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MEMORANDUM

TO: Interested Persons and Providers

FROM: Elizabeth Pitman, Director, Division of Medical Services

DATE: July 15, 2024

SUBJ: Notice of DMS Managed Care Quality Strategy

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

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

If you have any comments, please submit those comments in writing, no later than August 14, 2024.

NOTICE OF DMS MANAGED CARE QUALITY STRATEGY

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

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

The DMS Managed Care Quality Strategy is available for review at the Department of Human Services (DHS) Office of Policy and Rules, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download this notice and the full QS at ar.gov/dhs-proposed-rules. Public comments can be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than August 14, 2024. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you need this material in a different format, such as large print, contact the Office of Policy and Rules at 501-320-6428. The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed, and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color, or national origin.

Elizabeth Pitman, Director
Division of Medical Services

ARKANSAS DIVISION OF MEDICAL SERVICES
MANAGED CARE QUALITY STRATEGY 2024

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1. INTRODUCTION

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

1.1 Purpose and Scope

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

Arkansas Department of Human Services

VISION
Arkansas citizens are healthy, safe, and enjoy a high quality of life.

MISSION
Together we improve the quality of life of all Arkansans by protecting the vulnerable, fostering independence, and promoting better health.

This Quality Strategy is specifically focused on members of the PASSE program and sets a three-year vision for DMS to accomplish its quality goals and objectives. This Quality Strategy is intended to evolve over time. As of November 2024, Arkansas has moved from a dental managed care model to a fee for service dental model. Dental care is therefore no longer included in the scope of Arkansas's Quality Strategy for managed care organizations.

There are no officially recognized Tribes in Arkansas, so this group is not included in the scope of this document.

1.2 Mission of the Department of Human Services

The Mission of the Arkansas Department of Human Services (DHS) is to "improve the quality of life of all Arkansans by protecting the vulnerable, fostering independence, and promoting better healthcare."

The PASSE program employs a person-centered approach to coordinated care and outreach that aligns with the mission and belief of DHS that each person should be at the center of his or her health care.

1.3 Overview of Arkansas Managed Care Programs

PASSE History

The PASSE program is an innovative approach to organizing and managing the delivery of services for Medicaid clients with high functional needs due to a behavioral health or

IIDD diagnosis. The PASSE was created in the 2017 Arkansas General Session and codified as Ark. Code Ann. § 20-77-2701 et seq. Under this model of organized care, the PASSEs are responsible for integrating the physical health services, behavioral health services, and specialized developmental disabilities services for approximately 40,000 individuals who have intensive levels of treatment or care needs due to mental illness, substance abuse, or intellectual or developmental disability.

The PASSE program was implemented in two phases. Phase I, which began on February 1, 2018, was known as the "Arkansas Provider-led Care Coordination Program." In Phase I, Medicaid clients who were identified as receiving high levels of services due to a mental illness, substance abuse, or intellectual or developmental disability were attributed to a PASSE based on provider relationships. The PASSE began providing care coordination to that member, while all other services continued to be paid on a fee-for-service basis. The purpose of Phase I was to allow the PASSEs time to build their infrastructure and become more familiar with the population they serve and their unique needs.

Pursuant to 42 C.F.R. § 438.66(d), DHS conducted an on-site readiness review of potential entities in 2018. Each entity also submitted desk review items to DHS. After a desk review and onsite review, all entities passed the readiness reviews and were provided feedback, including necessary updates before full program go-live (i.e., Phase II).

In Phase II, which began on March 1, 2019, under concurrent 1915(b)/(c) Waiver and 1915(i) State Plan Amendment authorities, the PASSEs provide all services to members under a "full-risk" Managed Care Organization (MCO) model. The PASSEs continue to provide care coordination to assigned clients and assume responsibility for the development of members' Person-Centered Service Plans (PCSPs) and delivery of all services. At the start of the Phase II PASSE go-live, there were three PASSEs that entered into the PASSE Provider Agreement to provide care coordination, home and community-based services, and other medically necessary state plan services and Nonmedical Community Supports and Services (NCSS) to enrolled members. As of 2022, there are now four PASSEs providing services to members.

1.3.1 The Provider-led Arkansas Shared Savings Entities (PASSE)

Purpose and Scope

The purpose of the Arkansas PASSE program, pursuant to Title XIX of the Social Security Act (The Act) and Arkansas Act 775 of 2015, is to organize and manage the delivery of services for certain Medicaid clients who have complex behavioral health, intellectual and developmental disabilities service needs.

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

- Improve the experience of health care, including without limitation quality of care, access to care, and reliability of care, for enrolled members;

- Enhance the performance of the broader health care system leading to improved overall population health;
- Slow or reverse spending growth for the enrollable population and for covered services while maintaining quality of and access to care;
- Further the objectives of Arkansas payment reforms and the state's ongoing commitment to innovation;
- Discourage excessive use of services;
- Reduce waste, fraud, and abuse;
- Encourage the most efficient use of taxpayer funds; and
- Operate under federal guidelines for patient rights.

The State defines disability status in the context of the PASSE program through an independent assessment process initiated by provider referral. The PASSEs are responsible for the provision of comprehensive medically necessary and Nonmedical Community Supports and Services (NCSS) to the following groups as defined in Table 1:

- Clients who have a behavioral health diagnosis and received the independent assessment for behavioral health services and placed in Tier 2 or 3.
- Clients who have a developmental disability diagnosis and received the independent assessment for developmental disabilities services and placed in Tier 2 or 3, in the following categories:
    - Community and Employment Supports (CES) Waiver under 1915(c);
    - Waitlist for the CES Waiver; or
    - Residents of Private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Table 1. Division of Behavioral Health and Developmental Disabilities Tier Definitions

