ARKANSAS
PASSE
CARE COORDINATION
AGREEMENT
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SECTION I
PURPOSE, APPLICABILITY AND EFFECTIVE DATES

The purpose of the PASSE (Provider-Led Arkansas Shared Savings Entity) Care Coordination Agreement between the Arkansas Department of Human Services (DHS) and the PASSE is to implement and operationalize Phase I of the Arkansas Medicaid Provider-Led Organized Care Program pursuant to Ark. Code Ann. §20-77-2701 et seq. As a result, the terms and conditions contained herein are applicable only during Phase I of the program.

This PASSE Provider Agreement is effective immediately upon all necessary signatures being affixed hereto.

The service delivery effective date, i.e., Phase I of the PASSE program for delivery of Care Coordination services, is FEBRUARY 1, 2018. Each PASSE will receive payment for case management and care coordination for each enrolled member. DHS will continue to pay for services on a fee-for-service basis.

The PASSE Provider Agreement and service delivery under this Agreement terminates at midnight on DECEMBER 31, 2018, subject to any extension. It will be within the sole discretion of DHS to extend this PASSE Provider Agreement in 30-day increments.

During Phase I, PASSEs are given the opportunity to learn and implement program characteristics and features that will be required in Phase II. This includes administering and managing Care Coordination Services that will be provided by each PASSE, and building relationships with providers to ensure robust, well-rounded Provider Referral Networks. When full-risk managed care goes into effect in Phase II, the terms and conditions herein will be superseded by the terms and conditions of a new Agreement.

SECTION II
APPLICABLE LAW

A. STATE AND FEDERAL LAWS, STATUTES, POLICIES, PROCEDURES, RULES, REGULATIONS, GUIDELINES AND MANUALS

All Arkansas and Federal laws, statutes, policies, procedures, rules, regulations, guidelines and manuals, as they currently exist, or as they are subsequently modified, applicable to this Agreement are collectively referred to as “the applicable law.” The applicable law includes but not limited to:

1. Those governing, promulgated by and enforced by the Arkansas Insurance Department (AID), including but not limited to Arkansas’s “Any Willing Provider” laws (Ark. Code Ann. §23-99-801 et seq.);
2. Those promulgated by Arkansas Medicaid, including the PASSE Medicaid Provider Manual and other applicable Medicaid Provider Manuals; and
The PASSE is responsible for compliance with all requirements set forth in the applicable law, and any subsequent modifications, by the PASSE, by all staff, and by subcontractors and the staff thereof.

In the event that a provision of Federal or State law, regulation, or policy is repealed or modified during the term of this Agreement, effective on the date the repeal or modification by its own terms takes effect:

1. The provisions of this Agreement will be deemed to have been amended to incorporate the repeal or modification; and
2. The PASSE will comply with the requirements of the Agreement as amended, unless DHS and the PASSE otherwise stipulate in writing.

B. SEVERABILITY

If any statute or regulation is enacted which requires a change in this Agreement or any attachment, then both parties will deem this Agreement and any attachment to be automatically amended to comply with the newly enacted statute or regulation as of its effective date. If any provision of this Agreement (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both the Department and the PASSE will be relieved of all obligations arising under such provision. If the remainder of the Agreement is capable of performance, it will not be affected by such declaration or finding and will be fully performed.

C. SOVEREIGN IMMUNITY

The State and DHS in no way waives the protections of Sovereign Immunity by any language contained in this Agreement or by any action undertaken related to the Arkansas Medicaid Provider-Led Organized Care Program.

D. CHOICE OF LAW AND FORUM

This agreement will be governed by the laws of the State of Arkansas and all matters arising under it are subject to the requirements and remedies afforded under the Arkansas Administrative Procedure Act, Ark. Code Ann. §25-15-201 et seq.

SECTION III
DEFINITIONS AND ACRONYMS

See Appendix A, which sets forth acronyms and definitions used in this Agreement.
PASSE PROGRAM MANAGEMENT,
OVERSIGHT AND CONTRACT MONITORING

SECTION IV
PASSE ENROLLMENT ELIGIBILITY

To be eligible to enroll as a PASSE with Arkansas Medicaid, the entity must comply with the requirements set forth in the Arkansas Medicaid PASSE Medicaid Provider Manual and all applicable law.

SECTION V
READINESS REVIEW

DHS will conduct a Readiness Review of the PASSE. The purpose of the Readiness Review is to assess the PASSE’s operational readiness and its ability to provide Care Coordination Services to PASSE Members at the start of the PASSE Agreement duration. Subject to the availability of resources, DHS will provide technical assistance as appropriate.

The Readiness Review will be conducted by DHS prior to any Medicaid Enrollee being attributed to the PASSE as a PASSE Member. The PASSE will be permitted to commence providing care coordination only if the Readiness Review items are met to DHS’ satisfaction and approval.

DHS will verify implementation of plans and information reviewed during the Readiness Review. This is to ensure that each PASSE has operationalized the requirements as identified in the PASSE Medicaid Provider Manual and this Provider Agreement. DHS will continue ongoing monitoring of each PASSE, including on-site visits through the duration of this agreement.

*Update Language

Pursuant to 42 CFR §438.66, and the PASSE Medicaid Provider Manual, Section II, as minimum requirements, DHS will assess the ability and capacity of the PASSE to satisfactorily perform in the following areas:

A. Operations/Administration, including:
   1. Administrative staffing and resources (including Section VII)
   2. Delegation and oversight of Care Coordination responsibilities (multiple sections)
   3. PASSE Member services, including but not limited to communications, outreach and education capabilities (multiple sections)
   4. Grievance system required for Care Coordination (including Section XXIII)
   5. Provider Network management and services, including but not limited to communications, outreach and education capabilities, which will be utilized with providers that are both in and out of the Provider Referral Network, and will include utilization of EHR/EMR/HIT/HIE technology, such as data extraction from EHRs, and use of ADTs or similar methodology or software
to monitor PASSE Members’ use of certain providers and/or facilities
(multiple sections)
6. Program Integrity/Compliance (multiple sections)
7. Materials and PASSE Member required material, Outreach/education and
Marketing materials (including Section XVII)
B. Service delivery, including:
1. Initial Provider Referral Network adequacy (including Section X)
2. Continuing Provider Referral Network updates process (including Section X)
3. Case management/care coordination (including the Member Services Section)
4. Customer service process (including Section XVI)
5. Quality improvement planning (including the Quality Monitoring and Evaluation
Section)
6. Utilization review (includes, but is not limited to, e.g., cross-referencing PASSE
Member’s provider utilization of multiple providers of a single type or
obtaining multiple prior authorizations for a single condition)
7. Obtain proper documentation from each PASSE Member that allows each Care
Coordinator coordinate care between each/all of the PASSE Member’s
providers
8. PASSE Member documentation, including but not limited to, marketing materials,
PASSE Member handbook and all necessary inclusions therein
C. Budget management; and
D. Systems management, including:
1. Claims management for Care Coordination services
2. Encounter data and enrollment information management, including but not limited
to reporting on encounter data and enrollment information
3. Implementation of SFTP (Secured File Transfer Protocol) account for file transfer,
or use of another acceptable designated method

Subsequent reviews of PASSE operations or compliance are set forth below in Quality Monitoring and Evaluation.

SECTION VI
MARKETING

The PASSE will comply with all Federal and State provisions regarding marketing including 42 CFR
§438.104, and the PASSE Medicaid Provider Manual. Appendix B contains specific information
related to marketing activities undertaken by the PASSE.

SECTION VII
STAFF REQUIREMENTS AND SUPPORT SERVICES

A. STAFF REQUIREMENTS GENERALLY

The PASSE will have in place the organizational, operational, managerial and administrative systems
and staff capable of fulfilling all Agreement requirements whether through direct staff hiring,
entering agreements with subcontractors that hire staff, or hiring independent contractors or affiliated
The PASSE must:

1. Comply with all requirements contained in Appendix C pertaining to mandatory disclosure and verification when hiring staff;
2. Employ sufficient staff and utilize appropriate resources to attain compliance under this Agreement and to achieve stated outcomes in all functional areas within the organization;
3. Have local staff available 24 hours per day, seven (7) days per week to work with DHS and/or other State or Federal agencies on urgent issue resolutions for situations determined by DHS to be an emergency. The designated local PASSE staff will have access to information necessary to identify PASSE Members who may be at risk, their current health/service status, the ability to assist in transition activities, and have the ability to perform status checks at affected facilities and locations, and perform ongoing monitoring if necessary. The PASSE will supply DHS with the contact information for these staff. At a minimum the contact information will include a current 24/7 telephone number. DHS must be notified and provided back up contact information when the primary contact person will be unavailable;
4. Notify DHS prior to moving any functions outside the State of Arkansas and receive prior approval from DHS. The notification must include an implementation plan for the out-of-state transition; and
5. Be responsible for reasonable costs associated with on-site audits or other oversight and administrative activities which result in out-of-state travel and related expenses to the State when functions are located outside of the State of Arkansas.

B. KEY STAFF POSITIONS

At a minimum, the following key staff positions are required to be filled at all times:

1. Administrator/CEO/COO (hereinafter referred to as “CEO”), who is located in Arkansas, oversees the entire operation of the PASSE, and has the authority to direct, implement and prioritize work, regardless of where performed to ensure compliance with Agreement requirements, and oversees all staff performing functions related to this Agreement;
2. Chief Financial Officer/CFO (hereinafter referred to “CFO”) who is located in Arkansas, is available to fulfill the responsibilities of the position and to oversee the budget, accounting systems, and financial reporting implemented by the PASSE;
3. Care Coordination Manager, who is located in Arkansas, is responsible for overseeing all Care Coordinators and ensuring that all aspects of Care Coordination Services are being fulfilled;
4. IT/IS (Information Technology/Information Systems) Manager who is responsible for all information systems management, including coordination of the technical aspects of application infrastructure, server and storage needs, reliability and survivability of all date and data exchange elements including Business Continuity/Disaster Recovery activities; and
5. Compliance Officer is responsible for overseeing the activities of the Medical/Quality Management Committee and ensuring compliance with state and federal law.

An individual staff member is limited to occupying a maximum of two (2) of the Key Staff positions listed above, unless prior approval is obtained by DHS. The PASSE must submit its functional organizational chart to DHS. Thirty (30) days from the start of operations, the PASSE must report to DHS on the status of hiring Key Staff. DHS, in its discretion, may allow the PASSE additional time to finalize hiring Key Staff.

C. ADDITIONAL REQUIRED STAFF

At a minimum, the following additional required staff positions must be filled at all times:

1. Care Coordination staff who are located in Arkansas and who provide Care Coordination Services for PASSE Members. The Care Coordination staff must have the minimum qualifications set out in the PASSE Medicaid Provider Manual, Section II. Additionally, the Care Coordination staff must perform all duties described in the Care Coordination Services Requirements and Scope of Care Coordination Services in this Agreement, in addition to any and all duties under applicable law; and
2. IT/IS Staff who are able to ensure timely and accurate information system management to meet system and data exchange requirements as specified in Data and IT Requirements Section of this Agreement.

D. CHANGES IN STAFFING

The PASSE will inform DHS in writing, and provide updates to the functional organizational chart, related to any changes in personnel in a Key Staff position, including when an employee leaves one of the Key Staff positions listed. The name of the interim contact person should be included with the notification. The name and resume of the permanent employee should be submitted as soon as the new hire has taken place, along with a revised Organization Chart complete with Key Staff.

E. LOCAL PRESENCE

The PASSE is responsible for maintaining a significant local presence within the State of Arkansas, which includes, at a minimum, the full-time residency of Key Staff including the CEO, CFO and the Care Coordination Manager.

F. STAFF TRAINING AND MEETING ATTENDANCE

The PASSE will:

1. Ensure that all staff have appropriate training, education, experience and orientation to fulfill the requirements of the position;
2. Provide initial and ongoing staff training that includes an overview of applicable law specific to individual job functions;
3. Provide the appropriate staff representation for attendance and participation in meetings and/or events scheduled by DHS. All meetings will be considered mandatory unless otherwise indicated;
4. Ensure that all staff members having contact with PASSE Members or providers:
   a) Receive initial and ongoing training with regard to the appropriate identification and handling of quality of care/service concerns, as well as compliance with all privacy and HIPAA (Health Insurance Portability and Accountability Act of 1996, Public Law 104-191) requirements;
   b) Are trained in the geography of the state and have access to mapping search engines for the purposes of understanding the locations associated with all aspects of the Total Plan for Care.

G. WRITTEN POLICIES AND PROCEDURES

The PASSE will:

1. Develop and maintain written policies and procedures for each staffing functional area consistent in format and style;
2. Maintain written guidelines for developing, reviewing and approving all policies and procedures, including an annual review to ensure that the PASSE’s written policies reflect current practices and are dated and signed by the PASSE’s CEO;
3. With the assistance of DHS:
   a) Modify any policy or process that is inefficient or places an unnecessary burden on the PASSE Members or providers; and
   b) Create policies or processes necessary to fulfill the terms of this Agreement.

The written staff policies must also include those enumerated elsewhere in this Agreement, including but not limited to non-discrimination policies and PASSE Member Rights set forth herein.

SECTION VIII
MEDICAID ENROLLEE ATTRIBUTION AS PASSE MEMBER

A. ATTRIBUTION METHODOLOGY

The attribution methodology for PASSE Member enrollment is set forth in the PASSE Medicaid Provider Manual. On a periodic basis, as Medicaid Enrollees receive an Independent Assessment, DHS will attribute Medicaid Enrollees for enrollment in a PASSE as a PASSE Member.

B. NOTIFICATION TO PASSE AND EFFECTIVE DATE OF PASSE MEMBER ATTRIBUTION

On a periodic basis, the PASSE will receive a Roster of PASSE Members attributed to that PASSE that must be enrolled by the PASSE. Each Roster will contain names of PASSE Members who are newly attributed to the PASSE. Additionally, beginning with the second Roster, it will also contain the names of PASSE Members who are currently attributed to the PASSE.

The PASSE will be required to timely check for receipt of the Roster, and verify receipt with DHS.
The Roster will be in a spreadsheet or other widely-utilized and accepted format, and sent to the PASSE via the SFTP account the PASSE implemented through DHS, or other acceptable designated method.

The Roster will contain the minimum following personal information related to the PASSE Member:

1. Name
2. Date of Birth (DOB)
3. Medicaid ID Number
4. Address, phone, email and county of residence to extent available

The newly-attributed PASSE Members listed on the Roster will be based, in part, upon the updates to the Provider Referral Network due to DHS on or before the first Friday of each month. Beginning on the first day of month following receipt of the Roster, the PASSE will be responsible for providing Care Coordination services for each PASSE Member. The Roster will be distributed to the PASSE prior to the first day of the following month in order for each PASSE begin work on internal processes to provide Care Coordination as of the first of the month.

