Summit COMMUNITY CARE

Provider Manual

Provider Services: 844-462-0022

https://provider.summitcommunitycare.com

ARSMT-CD-PM-079033-25

How to apply for participation
If you're interested in applying for participation with Summit Community Care, please visit **summitcommunitycare.com/provider** or call Provider Services at **844-462-0022**.

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1. Introduction

Welcome to the Summit Community Care network provider family. We are pleased you have joined our network, which consists of some of the finest healthcare providers in the state.

The Provider-Led Arkansas Shared Savings Entity (PASSE) is a Medicaid program to address the needs of people with intensive behavioral, intellectual, and developmental disabilities service needs. The PASSE program is designed to improve people's health and let them take a more active role in their treatment with the support of comprehensive care coordination. Eligibility for coverage with the PASSE is determined through the Arkansas Department of Human Services (DHS). PASSE enrollment population includes only:

- Individuals receiving services through the 1915(c) Home- and Community-based Services Community and Employment Support (CES) Waiver;
- Individuals who are on the CES Waiver waitlist;
- Individuals who are in private developmental disability Intermediate Care Facilities (ICFs); and
- Individuals with a behavioral health diagnosis who has received an Independent Assessment resulting in Tier 2, 3, or 4, which determines the need for services.

The purpose of this provider manual is to highlight and explain the program's elements and to serve as a useful reference for providers who participate in the Summit Community Care network. An electronic version of this manual is available on our website at **provider.summitcommunitycare.com/docs/gpp/ARAR_CAID_ProviderManual.pdf.**

Please note some of the included website addresses found within the manual are operated by a third party and are provided for your convenience and reference only; Summit Community Care does not control such sites and does not necessarily endorse them. We are not responsible for their content, products, or services.

This manual, as part of the provider agreement and related addendums, may be updated at any time and is subject to change. If there is an inconsistency between information contained in the manual and the participating provider agreement, the agreement governs.

Frequent communication is provided in the form of newsletters, email alerts, fax, online postings, and other mailings. Archives of all postings can be found on the provider website at **Archives (summitcommunitycare.com)**. Providers may also sign up to receive email alerts at **provider.summitcommunitycare.com/arkansas-provider/home**.

This manual is not intended to be a complete statement of all policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially targeted communications.

Key Contact Information

Health plan		
Website	**summitcommunitycare.com**	
Address	650 S. Shackleford Road Suite 440 Little Rock, Arkansas 72211	
Department	**Phone and/or website**	**Fax and/or email address**
Member services	**844-405-4295 (TTY 711)**	
Provider services	**844-462-0022**	
Inpatient, outpatient PA requests	**844-462-0022**	**800-964-3627** **ARAR_CAID_PrecertificationRequestForm.pdf**
Utilization management	**844-429-9630**	
Behavioral health	**844-429-9630, option 3**	Inpatient: **844-452-8068** Outpatient: **844-442-8014**
24/7 Nurse line	**844-405-4295 (TTY 711)**	
Pharmacy services PA requests	**844-462-0022** Mon-Fri: 7 a.m. — 6 p.m. CT Sat: 9 a.m. — 1 p.m. CT Sun: Closed	Retail: **844-429-7761** Medical injectables: **844-429-7762**
Dental Services (managed by dental vendor)	**800-275-1131 (TDD 800-285-1131)**	For questions related to dental eligibility
EyeMed (routine and optometry services only)	**833-279-4364**	
Report suspected fraud, waste, abuse	**866-847-8247**	**https://provider.summitcommunitycare.com, scrolling to the bottom footer and click on Report Waste, Fraud or Abuse**
EDI claims assistance	**800-282-4548 (800-AVAILITY)**	
PASSE Ombudsman office	**844-843-7351 (TTU 888-987-1200, option 2)**	**501-404-4625** passeombudsmanoffice@dhs.arkansas.gov

2. Credentialing and Recredentialing

Credentialing is the process performed by Summit Community Care to verify and confirm each applicant within the scope of credentialing meets the established criteria and qualifications for consideration to join our network. Summit Community Care uses the current National Committee for Quality Assurance (NCQA) Health Plan Accreditation Requirements for the credentialing and recredentialing of licensed independent providers with whom it contracts and who fall within its scope of authority and action.

Summit Community Care's Discretion

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Summit Community Care's discretion in any way to amend, change or suspend any aspect of Summit Community Care's credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to Members. Summit Community Care further retains the right to approve, suspend, or terminate individual physicians and health care professionals, and sites in those instances where it has delegated credentialing decision making.

Credentialing Scope

Credentialing requirements apply to the following:

1. Practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision);
2. Practitioners who have an independent relationship with Summit Community Care
   An independent relationship exists when Summit Community Care directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as primary care practitioners; and
3. Practitioners who provide care to Members under Summit Community Care's medical benefits.

The criteria listed above apply to practitioners in the following settings:

- Individual or group practices
- Locum tenens:
  - Provisional Credentialing is required if these practitioners work less than 60 calendar days.
  - Full Credentialing is required if these practitioners work 60 calendar days or more.
  - Covering practitioners (e.g., locum tenens) who do not have an independent relationship with the Company are not included in the Credentialing scope.
- Facilities
- Rental networks
  - That are part of Summit Community Care's primary Network and include Summit Community Care Members who reside in the rental network area.
  - That are specifically for out-of-area care and Members may see only those practitioners or are given an incentive to see rental network practitioners; and
- Telemedicine
- PPO network:
  - If an organization contracts with a PPO network to provide health services to members who need care outside its service area, and if it encourages members to obtain care from that network when they are outside the network, NCQA considers this to be an
  - independent relationship if:
    - Information about the network is included in member materials or on an ID card that directs members to the network (e.g., network name, phone number, logo), ***or***

- There are incentives for members to see the PPO's practitioners.
- In this type of contractual arrangement, the organization must credential the
- practitioners or delegate credentialing to the PPO network.

Summit Community Care credentials the following licensed/state certified independent health care practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors
- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral health care specialists who provide treatment services under the Health Benefit Plan
- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dietitians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Use Disorder Practitioners

Summit Community Care credentials the following Health Delivery Organizations (HDOs):

- Hospitals
- Home Health agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance use disorder treatment in inpatient, residential or ambulatory settings, including:
    - Adult Family Care/Foster Care Homes
    - Ambulatory Detox
    - Community Mental Health Centers (CMHC)
    - Crisis Stabilization Units
    - Intensive Family Intervention Services
    - Intensive Outpatient – Mental Health and/or Substance Use Disorder
    - Methadone Maintenance Clinics
    - Outpatient Mental Health Clinics
    - Outpatient Substance Use Disorder Clinics

    - Partial Hospitalization – Mental Health and/or Substance Use Disorder
    - Residential Treatment Centers (RTC) – Psychiatric and/or Substance Use Disorder
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO
- Durable Medical Equipment Providers

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process as directed by CMS including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
  End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission
- Portable x-ray Suppliers (CMS Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)
- Orthotics and Prosthetics Suppliers (American Board for Certification in Orthotics and Prosthetics_(ABCOP) or Board of Certification/Accreditation (BOC) or The National Examining Board of Ocularists (NEBO))

Credentials Committee

The decision to accept, retain, deny or terminate a practitioner's or HDO's participation in on one or more of Summit Community Care's networks or plan programs is conducted by a peer review body, known as Summit Community Care's Credentials Committee (the "CC").

