EXHIBIT L

DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

SUBJECT: Adverse Decisions (20 CAR pts. 570, 600, 642)

DESCRIPTION:

Statement of Necessity
This rule results from changes in the Medicaid Fairness Act, Arkansas Code § 20-77-1701 et seq., as amended by Acts 515 and 635 of 2025 of, and to comply with Act 772 of 2025. Act 515 extends the provider appeal period in the Arkansas Medicaid Program, and institutes new requirements regarding adverse decisions and the basis for them. Act 635 modifies the definition of adverse decision and provides for administrative reconsideration. This rule implements the requirements of both Acts by revising the Arkansas Medicaid General Policy Provider Manual (General Policy), the Provider-Led Arkansas Shared Savings Entity (PASSE) Program Provider Manual, and by requesting an amendment to the Arkansas Medicaid State Plan (state plan). Act 772 prohibits coverage of certain human organ transplants or post-transplant care by the Arkansas Medicaid program and Arkansas Health and Opportunity for Me program. Additional updates are made to align a statutory definition and to update references and terminology.

Summary
This rule amends the manuals and state plan to reflect changes in the Medicaid Fairness Act made during the 2025 session of the General Assembly. This rule implements the new time limits allowed for reconsiderations and appeals in the General Policy manual and the state plan. It adds a new section to the General Policy manual to describe how a managed care organization must develop a grievance and appeals process, and how a member of a managed care organization can utilize the grievance and appeals process and request a fair hearing. It revises the PASSE manual to align the definition of Risk Based Provider Organization with Arkansas Code § 20-77-2703 and references the new section being added to the General Policy manual. Section I of the Medical General Policy Manual is updated to comply with new requirements regarding human organ transplants. Numerous grammatical, punctuation, and stylistic changes were made to both manuals to improve language, consistency, and references. Similar language and punctuation updates were made to the state plan. The specific substantive changes are detailed below.

Medicaid General Policy Provider Manual
Section 100.100: Removed language regarding a 30-day time limit for requesting administrative reconsideration or appeals for providers or beneficiaries. Added a description of the Managed Care due process subsection.

Section 106.000: The Arkansas Medicaid Program will comply with Ark. Code Ann. § 23-79-169 in providing coverage for human organ transplants.

Section 110.700: Changed time allowed from thirty-five (35) days to sixty-five (65) days for a provider to request administrative reconsideration or appeal.

Section 161.200: Changed the time limit for requesting an administrative reconsideration from thirty (30) days to sixty-five (65) days.

Section 161.300: Changed the time limit for administrative appeals from thirty (30) to sixty-five (65) days.

Section 161.400: Changed the time limit for sanction appeals from thirty (30) to sixty-five (65) days.

Section 162.000: Corrected the name of the Office of Appeals and Hearings to refer to the Office of Medicaid Provider Appeals of the Department of Health. Removed reference to DHS Policy 1098.

Section 169.100: Removed outdated language.

Section 190.001: Edited citation to Medicaid Fairness Act to cite to the entire subchapter.

Section 190.002: Edited definition of "adverse decision or adverse action".

Section 190.003: Edits to clean up language, style, and punctuation only.

Section 191.001: Edited definition of "adverse decision or adverse action" to more closely mirror 42 CFR 431.201, which applies to beneficiaries.

Sections 191.002, 191.003, 191.004, 191.005: Edits to clean up language, style, and punctuation, including updating the citation to the Arkansas Administrative Procedure Act.

Section 192.000 (192.001–192.010): This new section describes how a managed care organization must develop a grievance and appeals process and how a member of a managed care organization can utilize the grievance and appeals process and request a state fair hearing.

Provider-Led Arkansas Shared Savings Entity (PASSE) Program Provider Manual
Section 200.000: Changed Adverse Decision/Adverse Action to Adverse Benefit Determination to mirror federal managed care rules. Changed the definition of Risk Based Provider Organization to align with the definition in Arkansas Code § 20-77-2703.

Section 247.200: Removed language regarding appeals processes and replaced with a reference to the new Section 192.000 in the Medicaid General Policy Provider Manual.

Arkansas Medicaid State Plan: Amendment needed to change the time limit for administrative appeals from thirty calendar days to sixty-five (65) calendar days.

PUBLIC COMMENT: A public hearing was held on this rule on March 25, 2026. The public comment period expired on April 12, 2026. The agency provided the following public comment summary:

Commenter's Name: Derek Henderson
COMMENT: On March 12, 2026, the Department released proposed rule changes for public comment. References to the proposed rules will cite to the actual page number in the PDF document where the content is found.

1. Page 5: It is laudable that the Department seeks to define and describe managed care due process as a unique process that implicates beneficiaries' due process rights. The process is markedly different than other adjudicative functions the Department handles because the first instance of appeal involves a private company operating as a state actor.
RESPONSE: This process is taken directly from 42 C.F.R. Part 438, Subpart F, Grievance and Appeal System. These rules apply to PASSEs as managed care organizations and is the process required by the PASSE Agreements executed between each PASSE and DHS.

2. Pages 8, 9, 11: There are two separate definitions of "adverse decision or adverse action." Both definitions reference both providers and beneficiaries, so there is no apparent reason to separate these definitions. **RESPONSE:** Two separate definitions are included because state and federal statutes use different terminology. The Arkansas Medicaid Fairness Act defines the term "adverse decision" at Ark. Code Ann. § 20-77-1702(2). Federal law defines "action" at 42 C.F.R. § 431.201. Arkansas Medicaid providers must comply with both state and federal law and both definitions are included in this manual.

3. Page 14: Adding "failure to provide services in a timely manner" to the explicit definition of PASSE adverse benefit determination is an important safeguard for beneficiaries' rights. Whether it is explicitly stated or not, timely provision of services is required by 42 U.S.C. § 1396a's "reasonable promptness" provision, and it is also supported by care coordination regulations that require "delivery" of "appropriate" services. Even so, beneficiaries, PASSEs, and providers all benefit from having a provision in state regulations to firmly codify timeliness requirements.
RESPONSE: This phrase is included in the definition of "adverse benefit determination" found in Section 192.002. This is taken directly from the definition of "adverse benefit determination" that is found in 42 C.F.R. § 438.400(b).

4. Page 16: The proposed rules would require PASSEs to process expedited requests for prior authorization within 72 hours. This may be in direct violation of the Prior Authorization Transparency Act (PATA). Ark. Code Ann. § 20-99-1101 et seq. The PASSE Contract requires PASSEs to comply with the PATA, and this rule potentially supplants that. The PATA requires nonurgent requests to be processed within 2 business days and urgent requests within 1 business day. The 72 hour requirement could be added as a maximum that can never be exceeded due to weekends or holidays, but it cannot be the standard by itself without violating existing laws and contract provisions.

RESPONSE: DHS agrees with the comment; the language of Section 192.003(C) has been amended in response to this comment.

5. Page 17: Federal regulations require an appeal to be in writing unless it is an expedited appeal. An oral request for appeal can always be made and then followed by a written confirmation, but an oral request alone for non-expedited appeals may fail to meet federal requirements for the managed care appeal system. I appreciate any effort to make appeals more accessible, but this may present a compliance issue for the state. I absolutely support any requirement for PASSEs to assist members with memorializing an appeal in writing. **RESPONSE:** This is incorrect. 42 C.F.R. § 438.402(c)(3) allows a managed care enrollee to file both a grievance and an appeal either orally or in writing.

6. Page 18: The proposal would require the representative of a deceased PASSE member's estate to be party to an appeal. I am very concerned this may allow PASSEs to assert failure to exhaust administrative remedies as a defense to tort cases. If that is not the intent, the rule should clarify the circumstances to which it is referring.
RESPONSE: 42 CFR § 438.406(b)(6) provides that parties to the appeal include (i) the enrollee and his or her representative; or (ii) the legal representative of a deceased enrollee's estate. This is also consistent with Ark. Code Ann. § 16-62-101(a)(1) which states that action may be brought by the person injured or, after his or her death, by his or her executor or administrator against the wrongdoer. The deceased beneficiary's estate would be the necessary legal entity / party to the action in accordance with the state law and federal regulation.

7. Pages 19-20: I strongly object to the intervention process as described. The proposed process allows the Department complete discretion to enter a case and purports to give the Department immunity from judicial review when they do not choose to intervene. To start, the Department should never intervene to oppose the position of a beneficiary without legal counsel unless the Department also proposes to provide counsel for the beneficiary free of charge. This should apply at administrative hearings and judicial reviews. Without such a safeguard, the Department is proposing a process that is patently unfair to beneficiaries and potentially violates due process. Second, the Department cannot change or limit how the Administrative Procedure Act defines "agency." If a beneficiary can make a good faith claim that both the Department and a PASSE are agencies under that definition and have harmed the beneficiary through their actions, the Department cannot simply grant itself immunity from suit through regulatory means.
RESPONSE: Pursuant to 42 CFR § 438.408(f)(3), the parties to the State fair hearing include the MCO, PIHP, or PAHP (PASSE) as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate. The agency (Department) is not included as required party under the relevant federal regulations. If there is adverse action by the Department, a beneficiary's appeal rights and the procedures for such appeals are elsewhere defined in the relevant rules and regulations. However, where the Department has taken no action and is not involved as a party at the State fair hearing, it would not be a necessary party in Judicial Review proceedings under the APA; the Department Office of Appeals and Hearings would be the underlying quasi-judicial body and would have possession of the administrative record, but would not

respond to any Judicial Review proceedings other than to file the record as required. If the Department felt some need to intervene as the State Medicaid agency to address what it believes to be a broader Medicaid policy issue, it will do so. Again, this language in no way impacts a beneficiary's appeal rights when the Department has taken some action that the beneficiary believes to be adverse; those appeals rights are simply defined elsewhere --these provisions specifically relate to the PASSE grievance and appeal processes.

Commenter's Name: David Ivers, VP of External Affairs & General Counsel Easterseals Ark
COMMENT: Easterseals Arkansas appreciates the work that has gone into drafting new rules to implement Act 515 and Act 635 of 2025. We submit the following comments on the promulgation rule issued March 12, 2026, "Adverse Decisions."

1. Section 161.400 Sanction Appeals. This section should reference the ability to file an appeal not only after an adverse decision but also after a previous administrative reconsideration. To be consistent with 161.300, this would mean adding: "sixty-five (65) calendar days of receiving an administrative reconsideration decision that upholds all or part of any adverse decision or action, whichever is later." **RESPONSE:** DHS agrees. In response to this comment, and in compliance with Act 515 of 2025, Section 161.400 has been amended.

2. Section 190.002 [Corrective Action Plans]. Act 635 requires "imposition of corrective action plans" be added to the list of items that can constitute "adverse decisions." As it is written here, it is a subpart of gain sharing, risk sharing, etc. This does not appear to meet the intent of the Act. Corrective Action Plans appear in many other contexts as well. **RESPONSE:** DHS agrees; there appears to be a formatting error for the list under this definition. What is currently (2) should be subpart (j) and (2)(a) should be subpart (k). This will be corrected in the final rule and parts (3) and (4) will be renumbered accordingly.

3. PART 192 [PASSEs]. As it is written, this section only addresses beneficiary appeals under federal rules. This section should also reference the fact that the PASSEs are subject to the Medicaid Fairness Act with regard to providers. See, e.g.:

> *Medicaid Fairness Act, 20-77-1702*
>
> (2)(A) "Adverse decision" means any decision by the Department of Human Services or its reviewers or contractors that adversely affects a Medicaid provider or recipient in regard to...
>
> (7) "Department" means:
> (A) The Department of Human Services;
> (B) All the divisions and programs of the department, including the Arkansas Medicaid Program; and

(C) All the department's contractors, fiscal agents, and other designees and agents;

(11) "Medicaid" means the medical assistance program under Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., and Title XXI of the Social Security Act, 42 U.S.C. §1397aa et seq., that is operated by the department, including contractors, fiscal agents, and all other designees and agents;

RESPONSE: DHS will amend Section 192.001 to clarify that section applies to beneficiary appeals to managed care organizations (MCOs) and the role of MCOs in provider appeals. Providers are enrolled directly with MCOs and governed by provider agreements with the MCOs. The MCOs must comply with all applicable federal and state laws, as well as any agreements with the state, such as a PASSE agreement.

4. Publication of protocols. Where are the proposed rules related to Act 515, Section 5, Publication of protocols, procedures, and requirements? Will this be in a separate rule?
RESPONSE: DHS does not intend to publish a rule related to that portion of Act 515. That portion of the Act compels action by DHS and its contractors, not Arkansas Medicaid providers. Because it is a clear requirement by the legislature, DHS does not need to interpret the statute or establish procedures through rulemaking.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact.

Per the agency, the total estimated cost to implement this rule is $500,000 for the current fiscal year ($151,450 in general revenue and $348,550 in federal funds) and $500,000 for the next fiscal year ($153,850 in general revenue and $346,150 in federal funds). The total estimated cost by fiscal year to a state, county, or municipal government to implement this rule is $151,450 for the current fiscal year and $153,850 for the next fiscal year.

The agency indicated that there is a new or increased cost or obligation of at least $100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of those entities combined. Accordingly, the agency provided the following written findings:

(1) a statement of the rule's basis and purpose;
This change amends portions of the Medicaid General Policy Provider Manual to reflect changes in the Medicaid Fairness Act made during the 2025 session of the General Assembly, including extending the appeal period for providers in the Arkansas Medicaid Program.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;
This change is necessary to comply with changes in the Medicaid Fairness Act, Arkansas Code § 20-77-701 et seq., that were made by Acts 2025, Nos. 515 and 635.

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;
N/A

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
N/A

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
N/A

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and
N/A

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.
N/A

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

This rule implements Acts 515, 635, and 772 of 2026.

Act 515, sponsored by Senator Clint Penzo, amended the Medicaid Fairness Act, extended the appeal period for providers in the Arkansas Medicaid Program, required comprehensive information in notices of adverse decisions, and mandated publication of all policies, protocols, and requirements used in making an adverse decision.

Act 635, sponsored by Representative Zack Gramlich, amended the Medicaid Fairness Act, modified the definition of "adverse decision" under the Medicaid Fairness Act, and provided for administrative reconsideration under the Medicaid Fairness Act.

Act 772, also sponsored by Senator Penzo, created the End Organ and Genomic Harvesting Act, prohibited coverage of certain human organ transplant or post-transplant care, and prohibited certain genetic sequencers and genetic analysis technologies.

