# STATE OF ARKANSAS

**Department of Human Services**
**Office of Procurement**
**700 Main Street**
**Little Rock, Arkansas 72201**

# REQUEST FOR PROPOSAL

RFP SOLICITATION DOCUMENT

| SOLICITATION INFORMATION | | | |
|---|---|---|---|
| Solicitation Number: | 710-25-008 | Solicitation Issued: | September 25, 2025 |
| Description: | Utilization Management and Clinical Services | | |
| Department: | Department of Human Services, Division of Medical Services | | |

| SUBMISSION DEADLINE | | | |
|---|---|---|---|
| Proposal Submission Date and Time: | October 29, 2025, 1:00 p.m., Central Time | Proposal Opening Date and Time: | October 30, 2025, 2:00 p.m., Central Time |
| Proposals **shall not** be accepted after the designated bid opening date and time. In accordance with Arkansas Procurement Law and Rules, it is the responsibility of Contractors to submit proposals at the designated location on or before the bid opening date and time. Proposals received after the designated bid opening date and time **shall** be considered late and **shall** be returned to the Contractor without further review. It is not necessary to return "no bids" to the Office of Procurement (OP). | | | |

| DELIVERY OF RESPONSE DOCUMENTS | |
|---|---|
| Drop off Address: | Arkansas Department of Human Services<br>Attn: Office of Procurement<br>700 Main Street<br>Little Rock, AR 72201<br>***Note: Hand delivered responses must be delivered directly to and logged by the security desk at 700 Main Street prior to the bid submission deadline. Otherwise, these deliveries will not be accepted and may be disqualified. Receipts for submissions will NOT be issued to bidders.*** |
| United States mail (USPS): | Arkansas Department of Human Services<br>Attn: Office of Procurement<br>P.O. Box 1437 Slot W345<br>Little Rock, AR 72203-1437 |
| Commercial Carrier (UPS, FedEx or USPS Exp): | Arkansas Department of Human Services<br>Attn: Office of Procurement<br>112 West 8th Street, Slot W345<br>Little Rock, AR 72201<br><br>Delivery providers, USPS, UPS, and FedEx deliver mail to OP's street address on a schedule determined by each individual provider. These providers will deliver to OP based solely on the street address. **Prospective Contractors assume all risk for timely, properly submitted deliveries.** |
| Proposal's Outer Packaging: | Seal outer packaging and properly mark with the following information. If outer packaging of proposal submission is not properly marked, the package may be opened for proposal identification purposes.<br>▪ Solicitation number ▪ Date and time of proposal opening ▪ Vendor's name and return address |

| OFFICE OF PROCUREMENT CONTACT INFORMATION | | | |
|---|---|---|---|
| Department Buyer: | Tamara DeBord | Buyer's Direct Phone Number: | 501-683-5969 |
| Email Address: | DHS.OP.Solicitations@dhs.arkansas.gov | OP's Main Number: | 501-682-1001 |
| DHS Website:<br>OSP Website: | DHS Procurement Announcements<br>OSP Bid Opportunities | | |

# SECTION 1 – GENERAL INFORMATION AND INSTRUCTIONS

- ***Do not*** *provide responses to items in this section unless specifically and expressly required.*

## 1.1 INTRODUCTION
This Request for Proposal (RFP) is issued by the Arkansas Department of Human Services (DHS), Office of Procurement (OP) to obtain pricing and a contract for utilization management and clinical services. The Office of Procurement is the sole point of contact throughout this solicitation process.

## 1.2 INTERGOVERNMENTAL/COOPERATIVE USE OF PROPOSAL AND CONTRACT (NON-NEGOTIABLE)
According to §19-61-802, this proposal and resulting contract is available to any State Agency or Institution of Higher Education that wishes to utilize the services of the selected proposer, and the proposer agrees, they may enter into an agreement as provided in this solicitation.

## 1.3 TYPE OF CONTRACT
A. As a result of this RFP, OP intends to award a contract to a single Contractor.

B. The term of this contract shall be for three (3) years. The anticipated start date for the contract is July 1, 2026. Upon mutual agreement by the Prospective Contractor and agency, the contract may be renewed by OP, on a year-to-year basis, for up to four (4) years additional one-year terms or portions thereof.

C. The total contract term shall not be more than seven (7) years.

## 1.4 ISSUING AGENCY
The Office of Procurement (OP), as the issuing office, is the sole point of contact throughout this solicitation process. Contractor questions regarding this Bid Solicitation should be made through the Issuing Officer as shown on page one (1) of this document

## 1.5 BID OPENING LOCATION
Bids submitted by the opening date and time will be opened via video conference. DHS will publish a link to the live bid opening on the DHS website for public access. Individuals will not be permitted to attend in-person. If the bid opening cannot be held as scheduled due to technical or other issues, DHS will publish an updated schedule and video conference link on the DHS website.

## 1.6 ACCEPTANCE OF REQUIREMENTS
A. The words “**must**” and “**shall**” signify a Requirement of this solicitation and that the Contractor’s agreement to and compliance with that item is mandatory.

B. A Contractor’s proposal will be disqualified if a Contractor takes exceptions to any Requirements named in this RFP.

C. Contractor may request exceptions to NON-mandatory items. Any such request **must** be declared on, or as an attachment to, the appropriate section’s Agreement and Compliance Page. Contractor **must** clearly explain the requested exception and should reference the specific solicitation item number to which the exception applies. (See Agreement and Compliance Page.)

D. DHS **must** not be required to accept any requested exceptions. Only exceptions expressly accepted by DHS will become part of the resulting contract.

## 1.7 DEFINITION OF TERMS
A. Unless otherwise defined herein, all terms defined in Arkansas Procurement Law and used herein have the same definitions herein as specified therein.

B. “Prospective Contractor”, means a responsible offeror who submits a proposal in response to this solicitation. “Prospective Contractor”, “Contractor”, “bidder”, “vendor” and “respondent” are used synonymously in this document.

C. The terms “buyer” and “Issuing Officer” are used synonymously in this document.

D. The terms "Request for Proposal", "RFP," "RFP Solicitation," "Bid Solicitation" and "Solicitation" are used synonymously in this document.

E. "Responsive proposal" means a proposal submitted in response to this solicitation that conforms in all material respects to this RFP.

F. "Proposal Submission Requirement" means a task a Prospective Contractor shall complete when submitting a proposal response. These requirements will be distinguished by using the term "shall" or "must" in the requirement.

G. "Requirement" means a specification that a Contractor's commodity and/or service must meet or exceed in the performance of its contractual duties under any contract awarded as a result of this RFP. These specifications will be distinguished by using the terms "shall" or "must" in the requirement.

H. "State" means the State of Arkansas. When the term "State" is used herein to reference any obligation of the State under a contract that results from this solicitation, that obligation is limited to the State Department using such a contract.

I. "Adult Developmental Day Treatment" refers to habilitative day services to qualifying individuals with intellectual and/or developmental disabilities provided by a licensed adult day treatment clinic.

J. "Annual Re-Evaluation" means evaluations will continue to be performed at least every twelve (12) months by the DAABH RN in client's home, with the medical eligibility reaffirmed or revised and a written determination issued. In cases where a participant has experienced a significant change in circumstances (e.g., an inpatient hospital admission, skilled nursing facility admission, or the loss of a primary family caregiver), an evaluation will be performed, and based on the review of the evaluation, a reassessment may be requested.

K. "Arkansas Independent Assessment Instrument" is the system used to perform a functional-needs assessment to assist in the development of an individual's Person-Centered Service Plan (PCSP), and for certain populations to establish the per member per month payment to a managed care entity.

L. "Consult" Refers to a situation where a healthcare provider needs to contact the patient's insurance company to discuss the medical necessity of a specific treatment or medication after already submitting a prior authorization request and receiving initial approval, usually to provide further details or address any concerns raised by the insurer to before the treatment or medication can be fully authorized and dispensed.
Or
Refers to a situation where a healthcare provider needs to contact a medical doctor when the case involves a complex medical situation, a proposed treatment considered non-standard or experimental, or when the review team needs additional clinical expertise to determine the medical necessity of a procedure or treatment plan.

M. "Continuation of Need Review" is the process where a patient's ongoing need for a specific treatment, medication, or service is assessed to determine if it should be continued, modified, or discontinued based on their current health status and progress.

N. "DHS Eligibility Nurse" is a registered nurse authorized by the Arkansas Department of Human Services, Division of Medical Services (DMS) to perform reviews of all medical information available and, based on available information, to make a medical eligibility determination and then, if separately determined financially eligible, the application will be approved for ARChoices. DHS eligibility nurses are also responsible for reviewing evaluation documentation (IA, DHS-703, and client medical records) for material changes to medical need and requesting a reassessment if warranted.

O. "Early Intervention Day Treatment" is a program that offers services to children with developmental disabilities or delays. Services include diagnostic, screening, evaluation, preventive, therapeutic, palliative, rehabilitative and habilitative services.

P. "Early Periodic Screening Diagnostic Treatment" is a Medicaid program that provides preventative healthcare for children under 21 to ensure that children receive age-appropriate care such as checkups, immunizations, and developmental services.

Q. "Extension of Benefits" is a provision by which some insurance plans allow coverage to continue past the scheduled end date.

R. "Outpatient Behavioral Health Services" refers to services defined in the Counseling and Crisis Services Medicaid Manual.

S. "Hospital Acquired Conditions" is a process where healthcare professionals analyze patient medical records to identify and evaluate instances of complications or medical issues that develop while a patient is hospitalized and are not present upon admission

T. "Independent Assessment" is the process completed by registered nurses employed by the Independent Assessment Contractor utilizing the Arkansas Independent Assessment Instrument (ARIA) to assess functional need. This assessment of functional need is used by DHS as part of the process to make a final determination of medical eligibility and, if the person is determined to be eligible, to be used in the development of the Person-Centered Service Plans (PCSP).

U. "Inpatient Psychiatric Acute Care Services" refers to acute psychiatric hospitalization services defined in the Inpatient Psychiatric Services for Under Age 21 Medicaid Manual.

V. "Medicaid Management Information System" MMIS is an integrated group of procedures for claims processing and information retrieval.

W. "Prior Authorization (PA)" is the process where a healthcare provider contacts a health insurance company's utilization management department to request pre-approval for a specific medical procedure, test, or medication before administering it to a patient, ensuring the treatment is deemed medically necessary and cost-effective according to the plan's guidelines.

X. "Provider Preventable Conditions" means health conditions that are reasonably preventable and can occur due to medical errors or accidents.

Y. "Qualified Physician" means an individual who is legally qualified to practice medicine and possesses the requisite education, training, and licensure/regulation to make determinations regarding the presence of severe disabilities. To perform these reviews and make the requisite determinations, the Contractor will utilize physicians with expertise in:
   a. mental health/psychiatric care,

   b. general physical health practices, and

   c. developmental delays/learning disabilities

Z. "Reassessment" is the process completed by registered nurses employed by the Independent Assessment Contractor utilizing the Arkansas Independent Assessment Instrument (ARIA) to assess functional need when requested, based on evidence of a material change in medical eligibility documented at the annual evaluation. This information is used by DHS as part of the process to make a final determination of continued medical eligibility and, if the person is determined to remain eligible, is used in the development of the PCSP.

AA. "Registered Nurse" means an individual licensed as a Registered Nurse by the Arkansas State Board of Nursing in accordance with ACA 17-87-301.

BB. "Targeted Case Management" is a comprehensive assessment that includes medical, social, educational, and other services. It goes beyond the assessment process used in determining eligibility for 1915(c) waiver program(s). It addresses all facets of the individual's everyday life in determining how any problem or need might be met and what services are available in the individual's community.

## 1.8 RESPONSE DOCUMENTS

*A.* Original *Technical Proposal Packet*

The following items are Proposal Submission Requirements and **mus**t be submitted in the original *Technical Proposal Packet*.

1. A hard copy of the original *Technical Proposal Packet* **must** be received on or before the bid submittal date and time. Printed copies should be single sided.

2. The *Technical Proposal Packet* should be clearly marked "Original" and **must** include the following:

    a. Original signed *Proposal Signature Page*. (See *Technical Proposal Packet.)*

    b. Original signed *Agreement and Compliance Page*. (See *Technical Proposal Packet.)*

    c. Original *Proposed Subcontractors Form.* (See *Technical Proposal Packet*.)

    d. EO 98-04 Disclosure Form, Attachment A. (See *Standard Terms and Conditions, Disclosure*.)

    e. *Technical Proposal* response to the *Information for Evaluation* section included in the *Technical Proposal Packet*.

    f. Other documents and/or information as may be expressly required in this *Bid Solicitation*.

3. The following items should be submitted in the original *Technical Proposal Packet*.

    a. Copy of Contractor's *Equal Opportunity Policy*. (See *Equal Opportunity Policy*.)

    b. Signed addenda to this RFP, if applicable. (See Requirement of Addendum.)

    c. *Voluntary Product Accessibility Template* (VPAT), if applicable. (See *Technology Access.*)

4. **DO NOT** include any other documents or ancillary information, such as a cover letter or promotional/marketing information.

B. *Official Bid Price Sheet* and *Cost Proposal Template*. (See *Pricing.)*

1. Contractor's original *Official Bid Price Sheet* and the *Cost Proposal Template (Attachment H)* **must** be submitted in hard copy format.

2. Contractor should also submit one (1) electronic copy of the *Official Bid Price Sheet* and the *Cost Proposal Template* (Attachment H), in PDF format, preferably on a flash drive. All items on flash drive should be in PDF format.

The *Official Bid Price Sheet* and the *Cost Proposal Template* (Attachment H), including the hard copy and electronic copy, **must** be separately sealed from the *Technical Proposal Packet* and should be clearly marked as "Pricing". Vendor **must not** include any pricing in the hard copies or electronic copies of their *Technical Proposal Packet*.

C. Additional Copies and Redacted Copy of the *Technical Proposal Packet*
In addition to the original *Technical Proposal Packet*, *Official Bid Price Sheet*, and *Cost Proposal Template*, the following items should be submitted:

1. Additional Copies of the *Technical Proposal Packet*

    a. Three (3) complete hard copies (marked "COPY") of the *Technical Proposal Packet*.

    b. Four (4) electronic copy of the *Technical Proposal Packet*, preferably on flash drive. All items on flash drive should be in PDF format.

    c. All additional hard copies and electronic copies **must** be identical to the original hard copy. In case of a discrepancy, the original hard copy **shall** govern.

    d. One (1) redacted copy, in PDF format, if applicable, (marked "REDACTED") of the original *Technical Packet*, preferably on a flash drive. *(See Proprietary Information.)*

    e. If OP requests additional copies of the proposal, the copies **must** be delivered within twenty-four (24) hours of request.

D. Original *Technical Proposal Packets* **must** be submitted to the Office of Procurement on or before the day\time specified for bid opening. The *Technical Proposal Packet* **must** contain all documents, information, and

attachments as specifically and expressly required in the *Bid Solicitation*. Multiple proposals **must** be placed in separate packages and should be completely and properly identified. Late bids **shall not** be considered under any circumstances.

E. Contractor's proposals cannot be altered or amended after the bid opening except as permitted by regulation.

**1.9 ORGANIZATION OF RESPONSE DOCUMENTS**

A. It is strongly recommended that Contractors adhere to the following format and suggestions when preparing their *Technical Proposal Packet*.

B. The original *Technical Proposal Packet* and all copies should be arranged in the following order:

- *Response Signature Page*.
- *Agreement and Compliance Page*.
- Signed Addenda, if applicable.
- E.O. 98-04 – *Contract Grant and Disclosure Form*.
- *Equal Opportunity Policy.*
- *Proposed Subcontractors Form*.
- Other documents and/or information as may be expressly required in this *Bid Solicitation*. Label documents and/or information so as to reference the Bid Solicitation's item number.
- Technical Proposal response to the *Information for Evaluation* section of the *Technical Proposal Packet.*

**1.10 CLARIFICATION OF RFP SOLICITATION**

A. Contractor may submit written questions requesting clarification of information contained in this *Bid Solicitation.* Written questions should be submitted via email by 4:00 p.m., Central Time on or before October 2, 2025. Submit questions to the OP buyer as shown on page one (1) of this *Bid Solicitation*. It is the contractor's responsibility to guarantee receipt of the questions by the specific time and date. DHS accepts no responsibility for accurate or timely receipt of email submission.

B. The attached response template (Attachment B) should be used for submission of all written questions. For each question submitted, Vendor should reference the specific solicitation item number to which the question refers. Written questions submitted in a different format may not be answered by DHS.

C. Contractor's written questions will be consolidated and responded to by the State. The State's consolidated written response is anticipated to be posted to the OP website by the close of business on October 10, 2025.

D. Answers to verbal questions may be given as a matter of courtesy and must be evaluated at contractor's risk.

E. Oral statements by OP shall not be part of any contract resulting from this solicitation and may not reasonably be relied on by any vendor as an aid to interpretation unless it is reduced to writing and expressly adopted by DHS.

**1.11 RESPONSE SIGNATURE PAGE**

A. An official authorized to bind the Contractor(s) to a resultant contract **must** sign the *Response Signature Page* included in the *Technical Proposal Packet*.

B. Contractor's signature on this page **shall** signify contractor's agreement that either of the following **shall** cause the contractor's proposal to be disqualified:

1. Additional terms or conditions submitted intentionally or inadvertently.
2. Any exception that conflicts with a Requirement of this *Bid Solicitation*.

**1.12 AGREEMENT AND COMPLIANCE PAGE**

A. Contractor **must** sign the A*greement and Compliance Page* relevant to each section of the *Bid Solicitation Document.* The *Agreement and Compliance Page* is included in the *Technical Proposal Packet*.

B. Contractor's signature on this **shall** signify agreement to and compliance with all Requirements within the designated section.

**1.13 SUBCONTRACTORS**

A. Contractor **must** complete and submit the *Proposed Subcontractors Form* included in the *Technical Proposal Packet* to indicate contractor's intent to utilize, or to not utilize, subcontractors.

B. Additional subcontractor information may be required or requested in following sections of this *Bid Solicitation* or in the *Information for Evaluation* section provided in the *Technical Proposal Packet*. **Do not** attach any additional information to the *Proposed Subcontractors Form*.

C. The utilization of any proposed subcontractor is subject to approval by the State agency.

### 1.14 PRICING

A. Contractor(s) shall include all pricing on the Official Price Bid Sheet and the *Cost Proposal Template* (Attachment H) only**.** Any cost not identified by the successful contractor but subsequently incurred in order to achieve successful operation **shall** be borne by the Contractor. The *Official Bid Price Sheet and the Cost Proposal Template* (Attachment H) *are* provided as separate documents posted with this *Bid Solicitation*.

B. To allow time to evaluate proposals, prices **must** be valid for 180 days following the bid opening.

C. The *Official Bid Price Sheet*, and the *Cost Proposal Template* including the hard copy and electronic copy, **must** be separately sealed from the *Technical Proposal Packet* and should be clearly marked as "Pricing". DO NOT submit any ancillary information not related to actual pricing in the sealed pricing package. The *Official Bid Price Sheet* and *Cost Proposal Template* (if applicable) is provided as a separate file posted with this *Bid Solicitation*.

D. Contractor **must not** include any pricing in the hard copies or electronic copies of their *Technical Proposal Packet*. Should hard copies or electronic copies of their *Response Packet* contain any pricing, the response **shall** be disqualified.

E. Failure to complete and submit the *Official Bid Price Sheet* and *Cost Proposal Template* (if applicable) **shall** result in disqualification.

F. All proposal pricing **must** be in United States dollars and cents.

F. The Official Bid Price Sheet may be reproduced as needed.

G. Bid unit price F.O.B. destination. In case of errors in extension, unit prices shall govern. Prices shall be firm and shall not be subject to escalation unless otherwise specified in the Bid Solicitation. Unless otherwise specified, the bid must be firm for acceptance for thirty days from the bid opening date. "Discount from list" bids are not acceptable unless requested in the Bid Solicitation.

H. Do not include State or local sales taxes in the bid price. Trade discounts should be deducted from the unit price and the net price should be shown in the bid

### 1.5 PRIME CONTRACTOR RESPONSIBILITY

A. A single contractor **must** be identified as the prime contractor and shall be the sole point of contact.

B. The prime Contractor **shall** be held responsible for the contract and jointly and severally liable with any of its subcontractors, affiliates, or agents to the State for the performance thereof.

### 1.16 INDEPENDENT PRICE DETERMINATION

A. By submission of this proposal, the Contractor certifies, and in the case of a joint proposal, each party thereto certifies as to its own organization, that in connection with this proposal:

- The prices in the proposal have been arrived at independently, without collusion; and
- No prior information concerning these prices has been received from, or given to, a competitive company.

B. Evidence of collusion **shall** warrant consideration of this proposal by the Office of the Attorney General. All Contractors **shall** understand that this paragraph may be used as a basis for litigation.

### 1.17 PROPRIETARY INFORMATION (NON-NEGOTIABLE)

A. Documents submitted pertaining to this *Bid Solicitation* become property of the State and are subject to the Arkansas Freedom of Information Act (FOIA) (*see* Ark. Code Ann. § 25-19-101, et seq.).

B. In accordance with FOIA, all public records shall be open to inspection unless specifically exempted from disclosure. In the interest of promoting maximum competition in the State competitive bidding process, the State may maintain the confidentiality of certain types of information described in FOIA. Such information may be exempted from the Public Records Act pursuant to FOIA.

C. Prospective Contractor may designate appropriate portions of its response as confidential, consistent with and to the extent permitted under FOIA and any other applicable law by submitting a redacted copy of the response. By redacting any information contained in the response, the Contractor warrants that it has formed a good faith opinion having received such necessary or proper review by counsel and other knowledgeable advisors that the portions redacted are exempt from disclosure pursuant to Ark. Code Ann. § 25-19-105(b). The Arkansas FOIA has a presumption of openness. It is to be liberally interpreted, and exemptions are to be narrowly construed. For each redaction, Prospective Contractor **must** provide detailed justification as to how disclosure of the redacted information would give advantage to competitors. As custodian of the records, the State has the legal authority to review redactions to determine whether each are specifically and sufficiently justified to retain redaction prior release. **Evidence that demonstrates that the Prospective Contractor meets the minimum qualifications of this RFP must be minimally redacted.**

D. **Under no circumstances will pricing information be designated as confidential.**

E. One (1) complete electronic copy of the submission documents from which any proprietary information has been redacted should be submitted on a flash drive in the Technical Proposal Packet. Do not submit documents via e-mail or fax.

F. Except for the redacted information, the redacted copy **must** be identical to the original hard copy, reflecting the same pagination as the original and showing the space from which information was redacted.