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated. In states or regions where an Summit Community Care affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or an Summit Community Care medical director designee and the vice-chair must be a lead medical officer or an Summit Community Care medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (e.g., nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (e.g., Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member

(i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more Networks or Plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. Specifically, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulatory agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Summit Community Care's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of their right to correct erroneous information or provide additional details regarding the issue and will include the process for submission of this additional information. Depending on the nature of the issue, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's or HDO's credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Upon request, the practitioner or HDO will be provided with the status of their credentialing or re-credentialing application.

Summit Community Care may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Nondiscrimination Policy

Summit Community Care will not discriminate against any applicant for participation in its programs or provider network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Summit Community Care is required to include fields for the collection of practitioner race, ethnicity, and language on the application. However, Summit Community Care does not use such reported to discriminate against a practitioner, and the application includes a statement indicating the provision of such information is optional. Additionally, Summit Community Care will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Determinations as to which practitioners and providers require additional individual review by the Credentials Committee are made according to predetermined criteria related to professional conduct and competence. Credentials Committee decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Summit Community Care will review denials and terms for consistency and lack of discrimination annually to identify discriminatory practices in the selection of practitioners. These reviews are documented in a report summary format by reason for the denial or term for initial denials, recredentialing, terminations, and off-cycle terminations. The reasons for denial or term include: not board certified, license/board action, malpractice, education/training, hospital privileges, criminal conviction, DEA, hospital action, insurance, work history gap, and

federal sanctions. In addition, annually audits of practitioner complaints about credentialing shall be reviewed for evidence of alleged discrimination. Should discriminatory practices be identified through annual review or through other means, Summit Community Care will take appropriate action(s) to track and eliminate those practices.

Initial Credentialing

Each provider will complete the Summit Community Care credentialing application form. We will use the uniform standard credential application established by DHS.

Summit Community Care will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 120-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards. The application attestation including work history verification must be dated and verified within 180 calendar days prior to the Credentials Committee decision.

During the credentialing process, Summit Community Care will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, DNV NIAHO, CIHQ or ACHC accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state-controlled substance registrations • The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions, exclusions or limitations
Medicare, Medicaid or FEHBP sanctions and exclusions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element

Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions and exclusions

Re-credentialing

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions and exclusions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Summit Community Care credentialing standards ("Credentialing Standards").

All applicable practitioners and HDOs in the Network within the scope of the Credentialing Program are required to be re-credentialed every three years unless otherwise required by applicable state contract or state regulations.

Health Delivery Organizations

New HDO applicants will submit a standardized application to Summit Community Care for review. If the candidate meets Summit Community Care screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail below, in the "Summit Community Care Credentialing Program Standards" section, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Summit Community Care may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

Ongoing Sanction Monitoring

To support certain Credentialing Standards between the re-credentialing cycles, Summit Community Care has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with Credentialing Standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports monthly or within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General ("OIG")
- Federal and State Medicare/Medicaid Reports
- Office of Personnel Management ("OPM")
- State licensing Boards/Agencies
- Member/Customer services departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)

- Other internal Summit Community Care departments
- Any other information received from sources deemed reliable by Summit Community Care.

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

Appeals Process

Summit Community Care has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Summit Community Care's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Summit Community Care may wish to terminate practitioners or HDOs. Summit Community Care also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Summit Community Care's Networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB).

Additionally, Summit Community Care will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Summit Community Care's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Summit Community Care's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Summit Community Care's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

Reporting Requirements

When Summit Community Care takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its Networks or Plan programs, Summit Community Care may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

Summit Community Care Credentialing Program Standards

Eligibility Criteria

A. Health care practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

1. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;

2. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to Members;
3. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state; and
4. Meet the education, training and certification criteria as required by Summit Community Care.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

1. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.
2. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
3. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
4. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

    a. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
        i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;
        ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
        iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Summit Community Care's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

    b. Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Summit Community Care education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Summit Community Care review and approval. Reports submitted by delegates to Summit Community Care must contain sufficient documentation to support the above alternatives, as determined by Summit Community Care.

5. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (DNV NIAHO), Center for Improvement in Healthcare Quality (CIHQ), a Accreditation Commission for Health Care (ACHC) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not

relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

6. For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

7. For Registered Dieticians (RD), the applicant must have completed a bachelor's degree at a US regionally accredited university or college and course work accredited or approved by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics. Completion of an ACEND accredited supervised practice program at a healthcare facility, community agency, or a foodservices corporation or combined with undergraduate or graduate studies. Typically, a practice program will run six (6) to twelve (12) months in length. Must have passed a national examination administered by the Commission on Dietetic Registration (CDR).

Criteria for Selecting Practitioners

New Applicants (Credentialing):

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
4. No evidence of potential material omission(s) on application.
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members.
6. No current license action.
7. No history of licensing board action in any state.
8. No current federal sanction or exclusion and no history of federal sanctions or exclusions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one state must have a valid DEA/CDS registration for each applicable state.
10. Initial applicants who voluntarily have no DEA/CDS registration, the exception listed below may apply or if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:
    a. It can be verified that this application is pending.
    b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber;
    c. The applicant agrees to notify Summit Community Care upon receipt of the required DEA/CDS registration.
    d. Summit Community Care will verify the appropriate DEA/CDS registration via standard sources.
        i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day timeframe will result in termination from the Network.

Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Summit Community Care's Members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:

a. It can be verified that the applicant's application is pending; and
b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
c. The applicant agrees to notify Summit Community Care upon receipt of the required DEA registration; and
d. Summit Community Care will verify the appropriate DEA/CDS registration via standard sources; and
e. The applicant agrees that failure to provide the appropriate DEA registration within a 90-day timeframe will result in termination from the network.

Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:

a. controlled substances are not prescribed within his/her scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and
b. he or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber; and
c. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.

11. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for Practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating Practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.
12. No history of or current use of illegal drugs or history of or current substance use disorder.
13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
14. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.
15. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
16. A minimum of the past 10 years of malpractice claims history is reviewed.
17. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Summit Community Care's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
18. No involuntary terminations from an HMO or PPO.
19. No "yes" answers to attestation/disclosure questions on the application form with the exception of the

following:

a. Investment or business interest in ancillary services, equipment or supplies;
b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
c. Voluntary surrender of state license related to relocation or nonuse of said license;
d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window.
g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Participation Criteria and Exceptions for Non-Physician Credentialing.

The following participation criteria and exceptions are for non-MD practitioners. It is not additional or more stringent requirements, but instead the criteria and exceptions that apply for these specific provider types to permit a review of education and training.