After attribution and so long as the PASSE Member is enrolled in the PASSE, the PASSE shall be responsible for ensuring continued contact with the PASSE Member so that the PASSE Member receives appropriate Care Coordination services. This requirement is subject to any circumstances related to Abeyance and Closure in Section XVIII, and Enrollment Options for PASSE Members in Section XIX.

C. PASSE MEMBER INDEPENDENT ASSESSMENT INFORMATION

As Medicaid Enrollees receive an Independent Assessment and are initially attributed to the PASSE, they will be included in the Roster discussed above. In addition to the information contained in the Roster regarding each PASSE Member, DHS will transmit to the PASSE via the SFTP, or other acceptable designated method, the following information:

1. Independent Assessment (IA) Full Report
2. IA Summary
3. Tier Assignment

D. CLAIMS DATA

In addition to the Roster and Independent Assessment information noted above, for each PASSE Member, both newly- and currently-attributed, the PASSE will receive claims data. The claims data will be provided to the PASSE in an on-going basis, at least quarterly.

The claims data will sent to the PASSE via the SFTP, or other acceptable designated method.

The raw claims data will consist of the latest 12 months’ claims pulled from MMIS on a rolling basis. These claims will be those that have been filed by providers within the timely filing period, and may include unadjudicated, amended or later-withdrawn claims.

E. CARE COORDINATION SERVICES IMPLEMENTATION AND INITIAL
OUTREACH TO PASSE MEMBER

Care Coordination services for each PASSE Member begin the first day of month following receipt of the Roster. The first day of the month in which a Medicaid Enrollee becomes attributed as a PASSE Member will trigger all metrics and encounter data related to providing said Care Coordination services.

Within 15 days after the first day of each month after the PASSE receives a Roster, the PASSE must make an initial contact with each newly-attributed PASSE Member and begin providing Care Coordination services to that Attributed PASSE Member.

As the PASSE conducts initial outreach to each newly-attributed PASSE Member, the PASSE may become aware of any updates to the PASSE Member’s contact information that differs from the information contained in the Roster provided to the PASSE by DHS. In such instances, the PASSE must notify DHS of any updates to the PASSE Member’s contact information within 10 calendar days thereof.

SECTION IX
PAYMENTS

A. GENERALLY

During Phase I, DHS will make payments to the PASSE in accordance with the terms of this Agreement and as described in the PASSE Medicaid Provider Manual. These payments will be made to the PASSE based upon the PASSE’s performance is in compliance with the terms and conditions herein.

The only source of payment to the PASSE for the Care Coordination services provided hereunder is from funds under the control of DHS. The PASSE may not pledge or assign any payments that are due to be paid it by DHS.

This section will not prohibit DHS at its sole option from making payment to a fiscal agent hired by the PASSE.

B. CATEGORIES OF PAYMENTS

The payments made to the PASSE, as well as the conditions under which the payments will be made, are set out in the PASSE Medicaid Provider Manual and the Medicaid Provider-Led Organized Care Act (Act 775 of 2017, Ark. Code Ann. §20-77-2701 et seq.)

For the purposes of this Agreement and applicable only to Phase I, the following payments can or may be made by DHS to the PASSE:

1. Foundation Payment:
   a) This payment will be in the amount of $208.00 per PASSE Member;
   b) It will be paid only in the first month that a PASSE Member is enrolled in a PASSE;
c) If a PASSE Member transitions to another PASSE, if a PASSE Member leaves the Provider-led program and later returns the Provider-led program for any reason, or under another set of similar conditions, the Foundation payment will not be paid another time; and

2. Care Coordination Payment:
   a) This payment will be in the amount of $173.33 Per-Member-Per-Month (PMPM);
   b) It will be paid starting in the second month of PASSE enrollment and continuing thereafter so long as the PASSE Member does not enter into a change in status reflected below that results in non-payment, recoupment or other adjustment of the Care Coordination Payment;
   c) In order to continue to receive the full Care Coordination PMPM for an attributed PASSE Member, the PASSE must meet the Quality Performance standards set forth herein under Section XXIV and in the PASSE Provider Manual (PASSE Provider Manual §251.000); and
   d) If the PASSE fails to meet 2 of the 5 quality metrics for care coordination, DHS may take action to correct the failure or impose penalties on the PASSE, including but not limited to, suspension of PMPM payments for all attributed PASSE Members. (PASSE Provider Manual §252.000).

The Phase II Global Payment will replace both of these payments as the functions of the PASSE expand to full-risk care of the PASSE Members. A new Agreement will reflect the terms and conditions applicable thereto.

C. PAYMENT ADJUSTMENTS

1. GENERALLY

An error discovered by the State in the amount of fees paid to the PASSE, with or without an audit, will be subject to appropriate adjustments or measures taken to correct the over- or under-payment. When the PASSE identifies an overpayment by DHS, DHS must be notified and reimbursed within 30 days of identification.

DHS reserves the right to modify its policy on recoupments, adjustments and offsets at any time during the term of this Agreement.

2. CHANGE IN STATUS

If there is a change in a PASSE Member’s status, the PASSE will provide coverage for the month in which the status change occurred. The PASSE Member’s new status will be effective beginning the first day of the following month.

After each month, DMS may pay, recover or offset payments made to a PASSE for any PASSE Member if there is a change in status. A change in status includes, but is not limited to:

   a) Death of a PASSE Member;
   b) Incarceration in a public institution;
   c) Abeyance;
   d) Closure; and
e) An Independent Assessment determination of a Tier 1 level of need.

3. ADDITIONAL ADJUSTMENTS

Additionally, other adjustments may be made to payments to a PASSE. These include, but are not limited to:

a) Duplicate payments for the same PASSE Member; and
b) Adjustment based on a change in the Attributed Member’s eligibility for Medicaid.

SECTION X
PROVIDER REFERRAL NETWORK

A. DEVELOPMENT AND IMPLEMENTATION

1. GENERALLY

The PASSE will develop and maintain a Referral Network of providers as required by the PASSE Medicaid Provider Manual, the Medicaid Provider-Led Organized Care Act (Act 775 of 2017, Ark. Code Ann. §20-77-2701 et seq.) and AID requirements. The Referral Network must comply with these minimum requirements:

a) Be comprised of both Participating Providers and Direct Service Providers;
b) Include each type of provider in the Provider Network;
c) Include providers for both Behavioral Health and Developmental Disabilities services;
d) Comply with Medicaid provider rules:
   i) Every provider in the Referral Network must meet all requirements for, and be enrolled as, an Arkansas Medicaid provider;
   ii) Providers for specific types of services must meet all other requirements pertinent to the services provided, including Behavioral Health and Developmental Disabilities services;
   iii) For specific requirements on Provider Enrollment, refer to the appropriate DHS Medicaid Provider Manuals;
e) Ensure statewide coverage that will:
   i) Meet all time and distance requirements set out in the PASSE Medicaid Provider Manual, Section II;
   ii) Serve all eligible PASSE Members in every part of the state.

2. MINIMUM PASSE RESPONSIBILITIES

With regard to the Referral Network, the PASSE will be responsible, at a minimum, to:

a) Provide to DHS a Memorandum of Intent (MOI) or other executed documentary evidence of an agreement with each service provider enlisted in the network. The MOI should include at least the following information:
   i) Name and address of provider;
   ii) Provider type;
iii) Medicaid ID number, NPI number and TIN/EIN;
iv) Sites, facilities, or geographical areas of coverage that the provider will serve;
v) An attestation that the provider is currently enrolled as an Arkansas Medicaid provider and is in good standing;
vi) A description of the procedures you will use for determining, on an on-going basis, that each provider in your network is duly licensed or certified;
vii) The types of services to be provided;
b) By no later than the first Friday of each month, notify DHS when there are additions or changes of any kind to the PASSE’s network as described herein, which will inform the attribution of PASSE Members to the PASSE for enrollment under the schedule set forth below and in Section VIII, Medicaid Enrollee Attribution as a PASSE Member;
c) Update the PASSE website and directory with the additions and changes to the network as required below and in Section XVII, Member Information, Education and Outreach;
d) Conduct regular meetings with providers to address issues (or to provide general information, technical assistance, etc.) related to Federal and State requirements, changes in policy, reimbursement matters, prior authorization and other matters as identified or requested by DHS;
e) Establish a method for communication and care coordination with providers, both in and outside of the Provider Referral Network, which shall be disclosed to DHS during the Readiness Review process. The methodology should include, but not limited to, utilization of EHR/EMR and HIT/HIE technology, such as data extraction from EHRs, and use of ADTs or similar methodology or software to monitor PASSE Members’ use of certain providers and/or facilities.

B. PROVIDER NETWORK UPDATES AND DIRECTORY

1. PROVIDER/NETWORK CHANGES REPORT

The PASSE must submit a Provider/Network Changes Report on a monthly basis to DHS by the first Friday of each month, including additions and deletions to the PASSE Referral Network. DHS will monitor the adequacy of the network based, in part, on the report.

All updates to the PASSE Referral Network will be used by DHS to determine attribution of Medicaid Enrollees to the PASSE for enrollment as described in Section VIII, Medicaid Enrollee Attribution as PASSE Member.

The PASSE website must at all times display an accurate Provider Referral Network list for viewing by attributed PASSE Members.

The PASSE will provide a description of its procedures for determining, on an on-going basis, that each provider is duly licensed or certified, and update DHS on the status of the providers in its referral network by the first Friday of each month.

2. REFERRAL NETWORK DIRECTORY
The PASSE must create a Referral Network Directory that, at a minimum, complies with 42 CFR §438.10, the PASSE Medicaid Provider Manual and the Medicaid Provider-Led Organized Care Act (Act 775 of 2017; Ark. Code Ann. §20-77-2701 et seq.)
SECTION XI
SUBCONTRACTS

A. GENERALLY

The PASSE will maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Agreement notwithstanding any relationship(s) that the PASSE may have with any subcontractor, as required by 42 CFR §438.230. No subcontract will operate to terminate the legal responsibility of the PASSE to assure that all activities carried out by the subcontractor conform to the provisions of this Agreement. The PASSE will be held fully liable for the performance of all contract requirements and will develop and maintain a system for regular and periodic assessment of all subcontractors’ compliance with its terms.

Any Care Coordination Services or Administrative functions, including any outreach and customer service call centers, required to be provided by the PASSE pursuant to this Agreement may be subcontracted to a qualified person or organization.

Subcontracts must not create or impose barriers to care received by PASSE Members (e.g., the terms of the subcontract cannot act to discourage the full utilization of services by some PASSE Members), or result in discrimination or the abridgement of a PASSE Member’s rights under this Agreement or applicable law.

B. MINIMUM SUBCONTRACT PROVISIONS

Before entering into a subcontract which delegates duties or responsibilities to a subcontractor, the PASSE must evaluate the prospective subcontractor’s ability to perform the activities to be performed. All subcontracts must be in writing, and are subject to review by DHS.

To the extent that the PASSE’s activities or obligations under this Agreement are delegated to a subcontractor:

1. The activities and obligations, and related reporting responsibilities, must be specified in the contract or written agreement between the PASSE and the subcontractor;
2. The contract or written agreement between the PASSE and the subcontractor must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State of Arkansas, DHS or the PASSE determines that the subcontractor has not performed satisfactorily;
3. The subcontractor is subject to all applicable requirements contained in this Agreement;
4. The minimum subcontract provisions in Appendix D must be included in the terms of the subcontract; and
5. The PASSE’s local CEO must retain the authority to direct and prioritize any delegated Agreement requirements.

In order to determine adequate performance, the PASSE will monitor the subcontractor’s performance on an ongoing basis and subject it to formal review at least annually or more frequently if requested by DHS. As a result of the performance review, any deficiencies must be communicated to the subcontractor in order to establish a Corrective Action Plan (CAP). The results of the
performance review and the CAP will be communicated to DHS upon completion.

SECTION XII
AGREEMENT CONCLUSION

A. GENERALLY

In the event that the Agreement, or any portion thereof, is concluded via termination for any reason, expiration or other method, the PASSE will assist DHS in the transition of its PASSE Members to other PASSEs.

B. TRANSITION PLAN

The PASSE will submit a detailed plan to DHS for approval regarding the transition of PASSE Members in the event of Agreement expiration or termination within thirty (30) days of becoming active. The PASSE shall notify DHS at least 120 days prior to transition for any reason, and will be responsible for all necessary activities to close out the Agreement, including but not limited to those set out in Appendix E, Transition Plan Activities. This list is not exhaustive and additional information may be requested to ensure that all operational and reporting requirements have been met.

Any dispute by the PASSE, with respect to termination or suspension of this Agreement by DHS, will be exclusively governed by the laws of the State of Arkansas, and any applicable terms and conditions.

The name and title of the PASSE’s designated Transition Coordinator will be included in the Transition Plan.

SECTION XIII
MATERIAL CHANGE TO BUSINESS OPERATIONS

A. GENERALLY

The PASSE is responsible for evaluating all operational changes, including unexpected or significant changes, and determining whether those changes are material changes to the PASSE’s business operations. (42 CFR §438.207 (c)) Material change also includes any material changes by the PASSE that may impact the Referral Network, or the PASSE IT system changes and upgrades.

All material changes to the business operations must be approved in advance by DHS. The approval request must include, but is not limited to, changes to business operations, how the change will affect the delivery of Care Coordination Services, the PASSE’s plans for maintaining the quality of PASSE Member care, and communications to providers and PASSE Members. DHS will respond to the PASSE within 30 days of the submission. A material change in the PASSE’s business operations requires 30 days advance written notice to providers and PASSE Members. For situations determined by DHS to be an emergency, DHS will expedite the approval process.

B. MERGER, ACQUISITION, REORGANIZATION, JOINT VENTURE OR CHANGE IN OWNERSHIP
A termination of agreement, merger, acquisition, reorganization, joint venture, and change in ownership of the PASSE will require prior approval of DHS and AID. The PASSE must submit notification and a detailed Transition Plan to DHS and AID in accordance with AID statutes, rules and regulations, but in any case at least, but no later than, 120 days prior to the effective date. The purpose of the plan review is to ensure uninterrupted services to PASSE Members, evaluate the new entity’s ability to maintain and support the Agreement requirements, to ensure that services to PASSE Members are not diminished, and that major components of the organization and DHS programs are not adversely affected by such merger, reorganization, joint venture or change in ownership.

A merger, acquisition, reorganization, joint venture, and change in ownership of the PASSE may require an Agreement amendment. If the PASSE does not obtain prior approval, or DHS determines that a merger, acquisition, reorganization, joint venture or change in ownership is not in the best interest of the State, DHS may terminate this Agreement. DHS may offer open enrollment to the PASSE Members assigned to the PASSE should a merger, acquisition, reorganization, joint venture, or change in ownership occur.

This Agreement may be terminated without cause by the PASSE upon one-hundred (120) calendar days prior written notice to DHS.

