy would be occurring.	$750 per each day after the 15th day that a suitable replacement has not been submitted. The suitability of the replacement is at the sole discretion of the State.	3	1, 2, & 3

4. Quality Management Assurance and Structure

A. PASSE

In the PASSE model, the PASSEs are the first line of quality management and improvement and DHS provides oversight over each PASSE and its operations to ensure that quality services are being provided to each enrolled member. Additionally, DHS has contracted with an External Quality Review Organization (EQRO) that will conduct the external monitoring activities required by CMS in 42 CFR §438.350.

In addition to monitoring and authorizing the services provided by PASSE providers to enrolled members, the PASSE is responsible for the following quality assurance and improvement activities:

- Developing a Cultural Competency Plan (CCP)—PASSE Provider Agreement (PA) § 4.8
- Establishing and maintaining a Grievance and Complaint process—PA § 4.9.17—22
- Ensuring care coordinators monitor services provided in accordance with the Conflict-free Case Management rules from CMS—PA § 5.2.6
- Credentialing, monitoring, and inspecting PASSE Home and Community Based Services Providers—PA § 6.2.11(c)(xiii) & Exhibit I.II
- Establishing a Credential Review Committee—PA § 6.2.14
- Developing a Quality Assurance and Performance Improvement Plan (QAPI)—PA § 8.1
- Submitting required reports to DHS, including reports on quality metrics—PA §§ 8.2 & 8.6
- Establishing a Consumer Advisory Council (CAC)—PA § 8.5
- Creating a Fraud and Abuse Protection Program (FAPP) that includes a compliance plan, a named compliance officer, and a Regulatory Compliance Committee—PA § 10.2

DHS, through the Division of Medical Services (DMS), the Division of Developmental Disabilities Services (DDS), the Division of Aging, Adult, and Behavioral Health Services (DAABHS), and the

Division of Provider Services and Quality Assurance (DPSQA) will ensure the integrity of the entire PASSE program through the following activities:

- Monitoring compliance of the contract, including the monthly, quarterly, biannual, upon occurrence, and annual reports and the encounter data submitted by each PASSE (PA § 2.3.4)
- Auditing Person Centered Service Plans and the services provided in accordance with those plans (PA §§ 5.3.8—5.3.10)
- Conducing CAHPS and NCI surveys (PASSE 1915(b) Waiver Section B, Part II(c))
- Reviewing and approving all plans submitted by the PASSE under the Agreement
- Housing a PASSE Ombudsman Office to take complaints and monitor PASSE activities (PASSE 1915(b) Waiver Section B, Part II(k)
- Enforcing Sanctions for violations of the Provider Agreement (PA § 14)

B. Healthy Smiles

In the Healthy Smiles model, the DMOs are the first line of quality management and improvement and DHS provides oversight over each DMO and its operations to ensure that quality services are being provided to each enrolled member. Additionally, the contracted EQRO will conduct the external monitoring activities required by CMS in the managed care regulations (42 CFR § 438).

In addition to monitoring and authorizing the services provided by the DMOs to enrolled members, the DMOs are responsible for the following quality assurance and improvement activities:

- Developing a Cultural Competency Plan (CCP)—Dental Provider Appendix - Appendix § 3.8
- Establishing and maintaining a Grievance and Complaint process— Appendix § 4.1 – 4.3
- Developing a Quality Assurance and Performance Improvement Plan (QAPI)— Appendix § 8.2
- Submitting required reports to DHS, including reports on quality metrics— Appendix §8.4.2
- Creating a Fraud and Abuse Protection Program (FAPP) that includes a compliance plan, a named compliance officer, and a Regulatory Compliance Committee— Appendix § 10.2

DHS, through DMS, will ensure the integrity of the entire program through the following activities:

- Monitoring compliance with the contract, including the monthly, quarterly and annual reports and the encounter data submitted by each DMO - Appendix § 9

- Through the EQRO review of quality, including review of the DMO's PIPs. Each DMO must have one clinical and one nonclinical PIP - Appendix § 8
- Enforcing sanctions for violations of the Agreement - Appendix § 14

5. Performance Improvement Projects and Interventions

Performance Improvement Projects (PIP) and Interventions are required for both PASSE and Dental Managed Care Organizations (DMO) in Arkansas. The PASSE and Healthy Smiles DMOs must adhere to all PIP requirements as laid out in Section 8.1.2 of the PASSE Provider Agreement and Section 8.2 of the Dental Agreement Appendix. The DMOs in Arkansas are under the Healthy Smiles program and are required to follow the Request For Proposal (RFP) SP-17-0011 and their respective Healthy Smiles contracts.

A. PASSE

Section 8.1.2 of the PASSE Provider Agreement requires the PASSE to design and implement Performance Improvement Projects (PIPs) that will increase the quality of services and access to services. DHS may direct the PASSE on the subject or design of the PIP, but if DHS does not do so, the PASSE must design the PIP to improve the results of a quarterly quality metric the PASSE was deficient in, including HEDIS measures. PIPs should include a focus on both clinical and nonclinical metrics. If DHS does not provide specific PIP activities, the PASSE must submit their proposed PIPs to DHS for approval before implementation. (PASSE 1915(b) Waiver Section B, Part II(m)).

Section 8.1.2 of the Provider Agreement lays out the specific requirements that the PIP must meet. The PIP should include information on how the PASSE will collect and submit performance measurement data, a plan for detecting the underutilization and overutilization of services, a plan on how the PASSE will assess the quality and appropriateness of care for members with special health needs or those using LTSS.