Tier	Division of Behavioral Health Definition	Division of Developmental Disabilities Definition	Enrollment Status
1 or Not Enrolled	Counseling Level Services At this level, the score reflects that is that the individual can continue professional Counseling and Medication Management services but is not eligible for the additional array of services available in Tier 2 or Tier 3.	Community Clinic Level of Care At this level of need, the individual receives services in a day habilitation setting, i.e., an Early Intervention Day Treatment (EIDT) or Adult Development Day Treatment (ADDT).	Not Enrolled
2	Rehabilitative Level Services At this level of need, the score reflects difficulties with certain behaviors allowing eligibility for	Institutional Level of Care This level of need means that the client scored high enough in certain areas to be eligible for	Mandatory Enrollment

Tier	Division of Behavioral Health Definition	Division of Developmental Disabilities Definition	Enrollment Status
	an array of services to help the client function in home and community settings and move towards recovery.	paid services and supports.	
3	Intensive Level Services At this level of need, the score reflects difficulties with certain behaviors allowing eligibility for a full array of services including twenty-four hours a day, seven days a week residential services, to help the client move towards reintegrating back into the community.	Institutional Level of Care This level means that the client scored high enough in certain areas to be eligible for the most intensive level of services, including twenty-four hours a day, seven days a week paid supports and services.	
4	Tier IV is the designation for individuals already attributed to a PASSE with complex care needs due to mental illness or an Intellectual/ Developmental Disability who also have exhibited behaviors that cause a threat to community safety and have a history of with multi-system involvement. Eligibility for this level is determined by DHS.		

Individuals eligible for Medicaid in Arkansas as a Medically Frail individual under the Arkansas Health and Opportunity for Me (ARHOME) Section 1115 Demonstration Waiver are eligible for a PASSE. Individuals who receive services in a publicly owned Human Development Center (other than respite), in a skilled nursing facility (other than short-term rehabilitation), in an assisted living facility, through a home and community-based services waiver for adults with physical disabilities, or as a part of Program of All-Inclusive Care for the Elderly (PACE), Independent Choices, or the Arkansas Autism Waiver are excluded from enrollment in a PASSE, even if their diagnosis meets the needs criteria.

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

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

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

- All Case Management activities pursuant to Ark. Code Ann. § 20-77-2703(3) and 42 C.F.R. § 440.169, including but not limited to:
    1. Facilitating assessment of the member;
    2. Development of a PCSP;

3. Referral to services; and
4. Monitoring activities;

- Ensuring shared decision-making with the member and caregiver/family/ representative of the availability of services that are responsive to the member's needs regarding service delivery, personal goals, and preferences; and
- Integrated care services that support the member to remain in the least restrictive setting possible and access HCBS benefits to prioritize the member's choice of living in their own home or choosing an Alternative HCBS Setting rather than residing in an institution.

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

- Every enrolled member is receiving care coordination services;
- Every member has a PCSP, and it is being met;
- There is an organized formal network of providers to meet the enrolled member's needs;
- Information can be easily shared among health care providers, care coordinators, and family members to facilitate the enrolled member's PCSP;
- Every enrolled member receives all medically necessary and NCSS services; and
- Data is accurately reported to measure performance of each PASSE and hold them accountable to meeting the above goals.

The PASSE program evaluates progress in these goals in part through tracking of Adult and Child Core Set measures, delineated in Appendix 3, Table 1.

1.4 Quality Strategy Development and Public Input

DMS along with a core team of DHS employees from the Division of Adult, Aging, and Behavioral Health Services (DAABHS), came together to write the initial draft of the Quality Strategy. The goal of this Strategy is to lay out the goals and objectives of the PASSE program and a strategy for meeting those goals. After this group finalized an initial draft, it was sent through the internal DHS approval process.

The Quality Strategy will be put out for public comment from July 15, 2024, to August 14, 2024. To ensure the public is aware of the written quality strategy, DHS will place an advertisement in the Arkansas Democrat-Gazette, a paper with statewide circulation, as well as post the document on the DHS webpage. Links will be placed on the DHS Facebook page. It will also be sent to the major provider organizations, family and client organizations, and each PASSE. Comments will be summarized and responded to in Appendix 4 of this document.

DHS will consider future revisions to this quality strategy on a biannual basis and in the event of a significant program change. A significant change is an alteration of the demographics or participants in the program which results in a distinct shift in the service

and care requirements for beneficiaries, including but not limited to the addition of a covered population with different service needs, removal of a covered population, change in payment structures, and other changes at the discretion of DHS.

2. QUALITY IMPROVEMENTS & INTERVENTIONS

2.1 Areas of Focus

This document is the written quality strategy for assessing and improving the quality of health care and services furnished by the PASSEs in accordance with 42 C.F.R. § 438.340. With the purpose of the program in mind, Arkansas chose to focus its efforts in five key areas:

1) Access to services (i.e., network and access standards);
2) Person-centered care, care coordination, and outreach;
3) Quality of care metrics and encounter data;
4) Transitions of care; and
5) Program effectiveness and compliance.

Each of the goals and their respective objectives are designed to further one of these areas, with emphasis on the needs of the populations outlined in Section 1.3.1.

2.2 Goals and Objectives, 42 C.F.R. § 438.340(b)(2)

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

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

Goal 1: Deliver person-centered care by considering patient preferences, leveraging care coordination best practices, and conducting patient outreach whenever possible and appropriate.

		PASSE
Objective	1.1	Provide well-qualified and trained care coordinators.
	1.2	Establish a care coordination protocol that focuses on member and caregiver engagement in PCSP development guided by care coordination professionals.
	1.3	Improve PCSP development for enrolled members.
Activities		• Monitor compliance with PASSE Agreement requirements regarding training and development of the PCSP; and • Develop PCSPs in accordance with 42 C.F.R. § 441.540 including appropriately developing treatment goals and objectives and incorporating functional needs assessment findings for the member in their PCSP.
Measures		• Case manager caseloads; • Case manager training rates; • Initial contact with client; • LTSS Comprehensive Assessment and Update (CAU); and • Monthly contact with client.

Goal 2: Deliver services in a safe and appropriate care setting while promoting preventative services.