SECTION XIV
SANCTIONS AND REMEDIES

A. GENERALLY

In accordance with applicable law and the terms of this Agreement, DHS may impose sanctions and/or remedies for failure to comply with any provision of this Agreement. Failure to comply may include, but is not limited to:

1. Performance of any obligation under this Agreement;
2. Achievement of the desired outcomes;
3. Maintain compliance with any provision of this Agreement;
4. Material deficiencies of Referral Provider Network;
5. Failure to create and institute policies required by this Agreement, include detecting and reporting excluded, sanctioned or prohibited persons or entities; and
6. Comply with program integrity requirements.

Written notice will be provided to the PASSE specifying the sanction/remedy to be imposed and the grounds for such sanction/remedy. The PASSE may dispute the decision to impose a sanction/remedy in accordance with the process outlined in the Arkansas Administrative Procedure Act, Ark. Code Ann. §25-15-201 et seq.

DHS may also provide a written cure notice to the PASSE which will specify the period of time during which the PASSE must bring its performance back into compliance with Agreement requirements. If, at the end of the specified time period, the PASSE has complied with the cure notice requirements, DHS may decline to impose a sanction and/or another remedy.
Prior to taking any compliance action allowed under Section XIV, DHS will informally discuss with the PASSE any metric or target that is not achieved and consider all meaningful efforts that were taken to achieve such target. DHS shall request a corrective action plan if the PASSE does not demonstrate that it took meaningful efforts to substantially comply with this Agreement.

B. AVAILABLE SANCTIONS/REMEDIES

Sanctions or remedies that can be imposed by DHS are allowed under this Agreement and applicable law. Such sanctions/remedies include, but are not limited to, one (1) or more of the following:

1. Appoint temporary management of the PASSE (42 CFR §438.702(a)(2));
2. Cancel or shorten the PASSE’s existing provider agreement(s) (Arkansas Medicaid);
3. Cancel this Agreement (Arkansas Medicaid);
4. Suspend or terminate/de-certify the PASSE’s participation as a Medicaid Enrolled Provider (PASSE Provider Type) and/or in the Arkansas Medicaid Program (Arkansas Medicaid);
5. Evaluate staffing allocations and require staffing enhancements (this Agreement);
6. Impose additional monitoring (this Agreement);
7. Impose civil monetary penalties or assessments not to exceed $10,000 per year per violation (42 CFR §438.702(a)(1));
8. Require the PASSE submit a Corrective Action Plan (CAP) (Arkansas Medicaid and this Agreement);
9. Suspend new attribution, enrollment and voluntary transitions to the PASSE, including automatic mandatory attribution and enrollment after the effective date of the sanction, grant PASSE Members the right to terminate enrollment, and transition all PASSE Members to another PASSE (42 CFR §438.702(a)(3) and (4));
10. Suspend, withhold, recoup, adjust or recover payments, or any combination thereof, made to the PASSE (42 CFR §438.702(a)(5)) until there is a satisfactory resolution of the default;
11. Require additional staffing (this Agreement);
12. Conduct audits at any time, including on-site audits (this Agreement); and
13. Impose any/all sanctions contained in the PASSE Medicaid Provider Manual, the Medicaid Provider Manual for all providers, including any sanction identified in §152.000 of the PASSE Medicaid Provider Manual, those allowed under federal law and those set forth in this Agreement.

C. AGREEMENT TERMINATION

Notwithstanding any other provision herein, CMS mandates that under this Agreement, DHS may terminate the Agreement due to the PASSE’s failure to carry out the substantive terms of this Agreement, or failure to meet the applicable requirements of §1932, §1903(m) or §1905(t) of the Social Security Act.

Further, CMS requires the condition that upon termination of this Agreement, DHS may place PASSE Members into a different PASSE or provide Medicaid benefits through another State Plan.
D. TECHNICAL ASSISTANCE

If the PASSE (including any/all subcontractors) seeks or obtains Technical Assistance from DHS or other entity, the PASSE’s acceptance of such Technical Assistance will be subject to the following conditions:

1. DHS’ Technical Assistance to help the PASSE achieve compliance with any relevant Agreement terms or Agreement subject matter issues does not relieve the PASSE of its obligation to fully comply with requirements of this Agreement or any and all other terms in this Agreement;
2. The PASSE’s acceptance of DHS’ offer or provision of Technical Assistance will not be utilized as a defense or a mitigating factor in any appeal or enforcement action under this Agreement in which compliance with requirements of this Agreement or any and all other terms is at issue;
3. DHS not providing Technical Assistance to the PASSE as it relates to compliance with an Agreement requirement or any and all other terms, will not be utilized as a defense or a mitigating factor in any appeal or enforcement action under this Agreement in which compliance with requirements under this Agreement or any and all other terms is at issue; and
4. Should a subcontractor to the PASSE participate in the technical assistance matter, in full or in part, the subcontractor participation does not relieve the PASSE of its duties nor modify the PASSE Agreement obligations.
MEMBER SERVICES

SECTION XV
CARE COORDINATION SERVICES

A. GENERALLY

The PASSE will provide Care Coordination Services to each of its PASSE Members in accordance with all applicable laws, including those listed by reference, in attachments and this Agreement. Care Coordination Services requirements are specifically set forth, but are not limited to, those included in the PASSE Medicaid Provider Manual, Section II, the Medicaid Provider-Led Organized Care Act (Ark. Code Ann. §20-77-2701 et seq.), Act 775 of 2017, and Federal law and regulations.

The PASSE will ensure that each Care Coordinator’s case load does not exceed the maximum number of PASSE Members. The number of PASSE Members assigned to each Care Coordinator will be reported to DHS, and is currently at 50 for the maximum.

The PASSE will also ensure that, in the process of coordinating care, each PASSE Member’s privacy is protected in accordance with the privacy requirements including, but not limited to, 45 CFR Parts 160 and 164, Subparts A and E, and Arkansas law, to the extent that they are applicable.

During Phase I of the program, the PASSE’s involvement will be limited to Care Coordination Services. Under a subsequent Agreement for Phase II of the program, Care Coordination will continue in addition to the other services that will be provided by the PASSE as a Risk-Based Provider Organization when full-risk managed care goes into effect.

B. DEFINITION AND SCOPE

Primarily, Care Coordination Services under the PASSE model means ensuring that specialty services, and all applicable medical needs and treatment plans, are coordinated and appropriately delivered by medical and specialty providers (including Behavioral Health and Developmental Disabilities services, as appropriate). The PASSE must hire Care Coordinators or contract with entities who will work with the PASSE Member’s providers to ensure continuity of care across all services while maintaining independence from direct service providers. Conflict-free care coordination is a critical beneficiary protection and a matter of program integrity.

Care Coordinators or case managers who are employed or subcontracted by an organization that has responsibility for the development and delivery of a service plan for an enrollee shall not fulfill the responsibility of the PASSE to provide care coordination for that individual. Additionally, Care Coordinators shall not be related by consanguinity (3rd degree or less) or marriage to the individual enrollee, his or her paid caregivers, or anyone financially responsible for the individual.

C. CARE COORDINATION IMPLEMENTATION PROCESS
Prior to undertaking Care Coordination services, the PASSE must ensure that each PASSE Member has completed and returned a proper authorization that complies with all applicable Medicaid, HIPAA and privacy laws. The authorization must allow those who perform PASSE Care Coordination services to discuss medical matters with the PASSE Member and which each provider who renders medical and related services to the PASSE Member.

The process for implementation of Care Coordination Services is described in this Agreement, including under Section VIII, Medicaid Enrollee Attribution as PASSE Member, which includes:

1. The effective date for which Care Coordination services must be provided to PASSE Members;
2. Notification to the PASSE of PASSE Member attribution via a Roster for enrollment;
3. Information regarding each PASSE Member necessary for effective Care Coordination that will be provided to the PASSE; and
4. The effective date wherein Care Coordination services are to begin;
5. The effective date for measuring metrics and data set out in this Agreement, which include:
   a) Initial contact with each PASSE Member within 15 business days after the first day of the month following attribution to the PASSE;
   b) Monthly face-to-face contacts with each PASSE Member (After the initial in person face-to-face contact, ongoing face-to-face contact can be accomplished utilizing video conferencing);
   c) Follow up with a PASSE Member within seven (7) business days of visit to Emergency Room or Urgent Care Clinic, or discharge from Hospital or In-Patient Psychiatric Unit/Facility; and
   d) Ensure that all PASSE Members have selected a PCP, confirm that the member is seeing the PCP as needed, and if necessary, to assist AB with selecting/providing a referral to a PCP;
6. The effective date for ensuring that each PASSE Member receives the proper education and outreach documents, including but not limited to the PASSE Member Handbook, as discussed in Section XVII, Member Information, Education and Outreach.

D. PASSE CARE COORDINATOR RESPONSIBILITIES

Responsibilities encompassed by Care Coordination Services are outlined in the Arkansas Provider-Led Organized Care Act, specifically Ark. Code Ann. §20-77-2703(3), in the PASSE Medicaid Provider Manual, Section II, and under this Agreement.

The ultimate goal of the Care Coordinator is to assist the PASSE Member in remaining in the most appropriate, efficient and cost-effective treatment in the least-restrictive setting for that PASSE Member. In order to facilitate reaching that goal, the Care Coordinators should develop relationships with providers, both inside and outside of the Provider Referral Network.

As preparation for Phase II utilization review activities, monitoring and data collection should also comprise Care Coordinator responsibilities. In addition to the metrics set out in Quality Metrics and Reporting Requirements below, for each attributed PASSE Member assigned to a Care Coordinator, the Care Coordinator should monitor and report the following information identified by individual PASSE Member:
1. Log each attempt at contact with the PASSE Member (including method, date, time), and whether the contact is successful, including methods used to locate hard-to-find PASSE Members
2. Track required timelines and whether the Care Coordinator has met each timeline
3. Track access to services, and actions taken to reduce high-cost services, e.g., cross-referencing PASSE Member’s provider utilization of multiple providers of a single type or obtaining multiple prior authorizations for a single condition
4. Track hospital discharge plans and enforcement thereof

E. CARE COORDINATOR ACCESS

The PASSE must provide 24-hour-a-day-7-days-a-week access to Care Coordination Services by PASSE Members to accommodate emergency situations as part of providing Care Coordination services. The PASSE must provide DHS with its plan for this aspect of services.

F. TOTAL PLAN OF CARE

The Care Coordinator employed by the PASSE is further responsible for implementing and coordinating each and every Total Plan of Care created for each PASSE Member assigned to him or her, including but not limited to, the treatment and care plans described in the PASSE Medicaid Provider Manual, Section II:

1. Behavioral Health Treatment Plan;
2. Person Centered Service Plan for Waiver Clients;
3. Primary Care Physician Care Plan;
4. Individualized Education Program;
5. Individual Treatment Plans for developmental clients in day habilitation programs;
6. Nutrition Plan;
7. Housing Plan;
8. Any existing Work Plan;
9. Justice system-related plan;
10. Child welfare plan; or

The PASSE Care Coordinator is responsible for obtaining copies of all treatment and service plans related to a PASSE Member and coordinating services within and between those plans. The PASSE care Coordinator should also obtain the Assessment Report from the PASSE Member’s Independent Assessment (IA).

G. COMMUNITY AND EMPLOYMENT SUPPORTS (CES) WAIVER

The Care Coordinator will additionally assume the responsibility of providing care coordination (formerly “case management”) under the concurrent §1915(c) Home and Community Based Services (HCBS) Community and Employment Supports (CES) Waiver for PASSE Members who are Waiver participants. These responsibilities are set forth in the PASSE Medicaid Provider Manual, Section II.
The PASSE will comply with Conflict-Free Case Management rules. (PASSE Provider Manual §241.000)

SECTION XVI
CUSTOMER SERVICE AND MEMBER COMMUNICATION

A. GENERALLY

The PASSE shall keep regular business hours from 8:00 am to 5:00 pm, Central Time, Monday through Friday, exclusive of state holidays and inclement weather policies instituted by the State. PASSE staff must be present and available to PASSE Members, providers and DHS while the office is open, including coverage during lunch time and breaks.

The PASSE shall maintain stated office hours and message systems 100% of the time, unless documented exceptions are made by DHS in the event of unpreventable circumstances, i.e. inclement weather determined by the State of Arkansas.

B. TELEPHONE/FAX/EMAIL ACCESS

1. PHONE ACCESS AND CALL CENTER

The PASSE shall have a sufficient number of phones/phone lines to respond to PASSE Members as set forth in Appendix F, Call Center Requirements.

The PASSE must offer the use of a toll-free number to PASSE Members, including access to the Call Center.

Availability by phone shall be inclusive to the PASSE’s regular business hours, in addition to the 24/7 telephone access of Care Coordination staff.

The PASSE must have an automated method of receiving messages and information from providers after business hours and on holidays. The PASSE must be able to respond to providers within two (2) hours in an emergency situation.

2. FAX ACCESS

The PASSE shall have available at least one fax (facsimile) machine operational at all times to receive information from attributed PASSE Members, providers and DHS. The number for the fax shall be on a dedicated phone line, and the phone number shall be made available on the website, in the Beneficiary Handbook and in other materials so that the PASSE can be promptly reached by that methodology.

3. EMAIL ACCESS

The PASSE shall have a dedicated email addresses that are made available to attributed PASSE Members, providers and DHS for both routine and emergency contact. This shall include, but is not limited to, requests for general information, 24/7 Care Coordinator access, requests/inquiries from
providers for emergent matters and written documentation requests, e.g., a “hard copy” of the PASSE Member Handbook.

C. WEBSITE ACCESS

The PASSE shall develop and maintain a website that is concise, informational, user-friendly, functional, and subject to marketing material limitations described herein. The website must be accessible 24/7 to PASSE Members and shall contain, at a minimum, all written materials as required by this Agreement, as well as any other requirements under State or Federal law.

In addition, the website shall contain all PASSE contact information, including access methodologies set forth herein. If the PASSE intends to use the website for receiving Attributed PASSE Member requests for information or other similar purposes, it must demonstrate to DHS that all inquiries will be handled in a timely manner. The website content must receive prior approval from DHS before becoming operational.

SECTION XVII
MEMBER INFORMATION, EDUCATION AND OUTREACH

A. GENERALLY

After receipt of the Roster of attributed PASSE Members, the PASSE must provide to each PASSE Member, Representative/Guardian or household, the following:

a) PASSE Member Handbook;
b) Enrollment and transition procedure information;
c) Provider Directory;
d) PASSE Member Rights; and
e) Grievance/Appeals processes.

These documents must be available electronically and all PASSE Members must be notified of how to access the electronic version.

A paper copy of these documents must be made available upon request. Such request can be made verbally, in writing, or via the PASSE website. The PASSE must send the paper copy of the requested document(s) within five (5) business days of the request being made. This timeline and process should be reviewed by the QAPI Program for quality assurance and improvement opportunities.

Federal regulations, including 42 CFR §438.10 and 42 CFR §438.100, and the PASSE Medicaid Provider Manual, Section II, govern the minimum requirements regarding the following aspects of PASSE Member information, education and outreach:

a) Telephone access;
b) Website access;
c) PASSE Member Handbook, and
d) Additional written materials.
B. MINIMUM REQUIRED NOTICES AND TIMEFRAMES

The PASSE must give written notice to each PASSE Member when there are program changes as described in the PASSE Medicaid Provider Manual and under 42 CFR §438.