Office of Policy and Rules
P.O. Box 1437, Slot S295, Little Rock, AR 72203-1437
P: 501.320.6383 F: 501.404.4619

March 12, 2026

Mrs. Rebecca Miller-Rice
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
#1 Capitol, 5th Floor
Little Rock, AR 72201

Dear Mrs. Rebecca Miller-Rice:

Re: Adverse Decisions

Please arrange for this rule to be reviewed by the ALC-Administrative Rules Subcommittee. If you have any questions or need additional information, please contact me at 501-320-6383 or by emailing Mac.E.Golden@dhs.arkansas.gov.

Sincerely,

Mac Golden

Mac Golden
Attorney III
Office of Policy and Rules

Attachments

QUESTIONNAIRE FOR FILING PROPOSED RULES WITH THE ARKANSAS LEGISLATIVE COUNCIL

DEPARTMENT Department of Human Services
BOARD/COMMISSION Department of Medical Services
BOARD/COMMISSION DIRECTOR Elizabeth Pitman
CONTACT PERSON Mac Golden
ADDRESS P.O Box 1437, Slot S295, Little Rock, AR 72203-1437
PHONE NO. (501) 320-6383 **EMAIL** Mac.E.Golden@dhs.arkansas.gov
NAME OF PRESENTER(S) AT SUBCOMMITTEE MEETING
Elizabeth Pitman
PRESENTER EMAIL(S) Elizabeth.Pitman@dhs.arkansas.gov

INSTRUCTIONS

In order to file a proposed rule for legislative review and approval, please submit this Legislative Questionnaire and Financial Impact Statement, and attach (1) a summary of the rule, describing what the rule does, the rule changes being proposed, and the reason for those changes; (2) both a markup and clean copy of the rule; and (3) all documents required by the Questionnaire.

If the rule is being filed for permanent promulgation, please email these items to the attention of Rebecca Miller-Rice, miller-ricer@blr.arkansas.gov, for submission to the Administrative Rules Subcommittee.

If the rule is being filed for emergency promulgation, please email these items to the attention of Director Marty Garrity, garritym@blr.arkansas.gov, for submission to the Executive Subcommittee.

Please answer each question completely using layman terms.

****

1. What is the official title of this rule?
Adverse Decisions

2. What is the subject of the proposed rule? 20 CAR Parts 570, 600, & 642

3. Is this rule being filed under the emergency provisions of the Arkansas Administrative Procedure Act? Yes ☐ No ☑

If yes, please attach the statement required by Ark. Code Ann. § 25-15-204(c)(1).

If yes, will this emergency rule be promulgated under the permanent provisions of the Arkansas Administrative Procedure Act? Yes ☐ No ☐

4. Is this rule being filed for permanent promulgation? Yes ☑ No ☐

If yes, was this rule previously reviewed and approved under the emergency provisions of the Arkansas Administrative Procedure Act? Yes ☐ No ☑

If yes, what was the effective date of the emergency rule? _____

On what date does the emergency rule expire?_____

5. Is this rule required to comply with a *federal* statute, rule, or regulation? Yes ☐ No ☑

If yes, please provide the federal statute, rule, and/or regulation citation.

6. Is this rule required to comply with a *state* statute or rule? Yes ☑ No ☐

If yes, please provide the state statute and/or rule citation.

Arkansas Code § 20-77-1701 et seq., and § 20-77-2703

7. Are two (2) rules being repealed in accord with Executive Order 23-02? Yes ☐ No ☑

If yes, please list the rules being repealed.
If no, please explain.

Exception from the Governor

8. Is this a new rule? Yes ☐ No ☑

Does this repeal an existing rule? Yes ☐ No ☑
If yes, the proposed repeal should be designated by strikethrough. If it is being replaced with a new rule, please attach both the proposed rule to be repealed and the replacement rule.

Is this an amendment to an existing rule? Yes ☑ No ☐
If yes, all changes should be indicated by strikethrough and underline. In addition, please be sure to label the markup copy clearly as the markup.

9. What is the state law that grants the agency its rulemaking authority for the proposed rule, outside of the Arkansas Administrative Procedure Act? Please provide the specific Arkansas Code citation(s), including subsection(s).

Arkansas Code §§ 20-76-201, 20 77-107, and 25-10-129

10. Is the proposed rule the result of any recent legislation by the Arkansas General Assembly?
Yes ☑ No ☐

If yes, please provide the year of the act(s) and act number(s).

Acts 515, 635, and 772 of 2025

11. What is the reason for this proposed rule? Why is it necessary?

This rule results from changes in the Medicaid Fairness Act, Arkansas Code § 20-77-1701 et seq., as amended by Acts 515 and 635 of 2025, and to comply with Act 772 of 2025. Act 515 extends the provider appeal period in the Arkansas Medicaid Program, and institutes new requirements regarding adverse decisions and the basis for them. Act 635 modifies the definition of adverse decision and provides for administrative reconsideration. This rule implements the requirements of both Acts by revising the Arkansas Medicaid General Policy Provider Manual (General Policy), the Provider-Led Arkansas Shared Savings Entity (PASSE) Program Provider Manual, and by requesting an amendment to the Arkansas Medicaid State Plan (state plan). Act 772 prohibits coverage of certain human organ transplants or post-transplant care by the Arkansas Medicaid program and Arkansas Health and Opportunity for Me program.

12. Please provide the web address by which the proposed rule can be accessed by the public as provided in Ark. Code Ann. § 25-19-108(b)(1).

ar.gov/dhs-proposed-rules

13. Will a public hearing be held on this proposed rule? Yes ☑ No ☐

If yes, please complete the following:

Date: 03/25/2026

Time: 9:00 am

Place: Zoom meeting: ar.gov/dhspublichearings

Please be sure to advise Bureau Staff if this information changes for any reason.

14. On what date does the public comment period expire for the permanent promulgation of the rule? Please provide the specific date. 04/12/2026

15. What is the proposed effective date for this rule? 06/01/2026

16. Please attach (1) a copy of the notice required under Ark. Code Ann. § 25-15-204(a)(1) and (2) proof of the publication of that notice.

17. Please attach proof of filing the rule with the Secretary of State, as required by Ark. Code Ann. § 25-15-204(e)(1)(A).

18. Please give the names of persons, groups, or organizations that you anticipate will comment on these rules. Please also provide their position (for or against), if known.

19. Is the rule expected to be controversial? Yes ☐ No ☑

If yes, please explain.

NOTICE OF RULE MAKING

The Department of Human Services (DHS) announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 20 77-107, and 25-10-129. The projected effective date is June 1, 2026, if approved.

This rule implements changes in the Medicaid Fairness Act, as amended by Acts 515 and 635 of 2025, and institutes the prohibition regarding human organ transplants in compliance with Act 772 of 2025. Act 515 extends the provider appeal period in the Arkansas Medicaid Program, and institutes new requirements regarding adverse decisions and the basis for them. Act 635 modifies the definition of adverse decision and provides for administrative reconsideration. Act 772 prohibits coverage of certain human organ transplants or post-transplant care by the Arkansas Medicaid program.

This rule implements the Acts by revising the Arkansas Medicaid General Policy Provider Manual, the Provider-Led Arkansas Shared Savings Entity Program Provider Manual, and by requesting an amendment to the Arkansas Medicaid State Plan. The rule amends the manuals and state plan to implement the new time limits allowed for reconsiderations and appeals. Also, this rule adds two new sections to the General Policy manual. One describes how a managed care organization must develop a grievance and appeals process, and how a member of a managed care organization can utilize the grievance and appeals process to request a fair hearing. The second states that the Arkansas Medicaid Program will comply with Ark. Code Ann. § 23-79-169 in providing coverage for human organ transplants. Finally, the rule revises the PASSE manual to align the definition of Risk Based Provider Organization with Arkansas Code § 20-77-2703 and references the new section being added to the General Policy manual. The estimated financial impact is $500,000.00 per fiscal year.

The proposed rule 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 the proposed rule 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 April 12, 2026. 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.

A public hearing will be held online by remote access. Public comments may be submitted at the hearing. The details for attending the online public hearing appear at ar.gov/dhspublichearings.

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. **4502292178**

Elizabeth Pitman, Director
Division of Medical Services

From: Legal Ads
To: Lisa Teague
Cc: Jack Tiner; Mac Golden; Lakeya Gipson; Elaine Stafford
Subject: Re: Full Run Ad (Rule 310)
Date: Thursday, March 12, 2026 2:59:31 PM
Attachments: image001.png

Scheduled for Sat 3/14, Sun 3/15, and mon 3/16. thank you.

Gregg Sterne, Legal Advertising
Arkansas Democrat-Gazette
legalads@arkansasonline.com

From: "Lisa Teague" <Lisa.Teague@dhs.arkansas.gov>
To: "legalads" <legalads@arkansasonline.com>
Cc: "Jack Tiner" <jack.tiner@dhs.arkansas.gov>, "Mac Golden" <Mac.E.Golden@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>, "Elaine Stafford" <elaine.stafford@dhs.arkansas.gov>
Sent: Wednesday, March 11, 2026 10:07:00 AM
Subject: Full Run Ad (Rule 310)

Good morning,

Please run the attached Notice of Public Hearing in the *Arkansas Democrat-Gazette* on the following days:

- Saturday, March 14, 2026
- Sunday, March 15, 2026
- Monday, March 16, 2026

I am aware that the print version will only be provided to all counties on Sundays.

Invoice to: **AR Dept of Human Services**

P.O. Box 1437

Slot S535

Little Rock, AR 72203

ATTN: Lakeya Gipson

(Lakeya.Gipson@dhs.arkansas.gov)

Or email invoices to: dms.invoices@arkansas.gov

NOTE: Please reply to this email using "REPLY ALL"

Lisa Teague

Rules & Regulations Coordinator

Arkansas Department of Human Services

Office of Policy and Rules

P: 501.396.6428

lisa.teague@dhs.arkansas.gov

From:	Lisa Teague
To:	Arkansas Register
Cc:	Jack Tiner; Mac Golden; Lakeya Gipson; JAMIE EWING
Subject:	DHS/DMS - Proposed Rule - Adverse Decisions (r. 310)
Date:	Thursday, March 12, 2026 3:08:00 PM
Attachments:	SOS Initial - Adverse Decisions.pdf image001.png

Good afternoon,

Attached is the proposed rule titled “Adverse Decisions”. The public notice will run in the Arkansas Democrat – Gazette March 14, 15, & 16, 2026. The public comment period ends 04/12/26.

Please post.

Thank you,

Lisa Teague
Rules & Regulations Coordinator
Arkansas Department of Human Services
Office of Policy and Rules

P: 501.396.6428
lisa.teague@dhs.arkansas.gov

humanservices.arkansas.gov

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services
BOARD/COMMISSION _____
PERSON COMPLETING THIS STATEMENT Andy Morgan
TELEPHONE NO. _____ **EMAIL** Andy.Morgan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE Adverse Decisions

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes ☑ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule?
   Yes ☑ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☑ No ☐

   If no, please explain:

   (a) how the additional benefits of the more costly rule justify its additional cost;

   (b) the reason for adoption of the more costly rule;

   (c) whether the reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

   (d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

4. If the purpose of this rule is to implement a *federal* rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$151,450	General Revenue	$153,850
Federal Funds	$348,550	Federal Funds	$346,150
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 500,000.00	Total	$ 500,000.00

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

5. What is the total estimated cost by fiscal year to any private individual, private entity, or private business subject to the proposed, amended, or repealed rule? Please identify those subject to the rule, and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**
$ 0.00	$ 0.00

6. What is the total estimated cost by fiscal year to a state, county, or municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	**Next Fiscal Year**
$ 151,450.00	$ 153,850.00

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☑ No ☐

If yes, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

FINANCIAL IMPACT STATEMENT ADDENDUM

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☒ No

If yes, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

This change amends portions of the Medicaid General Policy Provider Manual to reflect changes in the Medicaid Fairness Act made during the 2025 session of the General Assembly, including extending the appeal period for providers in the Arkansas Medicaid Program.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

This change is necessary to comply with changes in the Medicaid Fairness Act, Arkansas Code § 20-77-701 et seq., that were made by Acts 2025, Nos. 515 and 635.

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

N/A

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

N/A

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

N/A

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an

explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

N/A

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;

(b) the benefits of the rule continue to justify its costs; and

(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

N/A

Statement of Necessity and Rule Summary
Adverse Decisions

Statement of Necessity

This rule results from changes in the Medicaid Fairness Act, Arkansas Code § 20-77-1701 et seq., as amended by Acts 515 and 635 of 2025 of, and to comply with Act 772 of 2025. Act 515 extends the provider appeal period in the Arkansas Medicaid Program, and institutes new requirements regarding adverse decisions and the basis for them. Act 635 modifies the definition of adverse decision and provides for administrative reconsideration. This rule implements the requirements of both Acts by revising the Arkansas Medicaid General Policy Provider Manual (General Policy), the Provider-Led Arkansas Shared Savings Entity (PASSE) Program Provider Manual, and by requesting an amendment to the Arkansas Medicaid State Plan (state plan). Act 772 prohibits coverage of certain human organ transplants or post-transplant care by the Arkansas Medicaid program and Arkansas Health and Opportunity for Me program. Additional updates are made to align a statutory definition and to update references and terminology.

Summary

This rule amends the manuals and state plan to reflect changes in the Medicaid Fairness Act made during the 2025 session of the General Assembly. This rule implements the new time limits allowed for reconsiderations and appeals in the General Policy manual and the state plan. It adds a new section to the General Policy manual to describe how a managed care organization must develop a grievance and appeals process, and how a member of a managed care organization can utilize the grievance and appeals process and request a fair hearing. It revises the PASSE manual to align the definition of Risk Based Provider Organization with Arkansas Code § 20-77-2703 and references the new section being added to the General Policy manual. Section I of the Medical General Policy Manual is updated to comply with new requirements regarding human organ transplants. Numerous grammatical, punctuation, and stylistic changes were made to both manuals to improve language, consistency, and references. Similar language and punctuation updates were made to the state plan. The specific substantive changes are detailed below.

Medicaid General Policy Provider Manual

Section 100.100: Removed language regarding a 30-day time limit for requesting administrative reconsideration or appeals for providers or beneficiaries. Added a description of the Managed Care due process sub-section.

Section 106.000: The Arkansas Medicaid Program will comply with Ark. Code Ann. § 23-79-169 in providing coverage for human organ transplants.

Section 110.700: Changed time allowed from thirty-five (35) days to sixty-five (65) days for a provider to request administrative reconsideration or appeal.

Section 161.200: Changed the time limit for requesting an administrative reconsideration from thirty (30) days to sixty-five (65) days.

Section 161.300: Changed the time limit for administrative appeals from thirty (30) to sixty-five (65) days.

Section 161.400: Changed the time limit for sanction appeals from thirty (30) to sixty-five (65) days.