		PASSE
Objective	2.1	Improve access to appropriate care through utilization of the Arkansas Medicaid network, including but not limited to primary care, medical, behavioral health, and IDD services.
	2.2	Improve development of innovative and value-added service models that cross service divisions.
	2.3	Ensure safety by monitoring compliance with incident and accident reporting requirements.
	2.4	
Activities		• Recruit providers; • Client and provider education and engagement; • Monitor compliance with PASSE Agreement requirements regarding provider network requirements; and • Conduct network adequacy analysis.
Measures		• See Appendix 3, Table 1 for a full list of PASSE Quality Measures.

Goal 3: Promote a health care delivery system that meets expectations and needs to improve member autonomy.

		PASSE
Objective	3.1	Improve member satisfaction with the PASSE.
	3.2	Develop and implement a method and system for tracking social determinants of health (SDoH) needs and referrals.

	PASSE
Activities	• Client surveys; • Monitor service utilization; and • Monitor SDoH referrals.
Measures	• Health Plan CAHPS Survey; and • Qualitative update regarding systems development to collect HCBS CAHPS data and the HEDIS Social Need Screening and Intervention (SNS-E) Measure.

Goal 4: Advance managed care models in the State by establishing and improving the continuous quality improvement cycle.

		PASSE
Objective	**4.1**	Monitor implementation of performance improvement projects and corrective action plans (if applicable) by the PASSEs.
	4.2	Monitor the impact and encourage the use of value-added services offered to enrolled members.
	4.3	Develop quality-based payment programs.
Activities		• Monitor performance improvement projects; and • Monitor impact of quality-based payment programs and value-added services.

	PASSE
Measures	• Measures will vary based on activity and performance improvement project.

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

2.3 Quality Metrics and Performance Targets, 42 C.F.R. § 438.340(b)(3)(i)

Arkansas's quality goals will be supported by key activities and performance metrics based on a combination of requirements applied to participating managed care organizations as well as the data comprising the Adult and Child Core Set Measures. A detailed list of quality metrics, performance, and performance targets during this quality strategy performance period can be found in Appendix 3.

2.4 Quality Management Assurance and Structure

2.4.1 PASSE

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

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

Activity	PASSE Provider Agreement (PA) Reference
Developing and reporting on a Cultural Competency Plan (CCP), including providing CAHPS Survey results	§ 4.8
Establishing and maintaining a grievance and complaint process	§ 4
Ensuring care coordinators monitor services provided in accordance with the Conflict-free Case Management rules from CMS	§ 5.2.7
Establishing a Credential Review Committee	§ 6.2.15
Developing a Quality Assurance and Performance Improvement Plan (QAPI)	§ 8.1
Submitting required reports to DHS, including reports on quality metrics	§ 8.3 & 8.7

Activity	PASSE Provider Agreement (PA) Reference
Establishing a Consumer Advisory Council (CAC)	§ 8.6
Creating a Fraud and Abuse Protection Program (FAPP) that includes a compliance plan, a named compliance officer, and a Regulatory Compliance Committee	§ 10.2

DHS, through the Division of Medical Services (DMS), the Division of Developmental Disabilities Services (DDS), the Division of Adult, Aging and Behavioral Health Services (DAABHS), and the Division of Provider Services and Quality Assurance (DPSQA), will ensure the integrity of the entire PASSE program through monitoring and oversight activities including but not limited to:

- Monitoring contract compliance;
- Critical incident monitoring;
- Auditing Person Centered Service Plans (PCSP);
- Housing the Ombudsman Office;
- Enforcing PASSE Provider Agreement sanctions; and
- Conducting monitoring and oversight activities required of various program authorities including 1915(b), 1915(c), and 1915(i) waivers.

2.5 Performance Improvement Projects and Interventions

Performance Improvement Projects (PIPs) and Interventions are required for PASSEs in Arkansas. The PASSE must adhere to all PIP requirements as laid out in Section 8.1.3 of the PASSE Provider Agreement. Arkansas's MCOs are required to develop new clinical and nonclinical PIPs each year. The current state of MCO PIPs can be found in the most recent EQRO Technical Report, available at https://humanservices.arkansas.gov/divisions-shared-services/medical-services/reports-publications/ .

2.5.1 PASSE

Section 8.1.3 of the PASSE Provider Agreement requires the PASSE to design and implement Performance Improvement Projects (PIPs) that will increase the quality of services and access to services. The 2023 PASSE Agreement includes requirements for PASSEs to implement a nonclinical PIP to increase access to home and community-based services (see § 8.1.4 of the PASSE Agreement) and encourage PASSEs to use the PIP process to develop incentive payments to providers (See § 8.1.5 of the PASSE Agreement). For additional PIPs, including the clinical PIP, the PASSE must provide a PIP design that includes information on how the PASSE will collect and submit performance measurement data, a plan for detecting the underutilization and overutilization of services, and a plan on how the PASSE will assess the quality and appropriateness of care for members with special health needs or those using LTSS. PIPs should include a focus on both clinical and nonclinical metrics. If DHS does

not provide specific PIP activities, the PASSE must submit their proposed PIPs to DHS for approval before implementation (PASSE 1915(b) Waiver Section B, Part II(m)).

A contracted External Quality Review Organization (EQRO) will analyze and validate the data relied upon in the PIPs in year one of their contract. In each subsequent year, the EQRO will be responsible for reviewing the outcome data submitted by the PASSEs for completed PIP projects.

2.6 Quality Assessment and Performance Improvement (QAPI)

To summarize and demonstrate how the managed care entities will establish and implement quality-related efforts, DMS requires PASSEs to develop Quality Assessment and Performance Improvement Strategic Plans.

As summarized in § 8.1.2 of the PASSE Agreement and 42 C.F.R. § 438.330, each of the PASSEs operating in the State of Arkansas are required to develop strategic plans that:

a. Improve the coordination of care with state agencies and non-medical service providers who also serve them;
b. Improve training of care coordinators;
c. Improve internal coordination between care coordination and utilization management;
d. Expand access by recruiting and enrolling more providers that specialize in providing in-home services;
e. Expand quality and access through value-based payment models;
f. Reduce institutional lengths of stay by treating preventable ambulatory sensitive conditions through community providers; and
g. Increase members' access to appropriate services for the following urgent needs populations.