C. TRANSLATION AND INTERPRETATION REQUIREMENTS

All materials provided by the PASSE must be available in English and Spanish. The PASSE must make available all materials or information in alternative formats upon request, of the PASSE Member, guardian, or Medicaid Enrollee at no cost. Materials must also be translated or provided in other languages when requested by a PASSE Member. Requirements set forth in 42 CFR §438.10, and in the PASSE Medicaid Provider Manual, include a list of vital materials to translate, tagline requirements, oral interpretation services, auxiliary aids and other requirements.

SECTION XVIII
ABEYANCE AND CLOSURE

A. GENERALLY

All definitions, policies and procedures under this section reside solely within the purview and authority of DHS. DHS will notify the PASSE Member and the PASSE of any decisions under this section.

After attribution and so long as the PASSE Member is enrolled in the PASSE, the PASSE shall be responsible for ensuring continued contact with the PASSE Member so that the PASSE Member receives appropriate Care Coordination services. This requirement is subject to any circumstances related to Abeyance and Closure herein, and Enrollment Options for PASSE Members in Section XIX.

B. ABNEYANCE

Abeyance is a temporary suspension of PASSE services to a PASSE Member by DHS, due to:

   a) A temporary loss of Medicaid eligibility;
   b) Placement in a setting excluded from the PASSE; or
   c) Loss of contact with the PASSE Member or guardian for more than forty-five (45) days.

The PASSE will notify DHS within three (3) business days after placement in a setting excluded from the PASSE or Loss of contact with the PASSE Member or guardian for more than forty-five (45) days that would place a PASSE Member in abeyance status. The PASSE will use the PASSE Provider Abeyance Notification Form found in Appendix G. This form must be completed by the CEO, CFO or the Care Coordination Manager.

Upon receipt of the Form, DHS will authorize temporary suspension of PASSE services for the identified PASSE Member, and will notify the PASSE Member and the PASSE. The PASSE will then cease to receive any payments for the identified PASSE Member during the abeyance period.
If the PASSE Member re-attains eligibility based on the criteria listed above, utilizing the original form, the PASSE must notify DHS that abeyance has ended. DHS will then re-instate the PASSE Member in the PASSE, and the PASSE must continue to provide Care Coordination services.

C. CLOSURE

Closure is a determination by DHS that a PASSE Member is no longer eligible to receive PASSE services. DHS reserves the right, at its discretion, to close any PASSE Member’s PASSE service after held in Abeyance for at least ninety (90) days.

SECTION XIX
ENROLLMENT OPTIONS FOR PASSE MEMBERS

1. GENERALLY

Typically, a PASSE Member will be attributed to and enrolled in a PASSE only once. In certain instances, a PASSE Member may be re-attributed or change enrollment to another PASSE.

A PASSE Member may transition from enrollment in one PASSE to another PASSE if any of these circumstances occur:

   a) The PASSE Member makes a timely request for a voluntary change;
   b) The PASSE Member makes a request for change based on cause;
   c) The PASSE Care Coordination Agreement is terminated or expires.

The PASSE cannot authorize the change in enrollment for any PASSE Member. The decision to allow or deny enrollment in another PASSE for cause will reside solely within the purview and authority of DHS, and DHS will notify the PASSE and the PASSE Member of any decisions under this section. DHS reserves the right to allow enrollment in another PASSE for any PASSE Member(ies) in compliance with 42 CFR §438.56 and the PASSE Medicaid Provider Manual, Section II.

After attribution and so long as the PASSE Member is enrolled in the PASSE, the PASSE shall be responsible for ensuring continued contact with the PASSE Member so that the PASSE Member receives appropriate Care Coordination services. Further, until DHS notifies the PASSE that the PASSE Member has enrolled in another PASSE, the original PASSE shall be fully responsible for any and all Care Coordination services and must provide such services. This requirement is subject to any circumstances related to Abeyance and Closure in Section XVIII, and Enrollment Options for PASSE Members herein.

2. PROCEDURES

To request a voluntary or for-cause enrollment in another PASSE, a PASSE Member or legal guardian may make either an oral or written request to DHS. If the PASSE Member or legal guardian instead notifies a Care Coordinator or the PASSE, the PASSE will notify DHS within 48 hours of receiving the request from the PASSE Member.
The PASSE must include all pertinent enrollment option information in the PASSE Member Handbook and on its website, including the correct address and phone number to initiate the change in enrollment procedure as required by the PASSE Medicaid Provider Manual, Section II. The address and phone number are set out in the Manual.

Change in enrollment from a PASSE to another will be processed by DHS after receipt of an oral or written request:

a) The effective date of an approved enrollment change must be no later than the first day of the second month following the month in which the PASSE Member request for enrollment change was received;
b) Failure by DHS to process a timely enrollment change request will result in an automatic approval of request; and
c) If the PASSE Member fails to properly state a For-Cause basis for enrollment change, DHS will notify the PASSE Member of the decision, and the PASSE Member will be afforded the right to reconsideration and/or appeal as set forth in the Arkansas Medicaid Provider Manuals.

3. VOLUNTARY OPEN ENROLLMENT PERIOD

a) 90-day open enrollment period: After the initial enrollment, the PASSE Member will have ninety (90) days to change enrollment to another PASSE, and will stay enrolled in that PASSE until the anniversary of enrollment;
b) Annual enrollment change: On the anniversary of enrollment in the PASSE, if the PASSE Member remains in Tier II or Tier III status, he or she will be allowed to choose to remain in the PASSE or enroll into another PASSE;
c) Limitation: The PASSE Member will not be permitted to change enrollment in their PASSE more than once in a twelve (12) month period, unless there is cause for enrollment change, as described in 42 CFR §438.56, is met.

4. FOR-CAUSE ENROLLMENT CHANGE

Enrollment change can be based on a For-Cause reason, as described in 42 CFR §438.56 and the PASSE Medicaid Provider Manual, Section II, as follows:

a) The PASSE in which the PASSE Member is enrolled is sanctioned pursuant to §152.000 of the Medicaid Provider Manual;
b) The PASSE does not, because of moral or religious objections, cover the service the PASSE Member seeks; or
c) Other reasons, including poor quality of care, lack of access to services covered under the PASSE agreement, or lack of access to providers experienced in dealing with the PASSE Member’s care needs.

SECTION XX
MEDICAL RECORDS
As a Medicaid enrolled provider, all records for which a PASSE relies on to provide Care Coordination Services must adhere to the standards and conditions set out in the Arkansas Medicaid PASSE Medicaid Provider Manual, Section I and the Medicaid Provider Manual for All Providers.

If a PASSE Member transitions to another PASSE, all medical records in the possession of the PASSE must be included in the documentation provided to the receiving PASSE. Further, the PASSE will comply with HIPAA requirements regarding data destruction related to the transitioned PASSE Member.

See Sections XXX through XXXIV for all Data and IT Requirements, and Section XXXV, Business Continuity and Recovery Plan.

SECTION XXI
ADVANCE DIRECTIVE


SECTION XXII
NON-DISCRIMINATION POLICY

A. NON-DISCRIMINATION OF PASSE MEMBERS BY PASSE

The PASSE will ensure that:

1. PASSE Members are provided Care Coordination Services without regard to race, color, national origin, sex, sexual orientation, gender identity, age or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation, gender identity, age or disability. (42 CFR §438.3(d));
2. PASSE Members are afforded their rights as delineated in 42 CFR §438.100;
3. PASSE Members and individuals with disabilities are accommodated to actively participate in the provision of services and have physical access to facilities, procedures and exams. For example, the PASSE must provide appropriate auxiliary aids and services to persons with impaired sensory, manual, or speaking skills. The PASSE must provide accommodations to PASSE Members and individuals with disabilities at no cost to afford such persons an equal opportunity to benefit from the Care Coordination Services. (45 CFR §§92.202 – 92.205)

B. PASSE MEMBER RIGHTS

The PASSE must have written policies addressing PASSE Member Rights as set forth in the PASSE Medicaid Provider Manual, Section II and 42 CFR §438.100. Further, the PASSE will ensure:
1. Compliance with any applicable laws that pertain to PASSE Member rights;
2. That its staff and subcontractors take those rights into account when furnishing services to PASSE Members; and
3. That each PASSE Member is free to exercise their rights and that the exercise of those rights does not adversely affect the way the PASSE or its subcontractors treat the PASSE Member.

SECTION XXIII
GRIEVANCE SYSTEM

The PASSE will have in place a written PASSE Member Grievance System process for Providers either enrolled as a member of the PASSE or who are part of the Referral Network, and subcontractors regarding either Administrative services or Care Coordination Services (CCS), that defines their PASSE Members’ rights regarding disputed matters with the PASSE. The PASSE’s Grievance System will comply with applicable law as set forth in the PASSE Medicaid Provider Manual and 42 CFR Part 438 Subpart F (Grievance and Appeal System).

The PASSE must provide reports to DHS on the Grievance System as required by the PASSE Medicaid Provider Manual.
QUALITY METRICS AND REPORTING REQUIREMENTS

SECTION XXIV
QUALITY METRICS AND REPORTING

A. GENERALLY

Quality metrics and reporting will be utilized by DHS to verify payment of PMPM amounts to the PASSE. Further, these metrics will allow DHS and other stakeholders, including the Arkansas Legislature and the Governor, to assess the quality and value of Care Coordination services provided under this model for Phase I. Quality metrics and reporting will be expanded under Phase II as the PASSE provides additional services under a full-risk system.

As preparation for Phase II utilization review activities, monitoring and data collection should be included in required reporting to DHS, and should be reviewed under the Quality Assurance and Performance Improvement (QAPI) Program set out in the Quality Monitoring and Evaluation Section below. Monitoring and data collection should include, at a minimum, the items set out in Section XV, Care Coordination Services.

Under the terms and conditions of this Agreement, DHS requires periodic reports that include data reporting as set out in the PASSE Medicaid Provider Manual. In addition, DHS may request ad hoc or new regular reporting.

B. CARE COORDINATOR METRICS AND REPORTING

Pursuant to the PASSE Medicaid Provider Manual, Section II, in order for the PASSE to continue to receive the full Per-Member-Per-Month (PMPM) payment for each PASSE Member, the Care Coordinators employed by the PASSE must meet Quality Performance standards set forth therein. These metrics, targets and required reports are summarized in Appendix H.

If the PASSE fails to meet two (2) of the five (5) quality metrics for Care Coordination Quality Performance Metrics, PASSE Quality Performance Metrics or any reporting requirements set forth herein, DHS may take action to correct the failure or impose penalties on the PASSE.

On a quarterly basis, in addition to other requirements, the PASSE will submit to DHS a list naming the Care Coordinators and the PASSE Members assigned to them.

C. PASSE METRICS AND REPORTING

Pursuant to the Ark. Code Ann. §20-77-2707 of the Medicaid Provider-Led Organized Care Act, and the PASSE Medicaid Provider Manual, the PASSE is responsible for submitting quarterly reports to DHS regarding performance measures set forth therein. These metrics, targets and required reports are summarized in Appendix H.

D. CARE COORDINATION QUALITY ASSURANCE AND PERFORMANCE
IMPROVEMENT

With regard to Care Coordination services being provided to PASSE Members, the PASSE shall undertake Quality Assurance and Performance Improvement (QAPI) activities through the QAPI Program. The QAPI Program will be overseen by the Medical/Quality Management (MQM) Committee. Through these PASSE QAPI Program activities, the PASSE shall develop internal processes and metrics to supplement the Quality Metrics currently required. In so doing, the PASSE will utilize the PASSE MQM Committee and PASSE Consumer Advisory Council (CAC), set out in Sections XXV through XXVIII below.

E. AUDITS

Audits, which may be conducted by DHS, are set out below in Quality Monitoring and Evaluation.
QUALITY MONITORING AND EVALUATION

SECTION XXV
QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Each PASSE must establish and maintain a PASSE Quality Assurance and Performance Improvement (QAPI) program, and form a Medical/Quality Management (MQM) committee. The QAPI program will oversee all Quality Assurance (QA) and Performance Improvement (PI) aspects of services provided in order to promote improvement in the quality of care provided to PASSE Members as required by 42 CFR §438.2, §438.310 and §438.330.

SECTION XXVI
PASSE MQM COMMITTEE

The MQM Committee must submit its charter/assignment and membership to DHS, which shall include and coordinate its activities with the Consumer Advisory Council (CAC) which is further detailed in Section XXVII below. It must also keep records of its meetings and activities, and report these to DHS at least on a quarterly basis.

The MQM Committee will examine the care coordination services being provided to PASSE Members for completeness, adequacy and appropriateness of care, quality of care and efficient utilization of provider resources. When reviewing programs and services, the MQM Committee must:

A. Assess and document whether care and services meet PASSE Member needs;
B. Identify unmet care coordination needs (under- or over-utilization) through monitoring and data collection (see Section XV, Care Coordination Services, and the Quality Metrics and Reporting Requirements section)
C. Establish and implement plans to address unmet needs.

Based on the review(s), the MQM Committee may establish and implement a quality improvement plan. Any quality improvement plan must include:

A. Evidence based practices;
B. Use of PASSE-wide outcomes measures to improve care coordination.
   Documentation should include:
   1. Measured outcomes, and
   2. Sample report(s);
C. Requirements for informing all PASSE Members and their responsible parties of the PASSE Members’ rights while accessing services.
SECTION XXVII
PASSE CONSUMER ADVISORY COUNCIL

As set forth in the PASSE Medicaid Provider Manual and the Medicaid Provider-Led Organized Care Act (Act 775 of 2017, Ark. Code Ann. §20-77-2701 et seq.), the PASSE must have and maintain a Consumer Advisory Council (CAC). The CAC will consist of at least one (1) consumer of DD services, one (1) consumer of BH services, and one (1) consumer of substance abuse treatment services.

The PASSE will submit to DHS the following:

A. Membership of the CAC upon formation;
B. The CAC charter/assignment upon establishment;
C. Upon determination, the designation of CAC members to participate in the activities of the Quality Assurance and Performance Improvement (QAPI) program described herein;
D. At least quarterly, the CAC should submit to DHS minutes and/or reports indicating the activities carried out by CAC;
E. At a minimum, the CAC should:
   1. Conduct meetings at least quarterly to discuss matters within the scope of CAC business;
   2. Review marketing materials for content and appropriateness;
   3. Review other informational materials for content and appropriateness;
   4. Review the results of the PASSE administration satisfaction survey; and
   5. Monitor and provide Quality Assurance to grievances filed by PASSE Members.

The QAPI program will be expected to consider suitable suggestions and solutions of the CAC, and the PASSE will be expected to integrate those into its operation if possible.