G. The Prospective Contractor is responsible for identifying all proprietary information and for ensuring the electronic copy is protected against restoration of redacted data.

H. The redacted copy shall be open to public inspection under the Freedom of Information Act (FOIA) without further notice to the Prospective Contractor.

I. If a redacted copy of the submission documents is not provided with Contractor's Technical Proposal Packet, a copy of the non-redacted documents, with the exception of financial data (other than pricing), will be released in response to any request made under the Arkansas Freedom of Information Act (FOIA).

J. The State will release any redacted information deemed to be subject to FOIA; the State will **<u>not</u>** contact the Prospective Contractor prior to the release of documents.

K. The State has no liability to a Prospective Contractor with respect to the disclosure of Prospective Contractor's confidential information ordered by a court of competent jurisdiction pursuant to FOIA or other applicable law.

### 1.18 CAUTION TO CONTRACTORS

A. Prior to any contract award, all communication concerning this *Bid Solicitation* **must** be addressed through the OP buyer.

B. Contractor **must not** alter any language in any solicitation document provided by the State.

C. Contractor **must not** alter the Official Bid Price Sheet.

D. All official documents and correspondence related to this solicitation **shall** be included as part of the resultant contract.

E. Proposals **must** be submitted only the English language.

F. The State **shall** have the right to award or not award a contract, if it is in the best interest of the State to do so.

G. Contractor **must** provide clarification of any information in their response documents as requested by OP.

H. Qualifications and proposed services **must** meet or exceed the required specifications as set forth in this *Bid Solicitation*.

I. Contractors may submit multiple proposals. Each proposal shall be submitted separately and must include all documents and information required under this RFP in order to advance to evaluation.

**1.19 REQUIREMENT OF ADDENDUM**

A. This *Bid Solicitation* **shall** be modified only by an addendum written and authorized by OP.

B. Contractors are cautioned to ensure that they have received or obtained, and have responded to, any and all addenda to the Bid Solicitation prior to submission of response.

C. An addendum posted within three (3) calendar days prior to the bid opening **shall** extend the bid opening and may or may not include changes to the Bid Solicitation.

D. The Contractor **shall** be responsible for checking the websites listed on page one (1) for any and all addenda up to bid opening.

**1.20 AWARD PROCESS**

A. Award Determination

The Grand Total Score for each Contractor, which shall be the sum of the Technical Score and Cost Score, shall be used to determine the ranking of proposals. The State may move forward to negotiations pursuant to Arkansas Code Annotated § 19-61-506, with those responsible Contractors determined, based on the ranking of the proposals, to be reasonably susceptible of being selected for award. Responsible Contractors reasonably susceptible of being selected for award is defined as any contractor that falls within the competitive range based on price and appears to provide the best value based on evaluation criteria.

B. Discussions and Negotiations

1. Arkansas Procurement Law allows for Discussions with responsible offerors whose proposals have been determined to be reasonably susceptible of being selected for award.
2. The Department reserves the discretion and the right to engage in Discussions to the fullest extent permitted under Arkansas Code Annotate § 19-61-506 and Office of State Procurement rules.
3. After initial evaluation, the Department may elect to request a best and final offer (BAFO) from a competitive range of responsible Prospective Contractors determined, based on the ranking of the proposals, to be reasonably susceptible of being selected for award.
4. Cost will be considered in establishing this range.

C. Anticipation to Award

1. Once the anticipated successful Contractor has been determined, the anticipated award will be posted on the websites listed on page one (1) of this RFP.

2. The anticipated award will be posted for a period of fourteen (14) days prior to the issuance of a contract. Contractors and agencies are cautioned that these are preliminary results only, and a contract will not be issued prior to the end of the fourteen-day posting period.

3. DHS **shall** have the right to waive the fourteen (14) day anticipated award posting period when it is in the best interest of the State.

4. It is the Contractor's responsibility to check the websites for the posting of an anticipated award.

5. These notices are anticipated awards only and are subject to protest.

D. Issuance of Contract

1. Any resultant contract of this *Bid Solicitation* **shall** be subject to State approval processes which may include Legislative review.

2. A State Procurement Official will be responsible for award and administration of any resulting contract.

3. DHS reserves the right to award multiple contracts.

## 1.21 EQUAL OPPORTUNITY POLICY

A. In compliance with Arkansas Code Annotated § 19-60-104, the State is required to have a copy of the anticipated Contractor's *Equal Opportunity (EO) Policy* prior to issuing a contract award.

B. *EO Policies* should be included as a hardcopy accompanying the solicitation response.

C. Contractors are responsible for providing updates or changes to their respective policies, and for supplying *EO Policies* upon request to other State agencies that must also comply with this statute.

D. Vendors who are not required by law by to have an *EO Policy* **must** submit a written statement to that effect.

## 1.22 COMBINED CERTIFICATIONS

A. Pursuant to Arkansas law, a Contractor must certify compliance with the certification requirements listed below that are relevant to the contractor's performance under the resulting contract and will remain so for the aggregate term of any resultant contract. Additionally, Contractor agrees and certifies they shall comply with all Arkansas laws applicable to the contractor's performance under the resulting contract.

1. Boycott Israel. See Arkansas Code Annotated § 25-1-503.
2. Knowingly employ or contract with illegal immigrants. See Arkansas Code Annotated § 19-60-105.
3. Boycott Energy, Fossil Fuel, Firearms, and Ammunition Industries. See Arkansas Code Annotated § 25-1-1102.
4. Employ a Scrutinized Company as a subcontractor. See Arkansas Code Annotated § 25-1-1203.

## 1.23 PAST PERFORMANCE

In accordance with provisions of State Procurement Law, specifically Ark. Code Ann. § 19-61-506 and OSP Rule 19 CAR § 1-527(b), a Contractor's past performance with the State may be used to determine if the Contractor is "responsible." Proposals submitted by Contractors determined to be non-responsible **shall** be disqualified.

## 1.24 TECHNOLOGY ACCESS

A. When procuring a technology product or when soliciting the development of such a product, the State of Arkansas is required to comply with the provisions of Arkansas Code Annotated § 25-26-201 et seq., which expresses the policy of the State to provide individuals who are blind or visually impaired with access to information technology purchased in whole or in part with state funds. The Contractor expressly acknowledges and agrees that state funds may not be expended in connection with the purchase of information technology unless that technology meets the statutory Requirements found in 36 C.F.R. § 1194.21, as it existed on January 1, 2019 (software applications and operating ICSs) and 36 C.F.R. § 1194.22, as it existed on January 1, 2019 (web-based intranet and internet information and applications), in accordance with the State of Arkansas technology policy standards relating to accessibility by persons with visual impairments.

B. ACCORDINGLY, THE CONTRACTOR EXPRESSLY REPRESENTS AND WARRANTS to the State of Arkansas through the procurement process by submission of a Voluntary Product Accessibility Template (VPAT) for 36 C.F.R. § 1194.21, as it existed on January 1, 2019 (software applications and operating ICSs) and 36 C.F.R. § 1194.22, that the technology provided to the State for purchase is capable, either by virtue of features included within the technology, or because it is readily adaptable by use with other technology, of:

1. Providing, to the extent required by Arkansas Code Annotated § 25-26-201 et seq., equivalent access for effective use by both visual and non-visual means;

2. Presenting information, including prompts used for interactive communications, in formats intended for non-visual use;

3. After being made accessible, integrating into networks for obtaining, retrieving, and disseminating information used by individuals who are not blind or visually impaired;

4. Providing effective, interactive control and use of the technology, including without limitation the operating system, software applications, and format of the data presented is readily achievable by nonvisual means;

5. Being compatible with information technology used by other individuals with whom the blind or visually impaired individuals interact;

6. Integrating into networks used to share communications among employees, program participants, and the public; and

7. Providing the capability of equivalent access by nonvisual means to telecommunications or other interconnected network services used by persons who are not blind or visually impaired.

C. State agencies cannot claim a product as a whole is not reasonably available because no product in the marketplace meets all the standards. Agencies **must** evaluate products to determine which product best meets the standards. If an agency purchases a product that does not best meet the standards, the agency must provide written documentation supporting the selection of a different product, including any required reasonable accommodations.

D. For purposes of this section, the phrase “equivalent access” means a substantially similar ability to communicate with, or make use of, the technology, either directly, by features incorporated within the technology, or by other reasonable means such as assistive devices or services which would constitute reasonable accommodations under the Americans with Disabilities Act or similar state and federal laws. Examples of methods by which equivalent access may be provided include, but are not limited to, keyboard alternatives to mouse commands or other means of navigating graphical displays, and customizable display appearance. As provided in Arkansas Code Annotated § 25-26-201 et seq., as amended by Act 308 of 2013 if equivalent access is not reasonably available, then individuals who are blind or visually impaired shall be provided a reasonable accommodation as defined in 42 U.S.C. § 12111(9), as it existed on January 1, 2019.

E. If the information manipulated or presented by the product is inherently visual in nature, so that its meaning cannot be conveyed non-visually, these specifications do not prohibit the purchase or use of an information technology product that does not meet these standards.

F. The proposed solution must comply with the State’s shared Technical Architecture which is a set of policies and standards that can be viewed here. Only those standards which are fully promulgated or have been approved by the Governor’s Office apply to this solution.

**1.25 PROCUREMENT CARD ACCEPTANCE**

A. Awarded Contractor should have the capability of accepting the State’s authorized Procurement Card (p-card) as a method of payment.

B. Price changes or additional fee(s) **shall not** be levied against the State when accepting the p-card as a form of payment.

C. P-card is not the exclusive method of payment.

**1.26 PUBLICITY**

A. Contractors **shall not** issue a news release pertaining to this *Bid Solicitation* or any portion of the project without OP’s prior written approval.

B. Failure to comply with this Requirement **shall** be cause for a Contractor’s proposal to be disqualified or for the contract to be terminated.

**1.27 RESERVATION**

The State **shall not** pay costs incurred in the preparation of a proposal.

**1.28 DATA LOCATION (NON-NEGOTIABLE)**

Contractor shall under no circumstances allow Arkansas data to be relocated, transmitted, hosted, accessed, or stored outside the continental United States in connection with any services provided under this contract entered into under this RFP, either directly by the Contractor or by its subcontractors.

## 1.29 SCHEDULE OF EVENTS

***SOLICITATION SCHEDULE***

| ACTIVITY | DATE |
|---|---|
| Public Notice of RFP | September 25, 2025 |
| Deadline for Receipt of Written Questions | October 2, 2025, at 4:00pm CT |
| Response to written Questions, On or About | October 10, 2025 |
| Proposal Due Date and Time | October 29, 2025, at 1:00pm CT |
| Opening Proposal Date and Time | October 30, 2025, at 2:00pm CT |
| Intent to Award Announcement Posted, On or About | February 20, 2026 |
| Contract Start Date (Subject to State Approval) | July 1, 2026 |

## 1.30 STATE HOLIDAYS

Holidays are those days as declared legal state holidays by authority of Act 304 of 2001. Those days are as follows:

| HOLIDAY | DATE |
|---|---|
| New Year's Day | January 1 |
| Dr. Martin Luther King's Birthday | Third Monday in January |
| George Washington Birthday | Third Monday in February |
| Memorial Day | Last Monday in May |
| Independence Day | July 4 |
| Labor Day | First Monday in September |
| Veteran's Day | November 11 |
| Thanksgiving Day | Fourth Thursday in November |
| Christmas Eve | December 24 |
| Christmas Day | December 25 |

Additional days can be proclaimed as holidays by the Governor through executive proclamation. State offices are normally closed on holidays; however, there are occasions (i.e., during legislative sessions) when it may become necessary to keep state offices open on holidays. The Contractor **shall** maintain adequate staff on such working holidays.

# SECTION 2 – SPECIFICATIONS

- ***Do not*** *provide responses to items in this section unless specifically and expressly required.*

## 2.1 INTRODUCTION

This Request for Proposal (RFP) is issued by the Arkansas Department of Human Services (DHS), Office of Procurement (OP) for the Division of Medical Services (DMS) to obtain pricing and a contract for a qualified Contractor to manage DHS' utilization review processes and provide clinical expertise in guiding patient care, aiming to optimize quality while controlling cost. The Office of Procurement is the sole point of contact throughout this solicitation process.

DHS, at its sole discretion, reserves the right to request services for additional DHS divisions and locations.

## 2.2 GOALS AND OBJECTIVES

State and Federal law impose requirements regarding the appropriateness, necessity, and efficiency of healthcare services and resources.

The primary objective is to obtain a contract to provide services to review and render decisions on the appropriateness of requested Medicaid services, ensure programmatic compliance with Medicaid policies and procedures, procure needed clinical expertise, and generate standard reporting templates that track trends which will drive additional Medicaid policy changes.

DHS' procurement goals for the new Utilization Management and Clinical Services RFP are as follows:

- Procure a robust review process for all Pre-Payment and Post-Payment reviews for DHS program services.
- Enhance reporting for Utilization Management for Clinical Services to better assist DHS with program efficiencies and policy management. Reports will be modernized to include visual capabilities, such as illustrations and graphics.
- Ensure confidentiality, security, integrity, and availability of data that support the business needs of DHS.
- Provide accurate, timely, consistent, and high-quality data and information needed for operational and decision-making activities.
- Improve Utilization Management Services performance, streamline processes, and bring cost-efficiency to meet the business needs of DHS.

DHS anticipates additional reviews will be added for a variety of populations throughout the life of this contract. Currently, DHS has two (2) programs in the implementation stage—maternal health services and home health services. At minimum, the Contractor should anticipate the inclusion of these reviews and associated providers.

Contractor's responsibilities may include:

A. Review and approve or deny all extension of benefits requests for services beyond those limits established in the respective Medicaid manuals and procedure code tables for each program.

B. A determination of whether sufficient documentation to provide medical necessity including confirming the completion and validity of all required forms and documents in accordance with section II of the respective Medicaid manuals and procedure code tables for each program.

C. A determination of whether the amount, duration, and intensity of services requested is medically necessary in accordance with the applicable Medicaid manual based on the supporting documentation submitted with the request for extension of benefits.

D. Medical necessity reviews conducted by Arkansas licensed clinicians as designated by DHS.

## 2.3 MINIMUM QUALIFICATIONS

The Contractor **must** meet the following requirements:

A. The Contractor **must** be registered to do business in the State of Arkansas and in good standing by the initial start of any resulting contract. For verification purposes, Contractor **must** provide a Certificate of Good Standing, Certificate of Authority, other required Arkansas Secretary of State documentation such as non-filing or nonqualifying statements, upon DHS request.

B. The bidder **must** include a copy of all required licensure and certification documents in the bidder's response to this solicitation. See "Response Documents."

C. The Contractor **must** be accredited by a national organization such as Utilization Review Accreditation Commission (URAC) or National Committee for Quality Assurance (NCQA). For verification purposes, Prospective Contractor **must** provide, with bid submission, a copy of accreditation.

D. The Contractor must meet the requirements for being designated as a Quality Improvement Organization (QIO) as set forth in 42 CFR Part 475 and appear on the CMS QIO Like Entity list. See https://www.cms.gov/files/document/qio-entity-certification-list-june-2024.pdf

E. Contractor **must** be bondable. For verification purposes the Prospective Contractor shall submit a Letter of Bondability from an admitted Surety Insurer with bid submission. The letter must unconditionally offer to guarantee, to the extent of one hundred percent (100%) of the resultant contract's annual price, the Prospective Contractor's performance in all respects of the terms and conditions of this RFP and the resultant contract. The Prospective Contractor shall be required to provide DHS with the Performance Bond described in this section upon contract start.

## 2.4 SCOPE OF WORK

DHS seeks a qualified Contractor to provide the following Scope of Work:

### 2.4.1 PROGRAM IMPLEMENTATION

A. Within sixty (60) calendar days of contract start, the Contractor shall:
1. Identify all key staff and receive approval from DHS in accordance with the contract terms
2. Provide a list of level two reviewers
3. Meet with subject matter experts at Office of Substance Abuse and Mental Health (OSAMH), Division of Aging, Adult, and Behavioral Health Services (DAABHS), Division of Developmental Services (DDS), and DMS to develop and finalize reporting templates and provider training materials
4. Develop appropriate trainings in conjunction with DHS that are recorded and posted to the Contractor's website for all affected provider types
5. Work with the Arkansas Medicaid Enterprise Project Management Office (AME PMO) to conduct a Planning Kick-off to discuss processes, tools, deliverables process, deliverable content, and other aspects of collaboration.
6. Coordinate with DHS to finalize the proposed implementation plan. DHS shall have the sole right to approve or reject, in whole or in part, the Contractor's implementation plan and amendments thereto. At DHS request, Contractor must modify the implementation plan and coordinate any revisions with DHS to accomplish DHS objectives and fulfill its needs.
7. The implementation plan shall reflect an ongoing reporting plan, an ongoing communication plan, an ongoing training plan (including content, format, and sequence), and transition of appeals functions from existing Contractors. The Contractor must adhere to the finalized implementation plan throughout the duration of the contract.

### 2.4.2 PRE-PAYMENT

**A. <u>Prior Authorizations of Medicaid Services</u>**

1. Within thirty (30) days of the start of contract, the Contractor shall meet with the appropriate DHS divisions and subject matter experts to establish the regular data reporting requirements (i.e. weekly, monthly) and appropriate data report content and format relating to each type of prior authorization required pursuant to this contract. Reports must be completed and approved by designated DHS staff by contract service start date.

2. DHS reserves the right to reasonably amend and adjust Contractor prior authorization data reporting requirements as necessary.

3. The Contractor must use the current Medicaid Management Information System (MMIS) provider portal as the single-entry point for providers for all prior authorization, review submission, determinations, etc.

4. All prior authorization reviews must be completed in accordance with the following guidelines and applicable CMS Rules, Transparency Act of 2025 (Ark. Code Ann. § 23-99-101 et seq.), including the Final Interoperability and Prior Authorization Rules (89 Fed. Reg. 8758, Feb. 8, 2024), and the Medicaid Fairness Act (Ark. Code Ann.§ 20-77-1701 et seq.)

5. All prior authorizations must be approved or denied within seven (7) calendar days of receipt of a request unless deemed an urgent request by DHS. Prior authorization requests for active PASSE members must be declined unless the service is excluded from PASSE coverage.

6. Urgent requests must be approved or denied within seventy-two (72) hours of receipt of a request unless otherwise directed by DHS. Urgent requests include those that would result in permanent injury, death or exacerbated illness of the beneficiary.

7. Reviews for medical necessity must be completed by individuals who hold the appropriate credentials as specified in this section of the RFP.

8. If the initial medical necessity reviewer determines the received documentation does not clearly establish the medical necessity of the requested amount, duration, and intensity of treatment services, the Contractor must have a level 2 reviewer agree with the lack of medical necessity determination before issuing a complete or partial denial. Level 2 reviewers must meet the reviewer timeframes and minimum qualifications as specified in Attachment I.

   a. The Contractor shall enter into the MMIS portal the following information for each approved prior authorization request:
      i. The procedure code(s);
      ii. The total number of service-time increments for each authorization;
      iii. The authorization control number; and
      iv. The prior authorized beginning and ending dates of service.

   b. Conflict of Interest
      i. Please be advised that reviewers must not have a relationship that could interfere with their ability to provide an unbiased decision in line with the requirements of 42 CFR 475.10.

      ii. DHS reserves the right to convert from prior authorization to retrospective review in cases where DHS, at its sole discretion, deems that conversion will be more cost effective.

**B. <u>Inpatient and Outpatient Medical Services</u>**

1. The Contractor shall review prior authorization and extension of benefits requests for services and procedures based on medical necessity and other factors to be determined by DHS with advice and input from the Contractor.

2. Inpatient and outpatient services include, without limitation, the following:
   a. Medical and surgical procedures, including assistant surgeons;
   b. Outpatient procedures and services
   c. Laboratory, radiology and other professional services (inpatient and outpatient);
   d. Inpatient hospital services, including hospital-based acute crisis units;
   e. Molecular Pathology;
   f. Anesthesia;
   g. Hyberbaric oxygen therapy; and
   h. Durable Medical Equipment (DME)
   i. Any additional program or services as requested by DHS, including but not limited to: maternal health and home health services.

3. The Contractor shall review requests for DME based on medical necessity and other factors to be determined by DHS and Contractor. DME shall include without limitation the following:
   a. Wheelchairs;
   b. Ventilators;
   c. Hyperalimentation equipment and specialty formula; and
   d. Prosthetics, orthotics and other durable medical equipment.

**C. <u>Habilitative Occupational, Speech, And Physical Therapy Over 90 Minutes Per Week Per Discipline</u>**

1. The Contractor shall review and approve or deny (partial or complete) all prior authorization requests for more than ninety (90) minutes of habilitative occupational therapy, habilitative physical therapy, and habilitative speech-language pathology treatment services per week.

2. Reviews shall include:
   a. Confirming the completion and validity of all required forms and documents in accordance with Section II of the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Medicaid Manual, including without limitation the following:
      i. Evaluation referral;
      ii. Treatment prescription;
      iii. Comprehensive evaluation report; and
      iv. Plan of care; and

   b. A determination of whether the amount, duration, and intensity of habilitative occupational therapy, habilitative physical therapy, and habilitative speech-language pathology treatment services requested is medically necessary in accordance with the Occupational therapy, Physical therapy, and Speech-language pathology Services Medicaid Manual based on the supporting documentation submitted with the prior authorization request.

3. Medical necessity reviews must be conducted by one (1) of the following appropriate Arkansas licensed clinicians depending on the services requested:
   a. Licensed Physical Therapist;
   b. Licensed Occupational Therapist; or
   c. Licensed Speech-language Pathologist.

**D. Applied Behavioral Analysis Therapy**

1. The Contractor shall review and approve or deny (partial or complete) all prior authorization requests for Applied Behavioral Analysis (ABA) therapy services through the Early Periodic Screening Diagnostic Treatment (EPSDT) program.

2. Reviews shall include:
   a. Confirming the completion and validity of all required forms and documents in accordance with Section II of the Applied Behavior Analysis Therapy Medicaid Manual, including without limitation the following:
      i. Qualifying diagnosis;
      ii. Evaluation referral;
      iii. Treatment prescription;
      iv. Comprehensive evaluation report; and
      v. Individualized treatment plan; and

   b. A determination of whether the amount, duration, and intensity of ABA therapy services requested is medically necessary in accordance with Section II of the Applied Behavior Analysis Therapy Medicaid Manual based on the supporting documentation submitted with the request for extension of benefits.

   c. Medical necessity reviews must be conducted by a Board-Certified Behavior Analyst (BCBA) with certification in good-standing from the Behavior Analyst Certification Board.