A contracted External Quality Review Organization (EQRO) will analyze and validate the data relied upon in the PIPs in year one of their contract. In each subsequent year, the EQRO will be responsible for reviewing the outcome data submitted by the PASSES for completed PIP projects. Because the PASSE model began in March 2019, PASSEs were not required to submit PIPs to DHS until Spring 2020.

B. Healthy Smiles

Arkansas DHS Request for Proposal (RFP) SP-17-0011 which forms the basis of the Agreement for dental managed care requires the DMOs design and implement PIPs that will increase quality of services, access to services, provider network adequacy, and customer satisfaction. PIPs should include a focus on both clinical and nonclinical metrics.

Section 3.9 of the RFP lays out the specific requirements the PIPs must meet. The PIPs should include information on how the DMOs will collect and submit performance measurement data, availability and utilization of services, and include measurable goals and objectives. The PIPs must also include all demographic and special needs groups, care settings, and types of services.

The DMO PIPs were due the first ninety (90) days after their go-live date of January 1, 2018. The DMOs submit quality improvement reports on those PIP's on a monthly basis. The EQRO also reviews and validates the PIPs.

6. Corrective Action Plans and Sanctions

The PASSE Provider Manual, PASSE Provider Agreement, and Healthy Smiles Agreement provide for the imposition of sanctions for failure to comply with any provision of applicable law, Medicaid manuals, waivers, or the Provider Agreement. A list of all available sanctions can be found in both the PASSE Provider Manual for the PASSEs and the Agreements for each program; however, DHS can impose a variety of sanctions ranging from the imposition of a corrective action plan to termination of the Agreement, including monetary penalties. The goal of implementing sanctions is to protect enrolled members and bring the DMOs into compliance with the requirements of the program.

A comprehensive list of available sanctions can be found in the Quality Metrics and Performance Targets section beginning on page 11 of this document.

7. Website

DMS will identify which quality measures and performance outcomes will be published at least annually on the DHS website, www.humanservices.arkansas.gov, as required under 438.10(c)(3).

STANDARDS

Both Arkansas managed care programs have network adequacy standards and availability of services as required by 42 CFR §438.68 and §438.206 as well as evidence based clinical practice standards required by 42 CFR §438.236.

1. PASSE

The PASSE Provider Agreement (PA) and the PASSE Provider Manual lay out very specific standards that the PASSEs must meet to ensure the quality of services provided to enrolled members. These standards are based on the requirements set out in the three authorizing documents:

1) The PASSE 1915(b) Waiver
2) The Community and Employment Supports (CES) 1915(c) Waiver
3) The Arkansas Community Integration 1915(i) State Plan Amendment

All three of these documents were approved by CMS in December 2018, prior to implementation of the PASSE model. Each standard described below moves us toward reaching the goals and objectives lined out in this Quality Strategy (*See* pp. 7-8, supra).

A. Network and Access Standards

Each PASSE must have a robust, state-wide network of providers for each service that it provides to members. The standard that must be met by each PASSE is set out in Section 226.000 of the PASSE Provider Manual and Section 6 of the Provider Agreement (PA). In that Section, it states that each PASSE "must maintain a network that is sufficient in numbers and types of providers to ensure that *all needed services* to [enrolled] members will be adequately accessible *without unreasonable delay*". The PASSEs must offer an appropriate range of acute care, preventative services, primary care, specialty services, rehabilitative services, LTSS, and HCBS. The standard not only includes a ratio of providers that must be included in the network for each number of enrolled members, but also time and distance requirements to ensure that no member must travel an unreasonable distance or length of time to receive a needed medical service. The Network Adequacy and Access Standards are included in Appendix 5.

The PASSE is responsible for monitoring the adequacy of its network by monitoring the ability of participating providers to furnish all services required by members. DHS must approve the PASSE's monitoring strategy. Additionally, the PASSE must submit bi-annual and annual reports on network adequacy metrics for review by DHS. And, as an added safeguard, the PA states that if a PASSE's provider network is not able to provide all necessary medical services to an enrolled member, the PASSE must adequately and timely cover the services out of network. *See* PA § 6.1.3.

As part of the annual report, each PASSE is required to identify any gaps in service capacity or capability and develop a corrective action pan to correct these gaps. *See* PASSE Provider Manual § 226.300.

Additionally, as added safeguards for network adequacy, DHS will be responsible for geographic mapping of each PASSE's provider network to ensure that the PASSE is meeting the network adequacy and access standards. *See* PASSE 1915(b) Waiver Section B, Part II(g). The EQRO will validate the measures and processes used by both the PASSEs and DHS to ensure network adequacy and access standards are being met.

B. Person-Centered Care and Care Coordination

"Care coordination is expected to improve health outcomes and lower costs by decreasing gaps in care, thereby lowering the rates of crisis and acute care, decreasing duplication of services, and improving medication management." *See* https://ajmc.s2.amazonaws.com/_media/_pdf-AJMC_10_2016_Schuster%20(final).pdf, pg. 678. And, states that have employed care coordination models have demonstrated savings through lower rates of emergency department visits, hospital admissions for ambulatory sensitive conditions, and hospital readmissions. *See* http://www.chcs.org/medica/MedicaidACOProgramsWebinar_01.17.17.pdf. The research shows that care coordination can have positive impacts on health, particularly for individuals with specialized service needs, such as individuals with Serious Mental Illness (SMI) and individuals with intellectual or developmental disability (IDD) or those individuals who are dually diagnosed with both SMI and IDD. For these reasons, care coordination lies at the heart of the PASSE model.