SECTION XXVIII
PROGRAM INTEGRITY

A. PRIVACY COMPLIANCE

As part of the written and enforced Corporate Compliance/Program Integrity Program, the PASSE, its employees, agents, and subcontractors and providers must all receive training and comply with the provisions of all applicable security and privacy laws, including but not limited to:

1. HIPAA (Health Insurance Portability and Accountability Act of 1996, Public Law 104-191);
2. HITECH (Health Information Technology for Economic and Clinical Health), enacted as part of the American Reinvestment & Recovery Act (ARRA) of 2009; and

The training and compliance must include, at a minimum, the HIPAA Privacy Rule, the HIPAA Security Rule, compliance and enforcement, sanctions/remedies, recognizing and reporting a breach,
mitigation strategies following a breach or incident, safeguarding Protected Health Information (PHI) and Personal Identifying Information (PII) in any form, including in verbal, documentary and electronic forms. The PASSE must notify DHS immediately of any compliance violations or breach, incident, issue, complaint, sanction or occurrence related to PII, PHI, HIPAA transaction and code set, or similar matter.

**B. DISCLOSURES, VERIFICATIONS AND PROHIBITIONS UNDER THE SOCIAL SECURITY ACT**

Any disclosures and verifications apply to the PASSE, its employees, its subcontractors (including administrative services subcontractors) and all employees thereof, and providers and all employees thereof, and for the purposes of Program Integrity under this Agreement, will be noted collectively as the “PASSE ENTITY” except as specifically exempted under the Social Security Act (SSA.)

1. Under 42 CFR §455.100 -- §455.106, certain mandatory disclosures are required to be made by the PASSE:
   a) Information on ownership and control (42 CFR §455.104);
   b) Information related to business transactions (42 CFR §455.105); and
   c) Information on persons convicted of crimes (42 CFR §455.106).

2. Under 42 CFR §455.436, the SSA requires certain verifications and disclosures be routinely and continuously performed to identify excluded, sanctioned or prohibited persons or entities;

3. The disclosures required herein must be made in all of these circumstances:
   a) Upon the PASSE ENTITY submitting the PASSE application;
   b) Upon the PASSE ENTITY executing or renewing this Agreement;
   c) Upon request of DHS, including but not limited to, during any re-validation of enrollment process under 42 CFR §455.414;
   d) Within 35 days after any change in ownership of the disclosing entity; and

4. Under the terms of this Agreement, CMS (the Center for Medicare and Medicaid Services) specifically prohibits the activities contained in Appendix I, Prohibitions.

**SECTION XXIX AUDITS**

DHS shall have the right to conduct on-going monitoring and audits, including on-site audits, at any time to verify information provided by the PASSE and/or that the PASSE is in compliance will all stated requirements. The Audits or reviews, include, but are not limited to:

1. Verification of the Quality Metrics information required to be reported by the PASSE
2. On-site “desk” reviews of required documentation
3. Procedures
4. IT and Data requirements.

The PASSE shall assist DHS by providing all necessary, pertinent, required and requested information during such audits.
DATA AND IT REQUIREMENTS

SECTION XXX
SYSTEMS AND DATA REQUIREMENTS

A. GENERALLY

The PASSE is required to exchange data with multiple entities relating to the requirements of this Agreement, to support the data elements set forth in this Agreement, or as required. For the purposes of this Agreement, any and all data, information and records captured, recorded, generated, obtained, sent or received will be referred to collectively as “data” and will be maintained in electronic form. Additionally, for the purposes of this Agreement, collecting, storing, analyzing, managing and producing data (including reports), will be referred to collectively as “maintaining” data.

The entities with which the PASSE sends, accepts/receives, generates or exchanges electronic data include, but are not limited to DHS, designated vendors, subcontractors or any Provider, or their assigned representative/authorized vendor. For the purposes of this Agreement, collectively these entities will be referred to as “ELECTRONIC EXCHANGE PARTNERS,” and these activities will be referred to collectively as the “exchange” of data.

No data will be exchanged between any/all ELECTRONIC EXCHANGE PARTNERS prior to approval from DHS and between the ELECTRONIC EXCHANGE PARTNERS. All data exchanged must be in the formats prescribed by DHS, and must comply with all applicable law, including the Health Insurance Portability and Accountability Act (HIPAA).

In the instance of material deficiencies of the PASSE’s data and IT requirements, or if the PASSE fails or is not in substantial compliance in the performance of any obligation under this Agreement, does not achieve the desired outcomes or substantially fails to maintain compliance with any provision of this Agreement, DHS may seek sanctions/remedies set forth in Section XIV, Sanctions and Remedies, the PASSE Medicaid Provider Manual, or the Medicaid Provider Manual, including but not limited to requiring the PASSE to undertake remedial actions.

B. PASSE MINIMUM IT AND SOFTWARE RESPONSIBILITIES

The PASSE must have a HIPAA-compliant IT/software system that is capable of exchanging appropriate secured electronic data to and from the ELECTRONIC EXCHANGE PARTNERS. In addition, the PASSE’s IT/software system must be capable of maintaining data for the purposes of financial, medical and operational management as set forth in this Agreement. The software system and its capabilities must be submitted to DHS for review and approval prior to becoming operational.

The costs of any software, changes in software or software upgrades will be the responsibility of the PASSE and are included in administrative costs paid by the PASSE. The PASSE will notify and provide a system change plan to DHS for review and approval for any significant upgrade or change to its core systems used to comply with the requirements in this agreement.
C. DATA EXCHANGE APPROVAL

Before a PASSE may exchange data with any ELECTRONIC EXCHANGE PARTNER, certain agreements, authorizations and control documents are required to be completed, submitted, reviewed and approved by DHS. These documents include, but are not limited to, entering into a BAA (Business Associate Agreement), Information Exchange Agreement and/or DUA (Data Use Agreement).

DHS will determine which activities, if any, are necessary prior to the exchange of any data which may contain HIPAA-protected information, such as receiving approval from the Security Advisory Committee (SAC) or other activity.

For the purposes of proper data exchange, undertaking other PASSE activity(ies) under this Agreement or for the effective administration of the PASSE, DHS may also require the PASSE to obtain explicit releases from PASSE Members or other parties. The PASSE will comply with any request made by DHS to effectuate data exchange functions or related activities.

D. ELECTRONIC DATA

In order to perform all functions required of the PASSE, the PASSE must exchange all required HIPAA-compliant electronic data from or to the ELECTRONIC EXCHANGE PARTNERS, and maintain data.

All exchanged data must be encrypted, in interoperable industry-standard-recognized formats, use secured electronic transmission protocols prescribed by DHS, and must comply with all applicable laws, including HIPAA.

If any data is maintained in a form other than electronic, the PASSE must convert that data to electronic data within three (3) business days from the receipt or generation thereof. The electronic data will be maintained in a format that meets interoperability industry standards as specified by DHS.

The data related to PASSE functions include, but are not limited to:

1. Evidence of eligibility, enrollment and attribution in the prescribed electronic data exchange formats;
2. Care Coordination functions;
3. Financial data;
4. PASSE Member geographic and demographic data and information;
5. PASSE Referral Network data and information;
6. Electronic Health Records (EHR) and Electronic Medical Records (EMR);
7. ADT (Admission, Discharge and Transfers) Notices use or use of similar methodology or software to monitor PASSE Members’ use of certain providers and/or facilities;
8. Independent Assessment information; and
9. Reporting requirements, including standard and ad hoc reports.

The PASSE is required to provide an attestation that any data transmitted is accurate and truthful, to the best of the PASSE’s CEO, CFO or designee’s knowledge. (42 CFR §438.606)
DHS may require testing of data transmissions prior to approving the PASSE IT/software system.

On a regular basis set forth by DHS, the PASSE will initiate a transfer of all data related to Care Coordination to DHS. This will occur at least monthly, or more often if required by DHS. Upon termination/expiration of this Agreement, the PASSE will comply with HIPAA requirements regarding data destruction.

E. DATA ERRORS

For the purposes of this Agreement, “data errors” includes, but is not limited to, submission or transmission of data or information that is inconsistent, incorrect/erroneous, delayed, incomplete, deleted or anomalous. The PASSE is responsible for identifying any data errors and immediately notifying DHS. If any unreported data errors are subsequently discovered, the PASSE will be responsible for the necessary adjustments to correct its records at its own expense.

Any data that does not meet the standards required by DHS will not be accepted by DHS.

The PASSE agrees to indemnify and hold harmless the State of Arkansas and DHS from any and all claims or liabilities, including but not limited to consequential damages, reimbursements or fees of any kind as a consequence of any error, deletion or erroneous insert caused by the PASSE in the submitted data, or arising from data errors, including incorrect or delayed payment(s) to the PASSE.

SECTION XXXI
DATA SECURITY

The PASSE must have the appropriate infrastructure to maintain data securely.

The PASSE is required to perform an annual security audit as part of a comprehensive quality assessment. The audit must review all aspects of the PASSE’s IT/software systems, data security systems, policies, procedures and controls related to security, availability or processing integrity of the PASSE’s system, and confidentiality/privacy. The PASSE must obtain DHS’s prior approval of the audit to be used (e.g., a Service Organization Control audit like the SOC2SM), how the test will be administered and by whom/what entity. The results of the audit will be promptly shared with DHS.

SECTION XXXII
OPERATIONS MONITORING AND REVIEW

DHS will monitor and review the PASSE’s operations to ensure compliance with all requirements under this Agreement and the applicable law, and to identify best practices. Monitoring may include any aspect of the PASSE’s operation and/or performance, or as required by applicable law, including but not limited to 42 CFR §438.66.

The operations monitoring review may identify and make recommendations for areas of improvement, monitor the PASSE’s progress towards implementing mandated programs or
operational enhancements, and provide the PASSE with technical assistance when necessary. The type and duration of the review will be solely at the discretion of DHS.

Prior to taking any compliance action allowed under Section XIV with respect to this Agreement, DHS will informally discuss with the PASSE any metric or target that is not achieved and consider all meaningful efforts that were taken to achieve such target. DHS shall request a corrective action plan if the PASSE does not demonstrate that it took meaningful efforts to substantially comply with this Agreement.

SECTION XXXIII
INFORMATION REQUESTS AND DISSEMINATION

DHS or designee/agent thereof may, at any time during the term of this Agreement, request financial or any other information from the PASSE. Responses will fully disclose all information requested. The PASSE may designate information as confidential, but it may not withhold information from DHS on that basis. Upon receipt of such requests, the PASSE will provide complete information as requested no later than three (3) business days after the receipt of the request, unless otherwise specified in the request itself.

Nothing in this section will abridge or impede the right of any regulatory agency, including but not limited to AID, DHS, OIG, CMS, MFCU, or OMIG, to seek information from the PASSE under statutory or regulatory authority.

Upon request, the PASSE will disseminate information prepared by DHS or the Federal government to its PASSE Members, and all costs will be the responsibility of the PASSE. Dissemination will comply with this Agreement and the PASSE Provider Manual, including the opt-in procedure to receive electronic notifications. All advertisements, publications and printed materials that are produced by the PASSE and refer to Care Coordination Services will state that such services are funded and provided under an agreement with DHS.

SECTION XXXIV
RECORDS RETENTION

The PASSE will maintain records, data and information relating to Care Coordination Services, receipt of payments and expenditures, reports to DHS and documentation used in the preparation of reports to DHS.

The PASSE will comply with all specifications for record keeping established by applicable law.
BUSINESS CONTINUITY

SECTION XXXV
BUSINESS CONTINUITY AND RECOVERY PLAN

The PASSE will develop a Business Continuity and Recovery Plan to deal with unexpected events that may affect its ability to adequately serve PASSE Members. For the purposes of this Agreement only, a complete back-up of all data be performed at least every three (3) business days, and data must be able to be recovered within three (3) business days.

The Plan will, at a minimum, include planning and training for:

1. Electronic/telephonic failure at the PASSE’s main place of business;
2. Complete loss of use of the main site or satellite offices out of State;
3. Loss of primary computer system/records;
4. Communication between the PASSE and DHS in the event of a business disruption;
5. Periodic Testing (at least annually); and
6. Processes for regular back-ups of all data, off-site storage of data and retrieval of off-site storage.

All staff will be trained on, and be familiar with, the Plan.

The Business Continuity and Recovery Plan will be updated annually. The PASSE will submit a summary of the Plan to DHS prior to beginning operations.
<table>
<thead>
<tr>
<th>PASSE OFFICER</th>
<th>DATE</th>
<th>DHS OFFICER</th>
<th>DATE</th>
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## APPENDIX A
### ACRONYMS AND DEFINITIONS

#### 1. ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ACA or Ark. Code Ann.</td>
<td>Arkansas Code Annotated</td>
</tr>
<tr>
<td>ADT</td>
<td>Admission, Discharge and Transfer Notices</td>
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<td>AID</td>
<td>Arkansas Insurance Department</td>
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<tr>
<td>BAA</td>
<td>Business Associate Agreement</td>
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<tr>
<td>BH</td>
<td>Behavioral Health</td>
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<tr>
<td>CAC</td>
<td>PASSE Consumer Advisory Council</td>
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<tr>
<td>CAP</td>
<td>Corrective Action Plan</td>
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<tr>
<td>CEO</td>
<td>Chief Executive Officer of the PASSE</td>
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<tr>
<td>CES</td>
<td>Community and Employment Support Waiver</td>
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<tr>
<td>CFO</td>
<td>Chief Financial Officer of the PASSE</td>
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<tr>
<td>CFR</td>
<td>Code of Federal Regulations</td>
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<tr>
<td>CHMS</td>
<td>Child Health Management Services</td>
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<tr>
<td>CMS</td>
<td>Center for Medicare and Medicaid Services</td>
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<tr>
<td>COO</td>
<td>Chief Operating Office of the PASSE</td>
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<tr>
<td>DD</td>
<td>Developmental Disabilities</td>
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<tr>
<td>DDTCS</td>
<td>Developmental Day Treatment Clinic Services</td>
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<tr>
<td>DHS</td>
<td>Arkansas Department of Human Services</td>
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<tr>
<td>DMS</td>
<td>Division of Medical Services (Arkansas Medicaid)</td>
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<tr>
<td>DUA</td>
<td>Data Use Agreement</td>
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<tr>
<td>ED</td>
<td>Emergency Department (also ER)</td>
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<td>EHR</td>
<td>Electronic Health Records</td>
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<tr>
<td>EMR</td>
<td>Electronic Medical Records</td>
</tr>
<tr>
<td>ER</td>
<td>Emergency Room (also ED)</td>
</tr>
<tr>
<td>FQHC</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td>HCBS</td>
<td>Home and Community Based Services</td>
</tr>
<tr>
<td>HHS</td>
<td>United States Department of Health and Human Services</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 – see Privacy definition</td>
</tr>
<tr>
<td>HITECH</td>
<td>Health Information Technology for Economic and Clinical Health, enacted as part of the American Reinvestment &amp; Recovery Act (ARRA) of 2009 – see Privacy definition</td>
</tr>
<tr>
<td>IA</td>
<td>Independent Assessment</td>
</tr>
<tr>
<td>ICF/DD/DD</td>
<td>Intermediate Care Facilities for persons with Developmental Disabilities or Intellectual Disabilities</td>
</tr>
<tr>
<td>ICF/IID</td>
<td>Intermediate Care Facilities for Individuals with Intellectual Disabilities</td>
</tr>
<tr>
<td>IT/IS</td>
<td>Information Technology/Information Systems</td>
</tr>
<tr>
<td>MFCU</td>
<td>Medicaid Fraud Control Unit of the Arkansas Attorney General’s</td>
</tr>
</tbody>
</table>
2. DEFINITIONS

§1915(b) The section of the Social Security Act (SSA) under which the Arkansas Provider Led Care Coordination Program Waiver of Medicaid services is authorized.