**E. Behavioral Health Services**

1. Authorization Specifications
   a. The Contractor shall perform medical necessity, certification of need (CON), prior authorizations, continuing stay authorizations, extension of benefits (EOB), as well as amendments and corrections of existing authorizations for the programs when requested by Arkansas Medicaid providers, in compliance with all criteria set out at 42 CFR Subchapter F, Part 475 and in compliance with the Medical Fairness Act (MFA):
      i. School-based Mental Health (SBMH);
      ii. Behavioral Health Counseling and Crisis Services programs including Acute Crisis Units and Infant Mental Health; and
      iii. Acute Inpatient Psychiatric Services for individuals under twenty-one (21) years of age.
      iv. Outpatient and Inpatient Substance Abuse services for Adults and Children based on the American Society of Addiction Medicine (ASAM) Criteria.

   b. Outpatient Behavioral Health and Substance Abuse Reviews must be completed in no more than seven (7) calendar days of receipt of the necessary information to process the request.

c. Certification of Need and Continued Stay Reviews for Acute Inpatient Psychiatric Services and Inpatient Substance Abuse services must be completed in one (1) calendar day (excluding weekends and State observed holidays as recognized by the Arkansas Secretary of State) of receipt of the necessary information to process the request, including transmittal of determination notices in compliance with the MFA.

d. Referral for independent assessment psychiatric acute admissions must be submitted within twenty-four (24) hours of reported admission or Certification of Need request.

e. The Contractor shall provide sufficient staffing to perform all specified reviews.

**F. <u>Personal care services</u>**

1. Review Specifications
   a. The Contractor shall review and process Personal Care PA Requests (including without limitation new, renewal, modification, closure, and provider change requests) for Medicaid beneficiaries who are not ARChoices Medicaid Waiver beneficiaries. For each request, Contractor shall make determinations to approve or deny, in whole or in part.

   b. Upon receipt of a Personal Care PA Request, the Contractor shall first verify the beneficiary's Medicaid eligibility (unless the Request is to close a current PA).
      i. For a beneficiary enrolled in the ARChoices Medicaid waiver program, Contractor shall forward within one (1) business day the PA Request to DHS for processing.
      ii. Verify whether the beneficiary has an active prior authorization for personal care services. Contractor shall deny the Personal Care PA Request if there is an active prior authorization with more than sixty (60) days remaining before expiration and the Request does not indicate a change of circumstances or change of provider. When a change of provider is indicated, the request must be accompanied by the signed DHS Transfer Form.
      iii. Prior to issuing the prior authorization, Contractor shall confirm that all required documentation has been sent with the request:
         1) For beneficiaries who are on a waiver and receiving personal care Contractor shall confirm prior to issuing a prior authorization that the personal care provider has obtained the following:
            - An independent assessment
            - 618 assessment and treatment plan
            - 618 TP signed by primary care provider

         2) For beneficiaries receiving personal care through the State Medicaid Plan Contractor shall confirm prior to issuing a prior authorization that the personal care provider has obtained the following:
            - 618 Assessment and Treatment Plan
            - 618 TP signed by primary care provider

**G. <u>Day Habilitation Services Under EPSDT</u>**

1. Contractor shall review and approve or deny all prior authorization requests for day habilitative services through the EPSDT program.

2. Reviews shall include:
   a. Confirming the completion and validity of all required forms and documents in accordance with Section II of the Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medicaid Manual, including without limitation the following:
      i. Developmental screen
      ii. DMS-693;
      iii. Other supporting assessments, evaluations, or medical information; and

   b. A determination of whether day habilitative services are medically necessary to correct or ameliorate defects and physical and mental illness conditions and will result in the maximum reduction of medical and physical disabilities and restore the child to his or her best possible functional level based on the supporting documentation submitted with the prior authorization request (Refer to Exhibit 1 CMS Best Practices for Adhering to EPSDT Requirements in bidder's library for newly released federal guidance).

c. Medical necessity reviews must be conducted by a registered nurse licensed in Arkansas.

d. If the initial medical necessity reviewer determines there was not the received documentation does not clearly establishing the medical necessity of day habilitative services, Contractor must have an Arkansas licensed and board certified or board eligible pediatrician or family physician agree with the lack of medical necessity determination before issuing a denial.

**H. <u>Dental services</u>**

1. The Contractor must process all prior authorization requests within seventy-two (72) hours, or when a requesting provider indicates or if the Contractor determines that following the standard timeframe could seriously jeopardize the Enrolled Member's life, health, or ability to attain, maintain or regain maximum function, the Contractor must make an expedited authorization decision and provide notices as expeditiously as the Enrolled Member's condition requires, but no later than seventy-two (72) hours after receipt of the request for services.

2. Reviews shall be conducted by a licensed dental hygienist or dentist, depending on the type of service under review.

3. Any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested must be made by a dentist, oral surgeon, or orthodontist licensed to practice in the State of Arkansas.

**I. <u>Vision Services</u>**

1. Vision consultants **must** be eligible to enroll as Arkansas Medicaid Provider. Contractor **shall** provide vision care consultation services as requested by DHS and **must** evaluate services for approval or denial of all special needs vision authorization requests submitted by Medicaid providers.

2. Vision Consultants must be licensed to practice and in good standing with the State of Arkansas by the State Board of Optometry and the Arkansas Optometric Association.

3. The Contractor shall accept all cases for review as assigned by DHS.

4. The process for prior authorizations for vision services is defined as follows:
   a. Vision providers will submit prior authorization requests to Arkansas Medicaid.
   b. Arkansas Medicaid screens the request and sends authorizations electronically to the vision care consultant.
   c. The vision care consultant reviews each request for medical necessity and compliance with the Arkansas Medicaid Vision Policy or applicable Arkansas Medicaid Vision program requirements.
   d. The vision care consultant must approve, partially approve, down-code or deny each request and send the results back to the Arkansas Medicaid Vision Unit.
   e. The Arkansas Medicaid Vision Unit notifies the provider and beneficiary and enters approved requests into the MMIS claims system.
   f. The vision consultant must approve or deny prior authorization requests for medical and vision necessity within three (3) calendar days of receiving the assignment from DHS. Decisions for expedited requests must be made within twenty-four (24) hours of receiving the assignment from DHS.

5. DHS, at its sole discretion, may process a prior authorization for vision services if deemed necessary.

6. A minimum of two (2) consultants must be available during normal business hours, Monday-Friday from 8:00 a.m. to 4:30 pm Central Time. Assigned vision consultants may work remotely i or onsite as approved by DHS.

7. Contractor's staff working remotely shall provide all equipment, materials, and supplies for remote work. The Contractor must have video conferencing equipment to maintain high-quality audio and video. Equipment required for video conferencing must include, without limitation, the following:
   a. Computer
   b. High resolution webcam
   c. Microphone
   d. Speakers
   e. Stable internet connection

f. Video Conference software or app (i.e. Zoom, Webex, Microsoft Teams)

8. The Contractor shall return authorization requests with a written determination approving or denying each authorization request and provide in detail the basis for the opinion within three (3) calendar days of the assignment. In no event shall prior authorization be given over the telephone. The approval of the request for prior authorization must be signed by the vision care consultant or authorized personnel and shall be assigned a prior authorization control number. The PA control number must be indicated on the authorization form.

9. DHS will periodically have meetings which may request advice and guidance with vision-related policy and practices. These meetings may require call-in or in-person attendance at the discretion of the Vision Unit. The consultant may also be required to attend administrative hearings or legislative meetings at the request of the Vision Unit.

10. The Contractor shall provide vision care advice and guidance when requested by DHS in program development projects.

11. The Contractor shall attend and participate in program development meetings and discussions as required by DHS.

12. The Contractor shall review development project material as requested by DHS and provide competent expert medical/optometric advice within ten (10) days of DHS' request.

13. The Contractor shall, utilizing its expertise, competently and adequately represent the state program before review boards or in court proceedings upon request by DHS.

14. The Contractor shall, upon DHS' request, represent the state program decisions in medical/optometric review board meetings.

15. The Contractor shall, upon DHS' request, represent the state as medical/optometric consultant in litigation upon request from DHS.

16. The Contractor shall provide appropriate competent expert consultants, to be approved by DHS, for Arkansas Legislative Council (ALC) Review Committee meetings when requested by DHS.

17. The Contractor shall provide appropriate competent expert consultants for Arkansas Legislative Council (ALC) Review committee meetings when requested and as approved by DHS.

18. If requested by DHS, the Contractor shall ensure participation in any scheduled AR Medicaid Vision Program ALC Review Committee meetings.

19. The Contractor shall provide meeting space, maintain consultants billing records, and partake in the annual audit for the contract.

20. The Contractor must provide appropriate competent expert consultants for peer review committee meetings, to be approved by DHS, to answer questions from optometric physicians when requested by DHS.

21. The Contractor must provide recommendations for revising the review methodology to ensure compliance, best practices, and cost effectiveness.

**J. <u>Extension Of Benefits of Medicaid Services</u>**

1. Early Intervention Day Treatment (EIDT) Services
   a. The Contractor shall review and approve or deny all extension of benefits requests for EIDT services beyond those limits established in the respective Medicaid manuals and procedure code tables for each program.

   b. Reviews shall include sufficient documentation to provide medical necessity including:
      i. Confirming the completion and validity of all required forms and documents in accordance with section II of the respective Medicaid manuals and procedure code tables for each program, including without limitation the following:

- Evaluation referral;
- Treatment prescription;
- Comprehensive evaluation reports; and
- Individualized Treatment Plan; and

ii. A determination of whether the amount, duration, and intensity of EIDT or ADDT services requested is medically necessary in accordance with the applicable Medicaid manual based on the supporting documentation submitted with the request for extension of benefits.

c. Medical necessity reviews must be conducted by one or more of the following appropriate Arkansas licensed clinicians depending on the services requested:
   - Physical Therapist;
   - Occupational Therapist;
   - Speech-language Pathologist; and
   - Doctor of Medicine

2. Early Periodic Screening Diagnostic Treatment (EPSDT) services
   Contractor Physician Advisor shall consult with DHS as needed for approval of medical services and procedures based on medical necessity and other factors to be determined by DHS and Contractor. Services and procedures shall be based on the result(s) of an EPSDT screening and may include non- covered services.

3. Emergency Medicaid Eligibility
   Contractor Physician Advisor shall consult with DHS as needed for reviews of applications for Medicaid enrollment based on medical necessity and other factors to be determined by DHS and Contractor. Application approvals shall be based on acute/emergent services billed for certain populations and exclude chronic conditions.

4. Ad Hoc Review: DMS Internal PA Review Procedure
   Contractor Physician Advisor shall consult with DHS as needed for review of medical services and procedures based on medical necessity and other factors to be determined by DHS and Contractor. DMS Internal PA Reviews shall include the following without limitation:
   a. Nutrition, including but not limited to, Formula, Sole-source nutrition, Enteral nutrition, Hyperalimentation (if not included on a list of pre- approved formula/nutrition);
   b. Hearing Aids (other than batteries or broken equipment)
   c. Home Health (Post-surgical in- home nursing care)
   d. Medical Supplies (extension of benefits); and
   e. Private Duty Nursing, and
   f. Non-covered services.

5. Ad Hoc Review: Code Set Reviews
   Contractor Physician Advisor shall provide consulting services to DHS on code set updates, including without limitation the following: ICD (International Classification of Diseases), CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System).

6. Ad Hoc Review: To Be Determined
   Contractor Physician Advisor shall provide consulting services to DHS on an ad hoc basis for additional Medicaid- related items. Contractor and DHS shall agree to the scope of the project and timeframe in which the project will be completed.

7. Ad Hoc Review: Standard of Care Review
   DHS consults with Contractor Physician Advisor as needed for review of medical services and procedures based on medical necessity, and other factors to be determined by DHS and Contractor. Non-Standard Care may be brought to DHS's attention by Contractor, DHS's own review, or by another source.

8. Denial of Applications for Program Services
   DHS consults with Contractor Physician Advisor as needed for review of program applications, based on medical necessity and other factors to be determined by DHS and Contractor. The programs for which

applications are submitted shall include, but are not limited to, the following, and shall be provided without limitation: Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and Autism Waiver.

9. Behavioral health services
   Contractor shall review and approve or deny (partial or complete) all extension of benefits requests for behavioral health services beyond those soft limits established in the respective Medicaid manuals and procedure code tables for each program.

   a. Reviews shall include:
      i. Confirming the completion and validity of all required forms and documents in accordance with section II of the respective Medicaid manuals and procedure code tables for each program, including without limitation the following: any or all documentation that established medical necessity of the requested amount, duration, and intensity of services.
      ii. A determination of whether the amount, duration, and intensity of behavioral health services requested is medically necessary in accordance with the applicable Medicaid manual based on the supporting documentation submitted with the request for extension of benefits.

   b. Medical necessity reviews must be conducted by one or more of the following appropriate Arkansas licensed clinicians depending on the services requested:
      - Master level mental health professional, licensed in the state of Arkansas
      - Doctor of Medicine

10. Lab, Radiology
    a. Contractor shall review and approve or deny (partial or complete) all extension of benefits requests for radiology services beyond those soft limits established in the respective Medicaid manuals and procedure code tables for each program.

    b. Reviews shall include:
       i. Confirming the completion and validity of all required forms and documents in accordance with section II of the respective Medicaid manuals and procedure code tables for each program, including without limitation the following:
          - Evaluation referral;
          - Treatment prescription;
          - Comprehensive evaluation reports; and
          - Personal Care Plan

       ii. A determination of whether the amount, duration, and intensity of EIDT or ADT services requested is medically necessary in accordance with the applicable Medicaid manual based on the supporting documentation submitted with the request for extension of benefits.

       iii. Medical necessity reviews must be conducted by one or more of the following appropriate Arkansas licensed clinicians depending on the services requested:
          - Physical Therapist;
          - Occupational Therapist;
          - Speech-language Pathologist; and
          - Doctor of Medicine

11. Outpatient Medical Procedures
    a. The Contractor shall review and approve or deny (partial or complete) all extension of benefits requests for outpatient medical services beyond those soft limits established in the respective Medicaid manuals and procedure code tables for each program.

    b. Reviews shall include confirming the completion and validity of all required forms and documents in accordance with section II of the respective Medicaid manuals and procedure code tables for each program, including without limitation the following:
       i. Evaluation referral;

ii. Treatment prescription;
iii. Comprehensive evaluation reports; and
iv. Individualized Treatment Plan; and

c. Targeted Case Management for Juveniles in Public Institutions

i. Targeted Case Management (TCM) for eligible juveniles in public institutions must be provided during the thirty (30) days prior to release (or no later than one (1) week, or as soon as practicable, after release) for at least thirty (30) days following release.

ii. The Contractor shall review and approve or deny (partial or complete) all extension of benefits requests for continued need of TCM after the first thirty (30) days following release. The Contractor shall review the service plan, documentation, and notes filed in the beneficiary's case record.

iii. An extension of benefits can be requested if continued medical services are needed beyond the thirty-day post-release period.

iv. Extension of benefits requests must be sent to the DHS Utilization Review Section.

v. For audit purposes, the extension of benefits must be in writing, placed in the beneficiary's file, and available for auditors.

**K. <u>Continuation of Need Reviews for Crisis Admissions</u>**

1. Medicaid Utilization Management Program (MUMP)
   The Contractor shall review and approve or deny (partial or complete) all continuation of inpatient stay under MUMP including all acute hospital stays after the seventh (7th) day of hospitalization, with the exception of children under one (1) year of age.

2. Psychiatric Hospital Acute Services
   The Contractor shall review and approve or deny (partial or complete) all continuation of Inpatient Acute Psychiatric stay includes all additional days beyond the initial approved requested days. Additional days must meet medical necessity.

### 2.4.3 POST PAYMENT

**A. Retrospective Reviews and Program Compliance Audit of Medicaid Services**

1. General

   a. A provider shall be given at least thirty (30) days to deliver or respond with the required service documentation related to each claim selected for review.

   b. If after initial review the reviewer believes recoupment is appropriate unless further information is submitted by provider, Contractor/Reviewer shall make a single request for additional information from provider. When Contractor issues a request for additional information, a provider must be given at least ten (10) business days to respond.

   c. Any claim which the initial reviewer recommends for recoupment must be reviewed by another similarly credentialed peer reviewer or licensed physician who must agree with the determination that recoupment is appropriate prior to Contractor officially reporting the claim to DHS as one subject to recoupment.

   d. All reviews shall be completed within timeframes indicated in Attachment I.

   e. The Contractor shall provide a comprehensive report of the results of each quarter's review upon completion. The Contractor and DHS will meet to agree upon an appropriate format and the content to be included in the quarterly comprehensive report, which may be updated on an as needed basis.

   f. Prior to the end of each quarter, Contractor must hold one or more meetings with DHS to discuss the results of its quarterly reviews and answer questions in connection with the comprehensive report.

   g. Retrospective review is a dual review process:

i. A medical necessity review that determines whether the amount, frequency, and duration of services provided were medically necessary; and

ii. A utilization review that determines whether billed services were prescribed and delivered as billed.
   1) DHS or its approved Contractor will perform retrospective reviews by reviewing client service records.
   2) DHS or its approved Contractor will review all billed and paid personal care services delivered one month prior to the start date of provider transfer.
   3) DHS or its approved Contractor will review a percentage random sample of all personal care services billed and paid through non-compliant EVV entries (i.e. manual entries).

2. Emergency Room Visits
   a. The Contractor shall review claims based on medical necessity and other factors to be determined by DHS and Contractor.

   b. The retrospective review shall be conducted in compliance with §1867 of the Social Security Act (Prudent Lay Person standard), i.e., inpatient or outpatient hospital services that a prudent layperson with an average knowledge of health and medicine would reasonably believe are necessary to prevent death or serious impairment of health and which, because of the danger to life or health, must be obtained at the most accessible hospital available and equipped to furnish those services.

3. Hospital admissions
   a. The Contractor shall review claims based on medical necessity and other factors to be determined by DHS and Contractor.

   b. The Contractor shall conduct post-payment reviews of a random sample of paid claims on all admissions, including inpatient stays of fifteen (15) calendar days or less, to ensure that medical necessity for the services is substantiated. Contractor and DHS shall agree on the size of the sample each year.

**B. Provider Preventable Conditions (PPC) and Hospital Acquired Conditions (HAC) Review**

1. The Contractor shall review one hundred percent (100%) of hospital inpatient or outpatient claims, including emergency room claims with reported incidence of PPC or HAC to ensure no Medicaid money was used to reimburse for services provided due to PPC or HAC.

2. These reviews shall be conducted in accordance with Section 2702 of the Patient Protection and Affordable Care Act of 2010 and subsequently issued regulations.

3. Reviewer credentials:
   a. All initial reviews of inpatient and outpatient medical services must be performed by an Arkansas licensed registered nurse with a minimum of three (3) years' experience in a health-care related field, preferably in an inpatient or outpatient setting.

   b. Denials may only be issued by an Arkansas licensed physician with a minimum of five (5) years post-graduate practice, board certified or board eligible in each specialty, and who have active clinical practices within their specialty field(s) for five (5) of the last seven (7) years.

   c. Reconsiderations must be conducted by an Arkansas licensed physician who meets the criteria set out in Paragraph 2 above.

**C. Behavioral health services**

1. Review Criteria (Outpatient)
   a. The Contractor must within fourteen (14) calendar days of the start of each quarter conduct a random sample review of approximately one quarter of providers. Each provider in the sample will have at least one (1) and up to twenty (20) beneficiary service records reviewed depending on the number of paid claims submitted by the provider the immediately preceding state fiscal year. The more paid claims submitted by a provider the more beneficiary service records that will be retrospectively reviewed. See Exhibit 6 in the bidder's library for a breakdown of claims ranges and the number of beneficiary service records to be reviewed. Contractor must provide its methodology for randomly selecting which

beneficiary service records to review for each provider in the sample. Contractor must ensure that every provider is selected for review at least one quarter each calendar year.

b. The Contractor shall ensure retrospectives reviews are in compliance with all criteria set out at 42 CFR Subchapter F, Part 475. Contractor shall ensure that each enrolled site is reviewed at least annually. Upon request, the contractor shall perform audits of medical records as provided in section 142.300(D) of the Arkansas Medicaid provider Manual.

c. Contractor shall provide sufficient staffing to perform specified reviews.

d. DHS reserves the right to make adjustments or additions to the auditing processes for any or all contractors.

2. Review Criteria (Inpatient)
   a. Contractor must pull a random sample of claims for each active Provider indicated (with a 95% CL +/- 5%) on an annual basis to conduct a retrospective chart review. These reviews should be divided out quarterly so that all providers are reviewed in one of the four quarters of the calendar year, with all Providers having had a statistically valid review by the end of the calendar year.

   b. Contractor shall ensure retrospective reviews are in compliance with all criteria set out at 42 CFR Subchapter F, Part 475. Upon request, the Contractor shall perform audits of medical records as provided in section 142.300(D) of the Arkansas Medicaid provider Manual.

   c. Contractor shall provide sufficient staffing to perform specified reviews.

   d. DHS reserves the right to make adjustments or additions to the auditing processes for any or all contractors.

3. Recoupment
   a. The Contractor shall retrospectively review provider and patient records for compliance with program requirements and conformity with professionally recognized standards of health care.

   b. The Contractor shall audit medical records for the purpose of validating those records against paid claims and adherence to the policies set forth in the program manual and medical necessity criteria.

   c. The Contractor shall initiate recoupment activities based on audit results. The fiscal agent is responsible for conducting the recoupment process based on approval from DHS. The claims reconciliation and automated recoupment of funds shall occur through use of an electronic data transmittal system in conjunction with DHS and its fiscal agent.

**D. Habilitative Occupational, speech and physical therapy less than 90 minutes per week per discipline**

1. Contractor shall within fourteen (14) calendar days of the start of a quarter pull a random sample of one quarter of the providers that in the immediately preceding state fiscal year had at least one (1) paid claim not subject to prior authorization (i.e. the beneficiary was prescribed ninety (90) minutes or less of weekly treatment services) for each of the following services:
   a. Habilitative Occupational therapy;
   b. Habilitative Physical therapy; and
   c. Habilitative Speech-language pathology.

2. Each provider in the sample will have at least one (1) and up to five (5) beneficiary service records reviewed depending on the number of paid claims submitted by the provider the immediately preceding state fiscal year. The more paid claims submitted by a provider the more beneficiary service records that will be retrospectively reviewed. See Exhibit 7 for a breakdown of claims ranges and the number of beneficiary service records to be reviewed. Contractor must provide its methodology for randomly selecting which beneficiary service records to review for each provider in the sample. The same beneficiary should not be reviewed more than once in the same calendar year.