The role of the PASSE is to organize and coordinate the continuum of care for each enrolled member, all of whom have an identified need for high level behavioral health or developmental disability services. Care coordination is specifically defined by the PASSE 1915(b) Waiver in Section A, Part 1(F)(8), and the PASSE Provider Manual § 241.000, and includes the following activities:

1) Health education and coaching.
2) Coordination with other healthcare providers for diagnostics, ambulatory care, and hospital services.
3) Assistance with social determinants of health, such as access to healthy food and exercise.
4) Promotion of activities focused on the health of a patient and their community, including, without limitation, outreach, quality improvement, and patient panel management.
5) Coordination of community-based management of medication therapy.

To ensure access to care coordination, each enrolled member must have an assigned care coordinator who meets with them at least monthly (this can be by phone or in-person). Each

PASSE must also provide access twenty-four (24) hours a day, seven (7) days a week to care coordination services through a hotline or web-based application.

The assigned Care Coordinator is responsible for developing the member's person-centered service plan (PCSP). The PCSP is defined as the total plan of care made with the member that includes the following:

1) Medical services in amount, duration, and scope sufficient to meet the needs of the member;
2) HCBS services, including, if appropriate, LTSS services;
3) The members strengths, needs, and preferences; and
4) A crisis plan for the member.

See PA, Section 1, Definitions, pg. 12. To ensure all the member's identified needs are met, the PCSP must address any needs identified in the following:

1) The Arkansas Independent Assessment (ARIA)
2) Health questionnaire
3) Any psychological testing results
4) Any adaptive behavior assessments
5) Any social, medical, physical or mental health histories
6) Risk assessments
7) Case plans for court-involved members
8) Individualized Education Plans (IEPs)
9) Any other assessment or evaluation used by the PASSE prior to or at the time of PCSP development

DHS has oversight of care coordination and the PCSP development process. Per the CES 1915(c) Waiver and the PA, DHS will conduct random samplings of each PASSE care coordinator's caseload each year. Samples will be pulled in accordance with CMS's recommended sample guide, *A Practical Guide for Quality Management in Home and Community-Based Waiver Programs.* The sample size will be based on a 95% confidence interval with a margin of error of +/- 8%. DHS reviews each PCSP in the sample to ensure that each member has a PCSP that meets their identified needs and that services are being provided in accordance with that PCSP. *See* PA §§ 5.3.8—5.3.9.

DHS will also conduct focused monitoring on a minimum of 10% of clients from each PASSE. This focused monitoring may include face-to-face interviews, attendance and/or observation of the PCSP development process, health and welfare visits, and observation of PCSP implementation and activities. DHS will review PCSPs to ensure PCSPs:

1) have been developed in accordance with applicable policies,
2) address the health and welfare of the clients, and
3) are implemented in accordance with the plan.

DHS will issue findings and the PASSE will be responsible for correcting deficiencies. If DHS finds a pattern of non-compliance, it may pursue sanctions against the PASSE. *See* PA §§ 5.3.10—5.3.11. In addition to DHS's retrospective review of PCSPs and focused monitoring, many of the quality metrics also monitor how well the PASSE is providing care coordination to its members.

C. Quality Metrics and Encounter Data

Each PASSE must report on and meet the quality metrics outlined in the PASSE Provider Manual, Section 259.300, and the Provider Agreement § 8.2. The quality metric grids can be found in Appendix 4.

The quality metrics reported fall into three categories: the quality of care coordination provided by the PASSE, the Healthcare Effectiveness Data and Information Set (HEDIS) measures for behavioral health services, and the National Core Indicators (NCI) survey for Developmental Disabilities providers. The PASSEs report on most of these metrics quarterly, and if the standards are not met, the PASSE may face recoupment or other sanctions. *See* PA § 8.2.2.

Additionally, each PASSE must create their own quality metrics for the quality, accuracy and timeliness of all providers who submit claims for services to the PASSE. After verifying the information submitted by the providers, the PASSE must compile a report and submit it to DHS with the quarterly metrics. *See* PA § 8.2.3(h).

The PASSEs are also required to collect and provide encounter data on a monthly basis for all services provided to enrolled members, including in lieu of services. The encounter data must be both complete and accurate, as defined by the Provider Agreement. Complete means that no less ninety-five percent (95%) of encounters for covered services provided by participating and non-participating providers is submitted. Accurate means that no less than 95% of the PASSE's encounter submissions pass the MMIS system edits. *See* PA §S 8.3.9—8.3.11. DHS must review and validate the encounter data submitted by the PASSEs to ensure it meets the quality requirements set out in the PASSE Provider Manual and the PASSE Agreement. Part of this review is to ensure that the encounter data is a complete and accurate representation of the services provided to enrollees under the PASSE Provider Agreement. *See* PASSE Provider Manual § 248.230.

Encounter data will be reviewed to monitor the coverage and authorization of services and the quality of care provided to PASSE members. *See* PASSE 1915(b) Waiver, Section B, Part II(s). The External Quality Review Organization (EQRO) will also be involved in the validation and analysis of encounter data.

D. Transitions of Care 42 CFR § 438.340(b)(5)

A member may voluntarily transition from their assigned PASSE to another chosen PASSE. A member will not be permitted to change their PASSE more than once within a twelve (12) month period, unless:

- The change occurs during the open enrollment period; or

- There is cause for transition, as described in 42 CFR § 438.56.

The annual open enrollment period when a member can transition their PASSE will be established by DHS and will last at least thirty (30) days. Open enrollment will occur on a yearly basis. If no action is taken by the member during open enrollment, they will remain in the PASSE and will not be permitted to change their PASSE, unless for cause, during the next calendar year.

DHS also completes transitions for cause, at any time, and in accordance with 42 CFR § 438.56. For cause reasons for transition include:

- The PASSE is sanctioned pursuant to the Agreement, the PASSE Provider Manual, or any state or federal regulations or laws;
- The PASSE does not, because of moral or religious objections, cover the service the member seeks; or
- Any other reason, including poor quality of care, lack of access to services covered under the Agreement, or lack of access to providers experienced in dealing with the member's care needs. Other just cause reasons will be determined by DHS, in its sole discretion.