Section 162.000: Corrected the name of the Office of Appeals and Hearings to refer to the Office of Medicaid Provider Appeals of the Department of Health. Removed reference to DHS Policy 1098.

Section 169.100: Removed outdated language.

Section 190.001: Edited citation to Medicaid Fairness Act to cite to the entire subchapter.

Section 190.002: Edited definition of "adverse decision or adverse action".

Section 190.003: Edits to clean up language, style, and punctuation only.

Section 191.001: Edited definition of "adverse decision or adverse action" to more closely mirror 42 CFR 431.201, which applies to beneficiaries.

Sections 191.002, 191.003, 191.004, 191.005: Edits to clean up language, style, and punctuation, including updating the citation to the Arkansas Administrative Procedure Act.

Section 192.000 (192.001–192.010): This new section describes how a managed care organization must develop a grievance and appeals process and how a member of a managed care organization can utilize the grievance and appeals process and request a state fair hearing.

Provider-Led Arkansas Shared Savings Entity (PASSE) Program Provider Manual

Section 200.000: Changed Adverse Decision/Adverse Action to Adverse Benefit Determination to mirror federal managed care rules. Changed the definition of Risk Based Provider Organization to align with the definition in Arkansas Code § 20-77-2703.

Section 247.200: Removed language regarding appeals processes and replaced with a reference to the new Section 192.000 in the Medicaid General Policy Provider Manual.

Arkansas Medicaid State Plan: Amendment needed to change the time limit for administrative appeals from thirty calendar days to sixty-five (65) calendar days.

750, Form 2 or DOM 400, Form 3), with audit adjustments, is presented fairly and in compliance with program policy and regulations.

1-9 Unauditable Situations

If a facility is unable or unwilling to provide necessary documentation to support the financial or statistical records contained in their cost report, the auditors will issue a "disclaimer" report signifying that the audit could not be accomplished. The Office of Long Term Care will advise the facility of the disclaimer in writing. A period of 90 days from the date of the letter of notification will be allowed to permit the facility to accumulate necessary documentation. A follow-up audit will be attempted upon expiration of the 90 day period or sooner if requested by the facility. If the audit can not be completed on the second attempt, the facility will be advised, in writing, that their agreement to participate in the Medicaid program will be terminated effective immediately. A period of 30 days from the date of such notification will be allowed to permit the orderly relocation of Medicaid recipients. The appeals procedures specified in Section 1-10 of this Manual are available to providers.

1-10 Appeal Procedures

A. Time Limit for Appeals

1. Any ~~Long Term~~Long-Term Care Facility may appeal the facility's reimbursement rate, ~~a recoupment, a cost disallowance, a fine, a sanction, the imposition of a civil money penalty, or suspension or termination from the program,~~ by submitting a written notice of appeal to the Director of the Department of Human Services within ~~thirty calendar days~~sixty-five (65~~06~~) calendar days ~~or subsequently, the timeframe allowed in (state statute)~~ following the date of the ~~appealed action~~notice from DHS regarding a final reimbursement rate. The appeal must clearly state the basis for appeal and must be accompanied by supporting documentation. If the facility wishes to utilize the "MEDIATION PROCESS" as contained in this section, it must so state in its written Notice of Appeal.

2. If an appeal is filed, the DHS Director or ~~his~~ designee will appoint an independent hearing officer to hear the appeal. The hearing officer will schedule all appeals within sixty (60) calendar days of receipt of written notice of appeal by the Division and will notify the parties in writing of the hearing schedule. ~~Provided that i~~If the appealing facility states in its written Notice of Appeal that it wishes to utilize the "MEDIATION PROCESS~~ES~~" and the department agrees, then the time for the DHS Director or ~~his~~ designee to appoint a Hearing Officer is waived. ~~However, t~~The appealing facility and the DHS Director or ~~his~~ designee shall implement the mediation process within the sixty (60) days. Upon the

termination of the mediation process, if any dispute stated in the notice of appeal remains unresolved,

750, Form 2 or DOM 400, Form 3), with audit adjustments, is presented fairly and in compliance with program policy and regulations.

1-9 Unauditable Situations

If a facility is unable or unwilling to provide necessary documentation to support the financial or statistical records contained in their cost report, the auditors will issue a "disclaimer" report signifying that the audit could not be accomplished. The Office of Long Term Care will advise the facility of the disclaimer in writing. A period of 90 days from the date of the letter of notification will be allowed to permit the facility to accumulate necessary documentation. A follow-up audit will be attempted upon expiration of the 90 day period or sooner if requested by the facility. If the audit can not be completed on the second attempt, the facility will be advised, in writing, that their agreement to participate in the Medicaid program will be terminated effective immediately. A period of 30 days from the date of such notification will be allowed to permit the orderly relocation of Medicaid recipients. The appeals procedures specified in Section 1-10 of this Manual are available to providers.

1-10 Appeal Procedures

A. Time Limit for Appeals

1. Any Long-Term Care Facility may appeal the facility's reimbursement rate, by submitting a written notice of appeal to the Director of the Department of Human Services within sixty-five (65) calendar days following the date of the notice from DHS regarding a final reimbursement rate. The appeal must clearly state the basis for appeal and must be accompanied by supporting documentation. If the facility wishes to utilize the "MEDIATION PROCESS" as contained in this section, it must so state in its written Notice of Appeal.

2. If an appeal is filed, the DHS Director or designee will appoint an independent hearing officer to hear the appeal. The hearing officer will schedule all appeals within sixty (60) calendar days of receipt of written notice of appeal by the Division and will notify the parties in writing of the hearing schedule. If the appealing facility states in its written Notice of Appeal that it wishes to utilize the "MEDIATION PROCESS" and the department agrees, then the time for the DHS Director or designee to appoint a Hearing Officer is waived. The appealing facility and the DHS Director or designee shall implement the mediation process within the sixty (60) days. Upon the termination of the mediation process, if any dispute stated in the notice of appeal remains unresolved,

TOC required

100.100 Introduction

~~9-15-09~~6-1-26

Section I ~~imparts~~ gives general program information about the Arkansas Medicaid Program. ~~-~~It includes information about beneficiary eligibility and explains the provider's role and responsibilities. ~~-~~The intent is to provide users with an understanding of Medicaid Program objectives and regulations. ~~-Additionally, i~~It contains details providers may need to answer questions often asked about the Medicaid Program. ~~-~~Seven (7) major areas are covered in Section I.

A. General information ~~about the program -~~ ~~Contains information regarding~~Describes the background, history, and scope of the Medicaid Program, including information about Medicaid waivers and~~/or~~ other programs administered by ~~the~~ Department~~ivision~~ of ~~Medical~~ Human Services (DHS).

B. Beneficiary eligibility - ~~Contains information about~~Explains Medicaid beneficiary aid categories, ~~beneficiaries'~~ eligibility for benefits, responsibilities, ~~and an explanation of~~ the Medicaid identification card, ~~the beneficiaries' responsibilities~~ and additional beneficiary information.

C. Provider participation - Specifies the provider enrollment procedures, ~~the~~ general conditions that must be met by providers to begin and ~~to~~ maintain program participation, and remedies and sanctions ~~that the Division of Medical Services~~DHS may employ in the administration and regulation of the Arkansas Medicaid Program.

D. Administrative remedies and sanctions - Describes the rules for imposing sanctions.

E. Provider due process - ~~Describes~~ Explains how a provider may request an administrative reconsideration or appeal of an adverse decision~~/action within 30 calendar days after the notice of the decision/action~~ or sanctions.

F. Beneficiary due process - Describes how a beneficiary may request an administrative ~~reconsideration~~ appeal of an adverse decision~~/action within 30 calendar days after the notice of the decision/action~~.

G. Managed Care due process – Describes how a managed care organization must develop a grievance and appeals process and how a member of a managed care organization can utilize the grievance and appeals process and request a state fair hearing.

H. Primary Care Case Management Program (PCCM) - Defines the scope of the Primary Care Case Management Program (PCCM) and regulations regarding provider and enrollee participation. ~~-~~It lists the categories of eligibility that are exempt from primary care ~~physician~~ provider (PCP) referral requirements and ~~it~~ itemizes the services that do not require PCP referral. ~~-~~PCP enrollment and enrollment transfer procedures are explained, as are PCP referral requirements and procedures.

106.000 Limitations on Coverage for Certain Organ Transplants

6-1-26

The Arkansas Medicaid Program will comply with Ark. Code Ann. § 23-79-169 in providing coverage for human organ transplants.

110.700 Medicaid Fraud Detection and Investigation Program

~~1-1-16~~6-1-26

Federal Regulations require the implementation of a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate utilization of care and services and excess reimbursements by the Medicaid program. ~~-~~The purpose of the Office of the Medicaid Inspector General (OMIG) is to investigate fraud allegations and ensure Arkansas~~'~~ Medicaid's compliance. ~~-~~**[Title XIX of the Social Security Act, Arkansas Code Annotated, 42 C.F.R. §455 and the Arkansas State Plan].**

The goal of the unit is to verify the nature and extent of services reimbursed by the Medicaid program, ~~while~~ ensur~~e~~ing reimbursements ~~made~~ are consistent with the quality of care being provided, and protect~~ing~~ the integrity of both state and federal funds.

Responsibilities of the unit include the following:

A. Verify~~ing~~ medical services meet an accepted standard of care and are rendered as billed;

B. Verify~~ing~~ services are provided by qualified providers to eligible beneficiaries;

C. Verify~~ing~~ reimbursement for services is correct and ~~that~~ all funds identified for collection prior to Medicaid reimbursement are pursued.

~~The~~ OMIG ~~Section~~ is responsible for conducting on-site medical reviews ~~for the purpose of~~ to verify~~ing~~ the above tasks, ~~as well as~~ record keeping, and other specified information. ~~-~~Providers selected for an on-site review will not be notified in advance. ~~-~~Review analysts may request additional information regarding the provider's medical practice. ~~-~~**View or print Office of Medicaid Inspector General contact information.**

~~Additionally~~When warranted, ~~the~~ OMIG ~~Section~~ is responsible for ~~the~~ identify~~ing~~~~ication~~ and recover~~ing~~~~upment of~~ questioned costs claimed for reimbursement from Medicaid funds ~~when warranted~~. ~~-~~Situations resulting in recoupment include such things as~~, but are not limited to,~~ the following:

A. When duplicate payments are made;

B. When the Quality Improvement Organization (QIO) denies all or part of a hospital admission;

C. When medical consultants to the Medicaid Program determine lack of medical necessity;

D. When Medicaid, Medicare, or the Attorney General's Medicaid Fraud Unit discovers evidence of overpayment;

E. When a provider has been assessed a monetary penalty for failure to follow a corrective action plan ~~which was~~ developed to correct a pattern of non-compliance ~~as provided in~~ (See Sections 151.000 and 190.005)

When a review is completed, ~~Office of Medicaid Inspector General~~OMIG will forward a findings report to the provider. ~~-~~If questioned costs are identified through the review, a "Notice of ~~Decision/~~Action" will be ~~forwarded~~ sent to the provider. ~~-~~The~~is~~ notice must comply with ~~Section 190.006 of this manual~~ required explanations of adverse decisions and must include the name(s) of the patient(s), date(s) of service, date(s) of payment, and the reason(s) for the recoupment decision.

Upon receipt of the~~is~~ notice, the provider has ~~thirty~~sixty-five (~~3~~65) calendar days ~~in which~~ to pursue one of the following actions:

A. Forward a check for the indicated recoupment amount;

B. Request administrative reconsideration;

C. Appeal.

~~See Sections 160.000 through 169.000 for r~~Rules, timelines, and procedures related to administrative reconsideration and appeals are further explained in ensuing sections of this manual.

161.200 Administrative Reconsideration 6-1-2~~65~~

A. Within ~~thirty (30)~~sixty-five (65) calendar days after notice of an adverse decision or~~/~~ action, the provider may request administrative reconsideration. ~~-~~Requests must be in writing and include:

1. A copy of the letter or notice of adverse decision or~~/~~ action; and
2. Additional documentation that supports medical necessity.

Administrative reconsideration does not postpone any adverse action that may be imposed pending appeal.

B. Requests for reconsideration must be submitted as follows:

1. In situations where the adverse decision or ~~/~~action has been taken by a reviewing agent, the request must be directed to that reviewing agent. ~~-~~Contact information for the department's reviewing agents can be found in Section V of this manual.
2. When an adverse decision~~/~~ or action has been taken by the Office of Medicaid Inspector General (OMIG) on behalf of Division of Medical Services (DMS), the request for reconsideration must be directed to ~~Office of Medicaid Inspector General (~~OMIG~~).~~ **View or print the Office of Medicaid Inspector General contact information.** ~~-~~ Within twenty (20) calendar days of receiving a timely and complete request for administrative reconsideration, OMIG will designate a reviewer and proceed according to its own procedures. When an adverse decision or ~~/~~action has been taken by the Utilization Review (UR) Section of DMS, the request for reconsideration must be directed to UR. **View or print the Utilization Review contact information**.

The ~~30-~~sixty-five-day time period to request a reconsideration begins to run five (5) days after the date of the written notice.

No administrative reconsideration is allowed if the adverse decision or ~~/~~action is due to loss of licensure, accreditation, or certification.

161.300 Administrative Appeals of Adverse Actions that are not Sanctions 6-1-2~~65~~

In addition to sanction reconsiderations and appeal procedures set forth in Sections 160.000-169.000, providers may appeal any other decision of the Department of Human Services, its reviewers, or contractors if that decision adversely affects a Medicaid provider or beneficiary with regard to receipt or payment of Medicaid-covered services. ~~-~~Such decisions and consequent actions are "non-sanction adverse actions."

Within ~~thirty~~ sixty-five (~~30~~65) calendar days of receiving notice of non-sanction adverse action, or ~~ten (10)~~sixty-five (65) calendar days of receiving an administrative reconsideration decision that upholds all or part of any adverse decision or ~~/~~action, whichever is later, the provider may appeal. ~~-~~ The time period for filing an appeal shall begin to run five (5) days after the date of the written notice of non-sanction adverse action or administrative reconsideration decision. An appeal must be in writing and must specify in detail all findings, determinations, and adverse decisions or ~~/~~actions that the provider alleges are not supported by applicable laws, including state and federal laws and rules, applicable professional standards, or both. ~~-~~ Providers shall mail or deliver the appeal to the **Arkansas Department of Health, Office of Medicaid Provider Appeals**.

161.400 Sanction Appeals 6-1-256

Within ~~thirty (30)~~sixty-five (65) calendar days of receiving notice of adverse decision or~~/~~ action, or sixty-five (65) calendar days of receiving an administrative reconsideration decision that upholds all or part of any adverse decision/action, whichever is later, the provider may appeal. The ~~thirty (30)~~ sixty-five (65) days begins to run five (5) days after the date of the written notice.