3. Notwithstanding the foregoing, Contractor must ensure every habilitative occupational therapy, habilitative physical therapy, and habilitative speech-language pathology billing provider that had at least one (1) paid

claim not subject to prior authorization in the immediately preceding state fiscal year is selected for review at least once every twelve (12) months.

4. Reviews shall be completed by a licensed clinician in good standing in the same service discipline as the service record under review.

5. Reviews shall include a review of the beneficiary service record to determine if services were performed in compliance with the Occupational Therapy, Physical Therapy, and Speech-language Pathology Services Medicaid Manual as interpreted by the Arkansas Department of Human Services, Division of Developmental Disabilities Services ("Therapy Manual"). DHS may require Contractor to add or remove specific items for review from time to time, but reviews would typically include without limitation:
   a. Confirming the proper and complete administration of an accepted standardized assessment(s) resulting in a qualifying score(s), or an in-depth detailed narrative function profile completed in compliance with Therapy Manual;

   b. Confirming the completion and validity of all required forms and documents in accordance with the Therapy Manual, including without limitation the following:
      i. Initial evaluation referral (or accepted substitute);
      ii. Treatment prescription;
      iii. Comprehensive evaluation report;
      iv. Individualized Treatment Plan; and
      v. Service delivery documentation;

   c. Confirming that services were performed in the amount, duration, intensity, and manner required by the prescription and individualized treatment plan;

   d. Confirming services were performed by an appropriately qualified and credentialed clinician; and

   e. Reviewing the beneficiary's service record to determine compliance with any other specific requirements included in the Therapy Manual.

**E. Personal Care**

1. The Contractor must within fourteen (14) calendar days of the start of each quarter conduct a random sample review of approximately one quarter of providers. Each provider in the sample will have at least one (1) and up to twenty (20) beneficiary service records reviewed depending on the number of paid claims submitted by the provider the immediately preceding state fiscal year. The more paid claims submitted by a provider the more beneficiary service records that will be retrospectively reviewed. See Exhibit 6 in the bidder's library for a breakdown of claims ranges and the number of beneficiary service records to be reviewed. Contractor must provide its methodology for randomly selecting which beneficiary service records to review for each provider in the sample. Contractor must ensure that every provider is selected for review at least one quarter each calendar year.

2. The Contractor shall ensure retrospectives reviews are in compliance with all criteria set out at 42 CFR Subchapter F, Part 475. Contractor shall ensure that each enrolled site is reviewed at least annually. Upon request, the contractor shall perform audits of medical records as provided in section 142.300(D) of the Arkansas Medicaid provider Manual.

3. Contractor shall provide sufficient staffing to perform specified reviews.

4. DHS reserves the right to make adjustments or additions to the auditing processes for any or all contractors.

**F. Dental Products and Services**

1. Within ten (10) business days of the start of each calendar quarter review a statistically significant random sample of Medicaid beneficiaries with paid dental claims during the previous quarter.

2. The Contractor shall retrospectively review provider and patient records for compliance with program requirements and conformity with professionally recognized standards of dental care. The Contractor shall audit dental records for the purpose of validating those records against paid claims and adherence to the

policies set forth in the program manual and medical necessity criteria. The Contractor shall initiate recoupment activities based on audit results. The fiscal agent is responsible for conducting the recoupment process based on approval from DHS. The claims reconciliation and automated recoupment of funds shall occur through use of an electronic data transmittal system in conjunction with DHS and its fiscal agent.

3. Contractor shall provide sufficient staffing to perform specified reviews. Retrospective reviews may be performed by any member of the Contractor's dental staff.

**G. Early Intervention Day Treatment and Adult Developmental Day Treatment**

1. Contractor shall within fourteen (14) calendar days of the start of a quarter pull a random sample of one quarter of Adult Developmental Day Treatment (ADDT) providers and one quarter of Early Intervention Day Treatment (EIDT) providers that had paid claims during the immediately preceding state fiscal year. Each provider in the sample will have five (5) beneficiary service records reviewed. Contractor must provide its methodology for randomly selecting which beneficiary service records to review for each provider in the sample. The same beneficiary should not be reviewed more than once in the same calendar year.

2. Notwithstanding the foregoing, every EIDT provider and every ADDT provider must have at least five (5) beneficiary different service records reviewed every calendar year.

3. Reviews shall be completed by an individual with at least five (5) years' experience in administering generally accepted assessment instruments relating to Medicaid or other medical services.

4. Reviews shall include a review of the beneficiary service record to determine if services were performed in compliance with the EDIT or ADDT Medicaid Manual, as applicable, as interpreted by the Arkansas Department of Human Services, Division of Developmental Disabilities Services ("Medicaid Manual"). DHS may require Contractor to add or remove specific items for review from time to time, but reviews would typically include without limitation:
   a. Confirming the proper and complete administration of an accepted standardized assessment(s) resulting in a qualifying score(s), or an in-depth detailed narrative function profile completed in compliance with the Medicaid Manual;
   b. For ADDT service claims, confirming the beneficiary has a qualifying diagnosis;
   c. Confirming the completion and validity of all required forms and documents in accordance with the Medicaid Manual, including without limitation the following:
      i. Initial evaluation referral (or accepted substitute);
      ii. Treatment prescription;
      iii. Comprehensive evaluation report;
      iv. Individualized Treatment Plan; and
      v. Service delivery documentation;
   d. Confirming that services were performed in the amount, duration, intensity, and manner required by the prescription and individualized treatment plan;
   e. Confirming services were performed by an appropriately qualified and credentialed clinician; and
   f. Reviewing the beneficiary's service record to determine compliance with any other specific requirements included in the Medicaid Manual.

**H. Applied Behavior Analysis (ABA) Reviews**

1. Contractor shall within fourteen (14) days of the start of a quarter pull a random sample of one quarter of the Applied Behavior Analysis billing providers from the immediately preceding state fiscal year. Each provider in the sample will have ten (10) beneficiary service records reviewed. Contractor must provide its methodology for randomly selecting which beneficiary service records to review for each provider in the sample. The same beneficiary should not be reviewed more than once in the same calendar year.

2. Notwithstanding the foregoing, every ABA billing provider must have at least ten (10) different beneficiary service records reviewed every calendar year, unless the provider billed less than ten (10) beneficiaries in the immediately preceding twelve (12) months.

3. Reviews shall be completed by an individual with at least five (5) years' experience practicing as a board certified behavioral analyst (BCBA).

4. Reviews shall include a review of the beneficiary service record to determine if services were performed in compliance with the Applied Behavior Analysis Therapy Services Medicaid Manual, as interpreted by the Arkansas Department of Human Services, Division of Developmental Disabilities Services ("Medicaid Manual"). DHS may require Contractor to add or remove specific items for review from time to time, but reviews would typically include without limitation:
   a. Confirming the proper and complete administration of skills-based assessment instrument(s) completed in compliance with the Medicaid Manual;
   b. Confirming the beneficiary has a qualifying autism spectrum disorder diagnosis;
   c. Confirming the completion and validity of all required forms and documents in accordance with the Medicaid Manual, including without limitation the following:
      i. Initial evaluation referral (or accepted substitute);
      ii. Treatment prescription;
      iii. Comprehensive initial evaluation and re-evaluation report(s);
      iv. Individualized Treatment Plan; and
      v. Service delivery documentation;

   d. Confirming that services were performed in the amount, duration, intensity, and settings required by the prescription and individualized treatment plan;
   e. Confirming services were performed by an appropriately qualified and credentialed professional; and
   f. Reviewing the beneficiary's service record to determine compliance with any other specific requirements included in the Medicaid Manual.

**I. Clinical Chart Reviews/Desk Reviews**

1. Contractor must conduct annual and random clinical quality reviews of client chart documentation based on recommendations derived from the analysis of the retrospective review, to ensure medically necessary services were delivered as well as professionally recognized standards of care were met for the following provider types:
   a. Behavioral Health Counseling and Crisis Services Fee-for-Service
   b. Inpatient and Outpatient Substance Abuse Treatment Facilities
   c. Inpatient Psychiatric Services provider Under Age 21 (each psychiatric inpatient hospital must have a minimum of 15 chart reviews annually)
   d. CSSPs/ILPs

2. Desk Reviews can be initiated based on request from DHS, Retrospective Reviews, Prior Authorizations, Billing Outliers, and any other criteria that may warrant an additional review. The Contractor shall complete desk reviews and submit them to DHS with a written report of findings in a manner acceptable to DHS and within thirty (30) calendar days of the receipt of provider records unless a written extension is obtained from DHS.

### 2.4.4 ADDITIONAL TYPES OF WORK

**A. Medical Reviews: Consultation Services**

1. Out of State Referrals
   Contractor Physician Advisor shall provide consultation services to DHS on approval requests for services not available in-state, which may include non-covered services, and based on medical necessity and other factors to be determined by DHS and Contractor. Examples of Out-of-State referral cases shall include, but are not limited to, the following without limitation:
   a. Specialty GI (Gastro- intestinal) procedures;
   b. Specialty Transplant procedures;
   c. Specialty Brain/Neurology procedures;
   d. Certain Genetic procedures; and
   e. Certain Behavioral health treatment, such as certain types of eating disorders.

2. Suspended Claims
   a. Contractor Physician Advisor shall provide consultation services to DHS as needed for approval of claims based on medical necessity and other factors to be determined by DHS and Contractor. Suspended claims shall include without limitation those that exceed pre-established limits or issues related to pricing/questionable billing, and shall include both surgical and non- surgical claims, and may include non- covered services.

b. Contractor Physician Advisor shall fulfill review, price, and approve claims onsite at DHS facilities at least once per month.

c. Emergency Transportation Contractor Physician Advisor shall provide consultation services to DHS as needed for approval of services based on medical necessity and other factors to be determined by DHS and Contractor; emergency transportation claims include those related to ground and air transportation services and may include non-covered services.

d. Transplants
Contractor Physician Advisor shall provide consultation services to DHS as needed for approval of services (covered and non- covered) based on medical necessity and other factors to be determined by DHS and Contractor. Transplant-related services shall include, but are not limited to, the following without limitation:
   i. Bone Marrow transplant;
   ii. Covered transplant procedures;
   iii. Hospital readmissions for complications related to organ/transplant complications.

**B. Medical Team Reviews**

1. Disability Determination on Medical Review Team (MRT)
   a. The Contractor shall provide reviews of medical records by qualified physicians to determine if individuals applying for Arkansas's Medicaid program have a severe disability based on the United States Social Security Administration's (SSA) listing of impairments and associated medical criteria for adults age eighteen (18) and over and children under age eighteen (18). The Contractor shall apply all relevant SSA guidelines when making severe disability decisions.

   b. Review Specifications
      i. The Contractor shall receive case assignments and completed review packets from the manager of the DHS Medical Review Team (MRT) via electronic means. Review packets typically include:
         - DCO-108 form – provides the description of the stated disability/ disabilities and a stated demographic background of the patient.
         - DCO-107/2602 form(s), if applicable – provides information completed by the primary care physician
         - Current medical and therapy records

      ii. Upon receiving assigned cases, the Contractor shall review all records to determine if the individual has a severe disability based on SSA guidelines.

      iii. If additional medical information is needed to make a determination regarding severe disability, the Contractor must notify the MRT within one (1) business day and request any additional information that is needed to assist in the determination.

      iv. Once a determination has been made, the Contractor must complete and sign the DCO- 112 form outlining the decision and all corresponding information, including:
         - Determine and mark if the disability is approved or denied. If approved, provide if the determination is permanent, needs review in a year or more, or is temporary.
         - Provide what disabilities were reviewed. Provide a description of the reason for the determination.
         - Complete sections for SSA determination guidelines and other criteria. Sign form for completion.

      v. The Contractor shall send all completed DCO- 112 forms to the manager of the MRT via electronic means.

      vi. The Contractor shall complete all assigned reviews within one (1) calendar week of receipt of case assignment and all supporting documentation from the manager of the MRT. The Contractor shall perform a reevaluation of the review decision for any cases for which the manager of the MRT identifies concerns and/or requests a reconsideration

2. Dental Services
   At a minimum, staffing must include the following:
   a. Six (6) Dental Hygienists,
   b. Two (2) Customer Service Representatives

c. One (1) Dental Physician Reviewer,
d. One (1) Dental Hygienist Supervisor, and
e. One (1) Provider Relations Coordinator.

3. Medical Services
At minimum, staffing must include registered nurses, physicians, geriatric specialist licensed in Arkansas or in another state.

**C. DCO Medical Unit – Medical Eligibility Determinations**

The Contractor shall provide a registered nurse to review medical information and records and make medical eligibility determinations for applicants/recipients of waiver services under Arkansas's Medicaid program. Before waiver services can be authorized, it must be determined that the applicant's/ recipient's condition warrants these services. Medical eligibility decisions are used as part of the process to determine if a person is eligible for services. The medical eligibility decision is based on the information submitted on the independent assessment result, DHS-703 form, and client medical records.

1. <u>Review Specifications</u>
   a. The Contractor shall receive case assignments from the DCO Medical Unit via electronic means. Each assignment will include a completed independent assessment from the DHS contractor responsible for independent assessments and/or a medical evaluation/DHS-703 from the DAABHS RN for review. *Note: the DHS-703 is the document used by the PCSP/CC RN to record the medical needs evaluation.*

   b. Upon receiving assignments, the Contractor shall review the following information on the current DHS-703 for the participant:
      i. Current demographic information for the recipient
      ii. Changes reported in demographic information for the recipient
      iii. Hospitalization dates
      iv. Receipt of hospice services
      v. Need for assistance with transferring, ambulation, toileting, nutritional status/eating, hearing, vision, speech/language, skin, behavior/attitude, mental status, orientation level, or other noted medical conditions
      vi. Current medications
      vii. Changes in medications
      viii. Medical equipment utilized by the client
      ix. PCSP/CC RN narrative/observations
      x. Any noted impairments
      xi. Any noted diagnosis of Alzheimer's or dementia

   c. Once the most recent DHS-703 evaluation has been reviewed, the Contractor shall compare the review findings to the Medicaid Waiver policy to determine if the participant meets the following criteria for medical eligibility:
      i. Age twenty-one (21) through sixty-four (64) and have been determined to have a physical disability through the Social Security Administration or the Department of Human Services (DHS) Medical Review Team (MRT) and require an intermediate level of care in a nursing facility, or be sixty-five (65) years of age or older and require an intermediate level of care in a nursing facility.

      ii. Established to have a functional need by meeting at least one (1) of the following three (3) criteria as determined by a licensed medical professional.
         a) The individual is unable to perform either of the following:
            - At least one (1) of the three (3) activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from, or total dependence upon another person; or
            - At least two (2) of the three (3) ADLs of transferring/ locomotion, eating, or toileting without limited assistance from another person; or

         b) The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to themselves or others; or

c) The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.

d. No individual who is otherwise eligible for waiver services shall have eligibility denied or terminated solely as the result of a disqualifying episodic medical condition that is temporary and expected to last no more than twenty-one (21) days. However, that participant shall not receive waiver services or benefits when subject to a condition or change of condition that would render the participant ineligible if the condition or change in condition is expected to last more than twenty-one (21) days.

e. Participants diagnosed with a serious mental illness or intellectual disability are not eligible for waiver services unless they have medical needs unrelated to the diagnosis of mental illness or intellectual disability and meet the other qualifying criteria. A diagnosis of severe mental illness of intellectual disability must not bar eligibility for participants having medical needs unrelated to the diagnosis of serious mental illness or intellectual disability when they meet the other qualifying criteria.

f. Upon completing the medical review to establish the current level of care, the following will occur:

   i. If the current level of care is to remain the same due to determining no changes occurred in the recipient's medical condition, the Contractor shall complete the DHS-704 listing the current level of care for the review period.

   ii. Based on evidence of a material change in medical eligibility documented at the evaluation, the Contractor shall request a new independent assessment to be completed.

g. Upon receipt of the completed independent assessment, the Contractor shall review the ADLS, memory and cognition, health, psychosocial, assessor conclusions, and ICD codes reported by the independent Contractor.

   i. Once the most recent DHS-703 evaluation has been reviewed, the Contractor shall compare the review findings to the Medicaid Waiver policy to determine if the participant meets the following criteria for medical eligibility:
   ii. Along with the DHS-703, and any medical records provided to determine if the individual meets the medical criteria for level of care established by Medicaid policy for Medical Needs Determinations.

h. Once the level of care (LOC) determination has been completed, the Contractor shall enter the LOC determination into the ARIES Level of Care screen and upload a completed DHS-704 to the U: drive and QuickBase. ARIES will trigger a task to the LTSS caseworker once the LOC determination has been entered.

**D. Specific Behavioral Health Work**

1. Referrals for Independent Assessments
   a. Contractor shall collaborate with DHS and the Independent Assessment (IA) Contractor to establish screening criteria to identify Outpatient Behavioral Health beneficiaries who might be eligible for Provider-Led Arkansas Shared Savings Entity (PASSE) services and who should be referred to the Independent Assessment (IA)

   b. Contractor for an Independent Assessment and accept and screen referrals from AR Medicaid enrolled outpatient providers who identify and refer clients for a BH IA.

   c. In certain instances, including but not limited to the following, Contractor shall refer the beneficiary for an IA:
      i. If Contractor's screening indicates that a beneficiary receiving Outpatient Behavioral Health services should be referred for an IA per the above-referenced criteria.
      ii. If a beneficiary is admitted to specified in- patient facilities as an acute admission, any request for a PA for that type of facility shall automatically trigger a referral of the beneficiary for an IA. Contractor and DHS shall establish criteria to identify such facilities and admission types.

   d. In making a referral, Contractor shall work with DHS and the IA Contractor to develop a procedure so that Contractor is able to:

i. Verify whether the referred beneficiary has an active BH IA score of Tier 2 or Tier 3 and/or assigned to a PASSE, and
ii. Is in an allowable AR Medicaid eligibility category
iii. Verify whether the referenced beneficiary has already been assessed for Tier 1 or assigned to a PASSE. If a beneficiary has previously been referred for an IA, but the previous referral was more than twelve (12) months prior to the current referral, the IA Contractor shall treat the referral as a new referral and conduct another IA.
iv. Immediate referral for IA for psychiatric acute admissions shall be made using the Optum ARIA portal. The Certification of Need (CON) for these admissions must be processed within forty-eight (48) hours.

**E. Care Coordination Medicaid Spend-Down**

1. The Contractor must identify Medicaid Spend-Down beneficiaries receiving Home and Community Based Services.
   a. At the time the individual is identified, the Contractor must contact the individual to complete a Person-Centered Service Plan (PCSP).
   b. The PCSP will serve as the authorization for the service that will be reimbursed once the beneficiary becomes Medicaid eligible.

2. The Contractor must provide Care Coordination, inclusive of Case Management, to all above identified beneficiaries. Care Coordination includes the following activities:
   a. Health education and coaching;
   b. Coordination with other healthcare providers for diagnostics, ambulatory care, and hospital services;
   c. Assistance with social determinants of health, such as access to healthy food and exercise;
   d. Promotion of activities focused on the health of a patient and their community, including without limitation, outreach, quality improvement, and patient panel management; and
   e. Coordination of Community-based management of medication therapy.

3. The Contractor must have sufficient Care Coordination staff to provide Care Coordination to all Members in this category of service. All Care Coordination staff must meet the minimum qualifications to provide Care Coordination under the contractor. Minimum qualifications are:
   a. Be a Registered Nurse (R.N.), a physician, or have a bachelor’s degree in a social science or health-related field;
   *OR*
   b. Have at least one (1) year of experience working with developmentally or intellectually disabled clients or behavioral health clients; AND
   c. be trained in accordance with the contractor’s Care Coordination training policy.

4. The assigned care coordinator or appropriate contractor team member must make initial contact with each Member within fifteen (15) business days of receipt of BH IA identification.

5. The Contractor, through Care Coordination activities, must ensure that all services are coordinated and appropriately delivered by providers.
   a. The Contractor must implement Care Coordination policies that ensure each Member has an ongoing source of care appropriate to their needs.
   b. The Contractor must have care coordinators who will work with the Member's providers and care givers to ensure continuity of care across all services.

6. The Contractor is responsible for assisting the Member with moving between service settings to ensure that the member is placed in or remains at the most appropriate, least restrictive setting that meets the member’s needs. For example, the care coordinator would help with the transition from a residential service setting to a HCBS setting.
   a. The Contractor must implement procedures to coordinate the services between care settings.
   b. The Contractor care coordinators must conduct appropriate discharge planning for short-term and long-term hospital and institutional stays.

7. The Contractor must comply with Conflict Free Case Management rules pursuant to 42 CFR § 440.169, as a critical protection for Member and as a matter of program integrity.

8. Care coordinators may be either hired or contracted.

a. Care coordinators must provide "Case Management" activities. As such, the care coordinators must be independent of any Direct Service Providers that provide any services to any Members. Case Management activities are:
b. Assisting members with scheduling an independent assessment or independent reassessment process required for HCBS eligibility;
   - Assistance with Medicaid eligibility process;
   - Development of a Person-Centered Service Plan;
   - Referral to services; and
   - Monitoring activities.

9. Care Coordinators or case managers must 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 or providers.

10. The Contractor care coordinator or appropriate contractor team member must conduct an initial services assessment of each Member within thirty (30) days of Tier Determination of the member. This initial services assessment must be used in the creation of the Member's PCSP, see Section Person Centered Service Plan (PCSP) Medicaid SPEND-DOWN.

11. The Contractor care coordinator is responsible for overseeing the development and implementation of the PCSP, see Section Person Center Service Plan (PCSP) Medicaid SPEND-DOWN.

**F. Person Centered Service Plan (PCSP) Medicaid Spend-Down**

1. The Contractor shall be responsible for the creation, monitoring, and updating of the PCSP for all Medicaid SPEND-DOWN members. The PCSP must adhere to content requirements as found at 42 CFR § 441.301(c) and 42 CFR § 441.540. The planning process and the PCSP must include, without limitation:
   a. The Member's health information, including:
      i. Relevant medical and mental health diagnoses;
      ii. Relevant medical and social history;
      iii. PCP and primary provider of Behavioral Health or Developmental Disability services;
      iv. The individual who has legal authority to make decisions on behalf of the Member; and
      v. Indication of whether or not an advance directive or living will has been created for or by the Member.
      vi. Reflect that the setting in which the individual resides is chosen by the individual;
      vii. Reflect the Member's strengths and preferences;
      viii. Reflect the clinical and support needs as identified;
      ix. Include individually identified goals and desired outcomes;
      x. Reflect the services and supports that are important for the Member to meet the needs as identified through an assessment of functional need, including services and supports in the community to avoid placement in an institution;
      xi. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals and desired outcomes;
      xii. Reflect the risk mitigation plan
      xiii. Includes strategies for solving conflict;
      xiv. Be finalized and agreed to in writing; and
      xv. Prevent the provision of unnecessary or inappropriate care.