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type based on state licensing regulations:
    a. Master or doctoral degree in social work.
    b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a doctor of social work will be viewed as acceptable.
    c. Licensure to practice independently.

2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC) or other master level license type based on state licensing regulations:
    a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
    b. Master or doctoral degrees in divinity, masters in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
    c. Practitioners with PhD training as a clinical psychologist can be reviewed.
    d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
    e. Licensure to practice independently or in states without licensure or certification:
        i. Marriage & Family Therapists with a master's degree or higher:
            a. Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).
        ii. Mental Health Counselors with a master's degree or higher:
            a. Provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) (proof of NBCC certification required) or meet

all requirements to become a CCMHC (documentation of eligibility from NBCC required).

3. Pastoral Counselors:
    a. Master's or doctoral degree in a mental health discipline.
    b. Licensed as another recognized behavioral health provider type (e.g., MD/DO, PsyD, SW, RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.
    c. A fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) OR meet all requirements to become a fellow or diplomat member of the ACPE [documentation of eligibility of ACPE required].

4. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
    a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
    b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
    c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing, or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and
    d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.

5. Clinical Psychologists:
    a. Valid state clinical psychologist license.
    b. Doctoral degree in clinical or counseling, psychology or other applicable field of study.
    c. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

6. Clinical Neuropsychologist:
    a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
    b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
    c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
        i. Transcript of applicable pre-doctoral training;
        ii. Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
        iii. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
        iv. Minimum of five years' experience practicing neuropsychology at least ten hours per week.

7. Licensed Psychoanalysts:
    a. Applies only to practitioners in states that license psychoanalysts.
    b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Summit Community Care Credentialing Policy (e.g., psychiatrist, clinical psychologist, licensed clinical social worker).
    c. Practitioner must possess a valid psychoanalysis state license.
        i. Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
        ii. Meet examination requirements for licensure as determined by the licensing state.

8. Process, requirements and Verification – Nurse Practitioners:
    a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the licensing agency does not verify highest level of education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Summit Community Care procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
    e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
        i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
        ii. American Academy of Nurse Practitioners – Certification Program;
        iii. National Certification Corporation;
        iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner);
        v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
        vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.
    f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.
    g. The NP applicant will undergo the standard credentialing processes outlined in Summit Community Care's Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for

failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

9. Process, Requirements and Verifications – Certified Nurse Midwives:
    a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
    b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Summit Community Care procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
    e. All CNM applicants will be certified by either:
        i. The National Certification Corporation for Ob/Gyn and neonatal nursing; or
        ii. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

This certification must be active. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.

    f. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
    g. The CNM applicant will undergo the standard credentialing process outlined in Summit Community Care's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the Network.

10. Process, Requirements and Verifications – Physician's Assistants (PA):
    a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.

c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Summit Community Care procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Summit Community Care Health Plan and submitted for individual review by the CC.
f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
g. The PA applicant will undergo the standard credentialing process outlined in Summit Community Care's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

Currently Participating Applicants (Re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Summit Community Care's Plan programs or provider Networks, federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Summit Community Care's other credentialed provider Networks.
4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction or exclusion and no new (since prior credentialing review) history of federal sanctions or exclusions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or substance use disorder;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;

11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    b. Voluntary surrender of state license related to relocation or nonuse of said license;
    c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;
    f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
15. No quality improvement data or other performance data including complaints above the set threshold.
16. Re-credentialed at least every three years to assess the practitioner's continued compliance with Summit Community Care standards.

*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for re-credentialing.

B. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Summit Community Care may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Summit Community Care may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member access need only when the CC review indicates compliance with Summit Community Care standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are re-credentialed at least every three years to assess the HDO's continued compliance with Summit Community Care standards.

1. General Criteria for HDOs:
    a. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
    b. Valid and current Medicare certification.
    c. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in Summit Community Care's Plan programs or provider Networks, exclusion from Medicare,

Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Summit Community Care's other credentialed provider Networks.

d. Liability insurance acceptable to Summit Community Care.
e. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Summit Community Care's quality and certification criteria standards have been met.

2. Additional Participation Criteria for HDO by Provider Type:

HDO Type and Summit Community Care Approved Accrediting Agent(s)

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, TCT, DNV NIAHO, ACHC, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, ACHC, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, DNV NIAHO, TJC, TCT
Home Infusion Therapy (HIT)	ACHC, CHAP, TCT, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC
Durable Medical Equipment Suppliers	TJC, CHAP, TCT, ACHC, BOC, HQAA

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	DNV NIAHO, ACHC, TJC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, ACHC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Use Disorder	ACHC, CARF, COA, DNV NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, ACHC, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Use Disorder	CARF, DNV NIAHO, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Use Disorder	CARF, COA, DNV NIAHO, ACHC, TJC

Facility Type (Behavioral Health Care - Rehabilitation)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	TCT, DNV NIAHO, ACHC, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Use Disorder Clinics	CARF, TJC, COA,

Credentialing requirements specific to Summit Community Care

Each provider must remain in full compliance with the Summit Community Care credentialing criteria as set forth in its credentialing policies and procedures and all applicable laws and regulations. Each provider will complete the Summit Community Care credentialing application form. We will use the uniform standard credential application established by DHS.

Credentialing scope

The following types of contracted healthcare practitioners will be credentialed by Summit Community Care:

- Independent behavioral health professionals who contract directly with the PASSE including licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed marriage/family therapist (LMFT), licensed independent substance abuse counselor (LISAC)
- Home- and Community-based provider who provides services under the CES Waiver or the 1915(i) authority
- Any non-contracted provider that is rendering services and sees 50 or more of the contractor's members per contract year

For Home- and Community-Based Services (HCBS) providers, or for providing submitting roster updates for atypical providers, a completed "Atypical and HCBS Provider" application and all supporting documentation, as identified in the application, must be received and with the signed, completed contract.

As of January 1, 2023, recredentialing for HCBS providers every 3 years in accordance with state requirements.

Each provider has the right to inquire about the status of its application via Availity if additional information is needed, please contact Provider Services at **844-462-0022**.

Reporting changes in address and/or practice status

Please report any status changes either by fax to fax or mail to:

Provider Services
Summit Community Care
P.O. Box 62429
Virginia Beach, VA 23466-2429

3. Digital Provider Engagement (DPE) and Provider Date Management (PDM)

Use the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all professional and facility care providers*. Going forward, the PDM application is now the preferred intake tool for care providers to submit demographic change requests, including submitting roster uploads. If preferred, Providers may continue to utilize the Provider Enrollment application in Availity Essentials to submit requests to add new practitioners under existing groups for available provider types.

Within the PDM application, Providers have the choice and flexibility to request data updates via the standard PDM experience or by submitting a spreadsheet via a roster upload.

Roster Automation is our new technology solution designed to streamline and automate provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel document. Any provider, whether an individual provider/practitioner, group, or facility, can use Roster Automation today.**

The resources for this process are listed below and available on our website. Visit **provider.summitcommunitycare.com**, then under For Providers, select Forms and Other Forms. The Roster Automation Rules of Engagement and Roster Automation Standard Template appear under the Digital Tools category.