Abeyance A temporary suspension of PASSE services, due to:

A. A temporary loss of Medicaid eligibility;
B. Placement in a setting excluded from the PASSE; or
C. Loss of contact with the PASSE Member/guardian for more than forty-five (45) days.

See Section XVIII, Abeyance and Closure.

Admission, Discharge, Transfer (ADT) Electronic notification to providers upon the admission to or discharge from a hospital, or upon the transfer to another facility from a hospital.

Any Willing Provider Arkansas laws that require health insurance entities to accept any qualified health care providers to join a network so long as the qualified provider is willing to accept the terms and conditions of participation. In Arkansas, this is enforced by the Arkansas Insurance Dept. (AID) pursuant to Ark. Code Ann. §23-99-801 et seq.
<table>
<thead>
<tr>
<th><strong>Applicable Law</strong></th>
<th>Includes Arkansas and Federal laws, statutes, policies, procedures, rules, regulations, guidelines and manuals, as they currently exist, or as they are subsequently modified, applicable to this Agreement. See Section II, Applicable Law.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Arkansas Code Annotated (ACA)</strong></td>
<td>The laws of the State of Arkansas. See Applicable Law definition.</td>
</tr>
<tr>
<td><strong>Arkansas Insurance Department (AID)</strong></td>
<td>Arkansas agency that licenses and oversees Risk Based Provider Organizations (RBPO).</td>
</tr>
<tr>
<td><strong>Arkansas Medicaid Provider-Led Organized Care Program</strong></td>
<td>Created pursuant to Arkansas Act 775 of 2017 (Ark. Code Ann. §20-77-2701 et seq.) See Applicable Law definition.</td>
</tr>
<tr>
<td><strong>Attribution</strong></td>
<td>The method by which DHS assigns an eligible Medicaid Enrollee to a PASSE as a PASSE Member.</td>
</tr>
<tr>
<td><strong>Behavioral Health (BH)</strong></td>
<td>The Division of Behavioral Health Services within DHS ensures that services are provided to those eligible individuals for which BH services are needed. BH providers and services are required to be included in a PASSE’s Referral Network.</td>
</tr>
<tr>
<td><strong>Business Associate Agreement (BAA)</strong></td>
<td>A contract between a HIPAA-covered entity and a HIPAA business associate (BA). The contract protects private medical information (PHI) in accordance with HIPAA guidelines.</td>
</tr>
<tr>
<td><strong>Business Continuity and Recovery Plan</strong></td>
<td>A plan to be created by the PASSE that sets forth the steps to be taken in advance of, and in the case of, a disaster that could affect the continuing operations of the PASSE. See Section XXXV, Business Continuity and Recovery Plan.</td>
</tr>
<tr>
<td><strong>Business Continuity/Disaster Recovery</strong></td>
<td>See Business Continuity and Recovery Plan definition.</td>
</tr>
<tr>
<td><strong>Care Coordination</strong></td>
<td>Also Care Coordination Services. See Section XV, Care Coordination Services.</td>
</tr>
<tr>
<td><strong>Care Coordination Payment</strong></td>
<td>Monthly PMPM payment to the PASSE for each attributed PASSE Member beginning in the second month of attribution. See Section IX, Payments.</td>
</tr>
<tr>
<td><strong>Care Coordinators</strong></td>
<td>PASSE personnel who will deliver Care Coordination Services to attributed PASSE Members. See Care Coordination definition.</td>
</tr>
<tr>
<td><strong>Center for Medicare and Medicaid Services (CMS)</strong></td>
<td>Federal agency that administers Medical Assistance (Medicaid) benefits and services.</td>
</tr>
<tr>
<td><strong>Chief Executive Officer (CEO)</strong></td>
<td>PASSE Key Staff. See Section VII, Staff Requirements and Support Services.</td>
</tr>
<tr>
<td><strong>Chief Financial Officer (CFO)</strong></td>
<td>PASSE Key Staff. See Section VII, Staff Requirements and Support Services.</td>
</tr>
<tr>
<td><strong>Chief Operating Officer (COO)</strong></td>
<td>PASSE Key Staff. See Section VII, Staff Requirements and Support Services.</td>
</tr>
<tr>
<td><strong>Closure</strong></td>
<td>A determination by DHS that a PASSE Member is no longer eligible to receive PASSE services. See Section XVIII, Abeyance and Closure.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Code of Federal Regulations (CFR)</td>
<td>Rules and regulations issued by federal agencies, including CMS. See Applicable Law definition.</td>
</tr>
<tr>
<td>Community and Employment Support (CES)</td>
<td>Current Arkansas Medicaid Waiver providing care coordination services. See Section XV, Care Coordination Services.</td>
</tr>
<tr>
<td>Compliance Officer</td>
<td>PASSE Key Staff. See Section VII, Staff Requirements and Support Services.</td>
</tr>
<tr>
<td>Conflict-Free Case Management or Rules</td>
<td>Ensures safeguards against conflict of interest under 42 CFR §438.58, and conflict-free case management under §1915 of the Social Security Act. See Section XV, Care Coordination Services.</td>
</tr>
<tr>
<td>Consumer Advisory Council (CAC)</td>
<td>See Section XXVII, PASSE Consumer Advisory Council, for composition and duties.</td>
</tr>
<tr>
<td>Corporate Compliance/Program Integrity Program</td>
<td>See Section XXVIII, Program Integrity, for minimum requirements to be taken by the PASSE.</td>
</tr>
<tr>
<td>Corrective Action Plan (CAP)</td>
<td>An organizational document that describes exactly how a specific problematic situation will be changed to better meet the goals of a company. The CAP should include a clear statement of the problem as well as a statement of the desired outcome. See XIV, Sanctions and Remedies.</td>
</tr>
<tr>
<td>Data</td>
<td>For the purposes of this Agreement, any and all data, information and records captured, recorded, generated, obtained, sent or received will be referred to collectively as “data” and will be maintained in electronic form. See Section XXX, Systems and Data Requirements.</td>
</tr>
<tr>
<td>Data Use Agreement (DUA)</td>
<td>A contractual document used for the transfer of data that has been developed by nonprofit, government or private industry, where the data is nonpublic or is otherwise subject to some restrictions on its use, including HIPAA. See Section XXX, Systems and Data Requirements.</td>
</tr>
<tr>
<td>Department of Human Services (DHS)</td>
<td>Arkansas agency that includes the Division of Medical Services (Medicaid.)</td>
</tr>
<tr>
<td>Developmental Disabilities (DD)</td>
<td>The Division of Developmental Disabilities Services within DHS ensures that services are provided to those eligible individuals for which DD services are needed. DD providers and services are required to be included in a PASSE’s Referral Network.</td>
</tr>
<tr>
<td>Direct Service Provider</td>
<td>An organization or individual that delivers healthcare services to attributed PASSE Members of a PASSE. Participating providers can be direct service providers.</td>
</tr>
<tr>
<td>Division of Medical Services (DMS)</td>
<td>In Arkansas, division of DHS that oversees the Medicaid program.</td>
</tr>
<tr>
<td>Dual Eligible</td>
<td>Individuals who are eligible for both Medicare and Medicaid.</td>
</tr>
<tr>
<td>Electronic Exchange Partners</td>
<td>For the purposes of this Agreement, the collective name for the entities with which the PASSE sends, accepts/receives, generates or exchanges electronic data include, but are not limited to DHS, designated vendors, subcontractors or any Provider, or their assigned representative/authorized vendor. See Section XXX, Systems and Data Requirements.</td>
</tr>
<tr>
<td><strong>Electronic Health Records (EHR)</strong></td>
<td>Health records of a patient that are gathered and stored electronically.</td>
</tr>
<tr>
<td><strong>Electronic Medical Records (EMR)</strong></td>
<td>Medical records of a patient that are gathered and stored electronically.</td>
</tr>
<tr>
<td><strong>Exchange of Data</strong></td>
<td>For the purposes of this Agreement, the activities between Electronic Exchange Partners. See Section XXX, Systems and Data Requirements.</td>
</tr>
<tr>
<td><strong>For-Cause Change</strong></td>
<td>A type of Enrollment change from one PASSE to another by PASSE Members. See Section XIX, Enrollment Options for PASSE Members.</td>
</tr>
<tr>
<td><strong>Foundation Payment</strong></td>
<td>Initial, and one-time-only, payment to the first PASSE for each attributed PASSE Member upon attribution. See Section X, Payments.</td>
</tr>
<tr>
<td><strong>Grievance</strong></td>
<td>A matter disputed by an attributed PASSE Member. See Section XXIII, Grievance System.</td>
</tr>
<tr>
<td><strong>Health and Human Services (HHS) (United States Department of)</strong></td>
<td>The federal agency that oversees CMS.</td>
</tr>
<tr>
<td><strong>Health Information Technology for Economic and Clinical Health (HITECH)</strong></td>
<td>Federal law under the American Reinvestment &amp; Recovery Act (ARRA) of 2009 designed to promote the adoption and meaningful use of health information technology.</td>
</tr>
<tr>
<td><strong>Health Insurance Portability and Accountability Act (HIPAA)</strong></td>
<td>Federal law that restricts access to individuals' private medical information. It addresses both privacy and security regarding Personal Identifying Information (PII) and Protected Health Information (PHI).</td>
</tr>
<tr>
<td><strong>HIPAA Privacy Rule</strong></td>
<td>See HIPAA definition.</td>
</tr>
<tr>
<td><strong>HIPAA Security Rule</strong></td>
<td>See HIPAA definition.</td>
</tr>
<tr>
<td><strong>Independent Assessment (IA)</strong></td>
<td>Assessment conducted by a DHS vendor.</td>
</tr>
<tr>
<td><strong>Information Exchange Agreement</strong></td>
<td>See Section XXX, Systems and Data Requirements.</td>
</tr>
<tr>
<td><strong>Key Staff</strong></td>
<td>Minimum staff members of the PASSE (CEO, CFO, Care Coordination Manager and IT/IS Manager). See Section VIII, Staff Requirements and Support Services.</td>
</tr>
<tr>
<td><strong>Maintaining Data</strong></td>
<td>For the purposes of this Agreement, collecting, storing, analyzing, managing and producing data (including reports), will be referred to collectively as “maintaining” data. See Section XXX, Systems and Data Requirements.</td>
</tr>
<tr>
<td><strong>Medicaid Provider Manual</strong></td>
<td>Arkansas Medicaid manual covering all Medicaid providers. See Applicable Law definition.</td>
</tr>
<tr>
<td><strong>Medical/Quality Management (MQM) Committee</strong></td>
<td>Oversees the Quality Assurance and Performance Improvement (QAPI) activities through the QAPI Program.</td>
</tr>
<tr>
<td><strong>Memorandum of Intent (MOI)</strong></td>
<td>Agreement between a PASSE and a provider to show provider participation in the PASSE provider network. See Section X, Provider Referral Network.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
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</tr>
<tr>
<td>National Provider Identifier (NPI)</td>
<td>A unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). See Section X, Provider Referral Network.</td>
</tr>
<tr>
<td>Office of the Inspector General (OIG)</td>
<td>United States Department of Health and Human Services (HHS) division that seeks to protect the integrity of HHS programs as well as the health and welfare of program beneficiaries. See Data and IT Requirements.</td>
</tr>
<tr>
<td>Office of the Medicaid Inspector General (OMIG)</td>
<td>Arkansas agency that seeks to prevent, detect, and investigate fraud, waste, and abuse within Medicaid. See Data and IT Requirements.</td>
</tr>
<tr>
<td>Participating Provider</td>
<td>An organization or individual that is a member of or has an ownership interest in a PASSE and delivers healthcare services to PASSE Members attributed to a PASSE.</td>
</tr>
<tr>
<td>PASSE Medicaid Provider Manual</td>
<td>Arkansas Medicaid manual covering PASSE providers. See Applicable Law definition.</td>
</tr>
<tr>
<td>PASSE Member</td>
<td>An eligible Medicaid Enrollee who is attributed to a PASSE based on an Independent Assessment (IA) or other methodology.</td>
</tr>
<tr>
<td>Per Member Per Month (PMPM)</td>
<td>See Care Coordination Payment definition.</td>
</tr>
<tr>
<td>Performance Improvement (PI)</td>
<td>See Quality Assurance and Performance Improvement (QAPI) definition.</td>
</tr>
<tr>
<td>Personal Identifying Information (PII)</td>
<td>See HIPAA definition.</td>
</tr>
<tr>
<td>Personal Information Protection Act (PIPA) (Arkansas)</td>
<td>Arkansas law created to protect sensitive personal information pursuant to Act 1526 of 2005 (Ark. Code Ann. §4-110-101 et seq.)</td>
</tr>
<tr>
<td>Primary Care Physician (PCP)</td>
<td>A provider selected by an attributed PASSE Member to be his or her primary medical contact.</td>
</tr>
<tr>
<td>Protected Health Information (PHI)</td>
<td>See HIPAA definition.</td>
</tr>
<tr>
<td>Provider Referral Network</td>
<td>See Section X, Provider Referral Network.</td>
</tr>
</tbody>
</table>
| Provider-Led Arkansas Shared Savings Entity (PASSE) | In Arkansas, a Risk Based Provider Organization (RBPO) that has enrolled in Medicaid and meets the following requirements:  
| | A. Is 51% owned by participating providers; and  
| | B. Has the following Members or Owners:  
| | 1. An Arkansas licensed or certified direct service provider of Developmental Disabilities (DD) services;  
| | 2. An Arkansas licensed or certified direct service provider of Behavioral Health (BH) services;  
| | 3. An Arkansas licensed hospital or hospital services organizations;  
| | 4. An Arkansas licensed physician’s practice; and  
<p>| | 5. A Pharmacist who is licensed by the Arkansas State Board of Pharmacy. |
| Quality Assurance (QA) | See Quality Assurance and Performance Improvement (QAPI) definition. |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Assurance and Performance Improvement (QAPI)</td>
<td>PASSE program that will oversee quality assurance and performance improvement functions, and will work in conjunction with the Consumer Advisory Council.</td>
</tr>
<tr>
<td>Quality Assurance and Performance Improvement (QAPI) Committee</td>
<td>A committee developed by the PASSE to oversee Quality Assurance and Performance Improvement of PASSE services.</td>
</tr>
<tr>
<td>Readiness Review</td>
<td>Required check of PASSE minimum requirements that will be conducted prior to any PASSE Member being attributed to the PASSE. See Section V, Readiness Review.</td>
</tr>
<tr>
<td>Risk-based Provider Organization (RBPO)</td>
<td>An entity that is licensed by the Insurance Commissioner under Act 775 of 2017 and the risk-based provider organization rules. See Provider-Led Arkansas Shared Savings Entity (PASSE) definition.</td>
</tr>
<tr>
<td>Security Advisory Committee (SAC)</td>
<td>DMS Committee that reviews and approves all HIPAA-related requests and activities. See Section XXX, System and Data Requirements.</td>
</tr>
<tr>
<td>Social Security Act (SSA)</td>
<td>The federal law that governs medical assistance (Medicaid) benefits and services. See Applicable Law definition.</td>
</tr>
<tr>
<td>State Plan Amendment (SPA) or State Plan authority</td>
<td>The authority under which Arkansas Medicaid offers services and coverage to eligible Medicaid Enrollees that varies from the services and coverage authorized under the Social Security Act. See Applicable Law definition.</td>
</tr>
<tr>
<td>Subcontractor</td>
<td>A person or entity that enters into an agreement with a PASSE to provide certain services. See Section XI, Subcontracts, and Appendix D, Minimum Subcontract Requirements.</td>
</tr>
<tr>
<td>The Act</td>
<td>Title XIX of the Social Security Act (SSA). See Applicable Law definition.</td>
</tr>
<tr>
<td>Tier I, II or III</td>
<td>Independent Assessment (IA) determination levels.</td>
</tr>
<tr>
<td>Total Plan of Care</td>
<td>With regard to a specific topic or area of need, a comprehensive document that sets forth problems/needs, goals, plan(s) of approach, specific activities, therapies, services, etc. Examples include BH treatment plan, PCP care plan, nutrition plan, housing plan, child welfare plan, etc. See Section XV, Care Coordination Services.</td>
</tr>
<tr>
<td>Transition Plan</td>
<td>A detailed plan to be developed by the PASSE and submitted to DHS for approval regarding the transition of attributed PASSE Members in the event of Agreement expiration or termination. See Section XII, Agreement Conclusion and Appendix E, Transition Plan Activities.</td>
</tr>
<tr>
<td>Voluntary Enrollment Options</td>
<td>The way for a PASSE Member to change from one PASSE to another. See Section XIX, Enrollment Options for PASSE Members.</td>
</tr>
</tbody>
</table>
APPENDIX B
MARKETING GUIDELINES