2.7 Corrective Action Plans and Sanctions

Section 270 of the PASSE Provider Manual, Section 14 of the PASSE Provider Agreement provides for the imposition of sanctions in accordance with 42 C.F.R. Part 438, Subpart I for failure to comply with any provision of applicable law, Medicaid manuals, waivers, or the Provider Agreement. A list of all available sanctions can be found in both the PASSE Provider Manual and the Agreements for each program; however, DHS can impose a variety of sanctions ranging from the imposition of a corrective action plan to termination of the Agreement, including monetary penalties. The goal of implementing sanctions is to protect enrolled members and bring the PASSEs into compliance with the requirements of the program.

2.8 Identifying Persons with Long-Term Care or Special Health Care Needs

Individuals enter the PASSE after they are identified through an independent functional assessment that also considers diagnoses; therefore, individuals entering the PASSE

have been identified to be eligible to receive LTSS services. The need for LTSS services is identified for each PASSE beneficiary during the development and updating of their PCSP, a process involving care coordinators, key providers, and the beneficiary and their family and supports.

2.9 Health Disparities

In accordance with 42 CFR § 438.206(c)(2), each PASSE must have a written Cultural Competency Plan (CCP) to ensure that services and settings are provided in a culturally competent manner to all members and including those with limited English proficiency. The CCP is submitted to DHS annually for review and approval and must address the following:

- A demographic description of the PASSE's members, including age, race, ethnicity, and sex;
- How the PASSE, PASSE employees, providers and systems will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms, and respects the worth of the Members and protects and preserves the dignity of each; and

Information demonstrating a direct link between the CCP and the annual evaluation that includes an analysis of the successes and challenges of meeting the previous year's goals and objectives.

Currently all four PASSEs use the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care in the development of their CCPs, which provides for definition and measurement of demographic and health inequity concerns.

Additional to the requirements of the CCP, PASSEs are obligated to make available the information in all member-facing documentation in the primary language of each beneficiary, and to maintain interpreter services for care coordination and call center activities.

2.10 Website

In April 2024, DHS published the annual EQRO Technical Report reflecting PASSE performance on key quality metrics. The report can be found on the DHS website as required under 42 C.F.R. § 438.10(c)(3) on the list of DHS publications available at https://humanservices.arkansas.gov/wp-content/uploads/2024_DHS_AR_EQRO_Technical_Report_PASSE_Final-1.pdf .

3. STANDARDS

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

3.1 PASSE

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

1) The PASSE 1915(b) Waiver (CMS approved April 2022);
2) The Community and Employment Supports (CES) 1915(c) Waiver; and
3) The Arkansas Community Integration 1915(i) State Plan Amendment (CMS approved March 2024).

All three of these authorities were approved by CMS in December 2018, prior to implementation of the PASSE model and have incorporated revisions since implementation to refine the program and align with updated requirements and policy. Most recent CMS approval dates are indicated in the list above.

Each standard described below moves us toward reaching the goals and objectives lined out in this Quality Strategy.

3.1.1 Network and Access Standards

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

The PASSE is responsible for monitoring the adequacy of its network by monitoring the ability of participating providers to furnish all services required by members. DHS must approve the PASSE's monitoring strategy. Additionally, the PASSE must submit bi-annual and annual reports on network adequacy metrics for review by DHS. As an added safeguard, the PA states that if a PASSE's provider network is not able to provide all necessary medical services to an enrolled member, the PASSE must adequately and timely cover the services out of network. DHS reviews the PASSE's submissions and corresponds with the organization to resolve gaps and develop strategies to address service shortages.

Additionally, as added safeguards for network adequacy, DHS utilizes geographic mapping of each PASSE's provider network to ensure that the PASSE is meeting the

network adequacy and access standards. See PASSE 1915(b) Waiver section B, Part II(g) Geographic Mapping. The EQRO validates the measures and processes used by both the PASSEs and DHS to ensure network adequacy and access standards are being met.

3.1.2 Clinical Practice Guidelines

As stated in § 9.11 of the PASSE Agreement, PASSEs must adopt practice guidelines that:

1. Are based on reliable clinical evidence or a consensus of providers in the particular field;
2. Consider the needs of the PASSE's members;
3. Are adopted in consultation with network providers; and
4. Are reviewed and updated periodically as appropriate.

Examples of previously used clinical practice guidelines include:

- Milliman Care Guidelines for inpatient levels of care, behavioral outpatient, and home and community based services (See https://provider.summitcommunitycare.com/arkansas-provider/medical-policies-and-clinical-guidelines); and
- HEDIS measurements for quality measures (See https://guidelines.carelonmedicalbenefitsmanagement.com/).

Each PASSE, as specified in the contract, is required to develop, or adopt and disseminate practice guidelines for physical and behavioral health services that are based on valid and reliable clinical evidence. For additional information on each PASSE clinical practice guidelines, please see the following websites:

Arkansas Total Care:

Practice Guidelines (arkansastotalcare.com)

CareSource:

https://www.caresource.com/ar/providers/education/patient-care/health-care-links/caresource-passe/

https://www.caresource.com/ar/providers/tools-resources/health-partner-policies/caresource-passe/

Empower Health Solutions:

Clinical-Practice-Guidelines-11-10-20.pdf (getempowerhealth.com)

Summit Community Care:

https://provider.summitcommunitycare.com/arkansas-provider/medical-policies-and-clinical-guidelines

https://guidelines.carelonmedicalbenefitsmanagement.com/

https://provider.summitcommunitycare.com/docs/gpp/AR_CAID_2023MayCUMG.pdf?v=202312221830

3.1.3 Person-Centered Care and Care Coordination

Additionally, states that have employed care coordination models have demonstrated savings through lower rates of emergency department visits, hospital admissions for ambulatory sensitive conditions, and hospital readmissions. The research shows that care coordination can have positive impacts on health, particularly for individuals with specialized service needs, such as individuals with Serious Mental Illness (SMI) and individuals with intellectual or developmental disability (IDD), or those individuals who are dually diagnosed with both SMI and IDD. For these reasons, care coordination lies at the heart of the PASSE model.

