Managed Care Program Annual Report (MCPAR) for Arkansas: Arkansas Provider Led Shared Savings Entity (PASSE)

Due date	Last edited	Edited by	Status
06/29/2023	07/07/2023	Chawnte Booker	Submitted

	Indicator	Response
	Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected

Point of Contact

Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Arkansas

A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Chawnte Booker
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	chawnte.booker@dhs.arkansas.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Chawnte Booker
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	chawnte.booker@dhs.arkansas.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	07/07/2023

Reporting Period

Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2022
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2022
A6	**Program name**	Arkansas Provider Led Shared Savings Entity (PASSE)

Auto-populated from report dashboard.

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

Find in the Excel Workbook
A_Program_Info

Indicator	Response
Plan name	Arkansas Total Care
	CareSource
	Empower
	Summit

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Find in the Excel Workbook
A_Program_Info

Indicator	Response
BSS entity name	DHS PASSE Beneficiary Support
	PASSE Ombudsman

Topic I. Program Characteristics and Enrollment

Find in the Excel Workbook
B_State

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the total number of individuals enrolled in Medicaid as of the first day of the last month of the reporting year. Include all FFS and managed care enrollees, and count each person only once, regardless of the delivery system(s) in which they are enrolled.	1,149,491
BI.2	**Statewide Medicaid managed care enrollment** Enter the total, unduplicated number of individuals enrolled in any type of Medicaid managed care as of the first day of the last month of the reporting year. Include enrollees in all programs, and count each person only once, even if they are enrolled in more than one managed care program or more than one managed care plan.	1,061,514

Topic III. Encounter Data Report

Find in the Excel Workbook
B_State

Number	Indicator	Response
BIII.1	**Data validation entity** Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness,	EQRO

	and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	

Topic X: Program Integrity

Find in the Excel Workbook
B_State

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities.	OMIG has two FTE conducting routine data analytics that are specific to both services and goods (prescription drugs, DME). These analytic schemes include but are not limited to random queries based on hotline tips, provider and beneficiary complaints, education received from counterparts in other states, and anecdotal information. Data produced from these efforts lead to regular and full audits of providers. In addition, multiple algorithms created in collaboration with Optum run on a regular schedule that produce reliable data for OMIG to use to support audits.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Section 10.5 of the PASSE Agreement

BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	If a Fraud referral from the PASSE generates an investigation, and corresponding legal action results in a monetary recovery to DHS, the reporting PASSE will be entitled to share in such recovery following final resolution (settlement agreement/final court judgment). 10.5.4 In cases involving wasteful or abusive Provider billing or service practices (including overpayments) identified by DHS or OMIG, DHS shall have the right to recover any identified overpayments directly from the Provider or to require the PASSE to recover the identified overpayment and repatriate the funds to the State Medicaid program as directed by DHS.
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	All Fraud, waste, abuse or overpayments due to suspected Fraud must be compiled into a quarterly report to DHS and OMIG, or at the request of DHS or OMIG. Any suspected incidents of Fraud must be reported within fifteen (15) business days of discovery to OMIG. Also, he PASSE meets quarterly with DHS and OMIG to discuss Fraud, waste, abuse, neglect, exploitation, and overpayment issues.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	The PASSEs are responsible for providing care coordination to its beneficiaries/members. These services include but are not limited to: assessment of an eligible individual, development of a specific care plan, referral to services and monitoring activities. Beneficiaries/members should have access to care coordination 24/7. Care coordinators are to reach out to consumers monthly via in person visits or phone calls. Care coordination is reported to DHS quarterly. The PASSEs must meet the metrics of: caseload, initial contact, follow-up care and PCP assignment.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider “for cause” terminations in a	Yes

	timely manner under 42 CFR 438.608(a)(4)? Select one.	
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	Yes
BX.7c	**Changes in provider circumstances: Describe metric** Describe the metric or indicator that the state uses.	The format is free text on an Excel template created by OMIG per the PASSE agreement.
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	Yes
BX.8b	**Federal database checks: Summarize instances of exclusion** Summarize the instances and whether the entity was notified as required in 438.602(d). Report actions taken, such as plan-level sanctions and corrective actions.	N/A
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to	Yes

	§455.104 and required by 42 CFR 438.602(g)(3).	
BX.9b	**Website posting of 5 percent or more ownership control: Link** What is the link to the website? Refer to 42 CFR 602(g)(3).	https://humanservices.arkansas.gov/divisions-shared-services/medical-services/healthcare-programs/passe/passe-contact-us/
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	OMIG has not conducted any audits regarding encounter data.