A. GENERALLY

The PASSE may create marketing materials to be utilized by Choice Counselors/Enrollment Brokers, Care Coordinators, any other health- or social services-related workers, PASSE Providers, or for use on its website. Marketing to the target audience, current Medicaid Enrollees to become attributed PASSE Members, is allowed within the guidelines set forth herein.

The PASSE shall submit to DHS any marketing and advertising materials referencing the services it is providing on behalf of DHS for approval at least thirty (30) days prior to intended use. Written approval from DHS of all marketing materials shall be required before the materials may be used.

All marketing materials must comply with all state and federal rules and regulations.

The following definitions apply to these marketing guidelines:

1. “Broadcast Media” means media that transmit information electronically, through methods such as film, radio, recorded messages or television
2. “Cold-call marketing” means soliciting applicants and Medicaid Enrollees to seek attribution with the PASSE through direct contact without the individual initiating the contact
3. “Digital Media” means media that comprises both internet and mobile mass communication including social media
4. “Print Media” means media that transmit information via physical objects such as books, magazines, newspapers, or pamphlets.

Marketing and advertisement materials include but are not limited to: bulk mailers, television advertisements, radio advertisements, newspaper advertisements, billboard artwork, etc.

B. TARGET MARKET OUTREACH AND EDUCATION EFFORTS

In addition to materials, the PASSE must set forth, and receive prior DHS approval of, a plan for marketing outreach and education to Medicaid Enrollees prior to attribution as a PASSE Member that outlines the following:

1. Objectives and strategies that will increase awareness and importance of the PASSE Program model for recipients of Tier 2 and Tier 3 services
2. The pathway to attribution as a PASSE Member
3. Care Coordination services to be provided by the PASSE and benefit of receiving said services
4. The duties and expectations for the PASSE and for the PASSE Member
5. Identifying providers in the Provider Referral Network and the extent of coverage to the potential PASSE Member
6. Collaboration approaches and efforts to be undertaken with DHS, Choice Counselors/Enrollment Brokers, Care Coordinators, any other health- or social services-related workers and PASSE Providers

7. Identification of specific events where the marketing materials will be distributed

All marketing materials must, at least, meet the minimum requirements regarding PASSE Member information, education and outreach materials set forth is Section XVII, Member Information, Education and Outreach, in the Provider Agreement.

C. REVIEW CRITERIA

1. DHS will review all marketing materials for the following:
   a. All statements contained within are accurate and do not mislead, confuse, or defraud the recipients or the State agency. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that:
      i. The recipient must be attributed to the PASSE in order to obtain benefits or in order to not lose benefits; or
      ii. The PASSE is endorsed by CMS, the Federal or State government, or similar entity.
   b. The materials do not seek to influence attribution in conjunction with the sale or offering of any private insurance;
   c. Content is culturally competent; and
   d. Content is written at an appropriate reading level for the intended audience.

2. The PASSE may prepare and use marketing materials to promote product(s) specified in the Agreement between PASSE and DHS under the following conditions:
   a. The PASSE shall submit proposed marketing materials to DHS for review and approval at least thirty (30) calendar days prior to their use by PASSE. A PASSE may use submitted marketing materials if DHS has not disapproved them within thirty (30) days of submission by PASSE.
   b. Marketing materials must be accurate and not mislead, confuse, or defraud the applicant or DHS.
   c. Marketing materials cannot contain any statement (whether written or oral) that the PASSE is endorsed by CMS, the federal government or the State of Arkansas.
   d. Marketing materials shall not contain an assertion or statement that the applicant or Medicaid Enrollees must be attributed to the PASSE to obtain benefits or to lose benefits.
   e. Materials must be written at or below a 6th grade reading level, except for language required by federal or state rules.
   f. Print media materials must be written in English, Spanish, and the languages of other major population groups in the State. DHS shall notify the PASSE of all “other major population groups” for which translation of print media materials is required no later ninety (90) days prior to the beginning of each calendar year. Marketing materials that are shared through other mass media venues, such as broadcast and digital media, may be translated at the option of the PASSE for other major population groups.
   g. The PASSE may not use absolute superlatives (e.g., “the best”, “highest ranked”, “rated number 1”) and/or qualified superlatives (e.g., “one of the best”, “among the highest ranked”) unless they are substantiated with supporting data provided to DHS as part
of the marketing review process. The PASSE is permitted to use data that DHS can substantiate (e.g., PASSE ABC has the best provider network).

3. PASSE will distribute marketing materials approved by DHS in the following manner:

   a. The PASSE shall not seek to influence attribution in conjunction with the sale or offering of any private insurance.
   b. The PASSE shall not directly or indirectly engage in door-to-door, telephone, email, texting, or other cold-call marketing techniques.
   c. The PASSE must not knowingly or willfully market to a PASSE Member attributed to another PASSE unless information is requested by that PASSE Member.

4. PASSE providers participating in the PASSE’s network may inform patients of the benefits, services, and specialty care services offered through a PASSE provided the following conditions are met:

   a. PASSE providers must not make unsolicited recommendations to Medicaid Enrollees regarding selecting one PASSE over another, or offer patients incentives to select one PASSE over another.
   b. At a patient’s request, PASSE providers may give patients the information necessary to contact a particular PASSE or refer the Medicaid Enrollee to a PASSE’s orientation material.

5. A PASSE may create a social media account specific to PASSE’s participation in the Provider-Led (PASSE) Program and use such account to communicate with the general public. All social media communications that are “marketing materials” must be submitted to DHS and comply with the requirements stated herein.

6. Upon attribution (i.e., the date upon which the PASSE receives notice that a specific Medicaid Enrollee has been attributed to the PASSE, notwithstanding the 90 day period in which an attributed PASSE Member may change his or her PASSE) and thereafter, the PASSE may generally communicate with Attributed PASSE Members, but not use for secure communications, via the following methods:

   a. Use social media such as Facebook and Twitter
   b. Use electronic communications (electronic ads, email, mobile apps, member apps, and text messages). The communication must provide the option for Attributed PASSE Members to unsubscribe from receiving electronic communications, and the PASSE is required to promptly honor all unsubscribe requests.
   c. Examples of general communications could include, but are not limited to, invitations to view new or updated documents on the website, and invitations to view the updated Provider Network list.

7. The PASSE may not use Spam or engage in any kind of Spammer.
A. GENERALLY

Under 42 CFR §455.100 -- §455.106, certain mandatory disclosures are required to be made by the PASSE:

a) Information on ownership and control (42 CFR §455.104);
b) Information related to business transactions (42 CFR §455.105); and

c) Information on persons convicted of crimes (42 CFR §455.106).

In addition, the Social Security Act requires certain verifications and disclosures be routinely and continuously performed to identify excluded, sanctioned or prohibited persons. (42 CFR §455.436)

B. OWNERSHIP AND CONTROL

The PASSE ENTITY must disclose the following information at the time of the stated occurrence(s) for every person or entity that has a direct, indirect or combined direct/indirect ownership or control interest of ≥5% of the PASSE ENTITY’s equity, or owns ≥5% of any mortgage, deed of trust, note or other obligation secured by the PASSE ENTITY if that interest equals at least 5% of the value of the PASSE ENTITY’s assets, or is an officer or director of a corporate PASSE ENTITY OR a partner in a PASSE ENTITY partnership:

1) For every person or entity, the following personal information:
   a) The name and address of any person (individual or corporation) with an ownership or control interest in the PASSE ENTITY. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;
   b) Date of birth and Social Security Number (SSN) in the case of an individual with an ownership or control interest in the PASSE ENTITY, including subcontractors;
   c) Other tax identification number (in the case of a corporation) with an ownership or control interest in the PASSE ENTITY, including any subcontractor, in which the PASSE ENTITY has a 5 percent or more interest;

2) Whether the person (individual or corporation) with an ownership or control interest in the PASSE ENTITY is related to another person with ownership or control interest in the PASSE ENTITY as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the PASSE ENTITY has a 5 percent or more interest is related to another person with ownership or control interest in the PASSE ENTITY as a spouse, parent, child, or sibling;

3) The name of any other PASSE ENTITY in which an owner of the PASSE ENTITY has an ownership or control interest;

4) The name, address, date of birth, and Social Security Number of any managing employee of the PASSE ENTITY;

5) Any other data, documentation, or information relating to the performance of the PASSE
ENTITY’s obligations as required by DHS or CMS;

C. BUSINESS TRANSACTIONS

The PASSE ENTITY shall furnish to DHS or CMS within 35 days of receiving a request, full and complete information, pertaining to:

1) The ownership of any subcontractor with whom the PASSE ENTITY has had business transactions totaling more than $25,000 during the 12-month period ending on the date of request; and
2) Any significant business transactions between the PASSE ENTITY, any subcontractor, and wholly owned supplier, or between the PASSE ENTITY and any subcontractor during the five year period ending on the date of the request.

D. PERSONS CONVICTED OF A CRIME

Upon entering or renewing this Agreement, or at any time when DHS makes a request, following mandatory procedures apply:

1) The PASSE ENTITY must disclose the identity of any person who:
   a) Has ownership or control interest in the provider, is an agent or managing employee of the provider, or is a medical provider in the Provider Network; and
   b) Has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.;
2) DHS must notify the federal HHS Office of Inspector General (OIG) of any disclosures made under this section within 20 business days from the date it receives the information; and
3) DHS must also promptly notify OIG of any action it takes on the PASSE ENTITY’s application for participation in the Medicaid Provider-Led Organized Care program.

E. VERIFICATIONS

The PASSE ENTITY shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities (including as a Medicaid medical or service provider or Federal health care programs) in Arkansas or under federal regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order 12549. (42 CFR §438.610 (a) & (b), 42 CFR §1001.1901(b), 42 CFR §1003.102(a)(2))

The PASSE is obligated to screen employees and subcontractors to determine whether they have been excluded from such participation. In addition, the SSA requires certain verifications and disclosures be routinely and continuously performed to identify excluded, sanctioned or prohibited persons, including employees and subcontractors. (42 CFR §455.436)

The PASSE ENTITY must:
1) Confirm the identity and determine the exclusion status of any person with an ownership or control interest in the PASSE ENTITY, and any person who is an agent or managing employee of the PASSE ENTITY (including Key Staff personnel described in this Agreement and providers in the Provider Network) through routine checks of Federal databases;

2) Disclose the identity of any of these Excluded Persons, including those who have ever been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs;

3) On a monthly basis, confirm the identity and determine the exclusion status through routine checks of:
   a) The List of Excluded Individuals (LEIE);
   b) The System of Award Management (SAM) formerly known as the Excluded Parties List System (EPLS);
   c) Any state or local agency/government list of excluded persons or entities, including but not limited to the Arkansas DHS Excluded Providers list; and
   d) Any other appropriate databases, including those directed by DHS or CMS;

4) Provide such information at the time of the following occurrence(s):
   a) Within 35 days after any change in ownership of the PASSE ENTITY;
   b) Upon request by DHS;
   c) Upon entering or renewing this Agreement; and/or
   d) At least annually.