Roster Automation Rules of Engagement: Is a reference document, available to ensure error-free submissions, driving accurate and more timely updates through automation.

Roster Automation Standard Template: Use this template to submit your information. More detailed instructions on formatting and submission requirements can also be found on the first tab of the Roster Automation Standard Template (*User Reference Guide*).

Upload your completed roster via the Availity PDM application.

Accessing PDM Application

Log onto **Availity.com** and select My Providers > Provider Data Management to begin the attestation process. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select Upload Rosters (see screen shot below) and follow the prompts.

Availity Administrators will automatically be granted access to PDM. Additional staff may be given access to Provider Data Management by an administrator. To find your administrator, go to My Account Dashboard > My Account > Organization(s) > Administrator Information.

* Exclusions:
Behavioral Health providers contracted with Carelon Behavioral Health who will continue to follow the process for demographic requests and/or roster submissions, as outlined by Carelon Behavioral Health.
Any specific state mandates or requirements for provider demographic updates

** If any roster data updates require credentialing, your submission will be routed appropriately for further action.

Get trained on Provider Data Management and Roster by visiting the **Provider Learning Hub**

Provider and Facility Digital Guidelines

Summit Community Care understands that working together digitally streamlines processes and optimizes efficiency. We developed the Provider and Facility Digital Guidelines to outline our expectations and to fully inform Providers and Facilities about our digital platforms.

Summit Community Care expects Providers and Facilities will utilize digital tools, unless otherwise prohibited by law or other legal requirements.

Digital guidelines establish the standards for using secure digital Provider platforms (websites) and applications when transacting business with Summit Community Care. These platforms and applications are accessible to both participating and nonparticipating Providers and Facilities and encompass Availity.com, electronic data interchange (EDI), electronic medical records (EMR) connections and business-to-business (B2B) desktop integration.

The Digital Guidelines outline the digital/electronic platforms Summit Community Care has available to participating and nonparticipating Providers and Facilities who serve its Members. The expectation of Summit Community Care is based on our contractual agreement that Providers and Facilities will use these digital platforms and applications, unless otherwise mandated by law or other legal requirements.

Digital and/or electronic transaction applications are accessed through these platforms by using Availity:

- Availity EDI Clearinghouse
- B2B application programming interfaces (APIs)
- EMR connections
- Digital guidelines available through Availity Essentials include:
- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response
- Prior authorization submissions including updates, clinical attachments, authorization status, and clinical appeals
- Claim submission, including attachments, claim status and disputes
- Remittances and payments
- Provider enrollment
- Demographic updates

Visit the **Provider Learning Hub** to take live and on-demand Availity training.

Additional digital applications available to Providers and Facilities include:

- Pharmacy prior authorization drug requests
- Services through Carelon Medical Benefits Management, Inc.
- Services through Carelon Behavioral Health, Inc.

Summit Community Care expects Providers and Facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (paper,

mail, fax, call, chat, etc.). All channels are consistent with industry standards. All EDI transactions use version 5010.

Note: As a mandatory requirement, all trading partners must currently transmit directly to the Availity EDI gateway and have an active Availity Trading Partner Agreement in place. This includes providers using their practice management software & clearinghouse billing vendors.

Providers and Facilities who do not transition to digital applications may experience delays when using non-digital methods such as mail, phone, and fax for transactions that can be conducted using digital applications.

Section 1: Accepting digital ID cards

As our members transition to digital member ID cards, Providers and Facilities may need to implement changes in their processes to accept this new format. Summit Community Care expects that Providers and Facilities will accept the digital version of the member identification card in lieu of a physical card when presented. If Providers and Facilities require a copy of a physical ID card, Members can email a copy of their digital card from their smartphone application, or Providers and Facilities may access it directly from Availity Essentials through the Eligibility and Benefits Inquiry application.

Section 2: Eligibility and benefits inquiry and response

Providers and Facilities should leverage these Availity Clearinghouse hosted channels for electronic eligibility and benefit inquiry and response:

- EDI transaction: X12 270/271 – eligibility inquiry and response
- Summit Community Care supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- Availity Essentials
- The Eligibility and Benefits Inquiry verification application allows a Provider and Facility to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs

Summit Community Care has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration opportunities.

Section 3: Prior authorization submission, attachment, status, and clinical appeals.

Providers and Facilities should leverage these channels for prior authorization submission, status inquiries and to submit electronic attachments related to prior authorization submissions:

- EDI transaction: X12 278 – prior authorization and referral:
- Summit Community Care supports the industry-standard X12 278 transaction for prior authorization submission and status inquiry as mandated per HIPAA.
- EDI transaction: X12 275 – patient information, including HL7 payload for authorization attachments:

- Summit Community Care supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
- Availity Essentials:
    - Authorization applications include the Availity Essentials multi-payer Authorization and Referral application.
    - This application enables prior authorization submission, authorization status inquiry, and the ability to review previously submitted authorizations.
- Provider desktop integration via B2B APIs:
    - Summit Community Care has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Section 4: Claims: submissions, claims payment disputes, attachments, and status

Claim submissions status and claims payment disputes

Providers and Facilities should leverage these channels for electronic Claim submission, attachments (for both pre- and post-payment) and status:

- EDI transaction: X12 837 – Professional, institutional, and dental Claim submission (version 5010):
- Summit Community Care supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.
- 837 Claim batch upload through EDI allows a provider to upload a batch/file of Claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – Claim status inquiry and response:
- Summit Community Care supports the industry standard X12 276/277 transaction set for Claim status inquiry and response as mandated by HIPAA.
- Availity Essentials: The Claims & Payments application enables a provider to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.
- Claim Status application enables a provider to access online Claim status. Access the Claim payment dispute tool from Claim Status. Claims Status also enables online claim payment disputes in most markets and for most claims. It is the expectation of Summit Community Care that electronic Claim payment disputes are adopted when and where it is integrated.
- Provider desktop integration via B2B APIs:
- Summit Community Care has also enabled real-time access to Claim Status via APIs, which can be directly integrated within participating vendor's practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Claim attachments

Providers and Facilities should leverage these channels for electronic Claim attachments from **Availity.com**:

- EDI transaction: X12 275 – Patient information, including HL7 payload attachment:

- Summit Community Care supports the industry standard X12 275 transaction for electronic transmission of supporting Claim documentation including medical records via the HL7 payload.
- Availity Essentials – Claim Status application enables a Provider or Facility to digitally submit supporting Claims documentation, including medical records, directly to the Claim.
- Digital Request for Additional Information (Digital RFAI) – The Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation including medical records are needed to process a Claim.

Section 5: Electronic remittance advice and electronic claims payment

Electronic remittance advice

Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your claims. Summit Community Care supports the industry standard X12 835 transaction as mandated per HIPAA.

Providers and Facilities can register, enroll, and manage ERA preference through **Availity.com**. Printing and mailing remittances will automatically stop thirty (30) days after the ERA enrollment date.