DHS shall process transitions with an effective date that is no later than the first day of the second month following the month in which the member requested transition. A transition is effective at midnight on the date provided in the enrollment or disenrollment file. If DHS fails to make a transition determination within the specified timeframe, the transition is considered approved for the effective date that would have been established had DHS made a determination in the specified timeframe.

The PASSE must implement transition policies and procedure, that at a minimum:

- Ensures that it does not restrict the member's right to voluntarily transition to a different PASSE, in any way;
- Requires the PASSE to provide timely notification to the receiving PASSE on the special needs of the transitioning member, and ensure timely receipt of medical records, PCSP, treatment plans, and care coordination files;
- When receiving a transitioning member, provides care coordination so that services are not interrupted, and provides required information on participating Network providers, assignment of a care coordinator, and all other new member information, in accordance with Section 4 of the Agreement;
- During transition, coordinates services (including those services on the PCSP) with the receiving or relinquishing PASSE to ensure smooth transition and continuity of care for 90 days or until the transition is completed, whichever is longer; and
- Is consistent with federal requirements outlined in 42 CFR § 438.62.

The PASSE and its subcontractors, providers, or vendors must assist in the transition of an enrolled member from its PASSE to another or vice versa.

If the PASSE dissolves, the PASSE must submit notification and a detailed Transition Plan to DHS and Arkansas Insurance Department (AID) in accordance with AID statutes, rules, and regulations, but in any case, at least, but no later than, one hundred twenty (120) calendar days prior to the effective date. The name and title of the PASSE's designated Transition Coordinator must be included in the Transition Plan. The Transition Coordinator identified will be the individual responsible for ensuring ongoing communication with DHS during the transition as well as ensuring transition of members to a new PASSE. The purpose of the plan review is to ensure uninterrupted services to PASSE Members, that services to PASSE Members are not diminished, and that major components of the organization and DHS programs are not adversely affected by the Agreement termination.

2. Healthy Smiles

The Healthy Smiles waiver and the Agreement (which incorporates several documents including the Request for Proposal (RFP) and Appendix) lay out very specific standards that the DMOs must meet to ensure quality of services provided to enrolled members. These standards are based on the requirements set out in the Healthy Smiles 1915(b) authorizing document.

Each standard described below moves the Healthy Smiles program toward reaching the goals and objectives lined out in this Quality Strategy (See pp. 9-11, supra).

A. Network and Access Standards

Each DMO must have a robust, state-wide network of providers for each service that it provides to members. The standard that must be met is set out in Section 3.4 of the RFP and Section 6 of the Appendix. In that Section, it states that each DMO must maintain a network that is sufficient in numbers and types of providers to ensure that all needed services to enrolled members will be adequately accessible without unreasonable delay. The standard not only includes a ratio of providers that must be included in the network for each number of enrolled members, but also time and distance requirements to ensure that no member must travel an unreasonable distance or length of time to receive a needed medical service. The Network Adequacy and Access Standards are included in Appendix 4.

The DMOs are responsible for monitoring the adequacy of its network by monitoring the ability of participating providers to furnish all services required by members. The DMOs must submit documentation of network adequacy. Additionally, they must submit, at a minimum, annual reports on network adequacy metrics for review by DHS. And, as an added safeguard, the Appendix states that if the provider network is not able to provide all necessary services to an enrolled member, the DMOs must adequately and timely cover the services out of network. *See* Appendix § 6.1.4.

Additionally, the EQRO will validate the measures processes used by both the DMOs and DHS to ensure network adequacy and access standards are being met.

B. Patient Centered Services and Outreach

The role of the DMOs is to conduct all outreach to clients enrolled in dental managed care. The DMOs take a proactive role in reaching out to clients to ensure each one has the information necessary to receive medically necessary. The DMOs must conduct regularly schedule and targeted outreach and education activities to work toward connecting members with a dental home.

The outreach activities shall meet the following standards:

- Target populations and service areas which must be identified and submitted to DHS.
- Conduct minimum of seventy-five (75) outreach events per year, at least fifteen (15) per quarter, equally distributed across the state in both urban and rural areas.
- Develop creative means to connect with clients.
- Must have an outreach plan.
- Ensure each enrolled member has a PCD.

C. Quality Metrics and Encounter Data

The DMOs are required to meet quality metrics outlined in the Agreement. The dental quality metrics focus on dental prevention, sealants, and reducing emergency room visits. The metric grid can be found in Appendix 4.

Metrics will be monitored through encounter data. The DMOs are required to collect and report on encounter data for all services provided to enrolled members, including value-added services, as required by the managed care regulations in 42 CFR § 438.818 and the Provider Agreement. The Encounter Data must include characteristics of the enrolled member and the network provider and must meet data quality standards, as established by CMS and DHS to ensure complete and accurate data for program administration.

Monthly encounter data submissions must include information on denied claims.

- The accuracy of the encounter data must be closely monitored and enforced because encounter data is used as the basis for the following by DHS:
    - Actuarially sound capitated payments to the DMOs for all covered services;
    - Determination of the DMO's compliance with the MLR requirement of eighty-five percent (85%);
    - Determination that the DMO has made adequate provisions against the risk of insolvency; and
    - Certification that the DMO has complied with the state's requirements of availability and accessibility of services, including network adequacy.