Topic I: Program Characteristics

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Provider-Led Arkansas Shared Savings Entity (PASSE) Provider Agreement; January 1, 2023 through December 31, 2026
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2023
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://humanservices.arkansas.gov/divisions-shared-services/medical-services/healthcare-programs/passe/for-passe-providers/
C1I.3	**Program type** What is the type of MCPs that contract with the state to	Managed Care Organization (MCO)

	provide the services covered under the program? Select one.	
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Long-term services and supports (LTSS)
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	Yes. Members served via the 1915(i) SPA are limited do not have access to the full slate of 1915 (c) waiver services.
C1I.5	**Program enrollment** Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	1,149,491
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	N/A

Topic III: Encounter Data Report

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data	Rate setting Monitoring and reporting

	collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Program integrity
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Timeliness of data corrections Timeliness of data certifications Use of correct file formats Provider ID field complete Overall data accuracy (as determined through data validation)
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	PA 5.5.6 and PA 8.3
C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	PA EXHIBIT I - Performance Standards
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to	N/A

	managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period.	There were no barriers to collecting or validating PASSE encounter data.

Topic IV. Appeals, State Fair Hearings & Grievances

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	The PASSE and the provider must submit incident reports upon the occurrence of any of the following events: a. Death of a member; *Requires Immediate Reporting within one hour of the PASSE becoming aware of the occurrence b. The use of restrictive interventions; c. Suspected maltreatment or abuse of member; d. Injury to a member that requires emergency room care, or a paramedic; e. Injury to a member that may result in a substantial permanent impairment; *Requires Immediate reporting within one hour of the PASSE becoming aware of the occurrence f. Injury to a member that requires hospitalization; g. Threatening or attempting suicide; h. Arrest; i. Any situation where the member eloped from a service and cannot be located within two (2) hours; j. Any event where a PASSE HCBS provider staff threatens, abuses, or neglects a member; and k. Medication errors that cause serious injury to the member.
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care	An appeal must be heard and notice of appeal resolution sent to the member no later than thirty (30) calendar days from the date of receipt of the Appeal.

	program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	The PASSE must resolve each expedited appeal and provide notice to appellant, as quickly as the member's health condition requires, within PASSE established timeframes not to exceed seventy-two (72) hours after receipt of the Appeal.
C1IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	The grievance investigation process must be completed, and the grievance resolved within thirty (30) days of the date of receipt.The 30-day timeframe may be extended up to fourteen (14) days, if the grievant asks for an extension, or the PASSE documents that additional information is needed to resolve the grievance, the information cannot be obtained within the 30-day timeframe, and it is in the member's best interest to extend the timeframe.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	ARTC moderate challenges: 90% of urban members with access to Community Support System Provider; 91.7% urban members and 86.7% rural members with access to Plastic Surgery; 90.7% urban members with access to Rheumatology; 90.7% of urban members with access to Vascular Surgery. Empower moderate

		challenges: 93.4% urban members with access to Outpatient Hospital. Summit moderate challenges: 94.3% of urban members with access to Outpatient Dialysis; 91.9% urban members and 90.8% rural members with access to Plastic Surgery.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	In the case of deficiences, plans and the State cooperate in identifying providers who could address the gaps, and the State may request a Corrective Action Plan when improvement is lacking. The State evaluates network adequacy every 6 months to check plan progress at rectifying gaps in coverage. However, in this submission, variance requests were granted for all gaps after review of member distribution within the plans and provider availability within the state. Even though these variance requests were granted, in part due to a pending adjustment in the way the State assessed the availability of providers to close reported gaps, plans were requested from the MCOs in order to confirm their approach to improving their coverage in the most affected specialties. These plans were reviewed and approved by the State following their request in the normal network feedback.

Topic V. Availability, Accessibility and Network Adequacy

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Find in the Excel Workbook
C2_Program_State

Access measure total count: 3

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

1 / 3

C2.V.2 Measure standard

Distance in miles from member to provider, ratio of members to providers. For certain services, the established standard is an attestation of the plan's ability to provide service in all counties. Appointment availability is also assessed.

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
All provider types, except those listed in measure 3.	Urban, Rurual and all counties	Adult, pediatric and MLTSS

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Every 6 months, with submission in January and July.