Viewing an ERA on Availity Essentials is under Claims & Payments, Remittance Viewer. Features of remittance viewer, include the ability to search a two (2) year history of remittances and access the paper image.

Viewing a portable document format (PDF) version of a remit is under Payer Spaces which provides a downloadable PDF of the remittance.

To stop receiving ERAs for your claims, contact Availity Client Services at **800-AVAILITY** (282-4548).

To re-enable receiving paper remittances, contact Provider Services.

Electronic claims payment

Electronic claims payment is a secure and fast way to receive payment, reducing administrative processes. There are several options to receive claims payments electronically.

Electronic Funds Transfer (EFT)

Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a Provider's or Facility's bank account at no charge for the deposit. Health plans can use a Provider's or Facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.

To enroll in EFT: Providers and Facilities can register, enroll, and manage account changes for EFT through EnrollSafe at **enrollsafe.payeehub.org**. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. For help with enrollment, **use this convenient EnrollSafe User Reference Manual**.

To disenroll from EFT: Providers and Facilities are entitled to disenroll from EFT. Disenroll from EFT payments through EnrollSafe at **enrollsafe.payeehub.org**.

Zelis Payment Network (ZPN) electronic payment and remittance combination: The Zelis Payment Network (ZPN) is an option for Providers and Facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to **Zelis.com**. Zelis may charge fees for their services.

Note that Summit Community Care may receive revenue for issuing ZPN.

ERA through Availity is not available for Providers and Facilities using ZPN.

To disenroll from ZPN payment, there are two (2) options:

- Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.
  or
- To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at **877-828-8770**.

Not being enrolled for EFT or ZPN will result in paper checks being mailed.

4. Provider Administration and Role of the Provider

Roles of the PCP, specialty care, LTSS, and HCBS providers

The primary care provider (PCP) is a board-certified or eligible network provider responsible for the complete care of the patient, our member. This practice holds true whether functioning as the provider of that care or by referral to the appropriate provider within the network. PCPs may include the following specialties:

- General practitioner
- Family practitioner
- Internist
- Pediatrician
- Obstetrician/gynecologist (OB/GYN) (for pregnant women only)
- Osteopath
- Nurse practitioner
- Specialist designated as PCP (with approval from Summit Community Care)

The specialty care provider is a network provider responsible for providing specialized care for members, usually upon appropriate referral from a PCP within the network. Specialty care provider may provider services that may include:

- Allergy and immunology services
- Burn services
- Community behavioral health (e.g., mental health and substance abuse) services
- Cardiology services
- Clinical nurse specialists, psychologists, clinical social workers – behavioral health
- Critical care medical services
- Dermatology services
- Endocrinology services
- Gastroenterology services
- General surgery
- Hematology/oncology services
- Neonatal services
- Nephrology services
- Neurology services
- Neurosurgery services
- OB/GYN services
- Ophthalmology services
- Orthopedic surgery services
- Otolaryngology services
- Perinatal services
- Pediatric services
- Psychiatry services (adult, child, and adolescent)
- Trauma services
- Urology services

For female members: If the member's PCP is not a woman's health specialist, she may see a participating woman's health specialist, without a referral, for covered services necessary to provide women's routine and preventive healthcare services.

Long-term services and supports (LTSS) providers and home- and community-based services (HCBS) providers are network providers who deliver home- and community-based services under the 1915(c) Community Employment Services (CES) waiver or under the 1915(i) Home- and Community-based Services State Plan amendment. These services include:

1915(c) HCBS Waiver services:

- Supported employment

- Supportive living
- Adaptive equipment
- Community transition services
- Consultation
- Environmental modification
- Supplemental support
- Respite
- Specialized medical supplies

1915(i) HCBS state plan services:

- Behavior assistance
- Adult rehabilitative day services
- Peer supports
- Family support partners
- Supportive life skills development
- Child and youth support services
- Supportive employment
- Partial hospitalization
- Mobile crisis intervention
- Therapeutic host home
- Therapeutic communities
- Residential community reintegration
- Planned and emergency respite services
- Complex care homes for I/DD

Telehealth

Virtual services are telemedicine, telehealth, e-consulting, and provider home visits that are part of a member care treatment plan and are provided in the individual's home or community setting. These services are provided using mobile secure telecommunication devices, electronic monitoring equipment, and include clinical provider care, and treatment provided to an individual at their residence.

Telemedicine is defined as the use of electronic information and communication technology to deliver healthcare services including without limitation, the assessment, diagnosis, consultation, treatment, education, follow-up behavioral health services, care management, and self-management of a member. Telemedicine includes store-and-forward technology and remote member monitoring.

For a telemedicine encounter to be covered by Medicaid, the practitioner and the member must be able to see and hear each other in real time.

Arkansas Medicaid provides payment to a licensed or certified healthcare professional or a licensed or certified entity for services provided through telemedicine if the service provided through telemedicine is comparable to the same service provided in-person.

Coverage and reimbursement for physician services provided through telemedicine will be on the same basis as for services provided in-person (with limited exceptions). While a distant site facility fee is not

authorized under the Telemedicine Act, if reimbursement includes payment to an originating site (as outlined in the above paragraph), the combined amount of reimbursement to the originating and distant sites may not be less than the total amount allowed for healthcare services provided in-person.

Telehealth can connect a provider's office to a **specialty center** by:

- Live video consult: The PCP and specialist meet at the same time using HIPAA compliant video conferencing technology.
- Telehealth offers multiple benefits to providers and members:
    - The members may continue to be cared for by their local provider.
    - The member does not need to travel long distances to receive specialist care.
    - The PCP receives all records and test results from the encounter.
    - The PCP consults with the specialist participating in the telehealth encounter to design any necessary course of treatment.

Telehealth can also be used for nonclinical consults such as community services, continuing medical education, and other provider training sessions.

To find out more about telehealth, or for contracting questions, please call Provider Services at **844-462-0022**.

Service standards:

- **Access:** Summit Community Care pays for telehealth care services delivered by care providers contracted with the health plan. Telehealth providers must confirm member eligibility every time members access virtual visits, like in-person visits.
- **Staffing Credentials:** All professional staff are certified or licensed in their specialty or have a level of certification, licensure, education and/or experience in accordance with state and federal laws.
- **Staff Orientation and Ongoing Training:** Telehealth providers must comply with all applicable state, federal and regulatory requirements relating to their obligations under contract with Summit Community Care. Telehealth providers must participate in initial and ongoing training programs including policies and procedures.
- **Service Response Time:** Telehealth providers will comply with the response time requirements outlined in their contract.
- **Compliance and Security:** The telehealth platform should be HIPAA compliant and meet state, federal and 508 compliance requirements. Telehealth providers will conduct all member virtual visits via interactive audio video telecommunications systems using a secure technology platform and will maintain member records in a secure medium, which meets state and federal law requirements for security and confidentiality of electronic patient information.
- **Certification:** Summit Community Care strongly encourages providers to obtain CHIQ, URAC or ATA accreditation.
- **Continuous Quality Improvement (CQI):** Telehealth providers must have a documented CQI program for identifying through data opportunities for real, time measured improvement in areas of core competencies. There must be demonstrated ties between CQI findings and staff orientation, training, policies, and procedures.