An appeal must be in writing and must specify in detail all findings, determinations, and adverse decisions or ~~/~~actions that the provider alleges are not supported by applicable laws~~,~~; including state and federal laws and rules, applicable professional standards, or both.~~-~~ Providers shall mail or deliver the appeal to the **Arkansas Department of Health, Office of Medicaid Provider Appeals**. No appeal is allowed if the adverse decision~~/~~ or action is due to loss of licensure, accreditation, or certification.

162.000 Notice of the Appeal Hearing ~~9-15-09~~6-1-26

When an appeal hearing is scheduled, the Office of ~~Hearings and Appeals~~ Medicaid Provider Appeals of the Department of Health shall notify the provider, or if the provider is represented by an attorney, the provider's attorney, in writing, of the date, time, and place of the hearing.~~-~~ Notice shall be mailed not less than ten (10) calendar days before the scheduled date of the hearing. ~~Hearings shall be conducted in accordance with DHS Policy 1098.~~ The decision of the Office of Medicaid Provider Appeals ~~and Hearings~~ is the final agency determination.

169.100 Recovery of the Costs of Services Continued During the Appeal Process ~~9-15-09~~6-1-26

42 CFR §431.230 entitled "Maintaining Services," which states in part:

> (b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or beneficiary to recoup the cost of any services furnished the beneficiary, to the extent they were furnished solely by reason of this section.

~~Federal regulation does not distinguish between beneficiary-filed and provider-filed appeals.~~

~~Providers filing appeals shall be subject to the same recovery procedures as beneficiaries. When both the provider and beneficiary appeal, liability shall be joint and several.~~

190.001 The Medicaid Fairness Act ~~12-15-11~~6-1-26

The Medicaid Fairness Act, Ark. Code Ann. §~~§~~ 20-77-1701 ~~– 20-77-1716~~et seq., requires that the Department of Human Services and its outside contractors treat providers with fairness and due process.

190.002 Definitions ~~9-15-09~~6-1-26

A. Adverse decision or~~/~~ adverse action: any decision or action by the Department of Human Services or its reviewers or contractors that adversely affects a Medicaid provider or beneficiary in regard to:

1. R~~r~~eceipt of and payment for Medicaid claims and services including but not limited to decisions as to:
   - ~~1~~a. Appropriate level of care or coding;~~,~~
   - ~~2~~b. Medical necessity;~~,~~
   - ~~3~~c. Prior authorization;~~,~~
   - ~~4~~d. Concurrent reviews;~~,~~

~~5~~e. Retrospective reviews~~,~~;

~~6~~f. Least restrictive setting~~,~~;

~~7~~g. Desk audits~~,~~;

~~8~~h. Field audits and onsite audits~~,~~; and

~~9~~i. Inspections or surveys~~.~~;

j. Payment amounts due to or from a particular provider resulting from gain sharing, risk sharing, incentive payments, or another reimbursement mechanism or methodology, including calculations that affect or have the potential to affect payment; and

k. Imposition of corrective action plans.

2. To constitute an adverse decision, an agency decision need not have a monetary penalty attached or a direct monetary consequence to the provider.

3. "Adverse decision" does not include the design of or changes to an element of a reimbursement methodology or payment system that is of general applicability and implemented through the rulemaking process.

B. Appeal: an appeal under the Arkansas Administrative Procedure Act, Ark. Code Ann. §~~§~~ 25-15-201 ~~– 25-15-218~~et seq.

C. Claim: a request for payment of services.

D. Concurrent review or concurrent authorization: a review to determine whether a specified beneficiary currently receiving specific services may continue to receive services.

E. Denial: denial or partial denial of a claim or authorization of services.

F. Department:

1. The ~~Arkansas~~ Department of Human Services~~,~~;

2. All of the divisions and programs of the ~~Arkansas~~ Department of Human Services, including the ~~state~~ Arkansas Medicaid Program~~,~~; and

3. All of the ~~Arkansas~~ Department of Human Services' contractors, fiscal agents, and other designees and agents.

G. Medicaid: the medical assistance program under Title XIX of the Social Security Act that is operated by the ~~Arkansas~~ Department of Human Services and its contractors, fiscal agents, and all other designees and agents.

H. Person: any individual, company, firm, organization, association, corporation, or other legal entity.

I. Primary care physician: a physician whom the department has designated as responsible for the referral or management, or both, of a Medicaid beneficiary's health care.

J. Prior authorization: the approval by the ~~state~~ Arkansas Medicaid Program for specified services for a specified Medicaid beneficiary before the requested services may be performed and before payment will be made by the ~~state~~ Arkansas Medicaid Program.

K. Provider: a person enrolled to provide health or medical care services or goods authorized under the ~~state~~ Arkansas Medicaid Program.

L. Recoupment: any action or attempt by the Department of Human Services to recover or collect Medicaid payments already made to a provider with respect to a claim by:

1. Reducing, withholding or affecting in any other manner current or future payments to a provider~~,~~; or

2. Demanding payment back from a provider for a claim already paid.

M. Retrospective review: the review of services or practice patterns after payment, including, but not limited to:

1. Utilization reviews;
2. Medical necessity reviews;
3. Professional reviews;
4. Field audits and onsite audits; and
5. Desk audits.

N. Reviewer: any person, including reviewers, auditors, inspectors, surveyors and others who, in reviewing a provider or a provider's provision of services and goods, perform review actions, including, but not limited to:

1. Reviews for quality;
2. Reviews for quantity;
3. Utilization;
4. Practice patterns;
5. Medical necessity;
6. Peer review; and
7. Compliance with Medicaid standards.

O. Technical deficiency: an error or omission in documentation by a provider that does not affect direct patient care of the beneficiary. Technical deficiency does not include:

1. Lack of medical necessity or failure to document medical necessity in a manner that meets professionally recognized applicable standards of care;
2. Failure to provide care of a quality that meets professionally recognized local standards of care;
3. Failure to obtain prior, concurrent, or mandatory authorization if required by regulation;
4. Fraud;
5. A pattern of abusive billing;
6. A pattern of noncompliance; or
7. A gross and flagrant violation.

190.003 Administrative Appeals

~~12-1-05~~6-1-26

A. The following appeals are available in response to an adverse decision:

1. A beneficiary may appeal on his or her own behalf;
2. A provider of medical assistance that is the subject of the adverse action may appeal on the beneficiary's behalf; and
3. If the adverse action denies a claim for covered medical assistance that was previously provided to a Medicaid-eligible beneficiary, the provider of such medical assistance may appeal on the provider's behalf. The provider does not have standing to appeal a non-payment decision if the provider has not furnished any service for which payment has been denied.

B. All appeals shall conform to the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 ~~– 25-15-218~~et seq.

C. Providers may appear in person, through a corporate representative or, with prior notice to the D~~d~~epartment of Human Services, through legal counsel.

D. Beneficiaries may represent themselves or they may be represented by a friend, by any other spokesperson except a corporation, or by legal counsel.

E. A Medicaid beneficiary may attend any hearing related to his or her care, but the department may not make his or her participation a requirement for provider appeals. ~~-~~The department may compel the beneficiary's presence via subpoena, but failure of the beneficiary to appear shall not preclude the provider's appeal.

F. If an administrative appeal is filed by both a provider and beneficiary concerning the same subject matter, the department may consolidate the appeals.

G. Any person who considers himself or herself injured in his or her person, business, or property by the decision rendered in the administrative appeal is entitled to judicial review of the decision under the Arkansas Administrative Procedure Act, Ark. Code Ann. ~~§§~~ § 25-15-201 ~~– 25-15-218~~et seq.

H. This rule shall apply to all pending and subsequent appeals that have not been finally resolved at the administrative or judicial level as of April 5, 2005.

191.001 Definitions ~~9-15-096~~-1-26

A. Adverse decision~~/~~ or adverse action~~:~~ means any decision or action by the Department of Human Services or its reviewers or contractors that adversely affects a Medicaid provider or beneficiary in regard to receipt of and payment for Medicaid claims and services by limiting, terminating, suspending, or reducing Medicaid eligibility or covered services in connection with, but not limited to:

1. A termination, suspension of, or reduction in covered benefits or services, including benefits or services for which there is a current approved prior authorization;
2. A termination, suspension of, or reduction in Medicaid eligibility, or an increase in beneficiary liability, including a determination that a beneficiary must incur a greater amount of medical expenses to establish income eligibility in accordance with 42 CFR § 435.121(e)(4) or 42 CFR § 435.831;
3. A determination that a beneficiary is subject to an increase in premiums or cost-sharing charges under 42 CFR part 447, subpart A; or
4. A determination by a skilled nursing facility or nursing facility to transfer or discharge a resident and an adverse determination by a State regarding the preadmission screening and resident review requirements of section 1919(e)(7) of the Social Security Act.~~Appropriate level or care or coding,~~

~~2. Medical necessity,~~

~~3. Prior authorization,~~

~~4. Concurrent reviews,~~

~~5. Retrospective reviews,~~

~~6. Least restrictive setting,~~

~~7. Desk audits,~~

~~8. Field audits and onsite audits, and~~

~~9. Inspections.~~

B. Beneficiary:

1. A person who has applied for medical assistance under the Arkansas Medicaid Program;, or

2. A person who is a beneficiary of medical assistance under the Arkansas Medicaid Program.

C. Department: The Department of Human Services.

191.002 Notice

12-1-056-1-26

A. If an application or claim for medical assistance is denied in whole or in part or is not acted upon with reasonable promptness, the dDepartment of Human Services shall provide written notice:

1. Of the beneficiary's right and opportunity for a fair hearing under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218,et seq.;

2. Of the method by which the beneficiary may obtain a fair hearing;, and

3. Of the beneficiary's right to:

a. Represent himself or herself;, or

b. Be represented by legal counsel, a friend, or any other spokesperson except a corporation.

B. A notice required under this rule shall include but not be limited to:

1. A statement detailing the type and amount of medical assistance that the beneficiary has requested;,

2. A statement of the adverse action that the department has taken or proposes to take;,

3. The reasons for the adverse action, which shall include but not be limited to:

a. The specific facts regarding the individual beneficiary that support the action;, and

b. The sources from which the facts were derived;,

4. An explanation of the beneficiary's right to request a fair hearing, if available, or in cases of an adverse action based on a change in law:

a. The circumstances under which a fair hearing will be granted;, and

b. An explanation of the circumstances under which medical assistance is provided or continued if a fair hearing is requested.

191.003 Determination of Medical Necessity – Content of Notice

12-1-056-1-26

If the adverse action that the dDepartment of Human Services has taken or proposes to take is based on a determination of medical necessity or other clinical decision, the notice required under Rule 191.002 shall include all of the following:

A. Specification of the medical records upon which the physician or clinician relied in making the determination;,

B. Specification of any portion of the criteria for medical necessity or coverage that is not met by the beneficiary;,

C. The specific regulation(s) that support the adverse action, or the change in federal or state law that has occurred since the application was filed that requires adverse action;, and

D. A brief statement of the reasons for the adverse action based upon the individual beneficiary's circumstances.

The department and others acting on behalf of the department may not cite or rely on policies that are inconsistent with federal or state laws and regulations or that were not properly promulgated. Generic rationales or explanations shall not suffice to meet the requirements of this rule.

191.004 Administrative Appeals 6-1-265

When notice of an adverse decision is received from the Division of Medical Services, the beneficiary may appeal. The appeal request must be in writing and submitted to the Department of Human Services, Office of Appeals and Hearings Section. **View or print the Department of Human Services, Office of Appeals and Hearings Section contact information.** The appeal request must be received by the Office of Appeals and Hearings Section no later than thirty (30) days from the date of written notice. The thirty (30) days begins to run five (5) days after the date of written notice.

All appeals shall conform to the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ § 25-15-201 – 25-15-218et seq. Beneficiaries may represent themselves or they may be represented by a friend, by any other spokesperson except a corporation, or by legal counsel.

If an administrative appeal is filed by both a provider and beneficiary concerning the same subject matter, the department may consolidate the appeals.

Any person who considers himself or herself injured in his or her person, business, or property by the decision rendered in the administrative appeal is entitled to judicial review of the decision under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218et seq.

191.005 Conducting the Hearing 12-1-056-1-26

If a beneficiary appeals an adverse action under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218et seq., the reviewing authority shall consider only those adverse actions that were included in the written notice to the beneficiary as required under Rules 191.002 and 191.003.

All determinations of the medical necessity of any request for medical assistance shall be based on the individual needs of the beneficiary and on his or her medical history.

192.000 MANAGED CARE DUE PROCESS

192.001 Scope 6-1-26

This section applies to beneficiary appeals to managed care organizations (MCO). A "managed care organization" includes, but is not limited to, a Provider-Led Arkansas Shared Savings Entity (PASSE) or other Risk Based Provider Organization. Provider appeals to MCOs are governed by all applicable state and federal laws and agreements or contracts between the provider and the MCO.

This section does not apply to non-emergency medical transportation Prepaid Ambulatory Health Plans (PAHPs) in accordance with 42 CFR § 438.9. This section also does not apply to Qualified Health Plans in the AR HOME program.

192.002 Definitions 6-1-26

A. Adverse benefit determination means any of the following:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

2. The reduction, suspension, or termination of a previously authorized service;

3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at 42 CFR § 447.45(b) is not an adverse benefit determination;

4. The failure to provide services in a timely manner;

5. The failure to act within the prescribed timeframes regarding the standard resolution of grievances and appeals;

6. For a resident of a rural area with only one (1) managed care organization, the denial of a member's request to exercise his or her right to obtain services outside the network; and

7. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, coinsurance, and other member financial liabilities.

B. Appeal means a review of an adverse benefit determination by an MCO.

C. Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationship such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the MCO, PIHP, or PAHP to make an authorization decision.

D. Grievance and appeal system means the processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

E. Managed Care Organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is:

1. A federally qualified HMO that meets the advance directives requirements of 42 CFR part 489, subpart I; or

2. Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:

a. Makes the services it provides to its members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity; and

b. Meets the solvency standards of 42 CFR § 438.116.

F. Managed Care Program means a managed care delivery system authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act.

G. Member means a Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program;

H. Prepaid ambulatory health plan (PAHP) means an entity that:

1. Provides services to members under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates;

2. Does not provide or arrange for, and is not otherwise responsible for the provision of inpatient hospital or institutional services for its members; and

3. Does not have a comprehensive risk contract.

I. Prepaid inpatient health plan (PIHP) means an entity that:

1. Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates;

2. Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and

3. Does not have a comprehensive risk contract.

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

1. Is fifty-one percent (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 with the Arkansas Insurance Department, enrolled as a Medicaid provider, and enter into an annual PASSE agreement with DHS.