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

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

To ensure access to care coordination, each enrolled member must have an assigned care coordinator who meets with them at least monthly (this can be by phone or in-person). Each PASSE must also provide access twenty-four hours a day, seven days a week to care coordination services through a hotline or web-based application.

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

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

To ensure all the member's identified needs are met, the PCSP must address any needs identified in the following:

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

DHS has oversight of care coordination and the PCSP development process, which is also evaluated by the EQRO. Per the CES 1915(c) Waiver, 1915(i) State Plan Amendment and the PASSE Agreement, DHS conducts random samplings of each PASSE care coordinator's caseload each year. Samples are pulled in accordance with CMS's recommended sample guide, *A Practical Guide for Quality Management in Home and Community-Based Waiver Programs.* The sample size is based on a 95% confidence interval with a margin of error of +/- 8%. Each PCSP in the sample is reviewed by the EQRO. In addition, DDS conducts a review of a separate sample based on a 95% confidence interval with a margin of error of +/- 5%, which is then reviewed and validated by the EQRO. These samples are used to ensure that each member has a PCSP that meets their identified needs and that services are being provided in accordance with that PCSP (See PASSE Agreement §§ 5.3.10—5.3.11).

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

3.1.4 Quality Metrics and Encounter Data

Each PASSE must report on and meet the quality metrics outlined in the PASSE Agreement § 8.3. The quality metric grids can be found in Appendix 3.

The quality metrics reported include but are not limited to quality-of-care coordination measures provided by the PASSE, the Healthcare Effectiveness Data and Information Set (HEDIS) measures for behavioral health services, and the National Core Indicators (NCI) survey for Developmental Disabilities providers. The PASSEs report on most of these metrics quarterly, and they are validated and reviewed by the EQRO.

The PASSEs are also required to collect and provide encounter data on a monthly basis for all services provided to enrolled members, including in lieu of services. The encounter

data must be both complete and accurate, as defined by the Provider Agreement. Complete means that no less than 95% of encounters for covered services provided by participating and non-participating providers are submitted. Accurate means that no less than 95% of the PASSE's encounter submissions pass the Medicaid Management Information System (MMIS) edits (See PASSE Agreement § 8.4.11). EQRO must review and validate the encounter data submitted by the PASSEs to ensure it meets the quality requirements set out in the PASSE Provider Manual and the PASSE Agreement. Part of this review is to ensure that the encounter data is a complete and accurate representation of the services provided to enrollees under the PASSE Provider Agreement.

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

3.1.5 Transitions of Care, 42 C.F.R. § 438.340(b)(5)

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

- The change occurs during the open enrollment period; or
- There is cause for transition, as described in 42 C.F.R. § 438.56.

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

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

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

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

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

- Ensures that it does not in any way restrict the member's right to voluntarily transition to a different PASSE;
- Requires the PASSE to provide timely notification to the receiving PASSE on the special needs of the transitioning member, and ensure timely receipt of medical records, PCSP, treatment plans, and care coordination files;
- When receiving a transitioning member, provides care coordination so that services are not interrupted, and provides required information on participating Network providers, assignment of a care coordinator, and all other new member information, in accordance with § 3.6.5 of the Provider Agreement;
- During transition, coordinates services (including those services on the PCSP) with the receiving or relinquishing PASSE to ensure smooth transition and continuity of care for 90 days or until the transition is completed, whichever is longer; and
- Is consistent with federal requirements outlined in 42 C.F.R. § 438.62.

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

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

3.1.6 Program Effectiveness and Compliance

Arkansas contracts with QSource to conduct an external quality review of the PASSE program. Upon reviewing the assessment results of the initial years of PASSE implementation, DHS chose to incorporate program effectiveness and compliance into the overall focus areas of this Quality Strategy. In addition to the transition, access, and quality of care standards summarized above, DHS includes compliance standards, and related sanctions (See § 14 of the PASSE Agreements) if necessary, throughout the PASSE Agreement, as well as ongoing opportunities for PASSEs to expand their impact including new exploration of value-add services and quality-based programs.

4 ASSESSMENT

4.1 DHS Role

DHS through DMS is the regulatory body and assesses the PASSE program through the monthly, quarterly, bi-annual, and annual reporting required by the EQRO Technical Report and Provider Agreement. Metrics reviewed, include, but are not limited to the following:

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

4.2 External Quality Review, 42 C.F.R. §§ 438.340(b)(4) and 438.340(b)(10)

The Balanced Budget Act of 1997 requires states to contract with an annual independent External Quality Review Organization (EQRO) to review of quality outcomes, timeliness of services, and access to services provided by Medicaid Managed Care Organizations and Prepaid Ambulatory Health Plans. DMS contracts with QSource to conduct ongoing evaluations of the PASSE program. The goal is to review and validate whether each PASSE is compliant with federal and state requirements. These activities are performed consistently to ensure compliance with Medicaid provisions under Subpart E of 42 C.F.R. § 438.340 and CMS protocols. The findings provided by the EQRO provide a basis for DMS actions toward the PASSEs regarding compliance remediation or quality improvement. The most recent EQRO report can be found in the list of DHS publications available at https://humanservices.arkansas.gov/divisions-shared-services/medical-services/reports-publications/.

DHS does not currently utilize the nonduplication of effort flexibilities offered in 42 C.F.R. § 438.340(b)(9). Accreditation is not required for PASSEs at this time and the EQRO is asked to conduct all activities.

4.3 Office of Medicaid Inspector General and Attorney General

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

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

5 CONCLUSIONS

5.1 Review of Quality Strategy

As previously stated, this Quality Strategy is intended to evolve over time. While it outlines a three-year approach, DMS continues to be innovative in our methods to provide clients with needed services. This strategy was updated in 2023 and released for public comment and CMS feedback in 2024. DMS will review the effectiveness of its quality strategy no less than once every three years.

5.2 Next Steps

As new data, information, and reviews become available DMS intends to expand and revise the Quality Strategy. DMS anticipates additional EQRO reports and information and has updates to the 2023 PASSE and Healthy Smiles agreements that will support the State's manage care model as it matures in the coming years.