- **Member Complaints:** Telehealth providers are not delegated for complaint resolution but will log, by category and type, member complaints and should refer member complaints to the National Call Center.
- **Regulatory Assessment Results:** Summit Community Care reserves the right to request access to any applicable regulatory audit results.
- **Utilization:** Telehealth providers will comply with the reporting requirements outlined in their contract.
- **Electronic Billing/Encounter Coding:** Telehealth providers will submit virtual visit encounters or claims with proper coding as part of their existing encounter submission process.
- **Eligibility Verification:** Telehealth providers will use existing eligibility validation methods to confirm virtual visit benefits.
- **Case Communication:** Telehealth providers will support patient records management for virtual visits using existing electronic medical record (EMR) systems and standard forms. Its Their EMR records should contain required medical information including referrals and authorizations.
- **Joint Operating Committee:** Telehealth providers will participate in Joint Operations Meetings (JOM) or similar committees with the health plan to review data reports, quality issues, and address any administration issues at least quarterly if applicable.
- **Professional Environment:** Telehealth providers will help ensure when conducting virtual visits with members, the rendering care provider is in a professional and private location. The telehealth provider (rendering care providers) will not conduct member virtual visits in vehicles or public areas.
- **Medical Director:** Telehealth providers will employ or engage a licensed care provider as medical director. The medical director is responsible for clinical direction.

Eligible Providers

A healthcare provider treating patients in Arkansas through telemedicine shall be fully licensed or certified to practice in Arkansas and is subject to the rules of the appropriate state licensing or certification board. The professional or entity at the distant site must be an enrolled Arkansas Medicaid Provider.

Source:
AR Medicaid Provider Manual. Section I General Policy. Rule 105.190. Updated Aug. 1, 2018. (Accessed Dec. 2020).

Virtual care can include an interdisciplinary care team or be provided by individual clinical service providers.

Source:
PASSE Program (3/1/19), Sec. II-9 (Accessed Dec. 2020).

Providers rendering telehealth services must comply with all credentialing requirements stipulated in their Provider Agreements.

Live Video Eligible Sites

Virtual and telehealth services may be provided in the individual's home or a community setting.

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

- Audio-only communication including without-limitation, interactive audio;.
- A fax machine;
- Text messaging; or
- Electronic mail systems.

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, documented in the patient integrated medical records, and submitted as a claims or encounter from a contracted provider as medically necessary service.

Source:
PASSE Program, p. II-9, (3/1/19). (Accessed Dec. 2020).

All laws regarding the privacy, security and confidentiality of healthcare information and a member's rights to his or her medical information and personal information shall apply to telehealth interactions. This section shall not be construed to alter the scope of practice of any healthcare provider or authorize the delivery of healthcare services in a setting, or in a manner, not otherwise authorized by law. Telehealth services are used to support healthcare when the provider and member are physically separated. Typically, the member communicates with the provider via interactive means. i.e., live audio/video feed. Participating providers and facilities shall be solely responsible for ensuring the security and privacy of their interactive audio/video platform. Such platform must, at a minimum, include technical, administrative and physical safeguards to ensure all information pertaining to covered members is protected in accordance with applicable law utilizing controls equivalent to those necessary for compliance with the Health Insurance Portability and Accountability Act (HIPAA). Providers rendering telehealth services must comply with all credentialing requirements stipulated in their provider agreements.

5. Behavioral health and intellectual/developmental disability

Overview

Behavioral health (BH) and Intellectual and Development Disabilities (I/DD) services are covered for the treatment of mental, emotional, or substance use disorders and intellectual and developmental disabilities (I/DD). In this chapter, we will refer to behavioral health providers and providers specializing in I/DD as specialty providers.

We provide coverage of medically necessary services if they are:

- In accordance with professionally accepted clinical guidelines and standards of practice in behavioral health and/or I/DD care.
- Furnished in the most appropriate and least restrictive setting in which services can be safely provided.
- The most appropriate level or supply of service can safely be provided.
- Unable to be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered.
- Not experimental or investigative.
- Not primarily for the convenience of the member or provider.

For more information about these services, providers should call **844-462-0022** and members should call **844-405-4295**.

Individuals with physical or intellectual and developmental disabilities

Before placement of a member with a physical disability into an intermediate or long-term care facility, Summit Community Care will assess the needs of the member and the community as supplemented by other Medicaid services. The Summit Community Care medical director will conduct a second opinion review of the case before placement. If the medical director determines the transfer to an intermediate or long-term care facility is medically necessary and the expected stay will be greater than 30 days, Summit Community Care will obtain approval from DHS before making the transfer.

Providers who treat members with physical, intellectual, or developmental disabilities must be trained in special communication requirements of individuals with disabilities. Summit Community Care is responsible for accommodating hearing-impaired members who require and request a qualified interpreter. Summit Community Care can will delegate the financial risk and responsibility to providers and is responsible for ensuring members have access to these services.

- Summit Community Care providers must be clinically qualified to provide DME and assistive technology services for both adults and children.
- Summit Community Care informational materials are approved by persons with experience in the needs of members with disabilities, thereby ensuring the information is presented in a way members understand the material, whether on paper or by voice translation.
- Summit Community Care provides training to its triage, Member Services and Case Management staff on the special communications requirements of members with physical disabilities. Summit Community Care will clearly indicate to its providers how this provision is to be implemented.

Behavioral health access standards

Service type	Maximum time for admission/appointment
Psychiatric inpatient hospital services	24 hours (involuntary)/24 hours (voluntary); travel distance does not exceed 30 minutes by public transportation for at least 98 percent of members.
24-hour psychiatric residential treatment	Within 14 calendar days of receipt of the request for service; if urgent, no later than 72 hours of receipt of the request for service
Outpatient	Within 14 calendar days; if urgent, within 72 hours of receipt of the request for service
Intensive outpatient (may include day treatment adult, intensive day treatment children and adolescent or partial hospitalization)	Within 14 calendar days; if urgent, within 72 hours of receipt of the request for service
Inpatient facility services (substance use)	24 hours (involuntary)/24 hours (voluntary)
24-hour residential treatment services (substance use)	Within 14 calendar days; if urgent, within 72 hours of receipt of the request for service
Outpatient treatment services (substance use)	Within 14 calendar days
Crisis stabilization	Within four hours of referral

Member records and treatment planning for behavioral health

Member records must meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews:

