PASSEs Starting March 1: Frequently Asked Questions

Starting in March 2019, individuals’ services will be managed by the Provider-led Arkansas Shared Savings Entity (PASSE) groups if individuals are on the Developmental Disabilities Waiver or Wait list, if they live in a private DD Institutional Care Facility, or if they have a Behavioral Health diagnosis and have received an Independent Assessment assigning them to tier 2 or tier 3.

Will I have coverage on March 1?

Yes, if you are a member assigned to a PASSE, you will have health coverage on March 1, 2019. The PASSEs have signed an agreement to cover your current plan of care as it is now, including prior authorizations, for at least 60 days. They must meet with you to discuss your plan of care before any changes can be made. Even if you have just been reassigned from ForeverCare to one of the other PASSEs, you will get to have your same plan of care for at least the first 60 days.

Are the PASSEs ready for the March 1 deadline?

The PASSEs have signed agreements to enter Phase II. The PASSEs have indicated they are ready for the March 1 start date because they have spent the past year hiring and training staff; documenting their policies; developing their billing systems; and planning for any issues that could arise. They have spent the past three months further developing their networks and training providers on their systems. The transition plan that all PASSEs agreed to also protects clients and makes sure clients’ existing services will be covered for the first 60 days.

This new program is a partnership between the Arkansas Department of Human Services (DHS) and the PASSEs. Every new program requires a transition period and can have some bumps when it begins, but the PASSEs and DHS are committed to quickly responding to assist clients and those who provide services and address issues if they arise. PASSEs will continue to develop their networks and improve their care for clients.

What if my doctor or pharmacy claim gets denied when PASSEs take over?

DHS and each PASSE is prepared to help providers to process claims. If your coverage claim that your service provider submits is denied on March 1, providers will be able to see that you are a PASSE member, and they will have phone numbers to contact people who will be ready to help solve your issue. DHS and the PASSEs will be open and taking calls through the weekend of March 1-3, 2019.

If your provider says it can’t fill your prescription or that Medicaid says you aren’t covered for services, you can tell them to call the PASSE Command Center for more information.

DHS and each PASSE also will be operating Internal Command Centers for providers and clients to address billing questions or concerns as they arise and to monitor any billing trends and address issues during the transition.
Will I have to get approval to see a new doctor or specialist?

Each PASSE can pay Medicaid enrolled providers for a service they have provided. Depending on the type of provider the rate may be different for a provider that has not joined the PASSE, an out-of-network provider as described below.

Each PASSE will develop their own rules for pre-approval for specialist services but will be required to honor any existing authorization for services for at least 60 days.

PASSE members are encouraged to communicate with their care coordinators regarding new specialist services needed to determine if those services should be added to the PASSE member’s person-centered service plan.

How will Medicaid caps on yearly visits work with the PASSE starting on March 1?

As PASSE members transition from the current fee-for-service system to the PASSE system, each individual PASSE will determine how their programs will work. Through their handbooks available online, the PASSEs will communicate to their members their policies for caps on yearly visits. For example, your PASSE will let you know how many times a year you can see your primary care physician. PASSEs can allow for more services access than traditional Medicaid, if they choose, so current Medicaid caps on annual visits may be removed for PASSE members.

How will in-network and out-of-network visits work?

If your provider has signed a contract to be a participating member of your PASSE’s network, that provider is considered “in network.” They will be notified of how to process claims for your PASSE, and they will have guaranteed rates with your PASSE.

If a provider is not a participating member of your PASSE, they will be considered “out of network.” The PASSE can still pay for your visit; however, you might have to get your services preapproved. Providers who are not “in network” with a PASSE will not have guaranteed rates with that PASSE. Each PASSE will handle out-of-network providers according to each PASSE’s internal practices and policies.

How do I know if my provider is in a PASSE?

To find out if your provider is in your PASSE’s network, check your PASSE’s network list on the PASSE’s website or call to ask them. Remember that PASSE networks will continue to grow throughout the program implementation as new providers sign contracts.

- Arkansas Total Care  www.arkansastotalcare.com  |  1-866-282-6280
- Empower Healthcare Solutions  www.getempowerhealth.com  |  1-866-261-1286
- Summit Community Care  www.summitcommunitycare.com  |  1-844-405-4295
Are Arkansas Children’s Hospital and UAMS in-network members of a PASSE?

UAMS and ACH have currently signed Phase I referral network agreements with all PASSEs. Each PASSE is currently negotiating contracts with UAMS and ACH to deliver signed contracts for Phase II and PASSE members will be able to access services and receive care at these facilities. As with other providers out of network benefits are allowed.

How will pharmacy costs change with the PASSEs?

In this new system with the PASSEs, the Medicaid-approved list of medicines will be available, and they won’t have copays at pharmacies. PASSEs do not have to adhere to the same caps that Medicaid has on the number of medications per client and will be able to examine the needs of each member. CVS Caremark is the pharmacy benefits manager for all PASSEs.

What if I want to switch my PASSE after March 1?

Open enrollment will happen during the month of May 2019. During that time, members will have the opportunity to switch to a new PASSE, if they want to. If members do nothing, they will stay with their current PASSE.

ForeverCare clients who have been reassigned to a new PASSE will have 90 days to switch PASSEs which will extend from February to May.

I still have questions. Who can I call?

If you are a member of a PASSE, and you have concerns or questions, you can call the PASSE Ombudsman office at 1-844-843-7351 or email PASSEOmbudsmanOffice@dhs.arkansas.gov. For more information on the PASSE, please visit www.passe.arkansas.gov.