K. Risk Based Provider Organization means an entity that:

1. Is licensed by the Insurance Commissioner under the rules established for risk-based provider organizations by the commissioner;

2. Is obligated to assume the financial risk for the delivery of specifically defined healthcare services to an enrollable Medicaid beneficiary population; and

3. Is paid by DHS on a capitated basis with a global payment made, whether or not a particular member of an enrollable Medicaid beneficiary population receives services during the period covered by the payment.

L. State Fair Hearing means an administrative review provided by the State that meets the requirements of 42 CFR part 431, subpart E, and will result in a final agency action in accordance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq.

192.003 Timing and Content in Notice of Adverse Benefit Determination by Managed Care Organizations 6-1-26

A. **Notice**. The MCO must comply with all applicable provisions of 42 CFR 438.210, Coverage and authorization of services, and the Arkansas Prior Authorization Transparency Act, Ark. Code Ann. 23-99-1101 et seq.

B. The notice must explain the following:

1. The adverse benefit determination the MCO has made or intends to make;

2. The reasons for the adverse benefit determination, including the right of the member to be provided upon request free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member 's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

3. The member 's right to request an appeal of the MCO's adverse benefit determination, including information on exhausting the MCO's one level of appeal and the right to request a State fair hearing from the DHS Office of Appeals and Hearings;

4. The procedures for exercising the rights specified in this section;

5. The circumstances under which an appeal process can be expedited and how to request it; and

6. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of these services.

C. **Timeframe for decisions**. The MCO must provide for the following decisions and notices:

1. Standard (nonurgent healthcare service) authorization decisions

a. For standard authorization decisions, provide notice as expeditiously as the member's condition requires and not more than two (2) business days of obtaining all necessary information to make the authorization or adverse benefit determination. Necessary information included the results of any face-to-face clinical evaluation or second opinion that may be required.

b. Standard authorization decisions may have an extension of up to 14 additional calendar days if the member or provider requests the extension and the MCO justifies the need for additional information and how the extension is in the enrollee's interest.

2. Expedited (urgent healthcare service) authorization decisions

a. For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than one (1) business day after receiving all information needed to completed the review of the requested service.

b. Expedited authorization decisions may have an extension of up to 14 additional calendar days if the member or provider requests the extension and the MCO justifies the need for additional information and how the extension is in the enrollee's interest.

192.004 Managed Care Organizations - Appeals 6-1-26

A. Each Managed Care Organization (MCO), including PASSEs, must have an appeal system in place for members. Non-emergency medical transportation providers are exempt from this section.

B. Each MCO may have only one level of appeal for members.

C. **Filing requirements.**

1. **Authority to file.** A member may request an appeal with the MCO. A member may request a State fair hearing with the DHS Office of Appeals and Hearings after receiving notice from the MCO that the adverse action is upheld.

a. **Deemed exhaustion of appeals processes.** In the case of an MCO that fails to adhere to the notice and timing requirements in section 192.003 the member is deemed to have exhausted the MCO's appeals process. The member may initiate a State fair hearing.

b. With the written consent of the member, a provider or an authorized representative may request an appeal, or request a State fair hearing, on

behalf of a member. This will be considered a member appeal, not a provider appeal under the Medicaid Fairness Act.

2. **Timing.** Following receipt of a notification of an adverse action by an MCO, a member has sixty (60) calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the MCO.

3. **Method.** The member may request an appeal to the MCO either orally or in writing by telephone, via mail, in person, or through other commonly available electronic means.

192.005 MCO Appeal Requirements 6-1-26

A. Each MCO must provide members any reasonable assistance in completing forms and taking other procedural steps related to an appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY or TTD and interpreter capability.

B. **Special requirements**. An MCO's process for handling member appeals of adverse benefit determinations must:

1. Acknowledge receipt of each appeal;

2. Ensure that the individuals who make decisions on appeals are individuals:

a. Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual;

b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member 's condition or disease:

i. An appeal of a denial that is based on lack of medical necessity;

ii. A grievance regarding denial of expedited resolution of an appeal; or

iii. A grievance or appeal that involves clinical issues; and

c. Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination;

3. Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals;

4. Provide the member with a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in this manual, including timeframes in the case of expedited resolution;

5. Provide the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, (or at the direction of the MCO), in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in this manual; and

6. Include, as parties to the appeal:

a. The member and his or her representative; or

b. The legal representative of a deceased member's estate.

192.006 Resolution and Notification of Managed Care Organization Appeals 6-1-26

A. Each MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this manual.

B. **Specific timeframes.**

1. **Standard resolution of grievances.** Grievances must be resolved with notice sent to affected parties within thirty (30) calendar days from the date the MCO receives the grievance.

2. **Standard resolution of appeals.** Appeals must be resolved with notice sent to affected parties within thirty (30) calendar days from the date the MCO receives the appeal.

3. **Expedited resolution of appeals.** For expedited resolution of an appeal and notice to affected parties, a timeframe that is no longer than seventy-two (72) hours after the MCO receives the appeal. This timeframe may be extended under subsection C of this section.

C. **Extension of timeframes.**

1. The MCO may extend the timeframes from subsection B of this section by up to fourteen (14) calendar days if:

   a. The member requests the extension; or

   b. The MCO shows to the satisfaction of DHS upon request that there is need for additional information and how the delay is in the member's interest.

2. **Requirements following extension.** If the MCO extends the timeframes not at the request of the member, it must complete all of the following:

   a. Make reasonable efforts to give the member prompt oral notice of the delay;

   b. Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and

   c. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

3. **Deemed exhaustion of appeals processes.** In the case of an MCO that fails to adhere to the notice and timing requirements in this section, the member is deemed to have exhausted the MCO's appeals process. The member may initiate a State fair hearing with the DHS Office of Appeals and Hearings.

D. **Format of notice.**

1. For all appeals, the MCO must provide written notice of resolution in a format and language that, at a minimum, meet the standards described in 42 C.F.R. § 438.10.

2. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.

E. **Content of notice of appeal resolution.** The written notice of the resolution must include the following:

1. The results of the resolution process and the date it was completed; and

2. For appeals not resolved wholly in favor of the members:

   a. The right to request a State fair hearing, and how to do so;

   b. The right to request and receive benefits while the hearing is pending, and how to make the request; and

   c. That the member may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's adverse action.

192.007 Expedited Resolution of Appeals 6-1-26

A. MCOs must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

B. **Punitive action.** The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

C. **Action following denial of a request for expedited resolution.** If the MCO denies a request for expedited resolution of an appeal, it must:

1. Transfer the appeal to the timeframe for standard resolution in accordance with this manual; and

2. Follow the requirements in section 192.006 above.

192.008 State Fair Hearings 6-1-26

A. Requirements for State fair hearings

1. **Availability.** A member may request a State fair hearing only after receiving notice that the MCO is upholding the adverse benefit determination.

a. Deemed exhaustion of appeals processes. In the case of an MCO that fails to adhere to the notice and timing requirements in section 192.003, the member is deemed to have exhausted the MCO's appeals process. The member may initiate a State fair hearing with the DHS Office of Appeals and Hearings.

2. **State fair hearing.** The member must have no less than ninety (90) calendar days from the date of the MCO's notice of resolution to request a State fair hearing.

3. **Parties.** The parties to the State fair hearing include the MCO, as well as the member and his or her representative or the representative of a deceased member's estate. DHS, by its own motion, may intervene and join as a party to the State fair hearing as determined by DHS to be necessary.

B. Requests for a State fair hearing shall be sent to the **DHS Office of Appeals and Hearings**.

192.009 Judicial Review 6-1-26

A. Adjudication of a State fair hearing will be the final agency action.

B. In cases of adjudication, any person who considers himself or herself injured in his or her person, business, or property by final agency action shall be entitled to judicial review of the action in accordance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq.

C. The parties to a judicial review action under the Arkansas Administrative Procedure Act will be those parties that participated in the State fair hearing. If DHS did not intervene and participate at the State fair hearing as a responsive party, then DHS will not be a responsive party during the judicial review proceedings. As a non-responsive party, the only initial obligation of DHS in a judicial review proceeding will be the filing of the administrative record.

D. **Filing the administrative record.**

1. Within thirty (30) days after service of the petition or within such further time as the court may allow but not exceeding an aggregate of ninety (90) days, the agency shall transmit to the reviewing court the original or a certified copy of the entire record of the proceeding under review.

2. The cost of the preparation of the record shall be borne by the agency.

192.010 Continuation of Benefits While the MCO Appeal and the State Fair Hearing Are Pending 6-1-26

A. **Definition.** As used in this section, "timely files" means files for continuation of benefits on or before the later of the following:

1. Within ten (10) calendar days of the MCO sending the notice of adverse benefit determination; or

2. The intended effective date of the MCO's proposed adverse benefit determination.

B. **Continuation of benefits.** The MCO must continue the member's benefits if all of the following occur:

1. The member files the request for an appeal timely in accordance with section 192.004(c)(2);

2. The appeal involves the termination, suspension, or reduction of previously authorized services;

3. The services were ordered by an authorized provider;

4. The period covered by the original authorization has not expired; and

5. The member timely files for continuation of benefits.

C. Providers cannot request continuation of benefits as specified in section 42 CFR § 438.420(b).

D. **Duration of continued or reinstated benefits.** If, at the member's request, the MCO continues or reinstates the member's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one (1) of following occurs:

1. The member withdraws the appeal or request for state fair hearing;

2. The member fails to timely request a state fair hearing after the MCO sends the notice of an adverse resolution to the member's appeal under section 192.008(A)(2) above; or

3. A State fair hearing officer issues a hearing decision adverse to the member.

E. Member responsibility for services furnished while the appeal or state fair hearing is pending. If the final resolution of the appeal or state fair hearing is adverse to the member, that is, upholds the MCO's adverse action, the MCO may, consistent with the state's usual policy on recoveries and as specified in the MCO's contract, recover the cost of services furnished to the member while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

TOC required

100.100 Introduction 6-1-26

Section I gives general program information about the Arkansas Medicaid Program. It includes information about beneficiary eligibility and explains the provider's role and responsibilities. The intent is to provide users with an understanding of Medicaid Program objectives and regulations. It contains details providers may need to answer questions often asked about the Medicaid Program. Seven (7) major areas are covered in Section I.

A. General information - Describes the background, history, and scope of the Medicaid Program, including information about Medicaid waivers and other programs administered by Department of Human Services (DHS).

B. Beneficiary eligibility - Explains Medicaid beneficiary aid categories, eligibility for benefits, responsibilities, the Medicaid identification card, and additional beneficiary information.

C. Provider participation - Specifies the provider enrollment procedures, general conditions that must be met by providers to begin and maintain program participation, and remedies and sanctions DHS may employ in the administration and regulation of the Arkansas Medicaid Program.

D. Administrative remedies and sanctions - Describes the rules for imposing sanctions.

E. Provider due process - Explains how a provider may request an administrative reconsideration or appeal of an adverse decision or sanctions.

F. Beneficiary due process - Describes how a beneficiary may request an administrative appeal of an adverse decision.

G. Managed Care due process – Describes how a managed care organization must develop a grievance and appeals process and how a member of a managed care organization can utilize the grievance and appeals process and request a state fair hearing.

H. Primary Care Case Management Program (PCCM) - Defines the scope of the Primary Care Case Management Program (PCCM) and regulations regarding provider and enrollee participation. It lists the categories of eligibility that are exempt from primary care provider (PCP) referral requirements and itemizes the services that do not require PCP referral. PCP enrollment and enrollment transfer procedures are explained, as are PCP referral requirements and procedures.

106.000 Limitations on Coverage for Certain Organ Transplants 6-1-26

The Arkansas Medicaid Program will comply with Ark. Code Ann. § 23-79-169 in providing coverage for human organ transplants.

110.700 Medicaid Fraud Detection and Investigation Program 6-1-26

Federal Regulations require the implementation of a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate utilization of care and services and excess reimbursements by the Medicaid program. The purpose of the Office of the Medicaid Inspector General (OMIG) is to investigate fraud allegations and ensure Arkansas Medicaid's compliance. **[Title XIX of the Social Security Act, Arkansas Code Annotated, 42 C.F.R. §455 and the Arkansas State Plan].**

The goal of the unit is to verify the nature and extent of services reimbursed by the Medicaid program, ensure reimbursements are consistent with the quality of care being provided, and protect the integrity of both state and federal funds.

Responsibilities of the unit include the following:

A. Verify medical services meet an accepted standard of care and are rendered as billed;

B. Verify services are provided by qualified providers to eligible beneficiaries;

C. Verify reimbursement for services is correct and all funds identified for collection prior to Medicaid reimbursement are pursued.

OMIG is responsible for conducting on-site medical reviews to verify the above tasks, record keeping, and other specified information. Providers selected for an on-site review will not be notified in advance. Review analysts may request additional information regarding the provider's medical practice. **View or print Office of Medicaid Inspector General contact information.**

When warranted, OMIG is responsible for identifying and recovering questioned costs claimed for reimbursement from Medicaid funds. Situations resulting in recoupment include such things as the following:

A. When duplicate payments are made;

B. When the Quality Improvement Organization (QIO) denies all or part of a hospital admission;

C. When medical consultants to the Medicaid Program determine lack of medical necessity;

D. When Medicaid, Medicare, or the Attorney General's Medicaid Fraud Unit discovers evidence of overpayment;

E. When a provider has been assessed a monetary penalty for failure to follow a corrective action plan developed to correct a pattern of non-compliance (See Sections 151.000 and 190.005)

When a review is completed, OMIG will forward a findings report to the provider. If questioned costs are identified through the review, a "Notice of Action" will be sent to the provider. The notice must comply with required explanations of adverse decisions and must include the name(s) of the patient(s), date(s) of service, date(s) of payment, and the reason(s) for the recoupment decision.

Upon receipt of the notice, the provider has sixty-five (65) calendar days to pursue one of the following actions:

A. Forward a check for the indicated recoupment amount;

B. Request administrative reconsideration;

C. Appeal,

Rules, timelines, and procedures related to administrative reconsideration and appeals are further explained in ensuing sections of this manual.

161.200 Administrative Reconsideration 6-1-26

A. Within sixty-five (65) calendar days after notice of an adverse decision or action, the provider may request administrative reconsideration. Requests must be in writing and include:

1. A copy of the letter or notice of adverse decision or action; and

2. Additional documentation that supports medical necessity.

Administrative reconsideration does not postpone any adverse action that may be imposed pending appeal.