The DMOs must submit weekly and certify all encounter data, to the extent required by 42 CFR 438.606. Such certification must be submitted to DHS with the certified data and must be based on the knowledge, information and belief of the Chief Executive Officer (CEO), Chief Financial Officer (CFO), Dental Director or an individual who has written delegated authority to sign for,

and directly reports to the CEO or CFO that all data submitted in conjunction with the encounter data and all documents requested by DHS are accurate, truthful, and complete. The DMOs must provide the certification at the same time it submits the certified data in the format and within the timeframe required by DHS.

D. Transitions of Care

An enrolled member may voluntarily transition from their assigned DMO and choose a DMO within ninety (90) calendar days of auto assignment. An Enrolled Member will not be permitted to change his/her DMO more than once within a twelve-month period, unless:

- The change occurs during the open enrollment period; or
- There is cause for transition, as described in 42 CFR § 438.56, and Section 2.4.1 of the Provider Agreement ("for cause" transition).

DHS shall complete transition of an enrolled member:

- For cause, at any time, and in accordance with 42 CFR § 438.56:
    - The DMO is sanctioned pursuant to the Agreement, the Healthy Smiles Waiver, or any applicable state or federal law.
    - The Enrolled Member loses Medicaid eligibility.
    - The Enrolled Member needs related services to be performed at the same time, and not all related services are available within the Network of the DMO. The Enrolled Member's PCD or other provider must determine that receiving the related services separately would subject the enrollee to unnecessary risk.
    - The DMO does not, because of moral or religious objections, cover the services the Enrolled Member seeks; or
    - Any other reason that rises to the level of good cause, including poor quality of care, lack of access to services covered under the Agreement, or lack of access to providers experienced in dealing with the Enrolled Member's care needs. Other just cause reasons will be determined by DHS, in its sole discretion.

The DMOs are not authorized to process transition requests. If the DMO receives a transition request from an enrolled member, they must forward the request to DHS's enrollment vendor.

DHS shall process transitions with an effective date that is no later than the first day of the second month following the month in which the enrolled member requested a transition. A transition is effective at midnight on the date provided in the enrollment or disenrollment file. If DHS fails to make a transition determination within a specified time, the transition is considered approved for the effective date that would have been established had DHS made a determination in the specified timeframe.

The DMOs must implement transition policies and procedures that, at a minimum:

- Ensure that it does not restrict the enrolled member's right to voluntarily transition to a different DMO in any way; and
- Are consistent with the federal requirements outlined in 42 CFR § 438.62.

The DMO and its subcontractors, providers and vendors must assist in the transition of an enrolled member from its DMO to another, and vice versa. The DMOs may not request that an enrolled member be transitioned to a different DMO unless it completes the following process: submits a request for transition to DHS's designated reviewer for approval. The request must be made in writing and must specify the reason for transition.

If DHS approves the request, the DMO must continue to provide services to the enrolled member until DHS sends notice to the enrolled member of the transition, the reason for the transition, the new DMO, and the effective date of the transition. Once the transition is approved, the current DMO must assist in the transition of the member.

At the end of the contract, the DMOs must work cooperatively with DHS and any new DMO to ensure efficient and timely transition with minimal disruption to clients and providers. At least six (6) months prior to the scheduled expiration of the contract the DMOs shall develop and provide a detailed full operations resources report. Thirty (30) days following turnover of operations the DMO must provide DHS with a transition results report.

ASSESSMENT

1. DHS Role

DHS through DMS is the regulatory body and assesses PASSE and Healthy Smiles programs through the monthly, quarterly, bi-annual, and annual reporting required by the Provider Agreements. Metrics reviewed, include, but are not limited to the following:

- Call center metrics
- Third Party Liability
- Undeliverable Mail
- Utilization reports
- Fraud, waste, abuse, and overpayment
- Appeals
- Claims
- Drug utilization data (PASSE)
- Provider/Network adequacy
- HEDIS and NCI (PASSE)
- Provider preventable conditions
- Complaint and grievances
- Cultural Competency Plan

2. External Quality Review §438.340(b)(4) and §438.340(b)(10)

The Balanced Budget Act of 1997 requires states to provide an annual independent External Quality Review Organization (EQRO) to review of quality outcomes, timeliness of services, and access to services provided by Medicaid Managed Care Organizations and Prepaid Ambulatory Health Plans. DMS contracts with an EQRO to conduct ongoing evaluations of the PASSE and Healthy Smiles programs. The goal is to review and validate whether each PASSE and DMO is compliant with federal and state requirements. These activities are performed consistently to ensure compliance with Medicaid provisions under Subpart E of §438.340 and CMS protocols. The findings provided by the EQRO provide a basis for DMS actions toward the PASSEs and DMOs compliance remediation or quality improvement.

3. Office of Medicaid Inspector General and Attorney General

On April 23, 2013, Arkansas Act 1499 was signed into law creating the Arkansas Medicaid Inspector General Office (OMIG). The mission of OMIG is to prevent, detect, and investigate fraud, waste, and abuse within the medical assistance program. This mission is achieved through auditing Medicaid providers and medical assistance program functions; recovering improperly expended funds; and referring appropriate cases for criminal prosecution. OMIG works closely with DHS to prevent fraud, waste, and abuse. Quarterly meetings are held with OMIG, DHS, and each PASSE and Healthy Smiles DMO to discuss fraud, waste, and abuse.

OMIG refers cases to the Arkansas Attorney General's Office Medicaid Fraud Control Unit (MFCU). This unit investigates and prosecutes violations of state and federal laws involving Medicaid providers and the abuse or neglect of nursing home residents.

CONCLUSIONS

1) Review of Quality Strategy

As previously stated, this Quality Strategy is intended to evolve over time. While it outlines a three-year (3) approach, DMS continues to be innovative in our methods to providing clients needed services.

2) Next Steps

As new data, information, and reviews become available DMS intends to expand and revise the Quality Strategy.