2. The PCSP must ensure that the Member's needs are being met in a way that is individualized and specific to that member's needs. The PCSP is the fundamental plan for assisting an individual to live safely and successfully in his/her own home or community and deference to it must be given by interested parties.
   a. It should be designed to meet the individual's goals and objectives for the next twelve (12) months.
   b. It must reasonably reflect the daily and weekly activities and routine a member chooses that is age and developmentally appropriate. It should also reflect progress towards a future goal. For example, it should include activities to assist member transition out of a residential or institutional setting.

3. Specifically, the PCSP must address any needs identified for the Member from the ARIA and Initial Services Assessment and the following sources, if made available:
   a. Any adaptive behavior assessments;
   b. Any social, medical, physical, or mental health histories;
   c. Risk Mitigation Plans;

   d. Case plans for court–involved Members;
   e. Any other assessment or evaluation used by the contractor prior to or at the time of PCSP development.

4. When developing the PCSP, the contractor care coordinator should give special attention to the following circumstances that a Member may have or experience:
   a. Receiving ongoing services such as daily in-home care, crisis behavioral health care, dialysis, home health, specialized pharmacy prescriptions, medical supplies, chemotherapy and/or radiation therapy, or who are hospitalized at the time of enrollment;
   b. History of inpatient psychiatric services, current psychiatric inpatient services, and transition plans for return to home and community when this represents a significant change of condition.

5. For any Member without an existing PCSP, the Contractor must develop the PCSP within sixty (60) calendar days from date of Tier Determination, which shall include the initial services assessment as described in Section Care Coordination Medicaid SPEND-DOWN.

6. The Contractor shall provide a quarterly PCSP report for DHS to review the number of approved, pending, and incomplete PCSPs for Members as well as the number of PCSP meetings held and number of PCSP meetings pending. This report should also include a comparison to the number of incomplete PCSPs in the previous submission to the number of those that have since been completed.

7. The Care Coordinator shall be responsible for coordinating and scheduling the PCSP Development meeting.
   a. The PCSP development meeting must be attended in person by:
      - The member and his or her parent/legal guardian;
      - The member's primary caregivers;
      - The care coordinator;

   b. The meeting should include other individuals who may attend in person, by telephone, or video conferencing such as:
      - HCBS service providers;
      - Professionals who have conducted evaluations or assessment; and
      - Anyone else the member desires to attend, including friends and family who support member.

   c. If the member objects to anyone's participation in the PCSP development meeting, the care coordinator must ensure that they are not allowed to participate.

   d. When developing the PCSP, those present must consider the member's preferences in regard to treatment goals, objectives, and services.

   e. The care coordinator is responsible for engaging the member in the process and documenting member engagement, or efforts to do so, in the PCSP.

   f. It is the responsibility of HCBS service providers of nonmedical services and supports to work with the contractor care coordinator to identify specific services that are needed to carry out the PCSP. As stated in federal regulations, there is no legitimate advantage to the individual or to Medicaid in providing unneeded services.

   g. The PCSP must be updated at least every twelve (12) months, as well as when the individual's conditions, circumstances, or needs change significantly or when the individual requests an update, for each Member in accordance with 42 CFR § 441.725(c). A change in condition, circumstances, or needs does not mean a change in a particular service or provider.

   h. The Contractor must adhere to the PCSP reporting requirements so that DHS can conduct monitoring and oversight of the PCSP in accordance with CMS regulations and the terms of the applicable Waiver assurances. Additionally, the Contractor must grant DHS or its agents, including the EQRO, OMIG, and Attorney General, access to any files and facilities needed to determine compliance with the PCSP development requirements set forth in the contract and the 1915(i) Home and Community Based Services State Plan Amendment. The purpose of the monitoring and oversight is to ensure that all Members have a PCSP that meets the member's needs and that all services are being provided in accordance with the member's PCSP. A determination of noncompliance may result in the imposition of sanctions by DHS in accordance with the contract.

i. DHS or its agent will conduct random sampling of the PCPSs on a quarterly basis. Sampling will be pulled in accordance with CMS recommended sample guide “A Practical Guide for Quality Management in Home and Community-based Waiver Programs.” The sample size is based on a 95% confidence interval with a margin of error of +/- 8%. The DHS Department of Research and Statistics pulls the appropriate sample size from the Medicaid SPEND-DOWN. DHS or its agent will then require the contractor to submit the PCSP for all individuals in the sample.

j. DHS or its agent will conduct a retrospective review of provided PCSPs based on critical elements for quality review inclusive of programmatic, financial, and administrative review. DHS or its agent will review plans to ensure they have been developed in accordance with applicable policies, that plans ensure the health and welfare of the member and are implemented in accordance with plan. DHS or its agents will communicate findings to the contractor including identification of areas requiring remediation or systemic changes. Patterns of non-compliance for a contractor may result in sanctions under the contract. Service plans must be maintained for a period of three (3) years as required by 45 CFR § 92.42.

k. In addition, DHS participates in the National Core Indicators (NCI) Project. Quality indicators that will be measured and used as part of the QIP for the program include assurance of member’s rights, freedom of choice of providers within networks, member assessment of service meeting their needs, and risk mitigation. Focused monitoring of Care Coordination will be included as part of the core measures.

**G. Incident Reports Medicaid Spend-Down**

1. For care coordination members, the Contractor and the provider must submit incident reports upon the occurrence of any of the following events:
   a. attempted suicide,
   b. suspected abuse or neglect by a staff person,
   c. elopement,
   d. use of restrictive interventions,
   e. death, and
   f. arrest.

2. Incidents which must be reported (but are not necessarily considered critical, unless also on the above list):
   a. Death
   b. The use of any restrictive intervention, including seclusion, or physical, chemical or mechanical restraint,
   c. Suspected maltreatment or abuse as defined in Ark. Code Ann. §§ 12-18-103 & 12-12-1703; 4. Any injury that:
      i. Requires the attention of an Emergency Medical Technician, a paramedic, or physician,
      ii. May cause death,
      iii. May result in a substantial permanent impairment, or d. Requires hospitalization.
      iv. Suicide, threatened or attempted,
      v. Arrest or conviction of any crime,
      vi. Any situation in which the location of a person has been unknown for two hours,
      vii. Any event in which a staff threatens a person served by the program,
      viii. Sentinel events, such as unexpected occurrences involving actual or risk of death or serious physical or psychological injury,
      ix. Medication errors made by staff that cause or have the potential to cause serious injury or illness,
      x. Any rights violation that jeopardizes the health and safety or quality of life of a person served by the program,
      xi. Communicable disease,
      xii. Violence or aggression,
      xiii. Vehicular accidents,
      xiv. Bio-hazardous accidents,
      xv. Use or possession of illicit substances or licit substances in an unlawful or inappropriate manner,
      xvi. Property destruction, and
      xvii. Any condition or event that prevents the delivery of services for more than two (2) hours

   d. Other than immediate reporting, all other Incidents must be reported within twenty-four (24) hours of the contractor becoming aware of the occurrence. Incident reports must contain the following information:
      i. Date of Incident;
      ii. Time of Incident;

iii. Member's Name and Date of Birth;
iv. Member's Medicaid ID;
v. Location of Incident;
vi. Persons involved;
vii. Persons notified: including APS, CPS, guardian/next of kin, law enforcement, and other agencies;
viii. Incident Description;
ix. Any action taken by the Provider, staff, or contractor;
x. Any expected follow-up related to the incident; and
xi. Name of Person that prepared the report with contact information.
xii. Any other information required by DHS

DHS intends to phase out Medicaid Spend Down services approximately six (6) months after the contract start.

**2.4.5 CLINICAL STAFFING: DHS EMBEDDED STAFF**
All embedded staff must meet the onsite requirements and qualifications as specified in Attachment J.

**A. Behavioral Health Clinician housed within the Division of Aging, Adult and Behavioral Health Services (DAABHS) Office of Substance Abuse and Mental Health (OSAMH)**

1. The Contractor **shall** provide a licensed Behavioral Health (BH) clinician who will complete all activities to plan, implement, and evaluate a comprehensive forensic diversion and behavioral health crisis system in the state of Arkansas. The successful candidate shall have extensive knowledge of the behavioral health landscape, direct experience in crisis assessment, referral, and placement as well as a working knowledge of the forensic system as it related to behavioral health crisis assessment, placement, and treatment options.

2. The BH clinician assigned to DMS **must** hold a Master's degree in social work, psychology, or counseling and be independently licensed in one of the following areas: Licensed Psychological Examiner – Independent (LPEI), Licensed Professional Counselor (LPC), Licensed Certified Social Worker (LCSW), with at least five (5) years' experience in assessing and treating individuals with mental health and substance use disorder diagnoses, minimum three (3) years' experience in a leadership role, and at least two (2) years' experience in providing direct crisis assessment and referral services

3. The BH clinician **shall** function as the coordinator of the crisis and forensic team and as a collaborative member of the overall behavioral health team.

4. The BH clinician **shall** perform, at minimum, the following duties:
   a. Lead/assist in the development of a comprehensive behavioral health crisis assessment and response system in Arkansas.

   b. Consult with designated staff working in the crisis and forensic assessment and intervention programs.

   c. Develop collaborative relationships with behavioral health, law enforcement, first responders, hospitals, and other community entities necessary for a comprehensive crisis system.

   d. Lead development and dissemination of program specific goals and deliverables to a wide audience.

**B. Clinical Staff housed within the Division of Youth Services (DYS)**

1. Contractor shall provide four (4) Behavioral Health Clinicians to provide services to the DHS Division of Youth Services (DYS) to include, without limitation, oversight, treatment monitoring, treatment recommendation and placement recommendation services for and on behalf of DYS clients to meet all BH goals and objectives.

2. A BH Clinician shall serve on a Treatment Team to conduct and complete all aspects of an Initial Assessment for and on behalf of DYS clients to develop a comprehensive Treatment Plan. As part of this activity, the BH Clinician shall:
   a. Review all historical clinical documents related to treatment;
   b. Complete face-to-face interviews and conduct observation of the client;
   c. Interview family members, guardians, or other parties to obtain psychosocial information;
   d. Complete the BH treatment component of client's Treatment Plan by developing treatment recommendations, frequencies, duration and measurable treatment goals and objectives;

e. Make recommendations for BH treatment, including treatment settings;

3. A BH Representative shall serve on a Treatment Team to conduct and complete all aspects of Treatment Monitoring, Reassessment and Review activities for and on behalf of DYS clients as part of a comprehensive Treatment Plan. As part of this activity, the BH Clinician shall:
   a. Complete face-to-face interviews and conduct observation of client;
   b. Oversight and review of the BH portion of the Treatment Plan;
   c. Continuous reassessment the client's progress towards stated goals;
   d. Work with the facility's BH service provider to review and update goals;
   e. Serve as a member of the facility's Treatment Team to review client progress;
   f. Make recommendations for a discharge plan, including after-care placement options and recommendations;
   g. Work with DYS to develop the reports under this section;
   h. Assist in development of and attend all meetings required by DYS to discuss specific cases including Treatment Plan development and adherence, general trends, options for improvement regarding treatment and operations, and other matters as needed
   i. Undertake all necessary activities for successful completion of the deliverables under this section

**C. Qualified Residential Treatment Program (QRTP) Assessment for the Division of Children and Family Services (DCFS)**

1. The Contractor shall provide five (5) BH clinicians who will complete all activities to deliver level of care assessments for youth who are placed in custody of the Arkansas Department of Human Services to determine eligibility for Qualified Residential Treatment Programs (QRTP).

2. The BH clinician shall serve as an assessor to conduct and complete all aspects of an assessment for and on behalf of DCFS clients to determine if the client is able to maintain in a family-like setting or needs a higher level of care provided in a QRTP program or other setting. As part of this activity, the BH clinician shall provide, but is not limited to, the following:
   a. Review all pertinent historical documents related to treatment and client's case;
   b. Complete face-to-face meetings with the client and his or her family and permanency team at a location that is convenient for the family when appropriate.
   c. Make recommendations for placement in a QRTP program or another level of care.
   d. Develop a list of child-specific short- and long term mental and behavioral health goals.
   e. If assessor determines the client cannot be placed in a foster home, the assessor must document in writing:
      i. Reasons why the needs of the client cannot be met by the family or in a foster home
      ii. Why the recommended placement in QRTP will provide the client with the most effective and appropriate level of care in the least restrictive environment,
      iii. How the placement is consistent with the short- and long-term goals for the client, as specified in the permanency plan.

   f. Once a youth is placed in a QRTP program for six (6) months, the Contractor shall administer a treatment plan update to address the goals and progress of the youth and if placement is still appropriate for treatment.

   g. The BH Clinician under this section must hold a Master's degree in social work or similar field and be licensed in one of the following areas: Licensed Professional Examiner – Independent (LPEI), Licensed Professional Counselor (LPC), Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Associates Counselor (LAC) and Licensed Psychological Examiner (LPE) with at least five (5) years' experience in assessing and treating youth with behavioral health diagnoses, including but not limited to mental health and substance abuse.

   h. The BH Clinician must receive training to allow them to utilize the Child and Adolescent Needs and Strengths (CANS) assessment tool or other DCFS approved assessment tool to complete the QRTP assessment as directed by DCFS. A second level review can be initiated by DCFS.

**D. Clinical Staff Housed within Division of Medical Services (DMS)**

1. The Contractor shall provide a Psychiatrist to serve as the psychiatric expert for the specialty populations as described in Attachment J.

2. The Contractor shall provide a Family Physician to provide consultation services as described in Attachment J.

3. The Contractor shall provide a pediatrician to provide consultation services as described in Attachment J.

4. The Contractor shall provide a Geriatric APRN to provide services as described in Attachment J.

**E. General Staffing**

1. Overview
   a. Within thirty (30) calendar days of the contract start date, Contractor must submit to DHS for approval an organizational chart showing all proposed staffing to perform the services specified in the scope of work and to meet the following minimum staffing requirements.

      i. Contractor shall report, and DHS shall approve in advance, any permanent or temporary changes to or reductions from Contractor's proposed staffing.

      ii. DHS reserves the right to require Contractor to reassign or otherwise remove from a project any Contractor staff found unacceptable by DHS during the course of this contract;

      iii. Contractor shall maintain a list of back-up/on-call staff or develop a process to expedite locating back-up/on-call staff to be used when vacancies arise. Contractor shall provide a copy of the list or process to DHS within sixty (60) days of the contract start date. The purpose of this requirement is to ensure that the scope of work requirements continue to be completed even if Contractor staff members leave or unable to work for whatever reason.

   b. Clinical and professional staff used to perform scope of work requirements must be licensed or certified, as applicable, in the State of Arkansas in their disciplines.

   c. Contractor must ensure all professional licensed or certified personnel maintain and provide documentation of current Arkansas license or certification and are in good standing with the appropriate licensing or certification board, as applicable. Contractor shall make these certifications and licenses available to DHS upon request.

   d. Contractor shall determine and maintain at least the minimum number of personnel required to perform the scope of all work under the contract.

   e. Contractor shall have staff available at all meetings or trainings as requested by DHS. Typically, availability by telecommunication (i.e. Zoom, Microsoft Teams) will be acceptable, but in rare instances on-site attendance my be required. Contractor shall incur any expenses related to initial and continuing training as required herein.

2. Leadership and Support Staffing Requirements:
   a. Contractor must provide the following Leadership and Support staff members without limitation to oversee and provide support for this contract:
      i. One (1) full-time equivalent (FTE) Project Manager with an advanced degree and five (5) years' experience in a utilization and quality control peer review setting.
      ii. One (1) FTE Provider Training and Support Program Director with a minimum of five (5) or more years of experience in clinical practice evaluations and at least three (3) years of management experience.
      iii. One (1) or more master's degree or higher educational- level statisticians to select record samples to be retrospectively reviewed and to be able to provide testimony in the event of any legal proceeding.
      iv. Sufficient administrative staff person/people to assist the Project Manager, clinical reviewers, or any other required Contractor staff to complete the requirements within this scope of work.

   b. Contractor must provide the following clinical review staff members without limitation:
      i. Licensed physicians with a minimum of five (5) years post- graduate practice, board certified or board eligible in each specialty, and who have active clinical practices within their specialty field for the last five (5) out of seven (7) years and have experience with the types of PA reviews, Retro reviews and Medical reviews/consults described herein.

ii. Registered nurses with a minimum of three (3) years of experience in a healthcare- related field.
iii. Physician advisor who is an Arkansas-licensed medical physician, to be located in the Contractor's Little Rock office and available via phone and email, at a minimum of .75 full-time equivalent (FTE) per month. At a minimum, the physician advisor must:
a) Be currently engaged in clinical practice, or who have active clinical practice within their specialty field, for the last five (5) out of seven (7) years;
b) Be experienced in population health;
c) Be experienced in development of coverage criteria and guidelines;
d) Be familiar with current national coding publications;
e) Participate in coding updates;
f) Perform medical review for prior authorizations;
g) Provide testimony in the event of any appeal as a result of a negative determination;
h) Be cognizant of current standards of care and evidenced-based medicine practices;
i) If the provided licensed medical physician should be unable to fulfill the minimum .75 FTE, the Contractor shall supply another licensed medical physician, knowledgeable in Medicaid, at no cost to DHS.

c. Peer Staff for review activities related to the entire Medicaid scope of services.

d. Adjunct reviewers may be necessary in certain instances. In such instances, Contractor must be able to secure the services of medical professionals to accommodate reviews and consults related to any service provided to beneficiaries who receive Medicaid and other services.

e. Contractor shall provide or designate clinical review staff to timely determine emergency PA, MRC or Ad Hoc requests.

f. The Contractor shall be accredited by a national utilization management accrediting authority ("Accrediting entity"). Compliance with the requirements imposed by the accrediting entity is deemed to be compliance with the provisions of this contract relating to the same subjects

g. The contractor shall provide sufficient staffing to perform all contract functions according to the specifications listed in Attachment I and Attachment J.

h. Contractor must provide sufficient designated clinical review staff to determine all prior authorization, extension of benefit, and medical review requests; as well as conduct an adequate number of retrospective reviews in a timely manner.

i. Additionally, Contractor must provide staff to conduct ad hoc reviews and research as requested by DHS.

j. Adjunct reviewers may be necessary to meet these requirements. In such instances, Contractor must be able to secure the services of appropriately credentialed medical reviewers to conduct reviews and consults related to any service provided to Medicaid beneficiaries.

k. Contractor must ensure all professional licensed personnel maintain and provide documentation of current Arkansas license and are in good standing with the appropriate licensing board. Contractor shall maintain sufficient office staff to maintain certifications and licenses of all clinical reviewers. Contractor shall make these certifications and licenses available to DHS upon request.

l. Contractor shall maintain a list of back-up/on-call reviewers or develop a process to expedite locating reviewers to be used as clinical review staff when vacancies arise. Contractor shall provide a copy of the list or process to DHS within sixty (60) days of the contract start date. The purpose of this requirement is to ensure that review determinations continue to be completed even if clinical review staff members leave or unable to work for whatever reason.

**F. Location, Schedule, and Travel**

1. The Contractor may primarily provide services offsite, and the Contractor's staff must have workspace, phones, materials, computers, and any other resources required to meet the requirements. However, the Contractor may be required to work individually or collaboratively onsite at State offices in Little Rock, Arkansas and shall do so as necessary as determined by DHS.
   a. DHS will provide reasonable notice of any onsite work requirements.

b. Should any overnight travel, or any travel from outside of the metropolitan Little Rock area be required, travel expenses shall be addressed with DHS at that time.
c. Long-distance travel shall be defined as any travel required by DHS that departs from outside of the metropolitan Little Rock area to the metropolitan Little Rock area as determined by DHS.
d. Overnight travel shall be defined and stipulated by DHS should that office determine that an extended stay within the metropolitan Little Rock area is warranted.
e. The established contract may include a travel reimbursement fund. All reimbursable travel must have prior written pre-approval from designated DHS staff
f. Travel reimbursement shall be consistent with State law and Arkansas travel reimbursement rates and limited to actual expenses for meals, lodging, transportation, and incidental expenses. Otherwise, the Contractor shall be responsible for all transportation, parking, or related expenses throughout the contract duration.
g. During on-site work at State offices, workspace and basic office supplies and equipment (copier, fax, etc.) will be provided. Contractor shall provide their own computer/laptop, and any supplies or equipment necessary for their offsite office location or to complete the service and deliverable requirements of the solicitation.
h. When working on-site at State offices, the Contractor shall adhere to that office's regulations regarding security, safety, office hours, parking, dress code, and any other applicable State office regulations or policies.

2. All services must be performed within the Continental United States throughout the duration of any resulting contract.

3. The Contractor and staff shall be available to DHS during normal business hours of Monday through Friday 8:00 a.m. to 4:30 p.m. Central Time. However, DHS may request after-hours participation in meetings to meet deadlines, the Contractor shall attend after-hours meetings as scheduled.

### 2.4.6 APPEALS OF ADVERSE DECISIONS

A. Contractor shall participate in all activities related to any appeal of its determinations or actions, and make documents and witnesses available for the defense of adverse decisions and litigation based in whole or in part on Contractor 's acts or omissions.

B. Contractor must advise Providers and Medicaid Beneficiaries of their right (as appropriate) to appeal an adverse action involving a PA denial, RR or MRC/Ad Hoc adverse determination of an adverse determination.

C. Contractor must adhere to the notification procedures for adverse action or determination as set forth below.
1. Notification of complete or partial denials must comply with 42 CFR § 457.732 and the Arkansas Medicaid Fairness Act, Ark. Code Ann. § 20-77-1701 *et seq*.
   a. Notification of denials must be sent to the requesting provider and the appropriate beneficiary and shall contain 1) a clear and detailed explanation of the rationale for the adverse decision and 2) citations to all specific protocols, procedures, or policy manual references that were relied upon in making the adverse decision.
   b. Notification must describe whether the benefits will continue pending appeal or reconsideration and any patient liability associated for continuation of benefits, if applicable.
   c. Notification must include information on the right to reconsideration and appeal and adequately describe how the provider and/or beneficiary may avail themselves of those rights.
   d. Notification templates must be approved by DHS prior to use by the Contractor.
   e. Notification may be sent in the following methods:
      a) Mail;
      b) Provider message in MMIS portal; or
      c) Email (beneficiary must elect to receive email communications).
   f. All timelines resulting from notices of action shall commence counting on the next day following postmark if mailed, transmittal verification if faxed or electronic time verification sent via HIPAA-compliant electronic means.