B. Requests for reconsideration must be submitted as follows:

1. In situations where the adverse decision or action has been taken by a reviewing agent, the request must be directed to that reviewing agent. Contact information for the department's reviewing agents can be found in Section V of this manual.

2. When an adverse decision or action has been taken by the Office of Medicaid Inspector General (OMIG) on behalf of Division of Medical Services (DMS), the request for reconsideration must be directed to OMIG. **View or print the Office of Medicaid Inspector General contact information.** Within twenty (20) calendar days of receiving a timely and complete request for administrative reconsideration, OMIG will designate a reviewer and proceed according to its own procedures. When an adverse decision or action has been taken by the Utilization Review (UR) Section of DMS, the request for reconsideration must be directed to UR. **View or print the Utilization Review contact information**.

The sixty-five-day time period to request a reconsideration begins to run five (5) days after the date of the written notice.

No administrative reconsideration is allowed if the adverse decision or action is due to loss of licensure, accreditation, or certification.

161.300 Administrative Appeals of Adverse Actions that are not Sanctions 6-1-26

In addition to sanction reconsiderations and appeal procedures set forth in Sections 160.000-169.000, providers may appeal any other decision of the Department of Human Services, its reviewers, or contractors if that decision adversely affects a Medicaid provider or beneficiary with regard to receipt or payment of Medicaid-covered services. Such decisions and consequent actions are "non-sanction adverse actions."

Within sixty-five (65) calendar days of receiving notice of non-sanction adverse action, or sixty-five (65) calendar days of receiving an administrative reconsideration decision that upholds all or part of any adverse decision or action, whichever is later, the provider may appeal. The time period for filing an appeal shall begin to run five (5) days after the date of the written notice of non-sanction adverse action or administrative reconsideration decision. An appeal must be in writing and must specify in detail all findings, determinations, and adverse decisions or actions that the provider alleges are not supported by applicable laws, including state and federal laws and rules, applicable professional standards, or both. Providers shall mail or deliver the appeal to the **Arkansas Department of Health, Office of Medicaid Provider Appeals**.

161.400 Sanction Appeals 6-1-26

Within sixty-five (65) calendar days of receiving notice of adverse decision or action, or sixty-five (65) calendar days of receiving an administrative reconsideration decision that upholds all or part of any adverse decision/action, whichever is later, the provider may appeal. The sixty-five (65) days begins to run five (5) days after the date of the written notice.

An appeal must be in writing and must specify in detail all findings, determinations, and adverse decisions or actions that the provider alleges are not supported by applicable laws, including state and federal laws and rules, applicable professional standards, or both. Providers shall mail or deliver the appeal to the **Arkansas Department of Health, Office of Medicaid Provider Appeals**. No appeal is allowed if the adverse decision or action is due to loss of licensure, accreditation, or certification.

162.000 Notice of the Appeal Hearing 6-1-26

When an appeal hearing is scheduled, the Office of Medicaid Provider Appeals of the Department of Health shall notify the provider, or if the provider is represented by an attorney, the provider's attorney, in writing, of the date, time, and place of the hearing. Notice shall be mailed not less than ten (10) calendar days before the scheduled date of the hearing. The decision of the Office of Medicaid Provider Appeals is the final agency determination.

169.100 Recovery of the Costs of Services Continued During the Appeal Process 6-1-26

42 CFR §431.230 entitled "Maintaining Services," which states in part:

> (b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or beneficiary to recoup the cost of any services furnished the beneficiary, to the extent they were furnished solely by reason of this section.

190.001 The Medicaid Fairness Act 6-1-26

The Medicaid Fairness Act, Ark. Code Ann. § 20-77-1701 et seq., requires that the Department of Human Services and its outside contractors treat providers with fairness and due process.

190.002 Definitions 6-1-26

A. Adverse decision or adverse action: any decision or action by the Department of Human Services or its reviewers or contractors that adversely affects a Medicaid provider or beneficiary in regard to:

1. Receipt of and payment for Medicaid claims and services including but not limited to decisions as to:
   a. Appropriate level of care or coding;
   b. Medical necessity;
   c. Prior authorization;
   d. Concurrent reviews;
   e. Retrospective reviews;
   f. Least restrictive setting;
   g. Desk audits;
   h. Field audits and onsite audits; and
   i. Inspections or surveys;
   j. Payment amounts due to or from a particular provider resulting from gain sharing, risk sharing, incentive payments, or another reimbursement mechanism or methodology, including calculations that affect or have the potential to affect payment; and
   k. Imposition of corrective action plans.
2. To constitute an adverse decision, an agency decision need not have a monetary penalty attached or a direct monetary consequence to the provider.
3. "Adverse decision" does not include the design of or changes to an element of a reimbursement methodology or payment system that is of general applicability and implemented through the rulemaking process.

B. Appeal: an appeal under the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq.

C. Claim: a request for payment of services.

D. Concurrent review or concurrent authorization: a review to determine whether a specified beneficiary currently receiving specific services may continue to receive services.

E. Denial: denial or partial denial of a claim or authorization of services.

F. Department:

1. The Department of Human Services;
2. All of the divisions and programs of the Department of Human Services, including the Arkansas Medicaid Program; and
3. All of the Department of Human Services' contractors, fiscal agents, and other designees and agents.

G. Medicaid: the medical assistance program under Title XIX of the Social Security Act that is operated by the Department of Human Services and its contractors, fiscal agents, and all other designees and agents.

H. Person: any individual, company, firm, organization, association, corporation, or other legal entity.

I. Primary care physician: a physician whom the department has designated as responsible for the referral or management, or both, of a Medicaid beneficiary's health care.

J. Prior authorization: the approval by the Arkansas Medicaid Program for specified services for a specified Medicaid beneficiary before the requested services may be performed and before payment will be made by the Arkansas Medicaid Program.

K. Provider: a person enrolled to provide health or medical care services or goods authorized under the Arkansas Medicaid Program.

L. Recoupment: any action or attempt by the Department of Human Services to recover or collect Medicaid payments already made to a provider with respect to a claim by:

1. Reducing, withholding or affecting in any other manner current or future payments to a provider; or
2. Demanding payment back from a provider for a claim already paid.

M. Retrospective review: the review of services or practice patterns after payment, including, but not limited to:

1. Utilization reviews;
2. Medical necessity reviews;
3. Professional reviews;
4. Field audits and onsite audits; and
5. Desk audits.

N. Reviewer: any person, including reviewers, auditors, inspectors, surveyors and others who, in reviewing a provider or a provider's provision of services and goods, perform review actions, including, but not limited to:

1. Reviews for quality;
2. Reviews for quantity;
3. Utilization;
4. Practice patterns;

5. Medical necessity;

6. Peer review; and

7. Compliance with Medicaid standards.

O. Technical deficiency: an error or omission in documentation by a provider that does not affect direct patient care of the beneficiary. Technical deficiency does not include:

1. Lack of medical necessity or failure to document medical necessity in a manner that meets professionally recognized applicable standards of care;

2. Failure to provide care of a quality that meets professionally recognized local standards of care;

3. Failure to obtain prior, concurrent, or mandatory authorization if required by regulation;

4. Fraud;

5. A pattern of abusive billing;

6. A pattern of noncompliance; or

7. A gross and flagrant violation.

190.003 Administrative Appeals 6-1-26

A. The following appeals are available in response to an adverse decision:

1. A beneficiary may appeal on his or her own behalf;

2. A provider of medical assistance that is the subject of the adverse action may appeal on the beneficiary's behalf; and

3. If the adverse action denies a claim for covered medical assistance that was previously provided to a Medicaid-eligible beneficiary, the provider of such medical assistance may appeal on the provider's behalf. The provider does not have standing to appeal a non-payment decision if the provider has not furnished any service for which payment has been denied.

B. All appeals shall conform to the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq.

C. Providers may appear in person, through a corporate representative or, with prior notice to the Department of Human Services, through legal counsel.

D. Beneficiaries may represent themselves or they may be represented by a friend, by any other spokesperson except a corporation, or by legal counsel.

E. A Medicaid beneficiary may attend any hearing related to his or her care, but the department may not make his or her participation a requirement for provider appeals. The department may compel the beneficiary's presence via subpoena, but failure of the beneficiary to appear shall not preclude the provider's appeal.

F. If an administrative appeal is filed by both a provider and beneficiary concerning the same subject matter, the department may consolidate the appeals.

G. Any person who considers himself or herself injured in his or her person, business, or property by the decision rendered in the administrative appeal is entitled to judicial review of the decision under the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq.

H. This rule shall apply to all pending and subsequent appeals that have not been finally resolved at the administrative or judicial level as of April 5, 2005.

191.001 Definitions 6-1-26

A. Adverse decision or adverse action means any decision or action by the Department of Human Services or its reviewers or contractors that adversely affects a Medicaid provider or beneficiary in regard to receipt of and payment for Medicaid claims and services by limiting, terminating, suspending, or reducing Medicaid eligibility or covered services in connection with, but not limited to:

1. A termination, suspension of, or reduction in covered benefits or services, including benefits or services for which there is a current approved prior authorization;
2. A termination, suspension of, or reduction in Medicaid eligibility, or an increase in beneficiary liability, including a determination that a beneficiary must incur a greater amount of medical expenses to establish income eligibility in accordance with 42 CFR § 435.121(e)(4) or 42 CFR § 435.831;
3. A determination that a beneficiary is subject to an increase in premiums or cost-sharing charges under 42 CFR part 447, subpart A; or
4. A determination by a skilled nursing facility or nursing facility to transfer or discharge a resident and an adverse determination by a State regarding the preadmission screening and resident review requirements of section 1919(e)(7) of the Social Security Act.

B. Beneficiary:

1. A person who has applied for medical assistance under the Arkansas Medicaid Program; or
2. A person who is a beneficiary of medical assistance under the Arkansas Medicaid Program.

C. Department: The Department of Human Services.

191.002 Notice 6-1-26

A. If an application or claim for medical assistance is denied in whole or in part or is not acted upon with reasonable promptness, the Department of Human Services shall provide written notice:

1. Of the beneficiary's right and opportunity for a fair hearing under the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq.;
2. Of the method by which the beneficiary may obtain a fair hearing; and
3. Of the beneficiary’s right to:
   a. Represent himself or herself; or
   b. Be represented by legal counsel, a friend, or any other spokesperson except a corporation.

B. A notice required under this rule shall include but not be limited to:

1. A statement detailing the type and amount of medical assistance that the beneficiary has requested;
2. A statement of the adverse action that the department has taken or proposes to take;
3. The reasons for the adverse action, which shall include but not be limited to:
   a. The specific facts regarding the individual beneficiary that support the action; and
   b. The sources from which the facts were derived;

4. An explanation of the beneficiary's right to request a fair hearing, if available, or in cases of an adverse action based on a change in law:
   a. The circumstances under which a fair hearing will be granted; and
   b. An explanation of the circumstances under which medical assistance is provided or continued if a fair hearing is requested.

191.003 Determination of Medical Necessity – Content of Notice 6-1-26

If the adverse action that the Department of Human Services has taken or proposes to take is based on a determination of medical necessity or other clinical decision, the notice required under Rule 191.002 shall include all of the following:

A. Specification of the medical records upon which the physician or clinician relied in making the determination;

B. Specification of any portion of the criteria for medical necessity or coverage that is not met by the beneficiary;

C. The specific regulation(s) that support the adverse action, or the change in federal or state law that has occurred since the application was filed that requires adverse action; and

D. A brief statement of the reasons for the adverse action based upon the individual beneficiary's circumstances.

The department and others acting on behalf of the department may not cite or rely on policies that are inconsistent with federal or state laws and regulations or that were not properly promulgated. Generic rationales or explanations shall not suffice to meet the requirements of this rule.

191.004 Administrative Appeals 6-1-26

When notice of an adverse decision is received from the Division of Medical Services, the beneficiary may appeal. The appeal request must be in writing and submitted to the Department of Human Services, Office of Appeals and Hearings. **View or print the Department of Human Services, Office of Appeals and Hearings contact information.** The appeal request must be received by the Office of Appeals and Hearings no later than thirty (30) days from the date of written notice. The thirty (30) days begins to run five (5) days after the date of written notice.

All appeals shall conform to the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq. Beneficiaries may represent themselves or they may be represented by a friend, by any other spokesperson except a corporation, or by legal counsel.

If an administrative appeal is filed by both a provider and beneficiary concerning the same subject matter, the department may consolidate the appeals.

Any person who considers himself or herself injured in his or her person, business, or property by the decision rendered in the administrative appeal is entitled to judicial review of the decision under the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq.

191.005 Conducting the Hearing 6-1-26

If a beneficiary appeals an adverse action under the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq., the reviewing authority shall consider only those adverse actions that were included in the written notice to the beneficiary as required under Rules 191.002 and 191.003.

All determinations of the medical necessity of any request for medical assistance shall be based on the individual needs of the beneficiary and on his or her medical history.

192.000 MANAGED CARE DUE PROCESS

192.001 Scope 6-1-26

This section applies to beneficiary appeals to managed care organizations (MCO). A "managed care organization" includes, but is not limited to, a Provider-Led Arkansas Shared Savings Entity (PASSE) or other Risk Based Provider Organization. Provider appeals to MCOs are governed by all applicable state and federal laws and agreements or contracts between the provider and the MCO.

This section does not apply to non-emergency medical transportation Prepaid Ambulatory Health Plans (PAHPs) in accordance with 42 CFR § 438.9. This section also does not apply to Qualified Health Plans in the AR HOME program.

192.002 Definitions 6-1-26

A. Adverse benefit determination means any of the following:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at 42 CFR § 447.45(b) is not an adverse benefit determination;
4. The failure to provide services in a timely manner;
5. The failure to act within the prescribed timeframes regarding the standard resolution of grievances and appeals;
6. For a resident of a rural area with only one (1) managed care organization, the denial of a member's request to exercise his or her right to obtain services outside the network; and
7. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, coinsurance, and other member financial liabilities.

B. Appeal means a review of an adverse benefit determination by an MCO.

C. Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationship such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the MCO, PIHP, or PAHP to make an authorization decision.

D. Grievance and appeal system means the processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

E. Managed Care Organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is:

1. A federally qualified HMO that meets the advance directives requirements of 42 CFR part 489, subpart I; or
2. Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:
   a. Makes the services it provides to its members as accessible (in terms of

timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity; and

b. Meets the solvency standards of 42 CFR § 438.116.

F. Managed Care Program means a managed care delivery system authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act.