DMS plans to do a crosswalk of the EQRO review, due in March 2021, and all MCO agreements to make the programs more efficient, effective, and responsive for all enrolled members. We will look at the ongoing challenges Arkansas faces in improving the quality of care for its Medicaid clients in planning future goals.

APPENDIX 1 – GLOSSARY OF TERMS

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, including to oversee the PASSE and Healthy Smiles programs.

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

Care Coordination: Care Coordination is a critical component of implementing a PASSE members PCSP. Activities involve 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, treatment plan follow-through, service coordination, monitoring the patient's adherence, and regularly updating necessary care and service. These activities focus on ensuring that 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. Requirements of care coordination are outlined in Section 5.2.

Centers for Medicare and Medicaid Services (CMS): An agency within the United States Department of Health and Human Services responsible for overseeing, among other things, the Medicaid and Children's Health Insurance Program.

Covered Services: Services that must be provided to an enrolled member including all services required through provider agreement and state and federal law.

Division of Medical Services (DMS): A division within DHS which administers and operates Medicaid including the PASSE and Healthy Smiles programs.

Healthy Smiles: the dental managed care program providing dental services for enrolled Medicaid clients under a 1915(b) waiver.

Enrolled Member: A Medicaid client assigned to a PASSE or Healthy Smiles DMO.

Medicaid: The medical assistance entitlement program authorized and funded pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and administered by DHS in Arkansas.

Medical Necessity: All Medicaid benefits are based upon medical necessity. A service is "medically necessary" if it is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap or cause physical deformity or malfunction and if there is no other equally effective (although more conservative or less costly) course of treatment available or suitable for the beneficiary requesting the service. For this purpose, a "course of treatment" may include mere observation or (where appropriate) no

treatment at all. Coverage may be denied if a service is not medically necessary in accordance with the preceding criteria or is generally regarded by the medical profession as experimental, inappropriate, or ineffective, unless objective clinical evidence demonstrates circumstances making the service necessary.

Network: All providers that have a contract with the Contractor (or a subcontractor) for the delivery of Covered Services to a client under the contract.

Nonmedical Community Supports and Services (NCSS): These supports and services are nonmedical in nature and are available under the federal authority of sections 1905, 1915(c), or 1915(i) or under state authority under Act 775 to provide such supports and services through an AR Medicaid enrolled provider as approved by a PASSE for an individual. NCSS are provided with the intention to prevent or delay entry into an institutional setting or to assist or prepare an individual to leave an institutional setting, meaning the service should assist the individual to live safely and successfully in his or her own home or in the community. The need for these supports and services is established by the functional deficits identified on the Independent Assessment (IA). The IA is an objective assessment that identifies that the need for services exists. However, the types and levels of supports and services needed to achieve his or her goals are beyond the scope of the IA and instead are developed by the PCSP process and ultimately described in the PCSP. The actual supports and services for each member are described in the member's PCSP which must be reviewed by the care coordinator and the member not less than monthly. To ensure the integrity of the PCSP, prior authorization and utilization review procedures should use criteria which would allow appropriately enrolled providers to perform nonmedical services and supports. The PASSE must ensure there are appropriate firewalls between the PASSE and providers and between internal staff and processes used to ensure services and supports are approved or denied in a conflict-free manner. The "independent review" requirement of 1915(i) also means there should be internal firewalls within the PASSE to separate the development of the PCSP from staff with fiscal duties or utilization review.

Person-Centered Service Plan (PCSP): The total plan of care made in accordance with the member as described in 42 CFR 441.301(c)(1) that indicates the following:

1. Medical services to achieve the goals and desired outcomes as identified through an assessment of functional need in accordance with 42 CFR 441.725;
2. HCBS services including, if appropriate, LTSS services;
3. The member's strengths, needs, and preferences; and
4. A crisis plan for the member.

LTSS services in HCBS settings may be a combination of medical and non-medical services. The PCSP is a process in nonmedical services and supports are individualized. The development of the PCSP reflects the possibility that particular services, or that the scope or frequency of them, may be inherently inappropriate or unnecessary for a given individual, especially as the individual's situation changes. There is no legitimate advantage to the individual or to Medicaid in providing unneeded services.

Although the functional assessment through the IA identifies areas in which the individual needs services or supports, it is clear under federal guidance that the IA is not the final word, and the responsibility for defining the specific services and supports belong to the PCSP. Even though the need for services were identified in the IA, a particular service may not be needed at all, or the amount of a service may be different when the PCSP is set. In other words, a tier assignment from an IA does not guarantee a specific type or level of service. Of course, PCSP must be revised if the condition or situation of the individual changes. Individuals may choose, or not, to include a provider of services on the planning team.

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:

1. Is at least 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 by AID, enrolled as a Medicaid provider, and enter into an annual PASSE agreement with DHS.

For purposes of meeting the 51% ownership interest by participating providers as required in Ark. Code Ann. § 20-77-2706(a)(3), a participating provider shall not be owned in whole or in part by an entity licensed by the Arkansas Insurance Department or by any state's insurance regulatory agency as an insurance carrier or health maintenance organization participating in the same PASSE. This section shall become effective on March 15, 2020. Monthly status reports must be submitted each month prior to the effective date.