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

2 / 3

C2.V.2 Measure standard

Ratio of providers to enrollees

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
All provider types, except those listed in measure 3.	Urban, Rurual and all counties	Adult, pediatric and MLTSS

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

every 6 months, with submissions in January and July

Complete

C2.V.1 General category: Exception to quantitative standard 3 / 3

C2.V.2 Measure standard

N/A

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ADDT; DME; Environemtal Modifications/Adaptive Equipment; Home Healt; Hyperalimentation; ICF; Personal Care; Specialized Medical Supplies; Supported Employment; Supportive Living/Respite/Supplemental Support and Ventilator Equipment)	Urban, Rural and all counties	Adult, pediatric, MLTSS

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

every 6 months, with submissions in January and July

Topic IX: Beneficiary Support System (BSS)

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS	https://humanservices.arkansas.gov/divisions-shared-services/medical-services/healthcare-programs/passe/passe-beneficiary-support/

	through electronic means. Separate entries with commas.	
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	"1. Call: 1.844.843.7351 Individuals who have a hearing or speech impairment can contact our office by calling toll free, 1.888.987.1200 option 2. 2. Online: Submit issues or complaints by emailing PASSEOmbudsmanOffice@dhs.arkansas.gov 3. Mail: Division of Medical Services Office of Ombudsman P.O. Box 1437 Slot S-418 Little Rock, AR 72203-1437 4. Fax: 501.404.4625"
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	BSS entities include the state's contracted vendor AFMC and the Beneficiary Support Unit / PASSE Ombudsman housed inside division. The Beneficiary Support/PASSE Ombudsman unit identifies any issues and the PASSE Compliance Unit investigates these and works on remediation and resolution of issues with the managed care organizations.
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	The state evaluates AFMC performance through weekly and monthly reports.

Topic X: Program Integrity

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Topic I. Program Characteristics & Enrollment

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1I.1	**Plan enrollment** What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	**Arkansas Total Care** 16495 **CareSource** 2472 **Empower** 20278 **Summit** 17569
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Arkansas Total Care** 1.4% **CareSource** 0.2% **Empower** 1.8% **Summit** 1.5%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1)	**Arkansas Total Care** 1.6% **CareSource** 0.2%

	• Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Empower** 1.9% **Summit** 1.7%

Topic II. Financial Performance

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR.	**Arkansas Total Care** 90.6% **CareSource** 96% **Empower** 89.6% **Summit** 94.7%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Arkansas Total Care** Statewide all programs & populations **CareSource** Statewide all programs & populations **Empower** Statewide all programs & populations **Summit** Statewide all programs & populations

Number	Indicator	Response
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**Arkansas Total Care** N/A **CareSource** Yes, BH-95%, IIDD-108%, IIDD_Waitlist-89% **Empower** N/A **Summit** N/A
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Arkansas Total Care** No **CareSource** No **Empower** No **Summit** No

Topic III. Encounter Data

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of	**Arkansas Total Care** The PASSE must submit encounter claims monthly following the date on which the PASSE adjudicated the claims. **CareSource**

	encounter within this program, please explain.	The PASSE must submit encounter claims monthly following the date on which the PASSE adjudicated the claims. **Empower** The PASSE must submit encounter claims monthly following the date on which the PASSE adjudicated the claims. **Summit** The PASSE must submit encounter claims monthly following the date on which the PASSE adjudicated the claims.
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.	**Arkansas Total Care** 0% **CareSource** 0% **Empower** 0% **Summit** 0%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period.	**Arkansas Total Care** 0% **CareSource** 0% **Empower** 0% **Summit** 0%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved as of the first day of the last month of the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Arkansas Total Care** 417 **CareSource** 12 **Empower** 91 **Summit** 250
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Arkansas Total Care** 0 **CareSource** 1 **Empower** 0 **Summit** 2
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable.	**Arkansas Total Care** 30 **CareSource**

	An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	13 **Empower** 0 **Summit** 31
D1IV.4	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”. Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”. The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal	**Arkansas Total Care** 89 **CareSource** 0 **Empower** 0 **Summit** 0

	preceded the filing of the critical incident.	
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Arkansas Total Care** 367 **CareSource** 9 **Empower** 13 **Summit** 233
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Arkansas Total Care** 43 **CareSource** 3 **Empower** 0 **Summit** 16
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Arkansas Total Care** 417 **CareSource** 11 **Empower** 17 **Summit** 250

D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**Arkansas Total Care** 0 **CareSource** 1 **Empower** 0 **Summit** 0
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Arkansas Total Care** 0 **CareSource** 0 **Empower** 0 **Summit** 0
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**Arkansas Total Care** 0 **CareSource** 0 **Empower** 0 **Summit** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response**	**Arkansas Total Care**

	to an appeal or grievance Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	0 **CareSource** 0 **Empower** 0 **Summit** 0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**Arkansas Total Care** 0 **CareSource** 0 **Empower** 0 **Summit** 0
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Arkansas Total Care** 0 **CareSource** 0 **Empower** 0 **Summit** 0