G. Member means a Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program;

H. Prepaid ambulatory health plan (PAHP) means an entity that:

1. Provides services to members under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates;

2. Does not provide or arrange for, and is not otherwise responsible for the provision of inpatient hospital or institutional services for its members; and

3. Does not have a comprehensive risk contract.

I. Prepaid inpatient health plan (PIHP) means an entity that:

1. Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates;

2. Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and

3. Does not have a comprehensive risk contract.

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

1. Is fifty-one percent (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 with the Arkansas Insurance Department, enrolled as a Medicaid provider, and enter into an annual PASSE agreement with DHS.

K. Risk Based Provider Organization means an entity that:

1. Is licensed by the Insurance Commissioner under the rules established for risk-based provider organizations by the commissioner;

2. Is obligated to assume the financial risk for the delivery of specifically defined healthcare services to an enrollable Medicaid beneficiary population; and

3. Is paid by DHS on a capitated basis with a global payment made, whether or not a particular member of an enrollable Medicaid beneficiary population receives services during the period covered by the payment.

L. State Fair Hearing means an administrative review provided by the State that meets the requirements of 42 CFR part 431, subpart E, and will result in a final agency action in accordance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq.

192.003 Timing and Content in Notice of Adverse Benefit Determination by Managed Care Organizations 6-1-26

A. **Notice**. The MCO must comply with all applicable provisions of 42 CFR 438.210, Coverage and authorization of services, and the Arkansas Prior Authorization Transparency Act, Ark. Code Ann. 23-99-1101 et seq.

B. The notice must explain the following:

1. The adverse benefit determination the MCO has made or intends to make;
2. The reasons for the adverse benefit determination, including the right of the member to be provided upon request free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member 's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;
3. The member 's right to request an appeal of the MCO's adverse benefit determination, including information on exhausting the MCO's one level of appeal and the right to request a State fair hearing from the DHS Office of Appeals and Hearings;
4. The procedures for exercising the rights specified in this section;
5. The circumstances under which an appeal process can be expedited and how to request it; and
6. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of these services.

C. **Timeframe for decisions**. The MCO must provide for the following decisions and notices:

1. Standard (nonurgent healthcare service) authorization decisions
   a. For standard authorization decisions, provide notice as expeditiously as the member’s condition requires and not more than two (2) business days of obtaining all necessary information to make the authorization or adverse benefit determination. Necessary information included the results of any face-to-face clinical evaluation or second opinion that may be required.
   b. Standard authorization decisions may have an extension of up to 14 additional calendar days if the member or provider requests the extension and the MCO justifies the need for additional information and how the extension is in the enrollee’s interest.
2. Expedited (urgent healthcare service) authorization decisions
   a. For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member’s health condition requires and no later than one (1) business day after receiving all information needed to completed the review of the requested service.
   b. Expedited authorization decisions may have an extension of up to 14 additional calendar days if the member or provider requests the extension and the MCO justifies the need for additional information and how the extension is in the

enrollee's interest.

192.004 Managed Care Organizations - Appeals 6-1-26

A. Each Managed Care Organization (MCO), including PASSEs, must have an appeal system in place for members. Non-emergency medical transportation providers are exempt from this section.

B. Each MCO may have only one level of appeal for members.

C. **Filing requirements.**

1. **Authority to file.** A member may request an appeal with the MCO. A member may request a State fair hearing with the DHS Office of Appeals and Hearings after receiving notice from the MCO that the adverse action is upheld.
    a. **Deemed exhaustion of appeals processes.** In the case of an MCO that fails to adhere to the notice and timing requirements in section 192.003 the member is deemed to have exhausted the MCO's appeals process. The member may initiate a State fair hearing.
    b. With the written consent of the member, a provider or an authorized representative may request an appeal, or request a State fair hearing, on behalf of a member. This will be considered a member appeal, not a provider appeal under the Medicaid Fairness Act.
2. **Timing.** Following receipt of a notification of an adverse action by an MCO, a member has sixty (60) calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the MCO.
3. **Method.** The member may request an appeal to the MCO either orally or in writing by telephone, via mail, in person, or through other commonly available electronic means.

192.005 MCO Appeal Requirements 6-1-26

A. Each MCO must provide members any reasonable assistance in completing forms and taking other procedural steps related to an appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY or TTD and interpreter capability.

B. **Special requirements**. An MCO's process for handling member appeals of adverse benefit determinations must:

1. Acknowledge receipt of each appeal;
2. Ensure that the individuals who make decisions on appeals are individuals:
    a. Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual;
    b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member 's condition or disease:
        i. An appeal of a denial that is based on lack of medical necessity;
        ii. A grievance regarding denial of expedited resolution of an appeal; or
        iii. A grievance or appeal that involves clinical issues; and
    c. Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination;

3. Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals;

4. Provide the member with a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in this manual, including timeframes in the case of expedited resolution;

5. Provide the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, (or at the direction of the MCO), in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in this manual; and

6. Include, as parties to the appeal:

   a. The member and his or her representative; or

   b. The legal representative of a deceased member's estate.

192.006 Resolution and Notification of Managed Care Organization Appeals 6-1-26

A. Each MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this manual.

B. **Specific timeframes.**

1. **Standard resolution of grievances.** Grievances must be resolved with notice sent to affected parties within thirty (30) calendar days from the date the MCO receives the grievance.

2. **Standard resolution of appeals.** Appeals must be resolved with notice sent to affected parties within thirty (30) calendar days from the date the MCO receives the appeal.

3. **Expedited resolution of appeals.** For expedited resolution of an appeal and notice to affected parties, a timeframe that is no longer than seventy-two (72) hours after the MCO receives the appeal. This timeframe may be extended under subsection C of this section.

C. **Extension of timeframes.**

1. The MCO may extend the timeframes from subsection B of this section by up to fourteen (14) calendar days if:

   a. The member requests the extension; or

   b. The MCO shows to the satisfaction of DHS upon request that there is need for additional information and how the delay is in the member's interest.

2. **Requirements following extension.** If the MCO extends the timeframes not at the request of the member, it must complete all of the following:

   a. Make reasonable efforts to give the member prompt oral notice of the delay;

   b. Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and

   c. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

3. **Deemed exhaustion of appeals processes.** In the case of an MCO that fails to adhere to the notice and timing requirements in this section, the member is deemed

to have exhausted the MCO's appeals process. The member may initiate a State fair hearing with the DHS Office of Appeals and Hearings.

D. **Format of notice.**

1. For all appeals, the MCO must provide written notice of resolution in a format and language that, at a minimum, meet the standards described in 42 C.F.R. § 438.10.
2. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.

E. **Content of notice of appeal resolution.** The written notice of the resolution must include the following:

1. The results of the resolution process and the date it was completed; and
2. For appeals not resolved wholly in favor of the members:
   a. The right to request a State fair hearing, and how to do so;
   b. The right to request and receive benefits while the hearing is pending, and how to make the request; and
   c. That the member may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's adverse action.

192.007 Expedited Resolution of Appeals 6-1-26

A. MCOs must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

B. **Punitive action.** The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

C. **Action following denial of a request for expedited resolution.** If the MCO denies a request for expedited resolution of an appeal, it must:

1. Transfer the appeal to the timeframe for standard resolution in accordance with this manual; and
2. Follow the requirements in section 192.006 above.

192.008 State Fair Hearings 6-1-26

A. Requirements for State fair hearings

1. **Availability.** A member may request a State fair hearing only after receiving notice that the MCO is upholding the adverse benefit determination.
   a. Deemed exhaustion of appeals processes. In the case of an MCO that fails to adhere to the notice and timing requirements in section 192.003, the member is deemed to have exhausted the MCO's appeals process. The member may initiate a State fair hearing with the DHS Office of Appeals and Hearings.
2. **State fair hearing.** The member must have no less than ninety (90) calendar days from the date of the MCO's notice of resolution to request a State fair hearing.
3. **Parties.** The parties to the State fair hearing include the MCO, as well as the member and his or her representative or the representative of a deceased member's estate. DHS, by its own motion, may intervene and join as a party to the State fair hearing as determined by DHS to be necessary.

B. Requests for a State fair hearing shall be sent to the **DHS Office of Appeals and Hearings**.

192.009 Judicial Review 6-1-26

A. Adjudication of a State fair hearing will be the final agency action.

B. In cases of adjudication, any person who considers himself or herself injured in his or her person, business, or property by final agency action shall be entitled to judicial review of the action in accordance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201 et seq.

C. The parties to a judicial review action under the Arkansas Administrative Procedure Act will be those parties that participated in the State fair hearing. If DHS did not intervene and participate at the State fair hearing as a responsive party, then DHS will not be a responsive party during the judicial review proceedings. As a non-responsive party, the only initial obligation of DHS in a judicial review proceeding will be the filing of the administrative record.

D. **Filing the administrative record.**

1. Within thirty (30) days after service of the petition or within such further time as the court may allow but not exceeding an aggregate of ninety (90) days, the agency shall transmit to the reviewing court the original or a certified copy of the entire record of the proceeding under review.
2. The cost of the preparation of the record shall be borne by the agency.

192.010 Continuation of Benefits While the MCO Appeal and the State Fair Hearing Are Pending 6-1-26

A. **Definition.** As used in this section, “timely files” means files for continuation of benefits on or before the later of the following:

1. Within ten (10) calendar days of the MCO sending the notice of adverse benefit determination; or
2. The intended effective date of the MCO's proposed adverse benefit determination.

B. **Continuation of benefits.** The MCO must continue the member's benefits if all of the following occur:

1. The member files the request for an appeal timely in accordance with section 192.004(c)(2);
2. The appeal involves the termination, suspension, or reduction of previously authorized services;
3. The services were ordered by an authorized provider;
4. The period covered by the original authorization has not expired; and
5. The member timely files for continuation of benefits.

C. Providers cannot request continuation of benefits as specified in section 42 CFR § 438.420(b).

D. **Duration of continued or reinstated benefits.** If, at the member's request, the MCO continues or reinstates the member's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one (1) of following occurs:

1. The member withdraws the appeal or request for state fair hearing;

2. The member fails to timely request a state fair hearing after the MCO sends the notice of an adverse resolution to the member's appeal under section 192.008(A)(2) above; or

3. A State fair hearing officer issues a hearing decision adverse to the member.

E. Member responsibility for services furnished while the appeal or state fair hearing is pending. If the final resolution of the appeal or state fair hearing is adverse to the member, that is, upholds the MCO's adverse action, the MCO may, consistent with the state's usual policy on recoveries and as specified in the MCO's contract, recover the cost of services furnished to the member while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

TOC required

200.000 DEFINITIONS

Adjusted Premium Revenue

Premium revenue as defined in 42 CFR § 438.8 minus the PASSE's Federal, State and local taxes, licensing and regulatory fees as defined in 42 CFR §438.8.

Administrative Cost Ratio

Administrative Cost Percentage [42 CFR § 438.116 (a) and (b)] is the total administrative expenses, divided by total payments received from State of Arkansas less premium tax.

Adverse ~~Decision/Adverse Action~~Benefit Determination

Any decision or action by the PASSE or DHS that adversely affects a Medicaid provider or beneficiary in regard to receipt of and payment for claims and services including but not limited to decisions or findings related to:

A. Appropriate level of care or coding,

B. Medical necessity,

C. Prior authorization,

D. Concurrent reviews,

E. Retrospective reviews,

F. Least restrictive setting,

G. Desk audits,

H. Field audits and onsite audits

I. Inspections, and

J. Payment amounts due to or from a particular provider resulting from gain sharing, risk sharing, incentive payments or another reimbursement mechanism or methodology.

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.

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.

Assignment

The process by which DHS assigns a newly eligible member among the active PASSEs. The individual will have 90 days from the date coverage begins to switch to a different PASSE. If the individual does not choose to switch to a different PASSE within this time, he/she will remain a member of that PASSE until the end of the coverage year.

Benefit Expenditure Report (BER)

The Benefit Expenditure Report documents how much was paid during the performance year by the PASSE, in the aggregate, to direct service providers for services provided to its members. A PASSE may choose to spend up to five percent (5%) of benefit expenditures on community investments. Community investments will be counted as benefit expenditures rather than administrative expenditures in calculating and reporting the medical loss ratio.

Care Coordination

Activities involving 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, medication management, treatment plan follow-through, service coordination, monitoring the patient adherence, and reevaluating the patient for medically necessary care and service. These activities focus on ensuring 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.

Case Management

Services furnished to assist individuals in gaining access to needed medical, social, educational, and others services in accordance with 42 CFR § 440.169.

Centers for Medicare & Medicaid Services (CMS)

The Centers for Medicare & Medicaid Services (CMS) is the federal agency delegated by the Secretary of the US Department of Health and Human Services to administer the Medicaid program under Title XIX of the Social Security Act and thereby has federal oversight responsibilities for the state and the PASSEs.

The state and the PASSEs must meet the requirements of a Medicaid managed care organization as defined in 42 CFR § Part 438.

Claims Payment

A claims payment is a payment made in full or in part to a service provider for the provision of medically necessary treatment and services to an eligible beneficiary that is a PASSE member. Claims types include hospital inpatient, outpatient, professional payments, clinic, ancillary, pharmacy, support service, and other institutional payments.

Claims Payment Process

A claims payment process involves all the business and operational processes, claims management information systems, and banking processes that are necessary to receive, validate, adjudicate, audit, and reimburse providers for services provided to eligible beneficiary. These business and operational activities, processes, and systems are performed and managed by the PASSE organization to meet the claims payment standards of the State.

Direct Service Provider

An organization or individual that delivers healthcare services to beneficiaries attributed to a PASSE. PASSE Equity Owners can be direct service providers.

Disenrollment

A determination by DHS that a member is no longer eligible to receive PASSE services.

Federal, State, and local taxes and licensing and regulatory fees

Federal, State, and local taxes and licensing and regulatory fees are as defined in 42 CFR §438.8.

Flexible Supports

Flexible supports are a person-centered support developed for an individual need, and is generally provided on a case-by-case basis. These supports do not have to be pre-approved by DHS.

Fraud Prevention Activities

Fraud Prevention Activities are as defined in 42 CFR § 438.8

Incurred Claims

Incurred claims are as defined in 42 CFR § 438.8

Independent Assessment

An Independent Assessment (IA) is required prior to becoming a member of a PASSE. Not all Medicaid enrollees can be enrolled in a PASSE. Individuals must be in need of behavioral health or developmental disabilities services. An IA is conducted by qualified individual using an assessment instrument approved by DHS. Individuals who are assessed as meeting a Tier II or Tier III level of care condition will be assigned into an active PASSE and are required to obtain all non-excluded Medicaid services through the PASSE.

An individual who is assessed as meeting a Tier I level of care condition may voluntarily enroll in a PASSE as of July 1, 2019 or later as specified by DHS.

The Tier is also used by DHS in the determination of the actuarially sound rates to be paid to a PASSE for that individual.