2. Provider Requests for Appeal are made to the Arkansas Department of Health, and Beneficiary Requests for Appeals are made to the DHS Office of Hearings and Appeals. If Contractor improperly receives a Request for Appeal, Contractor shall notify DHS the same day and shall consult with DHS as to the proper course of action.

3. Upon notification from DHS of appeals filed, Contractor shall prepare and submit to DHS a written hearing statement, to be created in a form and format approved by DHS, within fifteen (15) calendar days of receiving notice of an Appeal being filed.

4. Contractor shall provide witnesses (registered nurses, physicians, or both as necessary) who are familiar with and can explain the adverse determination for depositions and hearings as scheduled and which may be held in person or by phone, at the discretion of the administrative law judge, hearing officer, or DHS.

5. DHS may request additional information or documents related to the Appeal. Contractor shall supply additional information or documents to DHS within five (5) business days of a specific request.

6. Contractor shall respond, upon request, to DHS in letter format to any communication resulting from any adverse decision within a timeframe specified by DHS.

7. Contractor shall be responsible for taking any required actions transpiring within the specified timeframes related to an appeal, including attending all hearings as instructed by DHS.

8. In the event a case is remanded for payment due to Contractor error or neglect, Contractor shall be held responsible for any re-payment of the claim required by CMS.

9. Contractor shall work with the incumbent Contractor to transition and expedite actions and services related to in- progress Appeals.

10. Contractor shall submit to DHS a regular monthly report pertaining to Appeals and Appeal-related activities under this section.

11. The contractor shall issue a provisional billing authorization number to the provider of services if continuing services are denied, and the Medicaid beneficiary follows established procedure for opting to continue services pending an administrative hearing.

**2.4.7 RECONSIDERATION REQUEST PROCEDURES**

A. Overview

1. Contractor shall provide an opportunity for reconsideration of a partial or full denial of a PA, RR or MRC/Ad Hoc determination to Providers per the controlling Medicaid Manual(s), applicable federal and state laws, policies, regulations, guidelines, and other criteria approved by DHS.

2. A Provider shall be afforded the opportunity for only one (1) reconsideration request per denial of a PA, RR determination or MRC/Ad Hoc review determination.

3. In the event that the Contractor receives a reconsideration request from a Beneficiary, Contractor shall direct the Beneficiary to contact his or her provider to initiate the reconsideration process.

4. Reconsideration procedure must comply with all controlling Medicaid Manual(s), applicable federal and state laws, policies, regulations, guidelines, and other criteria approved by DHS.

5. A second, different reviewer with the appropriate Level 2 credentialing must review and determine the disposition of the reconsideration.

6. Contractor may not bill DHS for any Provider requests for reconsideration or work related thereto.

B. Reconsideration Request Procedure

1. Any Notice sent to the Provider regarding denial of benefits or services as the result of a PA, RR or MRC/Ad Hoc review, and described in the Notifications section above, shall apprise the Provider that a reconsideration request must:
   a. Clearly define the basis for reconsideration,
   b. Provide additional documentation in support of the basis for review, and
   c. Be made within the appropriate timeframe, by methods allowed under the Arkansas Medicaid Provider Manuals, and to the appropriate location/entity for valid receipt of the reconsideration request.

2. If a Provider's request for a reconsideration is untimely, sent to an incorrect location, both, or suffers from another procedural defect, that procedural defect shall not in itself be good cause to deny the request. Instead, Contractor shall consult with DHS as to the proper course of action, which may include proceeding with the reconsideration.

3. Contractor shall base a reconsideration determination on criteria as required by the applicable Arkansas Medicaid Provider Manual and on the entire record available, including credible documentation submitted by the Provider requesting the reconsideration, using pre- approved standards established within the general guidelines of the Medicaid manual but not excluding professional judgment.

4. Contractor must complete reconsideration determinations the timeframes specified in Attachment I and in accordance with the Arkansas Medicaid Policy or within guidelines set forth by DHS, state or federal statute or rules, including the Code of Federal Regulations (CFR), Arkansas Medicaid Policy and the Medicaid Fairness Act (MFA).

5. Contractor 's reconsideration determination may affirm, modify or reverse a PA, RR or MRC/Ad Hoc review determination.

6. Contractor 's notice of a reconsideration determination to a Provider must be approved by DHS prior to use and must conform to the requirements of federal and state law, and the controlling Medicaid Manuals, and must include proper notice of the right to appeal an adverse action.

7. Contractor must notify the Provider within three (3) business days of the reconsideration determination. The notice must include the outcome of all reconsideration requests and must accurately state the reviewing physician's rationale for any requested service that was not approved. The rationale must be case-specific; general or generic rationale is not acceptable.

8. Contractor must notify DHS and the Fiscal Agent of a reversal or modification, in whole or in part, of a PA denial, or RR or MRC/Ad Hoc adverse determination. The notification must be made within twenty-four (24) hours of determination. Contractor shall work with DHS and the Fiscal Agent to determine a process for notification and necessary action/actions related to reversal/modification of a determination and possible recoupment of claims as the result thereof.

9. Contractor shall work with the incumbent Contractor to transition and expedite actions and services related to in- progress reconsideration requests.

10. Contractor shall submit to DHS a regular monthly report pertaining to reconsideration requests and related activities under this section.

C. Additional EIDT/ADDT Specifications
The Contractor shall reconsider its determinations as required by the Arkansas EIDT/ADDT Medicaid Provider Manual and based on the entire record available, including credible documentation submitted by the clinic requesting the reconsideration.

D. Additional Medicaid Behavioral Health Specifications

1. The Contractor shall set forth a reconsideration (informal dispute resolution) process to reconsider medical necessity determinations, citations, deficiencies, or sanctions when requested by the provider.

2. The Contractor's reconsideration is contingent upon the provider submitting additional information. A second Arkansas licensed, board-certified psychiatrist must review and determine the disposition of the reconsideration. All reconsideration requests must be processed by the contractor within seven (7) calendar days of receipt from the provider. If services are denied in whole or in part upon reconsideration, the contractor must send a written notice of the contractor's final denial determination and case specific denial rationale to the provider and the beneficiary in compliance with the MFA and within the seven (7) calendar day timeframe specified above. Denial notices must include a statement of both the beneficiary's and the provider's right to an administrative hearing under the Arkansas Administrative Procedure Act. In addition to the reconsideration process, the contractor may opt to establish a renegotiation process with the provider.

3. However, renegotiations must be processed within the timeframes established above and the contractor may not bill DHS for any renegotiation.

E. Additional Desk Review Specifications
If citations or deficiencies are remedied in the reconsideration process for the desk review, the Contractor must revise the written report and send it to the provider and DHS within ten (10) calendar days of the new determination

**2.4.8 TRAINING**

A. Contractor shall provide training and technical support for providers, DHS Staff, and other appropriate stakeholders with regards to Contractor's processes relating to its scope of work and all applicable Medicaid rules and procedures related to PA, RR and other request types.

B. Contractor shall propose for DHS approval a training plan which may include a combination of the following components:
- In-Person Regional Trainings,
- On-Site Coaching,
- Web-based training,
- Provider Helpline, and
- Training Manual.
- Frequency, type, and content of Contractor trainings shall be subject to DHS revision based on need. Contractor

**2.4.9 REPORTING**

A. Contractor shall provide regular monthly, quarterly and special and/or ad hoc reports to DHS based on verifiable data.

B. Contractor shall submit reports to DHS no later than the fifteenth (15th) day after the end of the month, quarter or other timeframe upon which the report will be based.

C. Contractor shall adhere to deadlines established by DHS for special and/or ad hoc reports.

D. Contractor shall base all reports on data, records and information utilized, collected or maintained by Contractor in the course of fulfilling this contract.

E. Reports shall be submitted to DHS via the agreed-upon secured Health Insurance Portability and Accountability Act (HIPAA)-compliant methodology in Excel format or another format approved by DHS.

F. Monthly Reports shall include the following, based on verifiable data, without limitation:
1. Retrospective Reviews: Contractor's monthly reports to DHS shall include the number and disposition of Retrospective Reviews by therapy modality completed during the preceding month as well as any recommendations for further action by DHS.
2. Desk Reviews: Contractor's monthly reports to DHS shall summarize all desk reviews completed and pending for the previous month. Additionally, the contractor must submit to DHS a detailed written report of findings within fourteen (14) calendar days of the completed review unless documented exceptions are made by DHS. The contractor must submit revised or amended reports when citations or deficiencies are remedied in the reconsideration process for a desk review.
3. Validation Reviews: Contractor's monthly reports shall include statistical data from the preceding month representing the number of DMS 640 forms received, the number determined complete, the number determined to be incomplete, and the number of authorizations transmitted to the Arkansas MMIS/interChange.
4. Data Corrections: Contractor's monthly reports to DHS shall include all data corrections executed within the preceding month along with compliance metrics for required notifications.
5. IA Referrals: Contractor's monthly reports shall reflect all referrals to the IA Contractor for the preceding quarter, including without limitation the rationale for referral and all related data. This data shall be extractable as a separate detailed report.
6. Review Process – includes, but is not limited to, the number of PA, RR, MRC, Ad Hoc and other review determinations per month by review type, Provider type, disposition, the amount recouped in RRs, all relevant dates and timeframes for disposition;
7. Non-standard Care – includes, but is not limited to, each instance of non-standard care documented by Contractor, the type of PA review, and identifiable trends or patterns;

8. Due Process Reconsideration –includes, but is not limited to review type, Provider type, resolution, basis for request and determination (by categories/sub- categories), all relevant dates and timeframe for disposition, if the matter has been appealed and identifiable trends or patterns;
9. Appeal – should be a continuation of the Reconsideration report with additional bases, timeframes, disposition(s) and identifiable trends or patterns;
10. Contact/Correspondence
11. Complaint resolution process
12. Reports regarding Payment Integrity regarding whether PA requests and subsequent claims are inconsistent;
13. Reports regarding verification process
14. Data corrections and notification thereof

G. Quarterly Reports
1. Quarterly Reports shall include the following, based on verifiable data, without limitation:
   a. QAPI activities, including any requested metrics and outcomes to be tracked; and
   b. Special reports to be determined.
   c. Staffing, including name and number of review staff (overall and by category/subcategory) number of reviews performed per staff member (numbers overall and by category/sub-category) and resolution of reviews per staff member (numbers overall and by category).
   d. Provider training including trainings conducted (numbers overall, by topic/subtopic, and by method), participating providers (numbers overall, by topic/subtopic, and by method), provider evaluation (numbers overall, by category and written comments), and inclusion of specific providers (those identified through standard-of-care or outlier involvement).
   e. Review Requests: Contractor's quarterly reports shall reflect the number of PA, certification of need, continuing stay and extension of benefits requests received, categorizing the number approved, partially approved or denied and identifying timeliness metrics for compliance with the deadlines set forth herein.
   f. Retrospective Reviews: Contractor's quarterly reports shall include review activities and findings and all information regarding adverse decisions related to the recoupment of funds. This information shall also be transmitted to the DHS fiscal agent via the Arkansas MMIS/interChange.
   g. Due Process: Contractor's quarterly reports shall include all in-progress and completed due process actions for the preceding quarter by review type, provider type, resolution, basis for determination (by categories), all relevant dates and timeframes for disposition, and if the matter has been appealed.
   h. Appeals: Contractor's quarterly reports shall include all in-progress and completed administrative appeals for the previous quarter including timeframes and disposition(s);
   i. Complaint Resolution: Contractor's quarterly reports shall reflect all complaints received during the previous quarter including response times and resolutions.
   j. Payment Integrity: Contractor's quarterly reports shall provide analyses of inconsistencies between PA requests and subsequent claims.
   k. Trend Reporting: Contractor's quarterly reports shall include analyses of utilization patterns during the preceding quarter and a rolling annual review of patterns, including without limitation:
      i. Top five percent (5%) most expensive Medicaid Beneficiaries;
      ii. Outlier Providers based on billed outpatient procedure codes and determining the potential savings assuming the outlier's distribution of billing resembled the rest of the state; and
      iii. Recommendations for Desk Reviews. Desk Review recommendations shall only be actionable upon approval by DHS (see Section 2.9 Desk Reviews.)
      iv. Annual Reports, including Record Retention Compliance reports and any other annual reports requested by DHS, shall be submitted to DHS on or before a date agreed upon by DHS and the Contractor.

H. Annual Reports
Annual Reports, including Record Retention Compliance reports, support for annual PA metrics required by the Final Interoperability and Prior Authorization Rules (CMS-0057-F), and any other annual reports requested by DHS, shall be submitted to DHS on or before a date agreed upon by DHS and the Contractor.

I. Special and Ad Hoc Reports
1. At the direction of DHS, Contractor shall provide specific program management reports acceptable to DHS for evaluation of review processes within two (2) business days of request by DHS.

2. Any additional reporting requirements or special/ad hoc reports shall be determined by DHS in conjunction with Contractor and shall identify fields/variables to be included and how calculations will be made. Contractor shall be required to provide a maximum of fifty (50) ad hoc reports per year at the request of DHS.

J. Reports and Record Retention
   1. The Contractor must retain all data, reports, and records for ten (10) years after the final payment is made by DHS.
   2. These records must remain available for audit by DHS during the retention period.
   3. The Contractor must obtain written approval from DHS before destroying any data, reports, and records developed under this contract.
   4. Upon destruction of any data, reports, and records, the Contractor must provide DHS with a written attestation confirming that the destruction has been completed. This attestation must include the details of the destroyed items and the date of destruction.

**2.4.10 QUALITY IMPROVEMENT**

A. Health Professional Reviews - Dental
   The Contractor shall provide physician, dental hygienist, and/or dentist reviews on an ad hoc basis as requested by DHS for state-sponsored quality improvement activities that require medical or dental reviews.

B. Contractor Notifications
   1. Contractor shall notify the Provider, Beneficiary and Fiscal Agent of RR and MRC/Ad Hoc review request determinations.
   2. All Contractor notifications of review determinations shall be sent no later than the next business day after making the determination or in accordance with the procedures set out in the RFP.

   3. All notifications shall:
      a. Comply with applicable Arkansas Medicaid manuals, state and federal law, including the Final Interoperability and Prior Authorization Rules (CMS-0057-F);
      b. Be approved by DHS prior to use within and external to MMIS/InterChange;
      c. Clearly apprise the Provider and Beneficiary that a request for reconsideration or administrative appeal must contain a clearly stated basis, provide documentary support for the basis for review, and be made within the applicable timeframe to the appropriate location and entity for valid receipt of the request for reconsideration and administrative appeal.

   4. Contractor's PA notices to Providers and Beneficiaries shall include:
      a. The procedure code;
      b. The total number of service-time increments or units of service for each PA;
      c. The PA control number;
      d. The approval beginning and ending date of service, and
      e. Signature of Contractor's reviewer including credentials for the determination and date.

   5. Contractor's notices of adverse determinations shall include:
      a. A case-specific rationale based on the type of review conducted, which may be based at least in part on medical necessity, and
      b. A statement of Provider's right to administrative reconsideration or administrative appeal; and
      c. A statement of Beneficiary's right to an Appeal under Arkansas Administrative Procedure Act.

   6. All notifications and correspondence with Providers and/or Beneficiaries sent directly by Contractor must be maintained by Contractor as specified herein regarding data retention and maintained in a secure and HIPAA-compliant manner. Contractor shall not be responsible for notifications and correspondence contained within MMIS/InterChange, including those uploaded/appended to a claim or generated by MMIS/InterChange.

   7. Notices to Beneficiaries
      a. Contractor shall send all notices to Beneficiaries within three (3) business days from the date of a determination via U.S. postal mail unless otherwise noted herein; and
      b. The Contractor may be able to send notices to Beneficiaries via MMIS/InterChange or directly depending on the review process undertaken.

   8. Notices of adverse decisions shall include a case-specific rationale based on medical and dental necessity and a statement of beneficiary's right to administrative appeal under Arkansas Administrative Procedure Act.

   9. The Contractor shall respond to any informal (i.e., not part of a reconsideration or appeal) communication resulting from adverse decisions within five (5) business days.

10. The Contractor shall send a written acknowledgement of PA change request to the beneficiary by close of business on the next business day after receipt of the request.

    a. Notices to Providers
        i. The Contractor shall send retrospective review notices to Providers within the timeframes noted herein via U.S. postal mail, encrypted email/secure messaging or other methods approved by DHS.
        ii. For the PA process within MMIS/interChange, Contractor shall indicate in the system the appropriate notification to be sent to the requesting Provider.
        iii. MMIS/InterChange will:
            a) Automatically generate and mail the Notice;
            b) Create a PDF version of the Notice to the Provider and place it in the MMIS Provider Portal for viewing by the Provider.
        iv. The Contractor must produce PA notices when required, as mutually agreed upon in advance.
        v. Postage paid by MMIS InterChange owner in mailing letters to Providers will not be passed through to Contractor at this time.
        vi. Outside of MMIS/InterChange, notices to Providers may be sent via encrypted email/secure messaging or by US postal mail. Postage costs will be the responsibility of Contractor.
        vii. Notices shall be transmitted by electronic mail or other electronic means.

    b. Notification of DHS Fiscal Agent
        i. Notices shall be generated through the Arkansas MMIS/interChange. This shall include without limitation closing and end-dating current PAs and opening new PAs for a modification or provider change; and closing and end- dating current PAs upon request.

        ii. Contractor's data submissions shall have an error rate of no more than five percent (5%).

        iii. The Contractor shall correct errors and omissions in data and transmit them to the Arkansas MMIS within twenty-four (24) hours of discovery.

C. Additional Notification Specifications for Retrospective Reviews
The Contractor shall notify providers of cases selected and request documentation to support the medical and dental necessity of services provided to the identified Medicaid beneficiaries within ten (10) business days of selection.

**2.4.11 STANDARD PROCESSES AND REQUIREMENTS RELATED TO ALL REVIEW TYPES**

A. The Contractor shall perform related functions and processes, and adhere to the following standard requirements applicable to all process types including, but not limited to:

1. Any other tasks necessary to provide all the Deliverables as set forth herein.

2. Perform all functions under this contract in conformity with applicable laws, policies, regulations and guidelines, including those set forth by DHS, and including without limitation, Due Process as to all processes, timeframes, forms and notifications.

3. Adhere to all state and federal privacy and security laws and requirements.

4. Use only DHS pre-approved forms and letters for all correspondence, including legal notifications, and perform Provider and Beneficiary denial notifications as described herein. All correspondence must comply with all laws, rules and regulations, including those set forth by DHS, and including but not limited to Due Process.

5. Adhere to the timeframes for each review type set forth in Attachment I.

6. All timeframes shall begin upon receipt of a reviewable request for review. Unless specifically noted, the hours or days shall not include weekends, and any legal holidays observed by the Arkansas State government in the computation thereof.

7. Adherence to timeframes must be reported to DHS in monthly reports and shall be considered in Contractor 's Quality Assurance/Performance Improvement activities set out herein.

8. All reviews shall be conducted by clinical reviewers meeting the minimum education requirements specified in Attachment I.

9. Non-Standard Care. Contractor shall notify DHS within five (5) business days of instances wherein Contractor has identified a provider not meeting established standards of care if noted while carrying out PA, RR, MR/C and Ad Hoc review functions under this contract. If DHS agrees with the Contractor determination, DHS shall work with Contractor to establish the proper method of communicating such instances of non-standard care to DHS and Providers. Contractor shall provide educational materials and references to the Provider at the request of DHS to explain a finding of non-standard care.

**2.4.12 EXTERNAL PROCESS**

A. MMIS/InterChange Processes:

1. For Prior Authorizations (PAs), Contractor ‘s clinicians, other medical professionals and supervisors shall log in to Arkansas Medicaid MMIS to work through an assigned workflow queue and perform other tasks.

2. Workflow queues for PAs shall be populated via PAs submitted by Providers via the MMIS Provider Portal, and via PAs that are sent directly to DHS or the Contractor, and the Contractor shall input the PAs into MMIS for completion.

3. User roles, security levels, workflow queues, messaging and other functionality shall be based on user ID/email and qualifications.

4. Contractor shall be able to make notes on a file, send and receive messages, send and receive files/claims/requests for review, and perform other tasks for completion of work required under this Request for Proposal (RFP).

5. In collaboration with DHS, Contractor shall finalize user roles, security levels, messaging, workflow queues and other functions, and conduct a readiness review/functionality testing prior to Contractor becoming fully operational.

6. All actions will be automatically stamped with the date and time in MMIS to assist Contractor and DHS with tracking timeframes related to all activities.

B. PA Requests Initiated Outside MMIS/interChange:

1. Certain PAs will not originate via the MMIS Provider Portal.

2. In collaboration with DHS, Contractor shall develop a process to allow requests to be made by providers, including hospitals, via telephone, encrypted email/secure messaging, US mail or facsimile.

3. In such instances, Contractor shall:
   a. Have the capacity to receive requests so initiated.
   b. Create the PA in MMIS/interChange,
   c. Follow the same process as though the PA was initiated through the MMIS Provider Portal.

4. Contractor and DHS shall determine a secure methodology for assignments to be communicated to Contractor.

5. Cases involving urgent care may be initiated utilizing this method, and Contractor shall develop an internal process to receive and prioritize emergency requests.

6. The RR process will require interfaces to allow for data transfer:
   a. Weekly claims feed from Optum;
   b. Sending recoupment determinations to MMIS/interChange Contractor, and
   c. Receiving disposition and error reports from MMIS/interChange Contractor;
   d. All file transfers, data retention, including documents in support of requests and reviews, shall be transferred and retained in a secure and HIPAA-compliant manner.

7. MRC and Ad Hoc reviews shall be external to MMIS/InterChange.

C. Change Requests

1. Contractor shall receive requests to change beneficiary information, submitted electronically as well as paper-based requests. Upon receiving an information change request, Contractor shall electronically submit the change request to DHS and to the Independent Assessment Contractor in a form, format, and process to be determined by DHS. Contractor shall send a written acknowledgement of the change request to the provider(s) and beneficiary by close of business on the next business day after receipt of the request.
2. Contractor shall receive requests to change providers, submitted electronically as well as paper- based requests. Upon receiving a provider change request, Contractor shall send a written acknowledgement of the change request to both the current and new providers and to the beneficiary by close of business on the next business day after receipt of the request. Contractor shall contact the current provider to determine the number of units of service provided in the current month and then prorate the remaining units of service provided in that month by the new provider. Contractor shall then close and end-date the current PA and open a new PA for the new provider.

### 2.4.13 CONTACT/CORRESPONDENCE AND COMPLAINT RESOLUTION

A. Contractor shall operate as an effective liaison, as determined by DHS, between DHS, Providers and Beneficiaries by maintaining active feedback and assisting Providers, Beneficiaries, other persons or entities, and DHS with contacts, correspondence and complaints related to all processes under this contract.