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**Arkansas Total Care** 13 **CareSource** 0 **Empower** 0 **Summit** 30
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Arkansas Total Care** 73 **CareSource** 4 **Empower** 12 **Summit** 12
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient	**Arkansas Total Care** 123 **CareSource**

	mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	5 **Empower** 2 **Summit** 57
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**Arkansas Total Care** 111 **CareSource** 0 **Empower** 3 **Summit** 32
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**Arkansas Total Care** 58 **CareSource** 3 **Empower** 0 **Summit** 0
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does	**Arkansas Total Care** 0 **CareSource** 0

not cover skilled nursing services, enter "N/A".

Empower

0

Summit

0

D1IV.7g

Resolved appeals related to long-term services and supports (LTSS)

Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".

Arkansas Total Care

31

CareSource

1

Empower

0

Summit

30

D1IV.7h

Resolved appeals related to dental services

Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".

Arkansas Total Care

0

CareSource

0

Empower

0

Summit

0

D1IV.7i

Resolved appeals related to non-emergency medical transportation (NEMT)

Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".

Arkansas Total Care

0

CareSource

0

Empower

		0 **Summit** 0
D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i, enter "N/A".	**Arkansas Total Care** 10 **CareSource** 0 **Empower** 0 **Summit** 65

Topic IV. Appeals, State Fair Hearings & Grievances

State Fair Hearings

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	**Arkansas Total Care** 70 **CareSource** 1 **Empower** 19 **Summit** 16

D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Arkansas Total Care** 38 **CareSource** 0 **Empower** 2 **Summit** 2
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Arkansas Total Care** 16 **CareSource** 0 **Empower** 5 **Summit** 4
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) prior to reaching a decision.	**Arkansas Total Care** 11 **CareSource** 0 **Empower** 7 **Summit** 10
D1IV.9a	**External Medical Reviews resulting in a favorable**	**Arkansas Total Care**

	decision for the enrollee If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	2 **CareSource** N/A **Empower** 0 **Summit** 0
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Arkansas Total Care** 8 **CareSource** N/A **Empower** 0 **Summit** 0

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances Overview

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Arkansas Total Care** 15 **CareSource** 22

		Empower 97 **Summit** 62
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Arkansas Total Care** 0 **CareSource** 1 **Empower** 7 **Summit** 62
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**Arkansas Total Care** 1 **CareSource** 23 **Empower** 0 **Summit** 8
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who	**Arkansas Total Care** 2 **CareSource** 0 **Empower**

	previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	0 **Summit** 0
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(1) for requirements related to the	**Arkansas Total Care** 15 **CareSource** 22 **Empower**

	timely resolution of grievances.	94 **Summit** 62

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Arkansas Total Care** 0 **CareSource** 0 **Empower** 7 **Summit** 3
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does	**Arkansas Total Care** 10 **CareSource** 4 **Empower** 67 **Summit**

not cover this type of service, enter "N/A".

15

D1IV.15c

Resolved grievances related to inpatient behavioral health services

Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".

Arkansas Total Care

0

CareSource

1

Empower

8

Summit

3

D1IV.15d

Resolved grievances related to outpatient behavioral health services

Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".

Arkansas Total Care

0

CareSource

3

Empower

9

Summit

2

D1IV.15e

Resolved grievances related to coverage of outpatient prescription drugs

Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".

Arkansas Total Care

0

CareSource

5

Empower

9

Summit

12

D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Arkansas Total Care** 0 **CareSource** 0 **Empower** 0 **Summit** 3
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**Arkansas Total Care** 0 **CareSource** 0 **Empower** 0 **Summit** 3
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**Arkansas Total Care** 0 **CareSource** 0 **Empower** 1 **Summit** 0
D1IV.15i	**Resolved grievances related to non-emergency medical**	**Arkansas Total Care**

	transportation (NEMT) Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	0 **CareSource** 0 **Empower** 1 **Summit** 0
D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".	**Arkansas Total Care** 2 **CareSource** 9 **Empower** 80 **Summit** 21

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service**	**Arkansas Total Care** 3 **CareSource**

	Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	3 **Empower** 0 **Summit** 4
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Arkansas Total Care** 3 **CareSource** 3 **Empower** 0 **Summit** 0
D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Arkansas Total Care** 3 **CareSource** 6 **Empower** 3 **Summit** 46
D1IV.16d	**Resolved grievances related to quality of care**	**Arkansas Total Care**

	Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	1 **CareSource** 0 **Empower** 13 **Summit** 0
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Arkansas Total Care** 1 **CareSource** 0 **Empower** 0 **Summit** 0
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.	**Arkansas Total Care** 4 **CareSource** 4 **Empower** 70 **Summit** 10
D1IV.16g	**Resolved grievances related to suspected fraud**	**Arkansas Total Care** 0

	Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**CareSource** 0 **Empower** 0 **Summit** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Arkansas Total Care** 0 **CareSource** 0 **Empower** 2 **Summit** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**Arkansas Total Care** 0 **CareSource** 0 **Empower** 0 **Summit** 0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal**	**Arkansas Total Care**

	Enter the total number of grievances resolved during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	0 **CareSource** 0 **Empower** 0 **Summit** 0
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.	**Arkansas Total Care** 1 **CareSource** 6 **Empower** 9 **Summit** 2

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Find in the Excel Workbook
D2_Plan_Measures

Quality & performance measure total count: 1

Complete

D2.VII.1 Measure Name: N/A

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Arkansas Total Care

N/A

CareSource

N/A

Empower

N/A

Summit

N/A

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Find in the Excel Workbook
D3_Plan_Sanctions

Sanction total count: 2

Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 2

D3.VIII.2 Intervention topic
Performance improvement

D3.VIII.3 Plan name
Arkansas Total Care

D3.VIII.4 Reason for intervention

Failure to comply with quarterly care coordination member face-to-face contact metric.

Sanction details

D3.VIII.5 Instances of non-compliance
Q2, Q3, Q4 of 2021

D3.VIII.6 Sanction amount
$ 1,000

D3.VIII.7 Date assessed
06/09/2022

D3.VIII.8 Remediation date non-compliance was corrected
Remediation in progress

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

2 / 2

D3.VIII.2 Intervention topic
Performance improvement

D3.VIII.3 Plan name
Empower

D3.VIII.4 Reason for intervention

Failure to comply with quarterly care coordination member face-to-face contact metric.

Sanction details

D3.VIII.5 Instances of non-compliance
Q2, Q3, Q4 of 2021

D3.VIII.6 Sanction amount
$ 1,0000

D3.VIII.7 Date assessed

05/13/2022

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Topic X. Program Integrity

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Arkansas Total Care** 4 **CareSource** 22 **Empower** 1 **Summit** 2.5
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations have been opened by the plan in the past year?	**Arkansas Total Care** 50 **CareSource** 2 **Empower** 74 **Summit** 27

D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	**Arkansas Total Care** 3:19 **CareSource** 1:978472222 **Empower** 3:16 **Summit** 1:54
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations have been resolved by the plan in the past year?	**Arkansas Total Care** 13 **CareSource** 2 **Empower** 24 **Summit** 3
D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	**Arkansas Total Care** 0:856 **CareSource** 1:978,472,222 **Empower** 1:18 **Summit** 0:17
D1X.6	**Referral path for program integrity referrals to the**	**Arkansas Total Care**

	state What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	Makes referrals to the Medicaid Fraud Control Unit (MFCU) only **CareSource** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Empower** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Summit** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made.	**Arkansas Total Care** 5 **CareSource** Not applicable **Empower** Not applicable **Summit** Not applicable
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals	**Arkansas Total Care** Not applicable **CareSource** 0 **Empower** 5 **Summit** 0

D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.1) as the denominator.	**Arkansas Total Care** 0:302 **CareSource** 0:0 **Empower** 0:25 **Summit** 0:0
D1X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, for example, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 438.8(f)(2).	**Arkansas Total Care** The 2022 annual overpayment report was submitted on February 28, 2023. $312,105 were reported on the report as overpayments, which equates to 0.068% of premium revenue. **CareSource** 0 **Empower** SIU currently completes the quarterly PASSE 25 report which includes OP information. CY 2022; $1,237,498. **Summit** Total Overpayments recovered in CY2022= $1,145,512.79. Ratio: 0.2%
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Arkansas Total Care** Monthly **CareSource** Monthly **Empower** Monthly

		Summit Monthly

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Find in the Excel Workbook
E_BSS_Entities

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**DHS PASSE Beneficiary Support** State Government Entity **PASSE Ombudsman** State Government Entity
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**DHS PASSE Beneficiary Support** LTSS Complaint Access Point LTSS Grievance/Appeals Education LTSS Grievance/Appeals Assistance **PASSE Ombudsman** LTSS Complaint Access Point LTSS Grievance/Appeals Education LTSS Grievance/Appeals Assistance