APPENDIX 2 – COMMENTS AND RESPONSES

APPENDIX 3 – USEFUL LINKS

Arkansas Department of Human Services: https://humanservices.arkansas.gov/

DHS Dental Webpage: https://humanservices.arkansas.gov/about-dhs/dms/dental

DHS PASSE Webpage: https://humanservices.arkansas.gov/about-dhs/dms/passe

Division of Medical Services: https://humanservices.arkansas.gov/about-dhs/dms

PASSE Provider Manual: https://humanservices.arkansas.gov/about-dhs/dms/passe-provider-info/passe-resources-for-providers

APPENDIX 4 – QUALITY METRIC GRIDS

PASSE

Performance Standards		
Component	**Performance Standard**	**Damages**
Out-of-Network Provider Payment	Starting on January 1, 2020, no greater than 20% percent of the total dollars paid to the PASSE shall be paid for services billed by out-of-network providers.	$1000 for each percentage point over 20% dollars paid for services by out-of-network providers per quarter. The percentage point must be rounded up to the next whole number (e.g. 20.01% must be treated as 21%). In no event must the damages assessed for this performance metric exceed $20,000 per quarter.
Call Center Answer and Abandonment Rates	i. 95% of all calls answered within 3 rings or 15 seconds; ii. Number of busy signals not exceeding 5% of the total incoming calls; iii. The wait time in queue not longer than 2 minutes for 95% of the incoming calls; iv. The abandoned call rate not exceed 5% for any month.	$500.00 for each percentage point for each criteria (i, ii, iii, or iv) that falls below the standard during each one-month reporting period.
Call Center Return Calls	i. All calls requiring a call back to the Beneficiary or Provider returned within 1	$500 per telephone call that the PASSE fails to return in accordance with standards (i or ii)

	Business Day of receipt; ii. For calls received during non-Business hours, return calls to Beneficiaries and Providers made on the next Business Day.	during each one-month reporting period.
Website and Portal Availability	Contractor's website online at least 99% of the time each month, except that Contractor may take the website and portals down from 1:00 am to 5:00 am each Saturday for necessary maintenance.	$250 for each tenth of a percentage point below 99% (excluding maintenance time during the specified window) during the month.
Investigation and Resolution of Grievances	Investigate and resolve all Grievances within the following time frames: i. Acknowledgement in writing within five (5) business days of receipt of each grievance. ii. All grievances must be completed and resolved within 30 days of the filing date, unless an extension is granted in accordance with 4.9.19.c.iii of the PASSE Provider Agreement. iii. The PASSE must submit a grievance log with their quarterly report.	$500 for each Grievance or report the Contractor fails to administer in accordance with the standards (i, ii or iii) during each reporting period.
Claims Processing Denial, Approval, and Submission of Claims	Process, which means deny or approve and submit for payment claims within the following time frames: i. The PASSE must process seventy percent (70%) of all clean claims submitted	$250.00 for each percentage point for each criteria (I, ii, iii, or iv.) that falls below the standard during each one-month reporting period identified in each quarterly report.

	within seven (7) days. iii. The PASSE must process ninety-five percent (95%) of all clean claims submitted within thirty (30) days. iv. The PASSE must process ninety-nine percent (99% of all clean claims submitted within sixty (60) days.)	
Accuracy of Encounter Data – Clean Claims	At least ninety-five (95%) of all encounter data must pass through as a clean encounter claim submission to DXC or Magellan (or future contractors responsible for the collection of encounter claims)	$1,000 for each percentage point below the standard during the reporting period.
Timeliness of encounter data	All encounter data submitted in accordance with the timeframes established in the Contract.	$1,000 per each day past the deadline.
Report submission	All required reports submitted in accordance with timelines established in the Contract.	$1,000 per day past the deadline.
Key Personnel Vacancy	In the event of a Key Personnel Vacancy, propose a suitable Replacement to the Contract Monitor within 30 calendar days of the vacancy occurrence or from when the Contractor first knew or should have known the vacancy would be occurring.	$750 per each day after the 30th day that a suitable replacement has not been submitted. The suitability of the Replacement is at the sole discretion of the State.

Person Centered Service Plans	≥90% of enrolled members will have a PCSP or Interim Plan of Care.	$1,000 for each percentage point below the standard during the reporting period.
Person Centered Service Plans	≥80% of enrolled members will have a PCSP that includes all needed HCBS services.	$1,000 for each percentage point below the standard during the reporting period.
Care Coordinator to Client Caseload	≥90% of care coordinators will have a caseload of ≤50 members	$1,000 for each percentage point below the standard during the reporting period.
Initial Contact of Client	≥75% of members will be contacted by a care coordinator or appropriate PASSE team member within 15 business days after assignment to PASSE	$1,000 for each percentage point below the standard during the reporting period.
Monthly Contact of Client	≥75% of members are contacted monthly and in person quarterly by a care coordinator.	$1,000 for each percentage point below the standard during the reporting period.
Follow-Up Care	≥50% of members with a visit to Emergency room or discharge from hospital or Inpatient Psychiatric Unit/Facility will have a follow up from a PASSE care coordinator or appropriate PASSE team member within seven (7) business days.	$1,000 for each percentage point below the standard during the reporting period.
Primary Care Physician Assignment	≥80% of members will have selected a PCP and are on a PCP's caseload	$1,000 for each percentage point below the standard during the reporting period.
Appeals	4. Unless it is an expedited appeal request, an oral	$1,000 per day past the deadline.

	appeal request must be followed with a written, signed appeal within ten (10) calendar days of the oral filing, unless the appellant requests an expedited resolution. 5. The PASSE must acknowledge each PASSE appeal in writing within five (5) business days of receipt of each PASSE appeal, unless the appellant requests an expedited resolution. 6. Unless the appellant requested expedited resolution, an appeal must be heard and notice of appeal resolution sent to the member no later than thirty (30) calendar days from the date of receipt of the appeal.	