1. Contact/Correspondence
    a. Contractor shall respond to any informal inquiry or communication whether resulting directly or indirectly from a PA, RR or MRC/Ad Hoc review determination.
    b. Correspondence with Beneficiaries shall be by U.S. Postal Mail. Correspondence with Providers can be by U.S. Postal Mail, encrypted email/secure messaging or other method approved by DHS.
    c. Contractor shall maintain electronic versions of all correspondence, including but not limited to letters and encrypted email/secure messaging, sent outside of MMIS/InterChange, which shall be retrievable on demand. Additionally, Contractor shall maintain all correspondence and underlying information that served at the basis of the correspondence according to the data maintenance and retention requirements and schedule. This does not include documentation maintained in MMIS/InterChange.
    d. On a monthly basis, Contractor shall report to DMS the number of letters and/or communications with Providers, Beneficiaries or others by volume, topic addressed and other information as set forth in this RFP. Contractor shall be responsible for postage under this section.

2. Complaint Resolution
    a. Contractor shall establish a complaint resolution process to respond to written and verbal complaints which shall be approved by DHS.
    b. Contractor shall reply in writing within five (5) calendar days of receipt to all complaints received by Contractor (directly or indirectly) and shall send a copy of the complaint (if written) and the response to DHS.
    c. Correspondence with Beneficiaries shall be by U.S. Postal Mail. Correspondence with Providers can be by U.S. Postal Mail, encrypted email/secure messaging or other method approved by DHS.
        i. Any complaints received during normal business hours shall be addressed on the same business day as received.
        ii. Any complaints received after business hours shall be addressed by the end of the following business day.
        iii. All complaints, if not answered immediately, must be addressed within one (1) business day.
        iv. For quality assurance and auditing purposes, the Contractor shall provide a method for tracking and documenting all complaints received and/or made including the date/time, identity of the complainant, contact information, the basis for the call, a summary of discussion, and disposition of the complaint.
        v. Complaint data must be maintained for five (5) years. Follow-up communication may include written correspondence as required by the RFP.

### 2.4.14 QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

A. Contractor shall create and maintain a Quality Assurance (QA) and Quality Assurance/Performance Improvement (QAPI) program. The QAPI program shall be designed to promote qualitative improvements to services provided under this contract, including but not limited to reviews conducted, reports created and submitted to DHS, and required data generated and maintained by Contractor. At a minimum, Contractor must assess reviews undertaken and develop, implement, and monitor through ongoing measurements and interventions, improvements to these processes intended to have a favorable effect on the PA review process.

B. Contractor shall also develop and implement proactive Performance Self-improvement Projects, which are opportunities for improvement identified by internal data and information, such as internal workflow or systemic improvements.
   1. Contractor shall examine the services, processes and data being provided for completeness, adequacy, appropriateness, quality and efficiency, and shall integrate continuous QAPI processes, such as tracking and trending of issues, throughout all areas of the organization. When reviewing services provided and trends, the QAPI must:
      a. Assess and document whether services meet the needs of DHS, Providers and Beneficiaries/recipients with respect to the following and any other applicable standards identified by DHS:
         i. Timeliness: Reviews shall be conducted within specified timeframes, and required reporting shall be received on or before scheduled due dates;
         ii. Accuracy: Reviews, reports and data shall be gathered, prepared and maintained in strict conformity with appropriate authoritative sources and/or DHS- defined standards; and
         iii. Completeness: All required information and processes shall be fully disclosed in a manner that is both responsive and pertinent for the appropriate intent with no material omissions.

      b. Through monitoring and data collection, identify review needs that are unmet or could be improved upon, including but not limited to processes, education, access to resources and staffing.

      c. Establish and implementation plans to improve the areas identified above based on the following steps in a cycle or similar process:
         i. Identify an area that requires or would benefit from improvement, which may include but is not limited to language contained in forms, Contractor's correspondence process, use and functionality of MMIS, and the integration of Contractor's workflow with DHS's workflow.
         ii. Identify/develop objective quality indicators to measure baseline performance and performance improvement.
         iii. Implement system of interventions to achieve improvement in quality.
         iv. Evaluate the effectiveness of the interventions by comparing the results and analyzing the assessment.
         v. Plan and initiate activities for increasing or sustaining improvement.
         vi. Report activities to DMS, including QAPI activities related to DHS/ Centers for Medicare and Medicaid Services (CMS) standards.

      d. Based on its self-assessment, Contractor may establish and implement a quality improvement plan. Any quality improvement plan must include the following without limitation:
         i. Evidence-based practices.
         ii. Use of contract-wide outcomes measures to improve the review process. Documentation must include:
            - Measured outcomes, and
            - Reports, which may be modified by DHS as necessary

         iii. Requirements for informing and including all Contractor employees and subcontractors in the QAPI process.
         iv. Contractor shall use the quality improvement plan to develop improvements to any PA process and to continually evaluate work conducted by employees and subcontractors, including but not limited to those comprising the PA reviewers, both individually and as part of a review team. All suggested improvements shall be presented to DHS according to timeframes agreed upon by DHS and Contractor and in a DHS-approved format.
         v. The QAPI function should involve person(s) with experience in utilization and quality control peer review settings.

C. The Contractor shall work with DHS on DHS- suggested changes to implement improvement to a process or processes, including but not limited to the Reconsideration and Appeal processes.

D. The Contractor shall submit to DHS a regular quarterly report pertaining to QAPI and QAPI-related activities under this section.

**2.4.15 DATA MAINTENANCE**

A. Initial Contractor Database
Current PA, RR and MRC Contractors for DHS have created databases to support the Contractors' functions under multiple contracts. In order to provide Contractor with a workable database containing historical PA-related

information from the beginning of this contract, Contractor shall make a good faith effort to work with current PA/RR/MRC Contractors to extract a necessary amount of data as the Contractor's baseline database of historical PA/RR/MRC information.

B. Data Errors and Corrections
   1. Contractor shall be responsible for updating MMIS/interChange with any corrections within one (1) business day via the Contractor.
   2. Contractor shall notify the requesting Provider and the Fiscal Agent of any corrections within two (2) business days.
   3. Contractor shall report monthly to DHS any data corrections and timeframes for required notification.

C. Required Interfaces/Communications and Data/Information Flows:
   1. Contractor shall be able to interface/communicate with all persons, entities and systems necessary to comply with all requirements herein, including but not limited to:
      i. Providers,
      ii. Beneficiaries,
      iii. DHS,
      iv. Arkansas Medicaid MMIS/InterChange
      v. Fiscal Agent

   2. Certain interfacing/communicating may require Contractor to log in to another Contractor's system or receive a feed from another Contractor. Contractor and DHS shall work to identify any necessary interface/ communication processes and the current Contractor's requirements. Contractor shall work expediently and in good faith with each current Contractor in order to have all necessary interfaces/ communication processes operational prior to the contract start date.

   3. The Contractor shall create or make available additional means of interfacing/communicating with DHS, Providers, Beneficiaries, etc., via encrypted email/secure messaging, telephone, facsimile, etc., and shall disclose to DHS such methods prior to the contract start date and receive DHS approval for use of the communications method appropriate to the recipient.

D. Data Security and Breaches
   1. All data stored in Contractor's database shall be secure and comply with all state and federal laws, including without limitation HIPAA.
   2. The Contractor shall notify DHS immediately of any compliance violations or breach, incident, issue, complaint, sanction or occurrence related to Protected Health Information (PHI), Personal Identifying Information (PII), HIPAA transactions and code sets, or similar matters as identified by the Contractor or DHS.

E. Data Retention and Disposal
   1. The Contractor shall comply with all applicable laws regarding retention of records, data and information relating to this contract.
   2. Documentation related to all processes set out herein shall be maintained by Contractor in accordance with the Arkansas Records Retention Policy or at the conclusion of an Appeal or litigation, whichever is longer.
   3. The Contractor shall complete, file, retain, and make available upon request all program records in a secure, HIPAA-compliant manner. Such records exclude documents uploaded to MMIS/InterChange, but does include, without limitation, documents utilized by Contractor in providing services to DHS under this RFP, including those created by Contractor.
   4. The Contractor must develop and maintain means of legal proof that notices were sent in accordance with the timeframes set forth herein.
   5. At the end of this contract, or upon DHS's request, Contractor shall work with DHS to transfer all the data contained in its database.
   6. All data received and developed by Contractor shall be owned by DHS; Contractor shall not utilize data for any purposes other than those specified in this RFP unless specifically requested in writing by DHS.
   7. After Contractor has complied with any data transfers requested by DHS, Contractor shall comply with HIPAA requirements regarding data destruction.

F. The Contractor must provide a secure computer system, and any DHS requested system interfaces for the performance of the requirements set forth in the contract.

G. The Contractor shall maintain, revise and update a secure web-based data transmission system for accepting review requests from providers and returning determination notifications, including denial rationales, to providers in accordance with HIPAA and other mandatory security standards. Providers are not required to use the web-based system, so the contractor must be able to receive and respond to requests from the provider via fax, e-mail, or postal mail. The Contractor shall be solely responsible for the cost of maintenance, revisions, and updates of the database and transmission system as necessary to perform the services specified in the contract. Back-up systems or methods are required to ensure that data is received and transmitted in order to fulfill the contracted activities.

H. The Contractor shall maintain, revise and update a database and electronic system to communicate approval and denial determinations and automated recoupments to the Medicaid fiscal agent via the Arkansas MMIS/interChange. Communications must comply with the MFA, Ark. Code Ann. § 2077- 1701 et seq. The Contractor must detect and correct electronic data and data transmission errors as part of the daily verification process. The Contractor shall be solely responsible for the cost of maintenance, revisions, and updates of the database as necessary to fulfill the contract. Back-up systems or methods are required to ensure that data is received and transmitted in order to fulfill the contracted activities.

I. The Contractor shall enter into data use agreements with DHS and all other interested parties as necessary to fulfill the obligations of the contract.

J. The Contractor shall provide sufficient fax, data and telephone lines (local and toll-free long distance), and equipment to communicate as required by this contract

K. The Contractor shall provide read only access of the secure computer system to appropriate DHS staff for review and investigative purposes.

**2.4.16 FORMS**

A. The Contractor must seek and receive approval from DHS within sixty (60) calendar days from the contract award date on all forms used in performance of this contact prior to use by Contractor. Standard denials forms shall be submitted for approval by DHS within (15) calendar days of the contract award date.

B. All forms must notify recipients of Due Process rights under applicable law, including applicable time frames for preserving any Reconsideration or Appeal rights.

C. All PA forms must include minimum standard information including, but not limited to, the following without limitation:
   1. Date of request;
   2. Type of request; and
   3. Name of requestor and Medicaid Provider ID if applicable.

D. The Contractor shall develop and provide all required DHS-approved forms/correspondence, including without limitation the following:
   1. Provider and Medicaid Beneficiary notification of determinations pertaining to the following:
      a. Initial review process;
      b. Reconsideration process; and
      c. Appeals Process.

   2. All forms and correspondence related to complaint processes as set forth in Section 2.4.M (Contact/Correspondence and Complaint Resolution).

**2.5 PROVISION OF OFFICE SPACE AND EQUIPMENT**

A. The Contractor must provide a physical location within the State of Arkansas sufficient to staff and perform all operations covered under this RFP within ninety (90) days of the contract start date.

B. All computers, equipment and other resources necessary to fulfill the terms of this contract shall be at Contractor’s expense and shall be properly maintained to minimize any negative impact on performance of duties.

C. The Contractor shall have operating hours at a minimum of 8:00 a.m. to 5:00 p.m. CST, Monday through Friday, exclusive of State holidays, unless documented exceptions are made by DHS in the event of unpreventable circumstances, i.e. inclement weather.

D. The Contractor must be available during DHS regular business hours and have an automated method of receiving messages and information from providers or beneficiaries after business hours, on weekends and on holidays.

E. The Contractor shall furnish and maintain facilities and equipment to be able to utilize the MMIS/interChange system, as well receive requests via telephone, US mail and facsimile.

### 2.6 45 CFR § 95.617 SOFTWARE AND OWNERSHIP RIGHTS

A. General. The State or local government must include a clause in all procurement instruments that provides that the State or local government will have all ownership rights in software or modifications thereof and associated documentation designed, developed or installed with Federal financial participation under this subpart.

B. Federal license. The Department reserves a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, or otherwise use and to authorize others to use for Federal Government purposes, such software, modifications, and documentation.

C. Proprietary software. Proprietary operating/Contractor software packages which are provided at established catalog or market prices and sold or leased to the general public shall not be subject to the ownership provisions in paragraphs (a) and (b) of this section. FFP is not available for proprietary applications software developed specifically for the public assistance programs covered under this subpart.

### 2.7 PRIVACY AND SECURITY

A. The Contractor shall develop and maintain a System Security Privacy Plan (SSPP). The purpose of the Plan is to establish the approach to the PA Clinical Services adherence to privacy, confidentiality, and security standards.

B. DHS security and privacy compliance requires any contractor working with Medicaid systems, Affordable Care Act (ACA) administering entities, and their contractors and subcontractors adhere to the most stringent, up to date Federal ARC-AMPE, (applicable overlay), standards. Developed by CMS, the standards are based on the National Institute of Standards and Technology (NIST) Special Publication 800-53. This framework establishes the security and privacy requirements required for compliance under ARC-AMPE, ensuring the availability, confidentiality, and integrity of protected health information (PHI), personally identifiable information (PII), and federal tax information (FTI). The Contractor shall ensure and maintain compliance with the most current version of Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health (HITECH) and other Federal and State privacy and security standards.

C. The Contractor shall use the ARC-AMPE template and follow the monthly Plan of Action & Milestones (POAM) process. The Contractor shall encrypt all data using the latest/supported technology protocols, whether at rest/stored, in flight/transit, or communicated and/or accessed in any way. The Contractor shall obtain input from the State and its Stakeholders to ensure completeness and coverage, including network topology to uncover possible breakpoints or potentially negative impacts to Security and Privacy objectives. The Plan must, at minimum, follow HHS CMS' best practices that include, but are not limited to:

1. The plan for ensuring confidentiality and privacy standards is met
2. The technical approach to address and satisfy the following:
    a. Penetration testing
    b. Encryption as a requirement internal and external, at rest and in transit
    c. Integration with Statewide active directory (AD) services
    d. Static code scans
    e. Dynamic code scans
    f. Vulnerability scans
    g. Evidence of compliance with CIS Level 1 hardening
    h. Full software and hardware
    i. Compliance with Acceptable Risk Controls for ACA, Medicaid & Partner Entities (ARC-AMPE) within 180 days of release by CMS.
3. Approach to maximizing sharing of data provided from any external source while complying with all appropriate rules, regulations, and policies

4. User roles, security permissions, and administrative functions
5. Confirmation that the System Security and Privacy Plan aligns with the most stringent, up to date Federal ARC-AMPE, (applicable overlay), guidance.
6. Plan to maintain all confidentiality safeguards
7. Plan to adhere to all privacy requirements for different data elements
8. Any other relevant protocols or details to ensure privacy, confidentiality, and security standards are met
9. Roles and responsibilities to be performed by the Contractor and by the State
10. Compliance with Statement on Standards for Attestation Engagements (SSAE-18) SOC 2 Type 2 including all trust service principles.
11. The Contractor shall support and provide documentation for the following to support the SSPP:
    a. Plan of Action & Milestones (POA&M)
    b. Penetration Test (white box internal and external) using methodology from NIST special publication 800.115
    c. Organizational IT Policies
    d. Electronic Authentication (E-Authentication) Assessment (if applicable)
    e. Privacy Threshold/ Impact Assessment (PTA/PIA)
    f. Rules of Behavior (ROB)
    g. Contingency Plan (CP)
    h. Continuous Monitoring Plan
    i. System Inventory (Hardware/Software/Firmware)
    j. Incident Response Plan (IRP)
    k. Security Assessment Plan (SAP)
    l. Security Requirements Traceability Matrix (SRTM)
    m. Security Assessment Report (SAR)/ Risk Assessment Report (RAR)
    n. System Detailed Design Document
    o. High-Level Architecture (Designs/Diagrams)
    p. Configuration Management Plan
    q. Configuration Baselines and Guides
    r. List of System Accounts and Privileges
12. Address ongoing security audits and recommendations for improvement:
    a. Establish governance structures designed to assess the audits and make recommendations to improve the System Security and Privacy Plan obligations.
    b. Review unauthorized and authorized incidents, breaches, and effectiveness and adaptability of the process and procedural improvements.
    c. Establish audits and institute best-practice processes that ensure that security and privacy measures address all DHS, Federal and State policies, procedures, reporting and compliance training.
    d. Conduct a System Security and Privacy Plan risk analysis to identify system security and privacy policies, procedures, and administrative, physical, and technical (i.e., identity management) controls.

## 2.8 SECURITY AND ACCESS

A. AME data contains Personally Identifiable Information (PII) and Protected Health Information (PHI) and is considered sensitive. As such, the security of the data is critical to the success of the project, and the solution must include physical and virtual security methods, as well as role-based access to all environments and data at the proper levels. The DSS must include the protection of all data including, but not limited to:

1. Provision of access
2. Storage of all user access accounts
3. Audit trails of all events performed by DSS users and the DSS itself

4. Backup of all data, including reporting and analytics saved by users
5. Protection against viruses and threats, including, but not limited to, ransomware, rogue security software, Trojan horses, worms, denial of service, and SQL injections

B. The Contractor shall provide a solution that is able to support multiple user roles as defined and approved by DHS. User Roles and estimated numbers are estimates and subject to change. User Roles and estimated numbers shall include, but not be limited to:

1. Advance Power Users – the Agency estimates 50 users
2. Business Users/Analysts – the Agency estimates 200 users
3. Report Viewers – the Agency estimates 150 users
4. Executive Users – the Agency estimates 75 users
5. Data Analysts – the Agency estimates 30 users

C. AME envisions the PA Clinical Services to integrate into a centralized role-based account store controlled by DHS for single sign-on access across the AME. The role-based Single Sign-On solution must be built and managed by the SIS. The PA Clinical Services Contractor shall work with the SIS Contractor to implement Single Sign-On for the PA Clinical Services and other modules as required. The solution must provide flexibility to adapt to changing security and access approaches during the evolution of the AME, as well as State and/or Federal rules/regulations.

## 2.9 DISASTER RECOVERY/BUSINESS CONTINUITY & CONTINGENCY PLAN

A. The Contractor shall submit a Business Continuity and Contingency Plan (BCCP) for the business area operations.

B. Operations must be protected against human error, natural disasters, and other emergencies that could interrupt services. The BCCP must address recovery of business functions,. The BCCP shall include infrastructure and services recovery responsibilities associated with:

1. A partial loss of a function or of data for a brief amount of time; or
2. A worst-case scenario in which a man-made or natural disaster, data center equipment or infrastructure failure, or total system failure results.

C. The BCCP shall, at a minimum, include:

1. Documentation of "who" shall declare a "disaster or failover," escalation communication, and process for DHS approval to begin implementing the BCCP;
2. Identification of the critical business processes and functions to be recovered and the process for DHS approval and periodic review;
3. For each critical business process and function:
   a. Identification of potential system failures for the process,
   b. Risk analysis for potential failure,
   c. Impact analysis of potential failure, and
   d. Definition of minimum acceptable levels of output;
4. Documentation of contingency plans and identification of triggers for activating contingency plans;
5. Procedures for activating any special teams for business continuity;
6. Communication protocols and processes for restoring operations in a timely manner;

7. Review and update plans, as required

8. Plan for replacement of personnel, if needed;

9. Retention, storage and access to backup files and software;

10. Hardware backup for critical system components;

11. Backup for telecommunications links and networks;

**2.10 TRANSITION PLAN**

A. During the transition period, the Contractor shall work closely and cooperatively with DHS and the new contractor. The Contractor shall perform the activities required to transition to a subsequent contractor. End of Contract transition planning must ensure seamless operations including:
   1. Phase-in training of the new Contractor or other identified stakeholders
   2. Thorough and efficient transition activities
   3. Staffing continuity
   4. Uninterrupted service

B. At the direction of DHS, but no less than eighteen (18) months prior to the final contract year, including option years that have been exercised, and at least eighteen (18) months prior to the end of any Contract extension(s), the Contractor shall begin turnover activities in accordance with the approved transition plan. DHS reserves the right to request any turnover activities at any time during the contract period, even if the contract is not ending. DHS may also require that these services begin earlier than eighteen (18) months as needed for an orderly transition.

C. The Contractor shall work closely and cooperatively with the new Contractor to discontinue services to align with the new Contractor's implementation schedule.

D. DHS shall not be charged for the same services being performed by the incoming and outgoing Contractors.

E. The transition shall not be considered complete until all required activities are completed and approved, in writing, by DHS.

F. DHS must pre-approve the format and delivery method of all proprietary data. The transition plan shall include:
   1. Provisions for the delivery of all proprietary data collected and/or created during the life of the contract to DHS thirty (30) calendar days prior to the contract end date.
   2. All proprietary data collected and/or created during the final thirty (30) business days of the contract, or any proprietary data not captured in the initial delivery, shall be delivered to DHS no more than fifteen (15) business days following the contract end date.
   3. DHS reserves the right to request re-submission of any proprietary information deemed unacceptable after the Contractor's initial transfer.

G. Contractor must work in good faith and cooperate with any new contractor and the State during a transition period. The incumbent Contractor must participate in any transitional meetings as requested by the new contractor and/or the State. Additionally, incumbent Contractor and new contractor shall coordinate and cooperate in the transition of services as follows:
   1. Ninety (90) days from contract end date, incumbent Contractor shall facilitate virtual "shoulder to shoulder" observation of all aspects of the day- to-day contractual operations by new contractor for thirty (30) days;
   2. Sixty (60) days from contract end date, new contractor shall assume primary contractual responsibilities and facilitate incumbent Contractor's virtual "shoulder to shoulder" support for thirty (30) days.
   3. Thirty (30) days from the contract end date, incumbent Contractor shall remain available for questions and technical assistance for new contractor and the State on an as-needed basis.

H. The Contractor shall not implement the plan until it has received DHS's written approval of the plan. The Contractor shall take all reasonable action to provide a minimally disruptive turnover.

I. Deliverable Acceptance Process: If DHS rejects a deliverable, DHS will give the Contractor a written description of the changes that must be made to the deliverable. This cycle of submission, review, rejection, revision, and resubmission shall be repeated until DHS accepts the deliverable. The Contractor shall be liable for all costs associated with additional work related to deliverables rejected by DHS.

J. Ten (10) business days after the completed transition, Contractor must provide DHS with a Transition Results Report documenting the results of each step of the Transition Plan. The transition shall not be considered complete until this document is approved by DHS.