- Information related to the provision of appropriate services to a member must be included in his or her record to include documentation in a prominent place whether there is an executed declaration for mental health treatment.
- For members in the priority population, a comprehensive assessment describes the consumer's physical and mental health status at the time of admission to services. This comprehensive assessment covers:
    - A psychiatric assessment that includes:
        - Description of the presenting problem.
        - Psychiatric history and history of the member's response to crisis situations.
        - Psychiatric symptoms.
        - Diagnosis using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM).
        - Mental status exam.
        - History of alcohol and drug abuse.
    - A medical assessment that includes:
        - Screening for medical problems.
        - Medical history.
        - Present medications.
        - Medication history.
    - A substance use assessment that includes:
        - Frequently used over-the-counter medications.
        - Alcohol and other drugs and history of prior alcohol and drug treatment

episodes.
        - History reflects the impact of substance use in the domains of community functioning assessment.
    - A community functioning assessment or an assessment of the member's functioning in the following domains:
        - Living arrangements, daily activities (vocational/educational)
        - Social support
        - Financial
        - Leisure/recreational
        - Physical health
        - Emotional/behavioral health
        - An assessment of the member's strengths, current life status, personal goals and needs.
        - Use of social determinants of health language in treatment plan assessment of member's needs.
    - A patient-centered, wellness-oriented care plan, which is based on the psychiatric, medical, substance use, and community functioning assessments listed above, must be completed for any member who receives behavioral health services.
- The behavioral health treatment plan must be completed within the last year, or more frequently as necessary based on the member's progress towards goals or a significant change in psychiatric symptoms, medical condition and/or community functioning. The treatment plan should include any services for which the provider is requesting prior authorization
- There must be documentation in every case that the member and, as appropriate, his or her family members, caregivers~~,~~ or legal guardian, participated in the development and subsequent reviews of the treatment plan.
- For providers of multiple services, one comprehensive treatment/care/support plan is acceptable if at least one goal is written and updated as appropriate for each of the different services being provided to the member.
    - The treatment/support/care plan must contain the following elements:
        - Identified problem(s) for which the member is seeking treatment.
        - Member goals related to problem(s) identified, written in member-friendly language.
        - Measurable objectives to address the goals identified.
        - Target dates for completion of objectives.
        - Responsible parties for each objective.
        - Specific measurable action steps to accomplish each objective.
        - Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent, de-escalate or defuse crisis situations; names and phone numbers of contacts who can assist the member in resolving crisis; and the member's preferred treatment options, to include psychopharmacology, in the event of a mental health crisis.
        - Signatures of the member as well as family members, caregivers~~,~~ or legal guardian as appropriate.
        - Clinical progress notes written to document status related to goals and objectives indicated on the treatment plans.
        - Correspondence concerning the member's treatment and signed and dated notations of telephone calls concerning the member's treatment.

- A brief discharge summary must be completed within 15 calendar days following discharge from services or death.
- Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the member is receiving behavioral health services should also be included.
- Summit Community Care will monitor provider compliance with treatment plan requirements through medical record reviews or other measures. Providers who do not meet the goal of 100% compliance with treatment plan requirements may be subject to corrective action and may be asked to submit a plan for meeting the 100% requirement.

Behavioral health emergency services

Behavioral health emergency services are those services which are required to meet the needs of an individual who is experiencing an acute crisis resulting from a mental illness, which is at a level of severity that would meet the requirements for involuntary examination and who, in the absence of a suitable alternative or psychiatric medication, would require hospitalization.

Examples of behavioral health and alcohol and drug abuse emergency medical conditions are when:

- The member is suicidal.
- The member is homicidal.
- The member is violent with objects.
- The member has suffered a precipitous decline in functional impairment and cannot take care of his or her daily activities.
- The member is alcohol- or drug-dependent and there are signs of severe withdrawal.

In the event of a behavioral health and/or alcohol and drug abuse emergency, the safety of the member and others is paramount. The member should be instructed to seek immediate attention at an emergency room or behavioral health and alcohol and drug abuse crisis service facility. An emergency dispatch service or 911 should be contacted if the member is a danger to themselves or others and cannot go to an emergency setting.

Behavioral health medically necessary services

Summit Community Care defines medically necessary behavioral health services as those which are:

- Reasonably expected to prevent the onset of an illness, condition or disability; reduce or ameliorate the physical, behavioral or developmental effects of an illness, condition, injury or disability; and assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities appropriate for members of the same age.
- Reasonably expected to provide an accessible and effective course of treatment or site of service that is equally effective in comparison to other available, appropriate, and substantial alternatives and is no more intrusive or restrictive than necessary.
- Sufficient in amount, duration~~,~~ and scope to achieve their purpose as defined by federal law.
- Of a quality that meets standards of medical practice and/or healthcare accepted at the time services are rendered.

6. Provider responsibilities

The participating provider shall:

- Manage the healthcare needs of members, in collaboration with the Care Coordinator, including monitoring and following up on care provided by other providers; provide coordination necessary for referrals to specialists, including behavioral health providers and fee-for-service providers (both in and out-of-network); and maintain a medical record of all services rendered by the PCP and other providers.
- Provide 24-hour-a-day, 7-day-a-week coverage (PCPs only).
- Maintain regular hours of operation that are clearly defined and communicated to members. Hours of operation provided to PASSE members may be no less than the hours offered to commercial members or are comparable to Medicaid fee for service if the provider serves only Medicaid members.
- Provide services ethically, legally, and culturally competently, meeting the unique needs
- of members with special healthcare needs.
- Ensure no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin or any other classifications protected under federal or state laws shall be excluded from participation in, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider's obligation under its participation with Summit Community Care or in the employment practices of the provider.
- Ensure notices of nondiscrimination are posted in conspicuous places available to all employees and enrollees.
- Participate in the systems established by Summit Community Care that facilitate the sharing of records, including and not limited to the HEDIS®Hybrid season, subject to applicable confidentiality and *HIPAA* requirements.
- Implement policies and procedures for the provision of language assistance to members
- and/or the member's representative. Language assistance services include interpretation and translation services and effective communication assistance in alternative formats such as auxiliary aids to any member and/or the member's representative who needs such services including but not limited to members with limited English proficiency, members who are hearing impaired and individuals with disabilities. Such services will be provided free of charge and be available in the form of in-person interpreters, sign language or access to telephonic assistance (e.g., the TTY universal line). Providers will also employ appropriate auxiliary aids and services free of charge.
- Participate and cooperate with Summit Community Care in any reasonable internal or external quality assurance, utilization review, continuing education, training, technical assistance, or other similar program established by Summit Community Care.
- Make reasonable efforts to communicate, coordinate and collaborate with specialty providers including developmental disability and behavioral health providers involved in delivering care and services to members.
- Participate in and cooperate with complaint and grievance procedures when notified by Summit Community Care of a member grievance.
- Not balance bill members.
- Continue care in progress during and after termination of a participation agreement for

up to 60 days until a continuity of care plan is in place to transition the member to another provider or to transition a pregnant member through postpartum care for pregnant members in their second and third trimester.