Healthy Smiles

Performance Standards		
Component	**Performance Standard**	**Damages**
Access to Care: Distance	i. At least 90% of Beneficiaries have access to two or more Primary Care Dentists who are accepting new patients within 30 miles of the Member's residence in urban counties and 60 miles of the Beneficiary's residence in rural counties. ii. At least 85% of all Beneficiaries have access to at least one specialty provider within 60 miles of the Beneficiary's residence. iii. At least 90% of pediatric Beneficiaries must have access to Pediatric Dental Services through two or more Primary	$1,000 for each percentage point for each criterion (i or ii) that falls below the standard during each one-month reporting period.

	Care Dentist who are accepting new patients within 30 miles of the Beneficiary's residence in Urban counties and 60 miles of the Beneficiary's residence in Rural counties.	
Access to Care: Time	i. Emergency Care provided within 24 hours. ii. Urgent Care, including urgent specialty care, provided within 48 hours. iii. Therapeutic and diagnostic care provided within 14 days. iv. Primary Care Dentists make referrals for specialty care based on the urgency of the Beneficiary's dental condition, but no later than 30 days. v. Non-urgent specialty care provided within 60 days of authorization.	$250 for each instance the Contractor fails to meet any of the "Access to Care: Time" performance standard ('i' through 'v') for any Beneficiary.
Out-of-Network Provider Billing	No greater than 20% percent of the total dollars billed to the Contractor for outpatient services billed by out-of-network providers.	$1000 for each percentage point over 20% billed for outpatient services by out-of-network providers per quarter, per geographic area. The percentage point shall be rounded up to the next whole number (*e.g.* 20.01% shall be treated as 21%).
Call Center Answer and Abandonment Rates	i. 95% of all calls answered within 3 rings or 15 seconds; ii. Number of busy signals not exceeding 5% of the total incoming calls; iii. The wait time in queue not longer than 2 minutes for 95% of the incoming calls; iv. The abandoned call rate not exceed 3% for any month.	$500.00 for each percentage point for each criterion (i, ii, iii, or iv) that falls below the standard during each one-month reporting period.
Call Center Return Calls	i. All calls requiring a call back to the Beneficiary or Provider returned within 1 Business Day of receipt; ii. For calls received during non-Business hours, return calls to Beneficiaries and	$500 per telephone call that the Contractor fails to return in accordance with standards (i or ii) during each one-month reporting period.

	Providers made on the next Business Day.	
Website and Portal Availability	Contractor's website, Beneficiary portal, and Provider portal online at least 99% of the time each month, except that Contractor may take the website and portals down from 1:00 am to 5:00 am each Saturday for necessary maintenance.	$250 for each tenth of a percentage point below 99% (excluding maintenance time during the specified window) during the month
Investigation and Resolution of Grievances	Investigate and resolve all grievances as expeditiously as the Enrolled Member's health condition requires, but not to exceed ninety (90) calendar days. The timeframe may be extended as allowed in Section 4.3.3 of the Appendix, but the extension must be properly documented and shall not exceed fourteen (14) calendar days. Written resolution of the grievance must be sent to the Enrolled Member within two (2) business days of making. The written resolution must conform to the requirements laid out in Section 4.3.3 of the Appendix.	$500 for each Grievance the Contractor fails to administer in accordance with the standards (i, ii or iii) during each one-month reporting period.
Denial, Approval, and Submission of Claims	Deny or approve, and submit for payment: i. 100% of clean paper claims within 30 calendar days of receipt ii. 100% of clean electronic claims within 14 calendar days of receipt;	$250.00 for each percentage point for each criteria (i or ii) that falls below the standard during each one-month reporting period identified in each quarterly report.
Accuracy of encounter data	At least 99% of all encounter data must be accurate.	$1,000 for each percentage point below the standard during the reporting period.
Timeliness of encounter data	All encounter data submitted in accordance with the timeframes established in the Contract.	$1,000 per each day past the deadline.
Report submission	All required reports submitted in accordance with the timeframes established in the RFP and the provider enrollment agreement.	$2,000 per each day past the deadline for each report.
Key Personnel Vacancy	In the event of a Key Personnel Vacancy, propose a suitable Replacement to the Contract Monitor within 15 days of the Vacancy occurrence or from when the Contractor first knew or should have known the Vacancy would be occurring.	$750 per each day after the 15th day that a suitable Replacement has not been submitted. The suitability of the Replacement is at the sole discretion of the State.

Quality Metrics

Category	Measure	Target Level
Use of preventive dental services: Adult	Percentage of enrollees age 21 and older who had at least one preventive dental service during the year. *Excludes:* Enrollees who have been enrolled for less than 9 months of the measurement year	Goal: 12% Current: 6.6% Year 1 Target: 8.4% Year 2 Target: 10.2% Year 3 Target: 12%
Use of preventive dental services: Child (under age 21)	Percentage of enrollees under age 21 who had at least one preventive dental service during the year. *Excludes:* □ Enrollees who have been enrolled for less than 9 months of the measurement year. □ Enrollees under one year of age at the mid-point of the measurement year.	Goal: 64% Current: 54% Year 1: 57.3% Year 2: 60.6% Year 3: 64%
Sealants for children	Percentage of beneficiaries ages 6-14 who had at least one sealant service on one of the permanent first molars during the measurement year. *Excludes:* □ Enrollees who have been enrolled for less than 9 months of the measurement year. □ Enrollees who have previously had all their applicable teeth sealed, restored, or extracted.	Goal: 24% Current: 12% Year 1: 16% Year 2: 20% Year 3: 24%
Dental emergencies	Per capita emergency room visits during the measurement year for dental care *Excludes:* Enrollees who have been enrolled for less than 9 months of the measurement year.	Goal: 5.5 visits/1,000 Current: 6.72 visits/1,0003 Year 1: 6.32 visits/1,000 Year 2: 5.92 visits/1,000 Year 3: 5.5 visits/1,000