APPENDIX 1 – GLOSSARY OF TERMS

Arkansas Department of Human Services (DHS): The Arkansas Department of Human Services (DHS) is the designated single state agency with responsibilities to administer the Medicaid program, including overseeing the PASSE and Healthy Smiles programs.

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

Care Coordination: Care Coordination is a critical component of implementing a PASSE members PCSP. Activities involve a collaborative patient-centered engagement of the individual and their caregiver in service referral, follow up, and service navigation. The care coordination process includes assessing, collaborating on care planning, treatment plan follow-through, service coordination, monitoring the patient's adherence, and regularly updating necessary care and service. These activities focus on ensuring that the individual's healthcare and support service needs are met through effective provider and patient communication, information sharing, follow up, care transitions, and assurance of timely access to care that promotes quality, cost-effective outcomes. Requirements of care coordination are outlined in § 5.2.

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

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

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

Enrolled member: A Medicaid client assigned to a PASSE.

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

Medical necessity: All Medicaid benefits are based upon medical necessity. A service is "medically necessary" if it is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap or cause physical deformity or malfunction and if there is no other equally effective (although more conservative or less costly) course of treatment available or suitable for the beneficiary requesting the service. For this purpose, a "course of treatment" may include mere observation or (where appropriate) no treatment at all. Coverage may be denied if a service is not medically necessary in accordance with the preceding criteria or is

generally regarded by the medical profession as experimental, inappropriate, or ineffective, unless objective clinical evidence demonstrates circumstances making the service necessary.

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

Nonmedical Community Supports and Services (NCSS): These supports and services are nonmedical in nature and are available under the federal authority of sections 1905, 1915(c), or 1915(i) or under state authority under Arkansas Act 775 of 2015 to provide such supports and services through an Arkansas Medicaid-enrolled provider as approved by a PASSE for an individual. NCSS are provided with the intention to prevent or delay entry into an institutional setting or to assist or prepare an individual to leave an institutional setting, meaning the service should assist the individual to live safely and successfully in his or her own home or in the community. The need for these supports and services is established by the functional deficits identified on the Independent Assessment (IA). The IA is an objective assessment that identifies that the need for services exists. However, the types and levels of supports and services needed to achieve his or her goals are beyond the scope of the IA and instead are developed by the PCSP process and ultimately described in the PCSP. The actual supports and services for each member are described in the member's PCSP which must be reviewed by the care coordinator and the member not less than monthly. To ensure the integrity of the PCSP, prior authorization and utilization review procedures should use criteria which would allow appropriately enrolled providers to perform nonmedical services and supports. The PASSE must ensure there are appropriate firewalls between the PASSE and providers and between internal staff and processes used to ensure services and supports are approved or denied in a conflict-free manner. The "independent review" requirement of 1915(i) also means there should be internal firewalls within the PASSE to separate the development of the PCSP from staff with fiscal duties or utilization review.

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

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

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

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

Provider-Led Arkansas Shared Savings Entity (PASSE): A Risk Based Provider Organization (RBPO) in Arkansas that has enrolled in Medicaid and meets the following requirements:

1. Is at least 51% owned by PASSE Equity Partners; and
2. Has the following Members or Owners:
    a. An Arkansas-licensed or certified direct service provider of Developmental Disabilities (DD) services;
    b. An Arkansas-licensed or certified direct service provider of Behavioral Health (BH) services;
    c. An Arkansas-licensed hospital or hospital services organizations;
    d. An Arkansas-licensed physician's practice; and
    e. A pharmacist who is licensed by the Arkansas State Board of Pharmacy.

Among other things, each PASSE must be licensed by AID, enrolled as a Medicaid provider, and entered into an annual PASSE agreement with DHS.

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

APPENDIX 2 – QUALITY STRATEGY AND CFR REQUIREMENTS CROSSWALK

According to 42 C.F.R. § 438.340(a), "each State contracting with an MCO, PIHP, or PAHP as defined in 42 C.F.R. § 438.2 or with a PCCM entity as described in 42 C.F.R. § 438.310(c)(2) must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by the MCO, PIHP, PAHP or PCCM entity."[1] Table X includes the elements required in a State Managed Care quality strategy.

Table X. Quality Strategy and Managed Care CFR Requirements Crosswalk

CFR Reference	CFR Requirement	Quality Strategy Section
42 C.F.R. §438.340(b)(1)	"State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 C.F.R. § 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with 42 C.F.R. § 438.236."	Section 3.1.1 *Network and Access Standards* and 3.1.2 *Clinical Practice Guidelines*
42 C.F.R. §438.340(b)(2)	"The State's goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, PAHP, and PCCM entity described in 42 C.F.R. § 438.310(c)(2)."	Section 2.2 *Goals and Objectives*
42 C.F.R. §438.340(b)(3)(i)	The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, and PCCM entity described in 42 C.F.R. § 438.310(c)(2) with which the State contracts, including but not limited to, the performance measures reported in accordance with 42 C.F.R. § 438.330(c). The State must identify which quality measures and performance outcomes the State will publish at least annually on the website required under 42 C.F.R. § 438.10(c)(3)"	Appendix 3 *Quality Strategy Measures and Performance Targets*
42 C.F.R. §438.340(b)(3)(ii)	"The performance improvement projects to be implemented in accordance with 42 C.F.R. § 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP"	Section 2.5 *Performance Improvement Projects and Interventions*
42 C.F.R. §438.340(b)(4)	"Arrangements for annual, external independent reviews, in accordance with 42 C.F.R. § 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each MCO, PIHP, PAHP, and PCCM entity (described in 42 C.F.R. § 438.310(c)(2)) contract."	Section 4.2 *External Quality Review 42 C.F.R. §438.340(b)(4) and 42 C.F.R. §438.340(b)(10)*
42 C.F.R. §438.340(b)(5)	"A description of the State's transition of care policy required under 42 C.F.R. § 438.62(b)(3)."	Section 3.1.5 *Transitions of Care*