Medical/Quality Management Committee

A committee developed by the PASSE to oversee Quality Assurance and Quality Improvement activities of PASSE services.

Medical Loss Ratio

Each PASSE must report its Medical Loss Ratio (MLR) to AID and DHS. Calculation of the MLR is defined at 42 CFR § 438.8.

Member

A Medicaid beneficiary who is enrolled in a PASSE.

Network Provider

The provider who, under a contract with a PASSE or with its contractor/subcontractor, has agreed to provide Health Care Services to persons with an expectation of receiving payments directly or indirectly from the PASSE.

Open Enrollment Period

DHS will, on an annual basis, offer an open enrollment period for all current enrollees to choose a different PASSE for coverage beginning January 1 of the following year. If an individual does not make an active choice to switch PASSEs during the open enrollment period, that individual will remain a member of the same PASSE for the twelve (12) months of the new coverage year provided the individual is otherwise eligible.

Out-of-Network Provider

A provider who is enrolled in the Arkansas Medicaid program but who did not join the network of a particular PASSE. Payment to an out-of-network provider may differ from an in-network provider, but must comply with any applicable Arkansas Medicaid consent decree.

If an out-of-network provider renders a service to a PASSE member, it must do so in conformance with the rights of a Medicaid enrollee. These rights include that the provider accept the PASSE payment for services as payment in full and not bill the individual.

PASSE Equity Partners

An organization or individual that is a member of or has an ownership interest in a PASSE and delivers healthcare services to members or is an administrator of healthcare services.

Person-Centered Service Plan (PCSP)

The total plan of care made in accordance with person centered service planning as described in 42 CFR 441.301(c)(1) that indicates the following:

A. Services necessary for the member;

B. Any specific needs the member has;

C. The member's strength and needs; and,

D. A crisis plan for the member.

Performing Provider

Individual who is the rendering provider of a particular service.

Premium Revenue

Premium revenue is as defined in 42 CFR §438.8.

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:

A. Is 51% owned by PASSE Equity Partners; and

B. Has the following Members or Owners:

1. An Arkansas licensed or certified direct service provider of Developmental Disabilities (DD) services;
2. An Arkansas licensed or certified direct service provider of Behavioral Health (BH) services;
3. An Arkansas licensed hospital or hospital services organizations;
4. An Arkansas licensed physician's practice; and
5. 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 enter into an annual PASSE agreement with DHS.

Provider Network

The group of direct service providers that are contracted to provide services to members of a PASSE.

Quality Improvement

Activities that improve healthcare quality as defined in 42 CFR § 438.8. These activities must be designed to:

A. Improve health quality;

B. Meet specified quality performance measures;

C. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and or producing verifiable results and achievements;

D. Be directed toward individual members incurred for the benefit of specified segments of members or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-members; and

E. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

Risk-Based Comprehensive Global Payment

Risk-based comprehensive global payment is a capitated payment that is made in monthly prorated payment to the PASSE for each assigned PASSE member. Only a licensed Risk-Based Provider Organization/ Provider-Led Arkansas Shared Savings Entity (PASSE) in good standing in the State of Arkansas is eligible to receive a global payment under the program. Comprehensive means that the PASSE is at financial risk and obligated to pay for medically necessary inpatient hospital, outpatient, institutional, professional services, pharmacy, ancillary, long term care services and supports, and any other covered service, not exclusive or carved out, for members as specified in the scope of services identified in the State plan section 1905(a).

Risk-based Provider Organization (RBPO)

An entity that

A. Is licensed by the Insurance Commissioner under ~~Act 775 of 2017 and the risk-based provider organization rules.~~ the rules established for risk-based provider organizations by the Arkansas Insurance Commissioner;

B. Is obligated to assume the financial risk for the delivery of specifically defined healthcare services to an enrollable Medicaid beneficiary population; and

C. Is paid by DHS on a capitated basis with a global payment made, whether or not a particular member of an enrollable Medicaid beneficiary population receives service during the period covered by the payment.

Service Encounter

A standardized record of a health care-related service, procedure, treatment, or therapy rendered by a licensed provider or providers to a PASSE member. There are two types of service encounters, paid claim encounter and non-paid encounters that were performed but are not reimbursable.

Telemedicine

The use of electronic information and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient. It included store-and-forward technology and remote patient monitoring.

The following activities will not be considered a reportable encounter when delivered to a member of the PASSE:

A. Audio-only communication, including without-limitation, interactive audio;

B. A facsimile machine;

C. Text messaging; or

D. Electronic mail systems.

The Act

Title XIX of the Social Security Act.

Transition

The movement of a member from one PASSE to another, either by choice or for cause as defined in section 213.000 of this manual.

Value-based Payments

Payments made by a PASSE to its providers to promote efficiency and effectiveness of services, improve quality of care, improve patient experience and access to care, and promote most appropriate utilization in the most appropriate setting. Such payments may be made as part of a PASSE's Quality Assessment and Performance Improvement (QAPI) strategy.

Virtual and Home Visit Provider Services

Virtual services are telemedicine, telehealth, e-consulting, and provider home visits that are part of a patient care treatment plan and are provided at the individual's home or in a community setting. These services are provided using mobile secure telecommunication devices, electronic monitoring equipment, and include clinical provider care, behavioral health therapies, speech, occupational and physical therapy services, and treatment provided to an individual at their residence. Virtual provider services may use various evidence-based and innovative independence at-home strategies. They may include the provision of on-going care management, remote telehealth monitoring and consultation, face to face or through the use secure web-based communication and mobile telemonitoring technologies to remotely monitor and evaluate the patient's functional and health status. Virtual and telehealth services are provided in lieu of providing the same services at a practice site or provided at the individual's place of residence. Therefore, these services must have patient consent, be documented in the patient integrated medical records, and submitted as a claims or encounter from a contracted provider as medically necessary service. The provision of virtual care can include an interdisciplinary care team or be provided by individual clinical service provider.

247.200 Appeal of Adverse ~~Decision/Adverse Action~~ Benefit Determination of a PASSE

6-1-26~~5~~

When an adverse ~~decision/adverse action~~ benefit determination has been ~~taken~~ made by a PASSE, ~~the following appeals are available in response to that adverse decision/adverse action:~~

~~A. A member, or his or her guardian or legal representative may appeal on his or her own behalf.~~ the member may file an appeal in accordance with the procedures found in Section 192.000 of this Manual. A guardian, legal representative, or direct service provider may file an appeal on behalf of the member.

~~B. A direct service provider of medical assistance that is the subject of the adverse action may appeal on the member's behalf.~~

~~C. If the adverse decision/adverse action denies a claim for covered medical assistance that was previously provided to a Medicaid-eligible member, the direct service provider of such medical assistance may appeal on the direct service provider's behalf. The direct service provider does not have standing to appeal a non-payment decision if the direct service provider has not furnished any service for which payment has been denied.~~

~~D. When the adverse action denies a claim for previously authorized, covered medical assistance, the PASSE must send the notice of the adverse action no less than ten (10) days before the action will be taken in accordance with 42 CFR 431.211. In all other cases,~~

notice must be sent immediately after the adverse decision is made. If the member requests a hearing before the date of action, the PASSE may not terminate or reduce services until a decision is rendered after the hearing unless:

1. It is determined at the hearing that the sole issue is one of Federal or State law or policy; and
2. The PASSE promptly informs the member in writing that services are to be terminated or reduced pending the hearing decision.

E. If the PASSE's action is sustained by the hearing decision, and the member does not then seek an appeal to DHS, the PASSE may institute recovery procedures against the member to recoup the cost of any services furnished the member, to the extent they were furnished solely by reason of this section.

F. The appeal process must result in written notice of the resolution being sent to the member. This notice must include the member's right to appeal to the State.

The PASSE must adhere to the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 *et seq*. in the conduct of appeals and hearings.

The PASSE appeal process must be approved by DHS. This requires that:

A. Any proposed changes to the appeals process must be approved by DHS prior to implementation; and

The PASSE must send written notice to members of significant changes to the appeals process at least thirty (30) days prior to implementation.

TOC required

200.000 DEFINITIONS

Adjusted Premium Revenue

Premium revenue as defined in 42 CFR § 438.8 minus the PASSE's Federal, State and local taxes, licensing and regulatory fees as defined in 42 CFR §438.8.

Administrative Cost Ratio

Administrative Cost Percentage [42 CFR § 438.116 (a) and (b)] is the total administrative expenses, divided by total payments received from State of Arkansas less premium tax.

Adverse Benefit Determination

Any decision or action by the PASSE or DHS that adversely affects a Medicaid provider or beneficiary in regard to receipt of and payment for claims and services including but not limited to decisions or findings related to:

A. Appropriate level of care or coding,

B. Medical necessity,

C. Prior authorization,

D. Concurrent reviews,

E. Retrospective reviews,

F. Least restrictive setting,

G. Desk audits,

H. Field audits and onsite audits

I. Inspections, and

J. Payment amounts due to or from a particular provider resulting from gain sharing, risk sharing, incentive payments or another reimbursement mechanism or methodology.

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.

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.

Assignment

The process by which DHS assigns a newly eligible member among the active PASSEs. The individual will have 90 days from the date coverage begins to switch to a different PASSE. If the individual does not choose to switch to a different PASSE within this time, he/she will remain a member of that PASSE until the end of the coverage year.

Benefit Expenditure Report (BER)

The Benefit Expenditure Report documents how much was paid during the performance year by the PASSE, in the aggregate, to direct service providers for services provided to its members. A PASSE may choose to spend up to five percent (5%) of benefit expenditures on community investments. Community investments will be counted as benefit expenditures rather than administrative expenditures in calculating and reporting the medical loss ratio.

Care Coordination

Activities involving 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, medication management, treatment plan follow-through, service coordination, monitoring the patient adherence, and reevaluating the patient for medically necessary care and service. These activities focus on ensuring 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.

Case Management

Services furnished to assist individuals in gaining access to needed medical, social, educational, and others services in accordance with 42 CFR § 440.169.

Centers for Medicare & Medicaid Services (CMS)

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Medical Loss Ratio

Each PASSE must report its Medical Loss Ratio (MLR) to AID and DHS. Calculation of the MLR is defined at 42 CFR § 438.8.

Member

A Medicaid beneficiary who is enrolled in a PASSE.

Network Provider

The provider who, under a contract with a PASSE or with its contractor/subcontractor, has agreed to provide Health Care Services to persons with an expectation of receiving payments directly or indirectly from the PASSE.

Open Enrollment Period

DHS will, on an annual basis, offer an open enrollment period for all current enrollees to choose a different PASSE for coverage beginning January 1 of the following year. If an individual does not make an active choice to switch PASSEs during the open enrollment period, that individual will remain a member of the same PASSE for the twelve (12) months of the new coverage year provided the individual is otherwise eligible.

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PASSE Equity Partners

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Person-Centered Service Plan (PCSP)

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Premium Revenue

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3. An Arkansas licensed hospital or hospital services organizations;
4. An Arkansas licensed physician's practice; and
5. 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 enter into an annual PASSE agreement with DHS.

Provider Network

The group of direct service providers that are contracted to provide services to members of a PASSE.

Quality Improvement

Activities that improve healthcare quality as defined in 42 CFR § 438.8. These activities must be designed to:

A. Improve health quality;

B. Meet specified quality performance measures;

C. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and or producing verifiable results and achievements;

D. Be directed toward individual members incurred for the benefit of specified segments of members or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-members; and

E. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

Risk-Based Comprehensive Global Payment

Risk-based comprehensive global payment is a capitated payment that is made in monthly prorated payment to the PASSE for each assigned PASSE member. Only a licensed Risk-Based Provider Organization/ Provider-Led Arkansas Shared Savings Entity (PASSE) in good standing in the State of Arkansas is eligible to receive a global payment under the program. Comprehensive means that the PASSE is at financial risk and obligated to pay for medically necessary inpatient hospital, outpatient, institutional, professional services, pharmacy, ancillary, long term care services and supports, and any other covered service, not exclusive or carved out, for members as specified in the scope of services identified in the State plan section 1905(a).

Risk-based Provider Organization (RBPO)

An entity that

A. Is licensed by the Insurance Commissioner under the rules established for risk-based provider organizations by the Arkansas Insurance Commissioner;

B. Is obligated to assume the financial risk for the delivery of specifically defined healthcare services to an enrollable Medicaid beneficiary population; and

C. Is paid by DHS on a capitated basis with a global payment made, whether or not a particular member of an enrollable Medicaid beneficiary population receives service during the period covered by the payment.

Service Encounter

A standardized record of a health care-related service, procedure, treatment, or therapy rendered by a licensed provider or providers to a PASSE member. There are two types of service encounters, paid claim encounter and non-paid encounters that were performed but are not reimbursable.

Telemedicine

The use of electronic information and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient. It included store-and-forward technology and remote patient monitoring.

The following activities will not be considered a reportable encounter when delivered to a member of the PASSE:

A. Audio-only communication, including without-limitation, interactive audio;

B. A facsimile machine;

C. Text messaging; or

D. Electronic mail systems.

The Act

Title XIX of the Social Security Act.

Transition

The movement of a member from one PASSE to another, either by choice or for cause as defined in section 213.000 of this manual.

Value-based Payments

Payments made by a PASSE to its providers to promote efficiency and effectiveness of services, improve quality of care, improve patient experience and access to care, and promote most appropriate utilization in the most appropriate setting. Such payments may be made as part of a PASSE's Quality Assessment and Performance Improvement (QAPI) strategy.

Virtual and Home Visit Provider Services

Virtual services are telemedicine, telehealth, e-consulting, and provider home visits that are part of a patient care treatment plan and are provided at the individual's home or in a community setting. These services are provided using mobile secure telecommunication devices, electronic monitoring equipment, and include clinical provider care, behavioral health therapies, speech, occupational and physical therapy services, and treatment provided to an individual at their residence. Virtual provider services may use various evidence-based and innovative independence at-home strategies. They may include the provision of on-going care management, remote telehealth monitoring and consultation, face to face or through the use secure web-based communication and mobile telemonitoring technologies to remotely monitor and evaluate the patient's functional and health status. Virtual and telehealth services are provided in lieu of providing the same services at a practice site or provided at the individual's place of residence. Therefore, these services must have patient consent, be documented in the patient integrated medical records, and submitted as a claims or encounter from a contracted provider as medically necessary service. The provision of virtual care can include an interdisciplinary care team or be provided by individual clinical service provider.

247.200 Appeal of Adverse Benefit Determination of a PASSE 6-1-26

When an adverse benefit determination has been made by a PASSE, the member may file an appeal in accordance with the procedures found in Section 192.000 of this Manual. A guardian, legal representative, or direct service provider may file an appeal on behalf of the member.