The PASSE shall notify DHS immediately of any person associated with the PASSE ENTITY has been ascertained through this verification process, including the identity of that person, his or her position and connection to the PASSE ENTITY.
APPENDIX D
MINIMUM SUBCONTRACT REQUIREMENTS

All subcontracts between the PASSE and another person or entity must reference and require compliance with minimum subcontract provisions that include, but are not limited to:

1. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor;
2. Identification of the name and address of the subcontractor;
3. Identification of the population, to include patient capacity, to be covered by the subcontractor;
4. The amount, duration and scope of services to be provided, and for which compensation will be paid;
5. The term of the subcontract including beginning and ending dates, methods of extension, termination and renegotiation;
6. A description of the subcontractor’s patient, medical, behavioral health and developmental disabilities services, and record keeping system;
7. Specification that the subcontractor shall cooperate with quality management programs, and comply with the utilization control and review procedures specified in 42 CFR Part 456;
8. A provision stating that a merger, reorganization or change in ownership of an Administrative Services subcontractor of the PASSE shall require a contract amendment and prior approval of DHS;
9. A provision that indicates that DHS is responsible for decisions related to attribution, Transition, Abeyance or Closure of the covered population;
10. A provision that the subcontractor shall be fully responsible for all tax obligations, Worker’s Compensation Insurance, and all other applicable insurance coverage obligations which arise under this subcontract, for itself and its employees, and that DHS shall have no responsibility or liability for any such taxes or insurance coverage;
11. A provision that the subcontractor must obtain any necessary authorization from the PASSE or DHS for services provided to eligible and Attributed Beneficiaries;
12. A provision that the subcontractor must comply with data reporting and other requirements as described in the subcontract;
13. Provision(s) that allow the PASSE to suspend, deny, refuse to renew or terminate any subcontractor in accordance with the terms of this Agreement and applicable law and regulation;
14. A provision that the subcontractor may provide the Attributed Beneficiary with factual information, but is prohibited from recommending or steering an Attributed Beneficiary in the Attributed Beneficiary’s selection of a PASSE;
15. An indemnification clause to hold the contract or subcontractor liable in the event that DHS is held liable for actions taken by the contractor or subcontractor;
16. A clause holding DHS harmless in the event that the PASSE, or any of its contractors/subcontractors are injured, including monetary injury, either directly or indirectly as a result of this Agreement;
17. To comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions;
18. That DHS, OMIG, the Arkansas Attorney General Medicaid Fraud Control Unit (MFCU), CMS, the HHS Inspector General, the GAO Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic
systems of the subcontractor, or of the subcontractor’s contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the PASSE’s Agreement with Arkansas and DHS;

19. To make available, for the purposes of an audit, evaluation, or inspection by DHS, OMIG, MFCU, CMS, the HHS Inspector General, the GAO Comptroller General or their designees, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid Attributed Beneficiaries;

20. To agree that the right to audit by DHS, OMIG, MFCU, CMS, the HHS Inspector General, the GAO Comptroller General or their designees, will exist through 10 years from the final date of the Agreement period or from the date of completion of any audit, whichever is later; and

21. That if DHS, OMIG, MFCU, CMS, or the HHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, DHS, OMIG, MFCU, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.
APPENDIX E
TRANSITION PLAN ACTIVITIES

Below is a list of the activities that must be undertaken by the PASSE or any of the PASSE subcontractors for the transition of attributed PASSE Members in the event that the Agreement expires or is terminated.

1. Notify providers, subcontractors, members and attributed PASSE Members;
2. Submit quarterly Care Coordination Quality Management reports as appropriate to provide DHS with information on services rendered up to the date of Agreement termination. This will include Quality of Care (QOC) concern reporting based on the date of service;
3. Submit quarterly Medical/Quality Management Committee reports as required herein and as appropriate to provide DHS with information on Care Coordination Services rendered up to the date of Agreement termination. This will include Quality of Care (QOC) concern reporting based on the date of service;
4. Conclude all outstanding obligations for Care Coordination Services as necessary prior to Transition. If those Care Coordination Services are not able to be properly completed, ensuring that the PASSE that receives the attributed PASSE Members is given clear instructions on the outstanding Care Coordination Services;
5. Provide a Performance Bond, or other type of bond or financial surety instrument, or Bond Substitute upon notice to DHS or AID that the PASSE intends to cease operations on a date particular or within the next six (6) months. A formal request to release the Bond or other instrument, as well as a balance sheet, must be submitted when appropriate;
6. Indemnify DHS for any and all claim by any third party against the State or DHS arising from the PASSE’s performance of this Agreement, and for which the PASSE would otherwise be liable under this Agreement;
7. Return to DHS any funds paid to the PASSE for Care Coordination of attributed PASSE Members for periods after the date of termination. Funds must be returned to DHS within 30 days of termination of the Agreement;
8. Preserve and make available records within the timeframes required by state and federal law, including but not limited to, 42 CFR §438.3(u) and 45 CFR §164.530(j)(2); and
9. Concluding all outstanding financial obligations and activities related to Care Coordination Services, including but not limited to receipt of Per-Beneficiary-Per-Month (PMPM) payments, which are paid prospectively. The PASSE shall provide a monthly aging report for any and all financial activity (due the 15th day of the month, for the prior month).

The terms above are subject to change after notice from DHS.
APPENDIX F
CALL CENTER REQUIREMENTS

1. Specific service requirements for the Call Center include:
   a. Operating a toll-free, HIPAA-compliant, call center for attributed and potential PASSE Members and providers -- The Call Center must be able to accommodate all calls, including those requiring the use of interpreter services for the hearing impaired or for callers that have limited English proficiency. Callers may not be charged a fee for translator or interpreter services.
   b. Ensuring a sufficient number of adequately trained staff to operate the Call Center on Business Days from 8:00 am to 5:00 pm local time, at a minimum. All staff is expected to be responsive, courteous, and accurate when responding to calls.
   c. Having a method, approved by DHS, for handling calls received after normal Business hours and during state-approved holidays;
   d. Meeting Performance Standards, including:
      i. 95% of all calls must be answered within 3 rings or 15 seconds;
      ii. Number of busy signals or abandoned calls cannot exceed 5% of the total incoming calls;
      iii. The wait time in queue should not be longer than 2 minutes for 95% of the incoming calls;
      iv. All calls requiring a call back to the attributed or potential PASSE Member or Provider should be returned within 1 Business Day of receipt;
      v. The abandoned call rate should not exceed 3% for any month;
      vi. For calls received during non-Business hours, return calls to attributed or potential PASSE Members and Providers must be made on the next Business Day.
   e. Having the technological capability to allow for monitoring and auditing of calls, both by the PASSE and designated DHS personnel, for quality, accuracy, and professionalism;
   f. Having an electronic system that allows Call Center staff to document calls in sufficient detail for reference, tracking, and analysis. The documentation system must contain sufficient flexibility and reportable data fields to accommodate production and ad-hoc reports. The system must also have reportable fields to accurately capture the type (inquiry, request for assistance, request for paper documentation, Grievance, or other topic), date, and subject of each call;
   g. Having a plan approved by DHS by the Service Delivery Effective Date for providing Call Center services in the event the primary Call Center facilities are unable to function in their normal capacity; and
   h. Relinquishing ownership of the toll-free numbers upon PASSE Provider Agreement termination, at which time DHS shall take title to these telephone numbers.

2. During the Start-Up Period, the PASSE shall demonstrate to DHS that all hardware, software, and staff necessary to administer the Call Center are available and operational. DHS will approve or require corrective action as necessary.

3. During the PASSE Provider Agreement Term, the PASSE shall:
a. Track and report to DHS monthly the number of requests for assistance to obtain an appointment, including the county in which the attributed or potential PASSE Member required assistance.

b. Report the following information to DHS weekly for months 1–3 of the PASSE Provider Agreement; monthly for months 4–12; and quarterly, no later than 15 days after the end of each quarter of the Agreement Year, for the duration of the PASSE Provider Agreement Term:
   i. Total call volume;
   ii. Percentage of calls answered;
   iii. Percentage of calls answered that were on hold in 30 second increments;
   iv. Percentage of calls abandoned;
   v. Average speed of answer;
   vi. Average hold time before answer;
   vii. Average time before abandonment;
   viii. Average length of call;
   ix. Type and subject of call by volume;
   x. Average number of Business Days to return calls from calls received during non-business hours;
   xi. Percentage of calls answered within 3 rings or 15 seconds;
   xii. Percentage of calls on hold for 2 minutes or less; and
   xiii. Longest time to return a call.
APPENDIX G
PASSE PROVIDER ABEYANCE NOTIFICATION

Name of PASSE: ____________________________________________

Name of PASSE Member: _____________________________________
Medicaid ID: _______________________________________________
DOB: / / (mm/dd/yyyy) _______________________________________
Contact Information Used: ____________________________________

Dates Contact Attempted/Additional Information: ________________

Date Abeyance Began: / / (mm/dd/yyyy) _________________________
Basis for Abeyance: ___________________________________________

Name of Person Reporting (CEO, CFO, Care Coordination Mgr):
Date: _______________________________________________________

Date Abeyance Ended (if applicable): / / (mm/dd/yyyy) ...............
Basis if Abeyance Ended (if applicable): _________________________

Name of Person Reporting (CEO, CFO, Care Coordination Mgr):
Date: _______________________________________________________

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______________________________
APPENDIX H  
METRICS, TARGETS AND REPORTS

1. CARE COORDINATOR METRICS AND REPORTING

Below is a Summary Table of the Performance Metrics, Targets and Reporting Requirements for Care Coordinators. Prior to taking any compliance action allowed under Section XIV with respect to this Appendix, DHS will informally discuss with the PASSE any metric or target that is not achieved and consider all meaningful efforts that were taken to achieve such target. DHS shall request a corrective action plan if the PASSE does not demonstrate that it took meaningful efforts to substantially comply with this Appendix.

Strict compliance, defined as ‘close adherence to specific requirements and enforced rigorously’ is required with the metrics in the following table.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Target</th>
<th>Reporting to DHS (Frequency/Content)</th>
</tr>
</thead>
</table>
| CCs must complete monthly face-to-face contact with all PMs in their caseload:  
1. The initial contact must be face-to-face;  
2. Ongoing contacts can be accomplished utilizing video conferencing; and  
3. If a face-to-face contact is not made, the CC must document at least three (3) attempts to make face-to-face contact at the PM’s place of residence during that month, and the attempts must be at least 24 hours apart | 100% of CCs will complete monthly face-to-face contact with all PMs in caseload (strict compliance required) | Quarterly/ 
Details of each completion or attempt to complete every contact with PM in caseload |

Substantial compliance based upon documented efforts to obtain all needed information is required with the metrics in the following table.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Target</th>
<th>Reporting to DHS (Frequency/Content)</th>
</tr>
</thead>
</table>
| The Care Coordinators (CC) assigned caseload will be limited to a maximum of 50 attributed PASSE Members (PM) | 100% of CCs will have a caseload of ≤ 50 PMs (substantial compliance) | Quarterly/ 
Details of monthly caseload for each CC employed, including the names of each PM in the CC’s caseload |
| CCs must to initiate contact with each PM within 15 business days after attribution to the PASSE | ≥75% of CCs will contact each PM within 15 business days after attribution to PASSE  
*(substantial compliance required)* | Quarterly/ 
Details of initial contact time frame with each PM after attribution to PASSE, including, but not limited to, date of attribution, date of initial contact and date of completed contact |
| CCs must follow up with PMs within seven (7) business days of visit to Emergency Room or Urgent Care Clinic, or discharge from Hospital or In-Patient Psychiatric Unit/Facility | ≥50% of CC will follow up with PMs within seven (7) business days of visit to Emergency Room or Urgent Care Clinic, or discharge from Hospital or In-Patient Psychiatric Unit/Facility  
*(substantial compliance required)* | Quarterly/ 
Details of follow up with PMs within seven (7) business days of visit to Emergency Room or Urgent Care Clinic, or discharge from Hospital or In-Patient Psychiatric Unit/Facility, including but not limited to action or treatment plan to prevent/avoid such visits in the future |
| CCs must ensure that all PMs have selected a PCP, confirm that the PM is seeing the PCP as needed, and if necessary, to assist PMs with selecting/providing a referral to a PCP | 100% of PM will have selected a PCP  
*(substantial compliance required)* | Quarterly/ 
Details about:  
1. The number of PMs that have been referred to and have been assigned a PCP;  
2. PCP appointment attendance rates for PMs; and  
3. The percentage of PMs in the CCs’ caseload that have a PCP selected |

### 2. PASSE METRICS AND REPORTING

Below is a Summary of the PASSE Quality Measures that are tied to overall achievement. Additionally, the aggregated data can be used to track trends and other analytics to trigger internal Quality Assurance and Performance Improvement activities.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Target</th>
<th>Reporting to DHS (Frequency/Content)</th>
</tr>
</thead>
</table>
| PASSE Aggregated attributed PASSE Members (PM) Data | TBD | Quarterly/ 
Report will include, but is not limited to:  
-Total number of PMs attributed to the PASSE each month;  
-Unique PM identifier; |
- Delivery of Services data, including:
  > The provider of the service (including whether in or out of the Provider Referral Network);
  > The service provided (including the category, i.e., BH, DD, medical, hospital, pharmacy, etc.);
  > The location of the service provided (including the relative distance/within a geographic radius from the attributed PASSE Members);
- Outcome of Services; and
- Total Code of Care per PM

The report will show this data to determine the performance by each Care Coordinator and for the PASSE as a whole entity.

| PASSE Aggregated Quality Measures and Efficiencies Achieved | TBD | Quarterly/
| --- | --- | Report will include, but is not limited to:
  - Reduction in unnecessary hospital ER/ED utilization;
  - Adherence to prescribed medication regimens;
  - Reduction in avoidable hospitalizations for ambulatory-sensitive conditions; and
  - Reduction in hospital readmissions.

The report will show this data to determine the performance by each Care Coordinator and for the PASSE as a whole entity.

| Geographic and Demographic Data | TBD | Quarterly/
| --- | --- | Report will include, but is not limited to:
  - General geographic and demographic information of attributed PASSE Members and Service Providers;
  - Relative distances between an attributed PASSE Member’s home and the location of the Service Providers to ensure adherence with the time/distance requirements of Direct Service Providers in the Referral Network.

The report will show this data to determine the performance by each Care Coordinator and for the PASSE as a whole entity.

| Attributed PASSE Member Satisfaction | TBD | Quarterly/
| --- | --- | Report will include, but is not limited to:
  - Satisfaction scores from a PASSE-administered PASSE Members’ satisfaction survey;
  - Feedback from attributed PASSE Members regarding specific instances of Care Coordination Services delivery.

The report will show this data to determine the performance by each Care Coordinator and for the PASSE as a whole entity.
APPENDIX I
PROHIBITIONS

Under the terms of this Agreement, CMS (the Center for Medicare and Medicaid Services) specifically prohibits the PASSE ENTITY from engaging in the following activities:

1. Being controlled by a sanctioned individual under §1128(b)(8) of the Social Security Act (SSA);
2. Having a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with:
   a. An individual convicted of crimes described in §1128(b)(8)(B) of the SSA;
   b. Any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
   c. Any individual or entity that is excluded from participation in any Federal health care program under §1128 or §1128A of the SSA;
3. Employing or contracting, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity (or is affiliated with a person/entity) that:
   a. Is debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
   b. Is excluded from participation in any Federal health care program under §1128 or §1128A of the SSA;
   c. Would provide those services through an individual or entity debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
   d. Would provide those services through an individual or entity excluded from participation in any Federal health care program under §1128 or §1128A of the SSA;
4. Knowingly having any of the following who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549:
   a. A director, officer, or partner;
   b. A person with ownership of 5% or more of the PASSE ENTITY’s equity;
   c. A network provider;
   d. An employment, consulting, or other agreement for the provision of PASSE ENTITY Agreement items or services with a person; or
e. A subcontractor of the PASSE ENTITY;

5. Written disclosure is required if any of the following who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549:
   a. Director, officer, or partner;
   b. Subcontractor of the PASSE ENTITY;
   c. Person with ownership of 5% or more of the PASSE ENTITY’s equity;
   d. Network provider; or
   e. Employment, consulting, or other agreement for the provision of PASSE ENTITY Agreement items or services;

6. Written disclosure is required if any persons in (e) are An individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.