[1] https://www.law.cornell.edu/cfr/text/42/438.340

		42 C.F.R. §438.340(b)(5)
42 C.F.R. §438.340(b)(6)	"The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. For purposes of this paragraph (b)(6), "disability status" means, at a minimum, whether the individual qualified for Medicaid on the basis of a disability. States must include in this plan the State's definition of disability status and how the State will make the determination that a Medicaid enrollee meets the standard including the data source(s) that the State will use to identify disability status."	Section 2.9 *Health Disparities*
42 C.F.R. §438.340(b)(7)	"For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part."	Section 2.7 *Corrective Action Plans and Sanctions*
42 C.F.R. §438.340(b)(8)	"The mechanisms implemented by the State to comply with 42 C.F.R. § 438.208(c)(1) (relating to the identification of persons who need long-term services and supports or persons with special health care needs)."	Section 3.1.3 *Person-Centered Care and Care Coordination* and Section 2.8 *Identifying Persons with Long-Term Care Needs*
42 C.F.R. §438.340(b)(9)	"The information required under 42 C.F.R. § 438.360(c) (relating to nonduplication of EQR activities)."	Section 4.2 *External Quality Review, 42 C.F.R. §§ 438.340(b)(4) and 438.340(b)(10)*
42 C.F.R. §438.340(b)(10)	"The State's definition of a "significant change" for the purposes of paragraph (c)(3)(ii) of this section. Quality strategy must be updated whenever significant changes occur within the Medicaid program."	Section 1.4 *Quality Strategy Development and Public Input*
42 C.F.R. §438.340 (c)(1)(i)	"The State must make the strategy available for public comment before submitting the strategy to CMS for review, including obtaining input from the Medical Care Advisory Committee, beneficiaries, and other stakeholders."	Section. 1.4 *Quality Strategy Development and Public Input*
42 C.F.R. §438.340 (c)(1)(ii)	"If the State enrolls Indians in the MCO, PIHP, PAHP, or PCCM entity described in § 438.310(c)(2), consulting with Tribes in accordance with the State's Tribal consultation policy."	Section 1.1 *Purpose and Scope*
42 C.F.R. §438.340 (c)(2)	"Review and update the quality strategy as needed, but no less than once every 3 years."	Section 5.1 *Review of Quality Strategy*

APPENDIX 3 – QUALITY STRATEGY MEASURES AND PERFORMANCE TARGETS

Table 1. PASSE Quality Measure Matrix

Measure	Measure Type	Source	Baseline (Measure Year 2024)				Performance Target
			ARTC	Empower	Summit	Care Source	
Goal 1: Deliver person-centered care by considering patient preferences, leveraging care coordination best practices, and conducting patient outreach whenever possible and appropriate.							
Objective 1.1: Provide well-qualified and trained care coordinators							
Care Coordinator Caseloads	Compliance	PASSE	74.3%	98%	97.6%	N/A	90% or greater
Care Coordinator Training Rates	Compliance	PASSE	N/A	N/A	N/A	N/A	Measurement Year
Objective 1.2: Establish a care coordination protocol that focuses on member and caregiver engagement in PCSP development guided by care coordination professionals.							
Initial Contact with Client	Process	EQRO	68.9%	80.9%	91%	N/A	75% or greater
Objective 1.3: Improve PCSP development for enrolled members.							
LTSS Comprehensive Assessment and Update	Outcome (HEDIS - CAU)	PASSE	N/A	N/A	N/A	N/A	Measurement Year
Monthly Contact with Client	Process	EQRO	83.1%	86.6%	87.7%	N/A	75% or greater
Goal 2: Deliver services in a safe and appropriate care setting while promoting preventative services.							
Objective 2.1: Improve access to appropriate care through network adequacy including but not limited to primary care, medical, behavioral and IDD services.							
Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)[2]	Adult Core Set	PASSE	5.88%	8.11%	5.00%	11.63%	Measurement Year

[22] Baseline drawn from HEDIS metric {Follow up after Intensive Care Substance Use Disorder-7 Days {18-64}

Measure	Measure Type	Source	Baseline (Measure Year 2024)				Performance Target
			ARTC	Empower	Summit	Care Source	
Medical Assistance with Smoking and Tabacco Use Cessation (MSC-AD)	Adult Core Set	PASSE	N/A	N/A	N/A	N/A	Measurement Year
Antidepressant Medication Management (AMM-AD)[3]	Adult Core Set	PASSE	32.21%	29.66%	32.09%	NA	Measurement Year
Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD)	Adult Core Set	PASSE	N/A	N/A	N/A	N/A	Measurement Year
Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)[4]	Adult Core Set	PASSE	30.31%	23.97%	29.07%	11.63%	Measurement Year
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)[5]	Adult Core Set	PASSE	86.60%	59.84%	50.88%	N/A	Measurement Year
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c	Adult Core Set	PASSE	N/A	N/A	N/A	N/A	Measurement Year

[3] Baseline drawn from Hedis metric [Antidepressant Medication Management-Effective Continuation Phase Treatment]

[4] Baseline drawn from Hedis metric [Follow-Up After Hospitalization for Mental Illness-7days (18-64)]

[5] Baseline drawn from Hedis metric [Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are using Antipsychotic Medications]

Measure	Measure Type	Source	Baseline (Measure Year 2024)				Performance Target
			ARTC	Empower	Summit	Care Source	
(HbA1c) Poor Control (>9.0%) (HPCMI-AD)							
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	Adult Core Set	PASSE	N/A	N/A	N/A	N/A	Measurement Year
Follow-up After Emergency Department Visit for Substance Use: Age 18 and Older (FUA-AD)	Adult Core Set	PASSE	N/A	N/A	N/A	N/A	Measurement Year
Follow-up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)[6]	Adult Core Set	PASSE	37.07%	23.97%	29.07%	11.63%	Measurement Year
Weight Assessment Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)[7]	Child Core Set	PASSE	100%	82.97%	100%	78.68%	Measurement Year
Child Immunization Status (CIS-CH)	Child Core Set	PASSE	N/A	N/A	N/A	N/A	Measurement Year
Well-Child Visits in the First 30 Months of Life (W30-CH)	Child Core Set	PASSE	N/A	N/A	N/A	N/A	Measurement Year