### 2.11 PERFORMANCE STANDARDS

A. State law requires that all contracts for services include Performance Standards for measuring the overall quality of services provided. *Attachment C: Performance Standards* identifies expected deliverables, performance measures, or outcomes; and defines the acceptable standards the Contractor **must** meet in order to avoid assessment of damages.

B. The State may be open to negotiations of Performance Standards prior to contract award, prior to the commencement of services, or at times throughout the contract duration.

C. The State **shall** have the right to modify, add, or delete Performance Standards throughout the term of the contract, should the State determine it is in its best interest to do so. Any changes or additions to performance standards will be made in good faith following acceptable industry standards and may include the input of the Contractor so as to establish standards that are reasonably achievable.

D. All changes made to the Performance Standards **shall** become an official part of the contract.

E. Performance Standards **shall** continue throughout the term of the contract.

F. Failure to meet the minimum Performance Standards as specified may result in the assessment of damages.

G. In the event a Performance Standard is not met, the Contractor will have the opportunity to defend or respond to the insufficiency. The State may waive damages if it determines there were extenuating factors beyond the control of the Contractor that hindered the performance of services or if it is in the best interest of the State to do so. In these instances, the State **shall** have final determination of the performance acceptability.

H. Should any compensation be owed to the agency due to the assessment of damages, Contractor **shall** follow the direction of the agency regarding the required compensation process.

## SECTION 3 – SELECTION

- ***Do not** provide responses to items in this section.*

### 3.1 SELECTION PROCESS

A. OP will review each *Technical Proposal Packet* to verify submission Requirements have been met. *Technical Proposals Packets* that do not meet submission *Requirements* **shall** be rejected and **shall** not be evaluated.

B. An agency-appointed Evaluation Committee will evaluate and score qualifying Technical Proposals and pricing. Evaluation will be based on Prospective Contractor's response to the *Information for Evaluation* section included in the *Technical Proposal Packet* and pricing included on the *Official Bid Price Sheet*.

1. Members of the Evaluation Committee will individually review and evaluate proposals and complete an Individual Score Worksheet for each proposal. Individual scoring for each Evaluation Criteria will be based on the following Scoring Description.

| Quality Rating | Quality of Response | Description | Confidence in Proposed Approach |
|---|---|---|---|
| 5 | Excellent | When considered in relation to the RFP evaluation factor, the proposal squarely meets the requirement and exhibits outstanding knowledge, creativity, ability or other exceptional characteristics. Extremely good. | Very High |

| 4 | Good | When considered in the relation to the RFP evaluation factor, the proposal squarely meets the requirement and is better than merely acceptable. | High |
|---|---|---|---|
| 3 | Acceptable | When considered in relation to the RFP evaluation factor, the proposal is of acceptable quality. | Moderate |
| 2 | Marginal | When considered in relation to the RFP evaluation factor, the proposal’s acceptability is doubtful. | Low |
| 1 | Poor | When considered in relation to the RFP evaluation factor, the proposal is inferior. | Very Low |
| 0 | Unacceptable | When considered in relation to the RFP evaluation factor, the proposal clearly does not meet the requirement. Either nothing in the proposal is responsive in relation to the evaluation factor or the proposal affirmatively shows that it is unacceptable in relation to the evaluation factor. | No Confidence |

2. After individual evaluations are complete, the Evaluation Committee members will meet to discuss their individual ratings in a consensus scoring meeting. At this consensus scoring meeting, each evaluator will be afforded an opportunity to discuss his or her rating for each evaluation criteria.

3. After committee members have had an opportunity to discuss their individual scores of technical proposals, pricing will be opened for each responsible bidder. Evaluation Committee members will be given the opportunity to determine if pricing for each responsible bidder is unreasonable or unrealistic.

4. The Evaluation Committee Members will be given the opportunity to change their scores, if they feel appropriate.

5. The final scores of the evaluators will be recorded on the Consensus Score Sheets and averaged to determine the group or consensus score for each proposal. For purposes of scoring, only the final scores of the evaluators reflected on the Consensus Score Sheet will be used. Each evaluator shall sign the Consensus Score Sheet affirming that the score noted is the score intended by the evaluator.

6. Other agencies, consultants, and experts may also examine documents at the discretion of the Department.

### 3.2 TECHNICAL PROPOSAL SCORE

A. The *Information for Evaluation* section has been divided into sub-sections.

1. In each sub-section, items/questions have each been assigned a maximum point value of five (5) points. The total point value for each sub-section is reflected in the table below as the Maximum Raw Score Possible.

2. The Department has assigned Weighted Percentages to each sub-section according to its significance.

| Information for Evaluation Sub-Sections | Maximum Raw Points Possible | Sub-Section’s Weighted Percentage | * Maximum Weighted Score Possible |
|---|---|---|---|
| E.1 Implementation | 30 | 11 | 77 |
| E.2 Prior Authorization | 75 | 11 | 77 |
| E.3 Continuation of Needs & Extension of Benefits | 25 | 11 | 77 |
| E.4 Retrospective Reviews & Program Compliance Audit of Medicaid Services | 45 | 11 | 77 |

| | | | |
|---|---|---|---|
| E.5 Medical Review Consultation Services | 25 | 11 | 77 |
| E.6 Appeals & Reconsiderations | 10 | 11 | 77 |
| E.7 Staffing & Training | 55 | 12 | 84 |
| E.8 Data Management and Reporting | 60 | 11 | 77 |
| E.9 Project & Contract Management | 30 | 11 | 77 |
| **Total Technical Score** | **355** | **100%** | **700** |

*Sub-Section's Percentage Weight x Total Weighted Score = Maximum Weighted Score Possible for the sub-section.

C. The proposal's weighted score for each sub-section will be determined using the following formula:

(A/B)*C =D
A = Actual Raw Points received for sub-section in evaluation
B = Maximum Raw Points possible for sub-section
C = Maximum Weighted Score possible for sub-section
D = Weighted Score received for sub-section

D. The proposal's weighted scores for sub-sections will be added to determine the Total Technical Score for the Proposal.

**3.3 COST SCORE**

A. When scores are applied to pricing, the maximum amount of cost points will be given to the proposal with the lowest annual grand total as shown on the *Official Bid Price Sheet*. (See *Grand Total Score* for maximum points possible for cost score.)

B. The State reserves the right to determine that received costs from any vendor are unreasonable (too high for the requirements of the Solicitation) or unrealistic (too low to reflect the ability of the offeror to meet the requirements of the Solicitation). When it is determined by the State that pricing is potentially unrealistic or unreasonable, the State may request an offeror to clarify elements of pricing, and the offeror may be removed from consideration for a Solicitation, at the sole discretion of the State.

C. The amount of cost points given to the remaining proposals will be allocated by using the following formula:

(A/B)*(C) =D
A = Lowest Total Cost
B = Second (third, fourth, etc.) Lowest Total Cost
C = Maximum Points for Lowest Total Cost
D = Total Cost Points Received

**3.4 ORAL PRESENTATION/DEMONSTRATION SCORE**

A. The Prospective Contractors determined to be reasonably susceptive of being awarded after the completion of the initial evaluation may be contacted to schedule an oral presentation/demonstration. Key staff proposed must be available to participate in the Demonstration/Oral Presentation, if requested.

B. Should DHS elect to hold oral presentation/demonstrations, the buyer will create a second set of score sheets by copying the Excel workbook (including the scores entered) and titling each of the score sheets in that workbook as the "Post-Demonstration" score sheets.

C. After each oral presentation/demonstration is complete, the Evaluation Committee members will have the opportunity to discuss the oral presentation/demonstration and revise their individual scores on the Post-Demonstration Consensus Score Sheet based on the information provided during the oral presentation/demonstration.

D. The final individual scores of the evaluators on the Post-Demonstration Consensus Score Sheets will be averaged to determine the final Technical score for each proposal.

## 3.5 GRAND TOTAL SCORE

The Technical Score and Cost Score will be added together to determine the Grand Total Score for the proposal. The Prospective Contractor's proposal with the highest Grand Total Score will be selected as the apparent successful Contractor (*See Award Process*).

| | **Maximum Points Possible** |
|---|---|
| Technical Proposal | 700 |
| Cost | 300 |
| **Maximum Possible Grand Total Score** | **1,000** |

## 3.6 PROSPECTIVE CONTRACTOR ACCEPTANCE OF EVALUATION TECHNIQUE

A. Contractor **must** agree to all evaluation processes and procedures as defined in this solicitation.

B. The submission of a *Technical Proposal Packet* **shall** signify the Contractor's understanding and agreement that subjective judgments **shall** be made during the evaluation and scoring of the Technical Proposals.

# SECTION 4 – GENERAL CONTRACTUAL REQUIREMENTS

- ***Do not** provide responses to items in this section unless expressly required.*

## 4.1 PAYMENT AND INVOICE PROVISIONS

A. Invoices must be submitted by the 15th of each month. If the 15th falls on a weekend or a holiday, the invoice will be due the next business day.

B. Invoices must be itemized per division to include the item/description, invoiced quantity, unit price, and total cost.

C. Invoices shall be supported by a detailed summary report, separated by division, that addresses all activities performed and completed. This report will serve to inform DHS about the progress of programs. The report shall include, at minimum, the following:
- Number of approved, appended, denied prior authorizations
- Total number of reviews for each category
- Number of level one reviews
- Number of level two reviews
- Total number of FTE hours

D. This contract includes a risk corridor to control the risk associated with the contract to both the vendor and to DHS. DHS will determine risk corridor settlement after the end of each contract year. The risk corridor contains a margin of 5%. Meaning the methodology for some payments contained in this RFP plan average risk to determine the margin or risk adjustment.

E. As seen in the attached Cost Proposal, DHS has posted historical State Fiscal year annual data as well as Projected/Bid Annual Quantities. The Vendor should price with the understanding the risk that the number listed in the Projected/Bid Annual Quantities has a margin of 5%. Specifically, the Vendor is bidding under the assumption that the payment will be based upon doing 5% less of the Quantity listed or 5% more of the Quantity listed without a change in cost. Anything below 5% will be adjusted back to the State and anything above 5% will be adjusted back to the Vendor at the end of each contract year.

F. Payment will be made in accordance with applicable State of Arkansas accounting procedures upon acceptance goods and services by the agency.

G. The State **shall not** be invoiced in advance of delivery and acceptance of any goods or services.

H. Payment will be made only after the Contractor has successfully satisfied the agency as to the reliability and effectiveness of the goods or services purchased as a whole.

I. The Contractor should invoice the agency by an itemized list of charges. The agency's Purchase Order Number and/or the Contract Number should be referenced on each invoice.

J. Other sections of this *Bid Solicitation* may contain additional Requirements for invoicing.

K. Selected Contractor **must** be registered to receive payment and future *Bid Solicitation* notifications. Contractors must register on-line at vendor.ark.org.

## 4.2 GENERAL INFORMATION (NON-NEGOTIABLE)

A. The State **shall not** lease any equipment or software for a period of time which continues past the end of a fiscal year unless the contract allows for cancellation by the State Procurement Official upon a thirty (30) day written notice to the Contractor/lessor in the event funds are not appropriated.

B. The State **shall not** pay damages, legal expenses or other costs and expenses of any other party.

C. The State **shall not** continue a contract once any equipment has been repossessed.

D. Any claims the Contractor may assert under this Agreement shall be brought before the Arkansas State Claims Commission ("Commission"), which shall have exclusive jurisdiction over any and all claims that the Contactor may have arising from or in connection with this Agreement. Unless the Contractor's obligations to perform are

terminated by the State, the Contractor shall continue to provide the Services under this Agreement even in the event that the Contractor has a claim pending before the Commission. Any litigation involving the State **must** take place in Pulaski County, Arkansas.

E. The State **shall not** agree to any provision of a contract which violates the laws or constitution of the State of Arkansas.

F. The State **shall not** enter a contract which grants to another party any remedies other than the following:
   1. The right to possession.
   2. The right to accrued payments.
   3. The right to expenses of de-installation.
   4. The right to expenses of repair to return the equipment to normal working order, normal wear and tear excluded.
   5. The right to recover only amounts due at the time of repossession and any unamortized nonrecurring cost as allowed by Arkansas Law.

G. The laws of the State of Arkansas **shall** govern this contract.

H. A contract **shall not** be effective prior to award being made by a State Procurement Official.

I. In a contract with another party, the State will accept the risk of loss of the equipment or software and pay for any destruction, loss or damage of the equipment or software while the State has such risk, when:
   1. The extent of liability for such risk is based upon the purchase price of the equipment or software at the time of any loss, and
   2. The contract has required the State to carry insurance for such risk.

**4.3 CONDITIONS OF CONTRACT**

A. The Contractor **shall** at all times observe and comply with federal and State of Arkansas laws, local laws, ordinances, orders, and regulations existing at the time of, or enacted subsequent to the execution of a resulting contract which in any manner affect the completion of the work.

B. The Contractor agrees to the Performance Based Contracting standards as presented in Attachment C, DHS Standard Terms and Conditions as presented in Attachment D, a pro forma contract as presented in Attachment E, the Business Associate Agreement as presented in Attachment F, and the Organizational or Personal Conflict of Interest policy as presented in Attachment G. Do not complete and return any of the above-named attachments. They are for your information only.

C. The State shall have the right to accept or reject all or any part of a bid or any and all bids, to waive minor technicalities, and to award the bid to best serve the interest of the State.

D. Any contract entered into pursuant to this solicitation **shall not** be assignable nor the duties thereunder delegable by either party without the written consent of the other party of the contract.

E. This RFP incorporates all terms in Attachment D – *General Terms and Conditions for Non-State Agency* and *Services Contract (SRV-1).* The former shall be given priority in case of conflict between the terms.
   1. A Prospective Contractor's proposal may be rejected if a Prospective Contractor takes exception to any terms, conditions, or Requirements in this RFP.
   2. The Prospective Contractor agrees and **shall** adhere to all terms, conditions, and Requirements if selected as the Contractor.
   3. Items may only be modified if the legal requirement is satisfied and approved by the State during Discussions.

### 4.4 PERFORMANCE BONDING

A. The Contractor **shall** be required to obtain performance bonds to protect the State's interest as follows:

1. The amount of the performance bonds **shall** be one hundred percent (100%) of the annual contract price, unless the State determines that a lesser amount would be adequate for the protection of the State. Such performance bond must be provided to DHS prior to signing the contract.

2. The State **shall** require additional performance bond protection when a contract price is increased or modified.

3. The Contractor shall submit documentation to the satisfaction of the State that a performance bond has been obtained. The performance bond must be delivered to the Arkansas Department of Human Services Chief Procurement Officer within fourteen (14) days of contract execution and within one calendar day of DHS request thereafter.

4. The contractor **shall** notify the State of any changes, modification, or renewals for the performance bond during the term of the contract. The performance bond documentation **must** be provided to the State with each required notice.

5. Failure to provide is a breach of contract and may result in immediate contract termination, prohibition against future bidding with the State, the addition of Contractor to the DHS excluded provider list, etc.

B. The Contractor hereby represents and warrants to the State that there are no proceedings or investigations pending or threatened, before any court, regulatory body, administrative agency, or other governmental instrumentality having jurisdiction over the Contractor or its properties, including but not limited to, the United States Bankruptcy Court as of the date on the Response Signature Page. Additionally, Contractor **shall** provide immediate written notice to the State of any proceeding or investigation (i) seeking to prevent the consummation of any of the transactions contemplated by any resulting Contract; or (ii) seeking any determination or ruling that might materially and adversely affect the performance by the Contractor of its obligations hereunder, or the validity or enforceability of any resulting Contract. The State reserves the right to disqualify Prospective Contractor(s) subject to proceedings or investigations that may materially and adversely affect Contractor's ability to perform its obligations under the contract if it deems it to be in the best interest of the State.

### 4.5 RECORD RETENTION

A. The Contractor **shall** maintain all pertinent financial and accounting records and evidence pertaining to the contract in accordance with generally accepted principles of accounting and as specified by the State of Arkansas Law. Upon request, access **shall** be granted to State or Federal Government entities or any of their duly authorized representatives.

B. Financial and accounting records **shall** be made available, upon request, to the State of Arkansas's designee(s) at any time during the contract period and any extension thereof, and for five (5) years from expiration date and final payment on the contract or extension thereof.

C. Other sections of this *Bid Solicitation* may contain additional Requirements regarding record retention.

### 4.6 PRICE ESCALATION

A. Rates under this contract are governed by the Medicaid approved rates and any increases to Medicaid rates for Arkansas Medicaid enrolled providers. See Ark. Code Ann. §20-76-112 and §20-77-110.

B. Contract price increases may be considered at the time of contract renewal, but any request for an increase in rates must be submitted to DHS six (6) months prior to renewal with accompanying justification. However, DHS must abide by the approval protocols set forth in statutes regarding Medicaid provider rate increases. For contract prices not governed by Medicaid provider rate statutes, the vendor must provide to the Office of Procurement (OP) a written request for the price increase. The request must include supporting documentation demonstrating that the increase in contract price is based on an increase in bid price. DHS shall have the right to require additional information pertaining to the requested increase.

C. Increases shall not be considered to increase profit or margins.

D. DHS shall have the right to approve or deny the request.

**4.7 CONFIDENTIALITY**

A. The Contractor, Contractor's subsidiaries, and Contractor's employees **shall** be bound to all laws and to all Requirements set forth in this *Bid Solicitation* concerning the confidentiality and secure handling of information of which they may become aware of during the course of providing services under a resulting contract.

B. Consistent and/or uncorrected breaches of confidentiality may constitute grounds for cancellation of a resulting contract, and the State **shall** have the right to cancel the contract on these grounds.

C. Previous sections of this *Bid Solicitation* may contain additional confidentiality Requirements.

**4.8 CONTRACT INTERPRETATION**

Should the State and Contractor interpret specifications differently, either party may request clarification. However, if an agreement cannot be reached, the determination of the State **shall** be final and controlling.

**4.9 SEVERABILITY**

If any provision of the contract, including items incorporated by reference, is declared or found to be illegal, unenforceable, or void, then both the agency and the Contractor will be relieved of all obligations arising under such provision. If the remainder of the contract is capable of performance, it **shall not** be affected by such declaration or finding and **must** be fully performed.

**4.10 COMMODITIES (NOTE: NOT APPLICABLE TO SOLICITATIONS STRICTLY FOR SERVICES)**

A. **QUANTITIES**: Quantities stated in a *Bid Solicitation* for term contracts are estimates only, and are not guaranteed. Contractor **must** bid unit price on the estimated quantity and unit of measure specified. The State may order more or less than the estimated quantity on term contracts. Quantities stated on firm contracts are actual Requirements of the ordering agency.

B. **BRAND NAME REFERENCES**: Unless otherwise specified in the *Bid Solicitation*, any catalog brand name or manufacturer reference used in the *Bid Solicitation* is descriptive only, not restrictive, and used to indicate the type and quality desired. Bids on brands of like nature and quality will be considered. If bidding on other than referenced specifications, the bid **must** show the manufacturer, brand or trade name, and other descriptions, and should include the manufacturer's illustrations and complete descriptions of the product offered. The State **shall** have the right to determine whether a substitute offered is equivalent to and meets the standards of the item specified, and the State may require the Contractor to supply additional descriptive material. The Contractor **shall** guarantee that the product offered will meet or exceed specifications identified in this *Bid Solicitation*. Contractors not bidding an alternate to the referenced brand name or manufacturer **shall** be required to furnish the product according to brand names, numbers, etc., as specified in the solicitation.

C. **GUARANTY**: All items bid **shall** be newly manufactured, in first-class condition, latest model and design, including, where applicable, containers suitable for shipment and storage, unless otherwise indicated in the *Bid Solicitation*. The Contractor hereby guarantees that everything furnished hereunder **shall** be free from defects in design, workmanship and material, that if sold by drawing, sample or specification, it **shall** conform thereto and **shall** serve the function for which it was furnished. The Contractor **shall** further guarantee that if the items furnished hereunder are to be installed by the Contractor, such items **shall** function properly when installed. The Contractor **shall** guarantee that all applicable laws have been complied with relating to construction, packaging, labeling and registration. The Contractor's obligations under this paragraph **shall** survive for a period of one year from the date of delivery, unless otherwise specified herein.

D. **SAMPLES**: Samples or demonstrators, when requested, **must** be furnished free of expense to the State. Each sample should be marked with the Contractor's name and address, bid or contract number and item number. If requested, samples that are not destroyed during reasonable examination will be returned at Contractor's expense. After reasonable examination, all demonstrators will be returned at Contractor's expense.

E. **TESTING PROCEDURES FOR SPECIFICATIONS COMPLIANCE**: Tests may be performed on samples or demonstrators submitted with the bid or on samples taken from the regular shipment. In the event products tested fail to meet or exceed all conditions and Requirements of the specifications, the cost of the sample used and the reasonable cost of the testing **shall** be borne by the Contractor.

F. **DELIVERY ON FIRM CONTRACTS**: This solicitation shows the number of days to place a commodity in the ordering agency's designated location under normal conditions. If the Contractor cannot meet the stated delivery, alternate delivery schedules may become a factor in an award. The Office of State Procurement

**shall** have the right to extend delivery if reasons appear valid. If the date is not acceptable, the agency may buy elsewhere, and any additional cost **shall** be borne by the Contractor.

G. **DELIVERY REQUIREMENTS**: No substitutions or cancellations are permitted without written approval of the Office of State Procurement. Delivery **shall** be made during agency work hours only 8:00 a.m. to 4:30 p.m. Central Time, unless prior approval for other delivery has been obtained from the agency. Packing memoranda **shall** be enclosed with each shipment.

H. **STORAGE**: The ordering agency is responsible for storage if the Contractor delivers within the time required and the agency cannot accept delivery.

I. **DEFAULT**: All commodities furnished **shall** be subject to inspection and acceptance of the ordering agency after delivery. Back orders, default in promised delivery, or failure to meet specifications **shall** authorize the Office of State Procurement to cancel this contract or any portion of it and reasonably purchase commodities elsewhere and charge full increase, if any, in cost and handling to the defaulting Contractor. The Contractor **must** give written notice to the Office of State Procurement and ordering agency of the reason and the expected delivery date. Consistent failure to meet delivery without a valid reason may cause removal from the Contractors list or suspension of eligibility for award.

J. **VARIATION IN QUANTITY**: The State assumes no liability for commodities produced, processed or shipped in excess of the amount specified on the agency's purchase order.

K. **AWARD**: Term Contract: A contract award will be issued to the successful Contractor. It results in a binding obligation without further action by either party. This award does not authorize shipment. Shipment is authorized by the receipt of a purchase order from the ordering agency. Firm Contract: A written State purchase order authorizing shipment will be furnished to the successful Contractor.