[6] Baseline drawn from Hedis metric [Follow-up After Emergency Department Visit for Mental Illness 18 and older]

[7] Baseline drawn from Hedis metric [Weight Assessment Counseling for Nutrition and Physical Activity for Children/Adolescents 3-11 ages and 12-17 ages]

Measure	Measure Type	Source	Baseline (Measure Year 2024)				Performance Target
			ARTC	Empower	Summit	Care Source	
Immunizations for Adolescents (IMA-CH)[8]	Child Core Set	PASSE	90.75	49.39%	85.89%	N/A	Measurement Year
Developmental Screening in the First Three Years of Life (DEV-CH)	Child Core Set	PASSE	N/A	N/A	N/A	N/A	Measurement Year
Child and Adolescent Well-Care Visits[9]	Child Core Set	PASSE	47.27%	11.12%	45.25%	37.67%	Measurement Year
Follow-up Care for Children Prescribed Attention-deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)[10]	Child Core Set	PASSE	100%	72.60%	83.88%	N/A	Measurement Year
Screening for Depression and Follow-up Plan: Ages 12 to 17 (CDF-CH)	Child Core Set	PASSE	N/A	N/A	N/A	N/A	Measurement Year
Follow-up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)[11]	Child Core Set	PASSE	60.26%	42.50%	57.21%	17.09%	Measurement Year
Metabolic Monitoring for Children and Adolescents on	Child Core Set	PASSE	49.96%	50.95%	53.40%	N/A	Measurement Year

[8] Baseline drawn from HEDIS metric [Immunizations for Adolescents-Combination 1

[9] Baseline drawn from HEDIS metric [Child and Adolescent Well-Care-Visits 3-21ages (Total)

[10] Baseline drawn from HEDIS metric [Follow-Up Care for Children Prescribed ADHD Medication-Initiation, Continuation, and Maintenance Phase.]

[11] Baseline drawn from HEDIS metric [Follow-Up After Hospitalization for Mental Illness 7 days 6-17 ages]

Measure	Measure Type	Source	Baseline (Measure Year 2024)				Performance Target
			ARTC	Empower	Summit	Care Source	
Antipsychotics (APM-CH)[12]							
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)[13]	Child Core Set	PASSE	89.25%	78.38%	78.20%	N/A	Measurement Year
Follow-up After Emergency Department Visit for Substance Use: Ages 13 to 17 (FUA-CH)	Child Core Set	PASSE	N/A	N/A	N/A	N/A	Measurement Year
Follow-up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)[14]	Child Core Set	PASSE	60.26%	47.83%	57.21%	N/A	Measurement Year
Objective 2.2: Improve development of innovative and value-added service models that cross service divisions.							
Various measures and qualitative update.	N/A	PASSE	N/A	N/A	N/A	N/A	N/A
Objective 2.3: Ensure safety by monitoring compliance with incident and accident reporting requirements.							
Percentage of PASSE Care Coordinators and HCBS Providers who reported critical incidents to DMS or DDS within required timeframes.	Compliance	DMS	57.3%	60.5%	69.1%	N/A	Measurement Year

[12] Baseline drawn from HEDIS metric {Metabolic Monitoring for Children and Adolescents on Adolescents on Antipsychotics-Blood Glucose and Cholesterol Testing Total ages 1-11 and ages 12-17.]

[13] Baseline drawn from HEDIS metric [Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics Total ages 1-11 and ages 12-17 ages.]

[14] Baseline drawn from HEDIS metric [Follow-up After Emergency Department Visit for Substance Use 7 days ages 6 to17]

Measure	Measure Type	Source	Baseline (Measure Year 2024)				Performance Target
			ARTC	Empower	Summit	Care Source	
Percentage of PASSE Care Coordinators and HCBS Providers who took required corrective actions regarding critical incidents to protect the health and welfare of the member.	Compliance	PASSE	65.8%	61.1%	60.5%	N/A	Measurement Year
Goal 3: Promote a health care delivery system that meets expectations and needs to improve members autonomy							
Objective 3.1: Improve member satisfaction with the PASSE.							
Health Plan CAHPS Survey	Outcome (CAHPS Survey)	PASSE	N/A	N/A	N/A	N/A	Measurement Year
Objective 3.2: Develop and implement a method and system for tracking social determinants of health (SDoH) needs and referrals							
Qualitative update regarding systems development to collect HCBS CAHPS data and the HEDIS Social Need Screening and Intervention (SNS-E) Measure	N/A	PASSE	N/A	N/A	N/A	N/A	Measurement Year
Goal 4: Advance managed care models in the State by establishing and improving the continuous quality improvement cycle.							
Objective 4.1 Monitor implementation of performance improvement projects and corrective action plans (if applicable) by the PASSEs.							
Various measures and qualitative update. Assess performance improvement project results and collaborative quality initiatives.	N/A	PASSE	N/A	N/A	N/A	N/A	Measurement Year
Objective 4.2: Monitor the impact and encourage the use of value-added services offered to enrolled members							

Measure	Measure Type	Source	Baseline (Measure Year 2024)				Performance Target
			ARTC	Empower	Summit	Care Source	
Various measures and qualitative update.	N/A	PASSE	N/A	N/A	N/A	N/A	Measurement Year
Objective 4.3: Develop quality-based payment programs.							
Various measures and qualitative update. Assess provider incentive payments project results and collaborative quality initiatives.	N/A	PASSE	N/A	N/A	N/A	N/A	Measurement Year

APPENDIX 4 – COMMENTS AND RESPONSES

TBD – To be added after public release.

APPENDIX 5 – USEFUL LINKS

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

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

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

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

2022 EQRO Annual Technical Report: https://humanservices.arkansas.gov/wp-content/uploads/2023_DHS_AR_EQRO_Technical_Report_Final.pdf

DHS List of Online Publications: Reports & Publications - Arkansas Department of Human Services