- Comply with all applicable federal and state laws regarding patient confidentiality.
- Develop and have an exposure control plan regarding blood-borne pathogens in compliance with Occupational Safety and Health Administration (OSHA) standards.
- Meet the federal and state physical and mental accessibility standards and those defined in the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973 applicable to his or her practice location.
- Support, cooperate and comply with the Summit Community Care Quality Improvement Program initiatives and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner.
- Inform Summit Community Care if a member objects for religious reasons to the provision of any counseling, treatment or referral services.
- Treat all members with respect and dignity; provide members with appropriate privacy; and treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse the release of such records as allowed under applicable laws and regulations.
- Provide members complete information concerning their diagnosis, evaluation, treatment, and prognosis.
- Give members the opportunity to participate in decisions involving their healthcare, except when contraindicated for medical reasons.
- Advise members about their health status, medical care, or treatment options, including medication treatment options, regardless of whether benefits for such care are provided under the program.
- Advise members of treatments that may be self-administered.
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
- Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies, and poison control centers to provide quality patient care.
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention that is part of a clinical research study is clearly distinguished from entries pertaining to non-research-related care.

Summit Community Care will not prohibit a provider, acting within the scope of his or her practice, from advising a member about his or her medical care or treatment for the condition or disease regardless of whether benefits are provided by Summit Community Care. Summit Community Care will not retaliate against a provider for advising the member.

Primary Care Provider (PCP) Access and Availability

All providers are expected to meet the federal and state physical accessibility standards and those defined in the *Americans with Disabilities Act of 1990* and *Section 504 of the Rehabilitation Act of 1973*.

Healthcare services provided through Summit Community Care must be accessible to all members. Summit Community Care is dedicated to ensuring

- Providers are available to provide medically necessary services.
- Covering physicians follow the referral/prior authorization guidelines.
    - The automatic direction of a member to the emergency room when the PCP is **not** available never occurs.

We encourage our PCPs to offer after-hours office care in the evenings and on weekends.

PCPs or extenders are required to adhere to the following access standards:

- Patient Load: 2,500 or less for physicians; half for physician extenders.
- Appointment/wait times: usual and customary practice, not to exceed three weeks from date of a patient's request for regular appointments and 24 hours for urgent care; wait times shall not exceed 45 minutes.

To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements for their members to contact the PCP after normal business hours:

- Have the office telephone answered after-hours by an answering service that can contact the PCP or another designated network medical practitioner. All calls answered by an answering service must be returned by the PCP within 60 minutes.
- Have the office telephone answered after normal business hours by a recording in the language of each of the major population groups served by the PCP, directing the member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
- Have the office telephone transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or a designated Summit Community Care network medical practitioner who can return the call within 60 minutes.

The following telephone answering procedures are **not** acceptable:

- Office telephone is only answered during office hours.
    - Office telephone is answered after-hours by a recording that tells members to leave a message.
    - Office telephone is answered after-hours by a recording which directs members to go to an emergency room for any services needed.
- Returning after-hours calls outside of 60 minutes.

Specialty care providers

While we prefer members seek referrals from their PCP, Summit allows members to self-refer to Specialty Care providers. This includes self-referrals to mental health and substance abuse providers Obligations of the specialists include the following:

- Complying with all applicable statutory and regulatory requirements of the Medicaid
- program.
    - Meeting eligibility requirements to participate in the Medicaid program.
- Accepting all members referred to them if the referrals are within the scope of the specialist's practice.

- Submitting required claims information.
- Arranging for coverage with other network providers while off-duty or on vacation.
- Verifying member eligibility and prior authorization of services (when required) at each
- visit.
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis following a referral or routinely scheduled consultative visit.
- Notifying the PCP and Summit Community Care and requesting prior authorization as appropriate when scheduling a hospital admission or any other procedure requiring prior approval. Coordinating care, as appropriate, with other providers involved in providing care for members, especially in cases where there are medical and behavioral health comorbidities or co-occurring mental health and substance abuse disorders.
- Ensuring no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws is excluded from participation in, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider's obligation under its agreement or in the employment practices of the provider.
- Cooperating with Summit Community Care during discrimination complaint investigations and report discrimination complaints and allegations to Summit Community Care including allegations of discrimination.

Specialty care access and availability

Summit Community Care will ensure access to specialty providers (specialists) for covered services.

Referral appointments to specialists (e.g., specialty provider services, hospice care, home healthcare, substance abuse treatment, rehabilitation services, etc.) shall not exceed 60 days for routine care or 24 hours for urgent care. All emergency care is immediate at the nearest facility available regardless of contract. Wait times shall not exceed 24 hours.

All other services not specified here will meet the usual and customary standards for the community.

Responsibilities of LTSS providers

The nature of home- and community-based services is LTSS providers support members in their homes and community settings, which makes them particularly suited to collaborating with Care Coordinators and other providers to support members in meeting their goals.

LTSS providers include:

- CES Waiver providers
- Home health and private duty nursing providers
- Personal care providers
- Adult Developmental Day Treatment (ADDT) providers
- Early Intervention Day Treatment (EIDT) providers
- Intermediate Care Facilities (ICFs)

LTSS providers are obligated to adhere to the following for members, who have a developmental disability and/or behavioral health diagnosis, and have approved Person-Centered Service Plans (PCSP) or have been authorized by Summit Community Care:

- Comply with all applicable statutory and regulatory requirements of the Medicaid program, including program-specific requirements from the Division of Developmental Disabilities and the Division of Behavioral Health.
- Meet eligibility requirements to participate in the Medicaid program, as well as specific requirements applicable to the program.
- Submit required claims information.
- Comply with program-specific documentation and service delivery requirements.
- Participate with the member's interdisciplinary team in developing and implementing the PCSP, when applicable.

Responsibilities of HCBS providers

As listed above, the nature of home- and community-based services is HCBS providers also support members in their homes and community settings. These providers are expected to collaborate with the Care Coordinators and other providers to support members in meeting their goals.

HCBS services include:

- Partial hospitalization
- Adult rehabilitative day service
- Supportive employment
- Supportive housing
- Adult life skills development
- Peer support
- Treatment plan
- Aftercare recovery support (for substance abuse)
- Therapeutic communities
- Assertive community treatment
- Behavioral assistance
- Crisis stabilization intervention
- Intensive In-Home (IIH for children)
- Family support partners
- Pharmacologic counseling by RN
- Respite
- Supportive life skills development
- Child and youth support services
- Therapeutic host homes
- Substance abuse detox (observational)
- Residential community reintegration program
- Complex care homes for I/DD
- Community transition services
- Personal care services

HCBS providers who have members diagnosed with developmental disability and/or behavioral health diagnosis and who have approved PCSPs or have been authorized by Summit Community Care

are obligated to adhere to the following:

- Comply with all applicable statutory and regulatory requirements of the Medicaid program, including program-specific requirements from the Division of Developmental Disabilities and the Division of Behavioral Health.
- Meet eligibility requirements to participate in the Medicaid program, as well as specific requirements applicable to the program.
- Submit required claims information.
- Comply with program-specific documentation and service delivery requirements.
- Participate with the member's interdisciplinary team in developing and implementing the PCSP, where applicable.

All providers strictly adhere to statutes related to maltreatment, abuse, and exploitation. To ensure compliance and enhance the protection of vulnerable individuals, it is crucial that providers conduct annual staff training on the recognition and prevention of exploitation, abuse, and neglect. Providers may be required to submit an annual attestation confirming that the training has taken place, along with the percentage of staff who have completed it. This commitment to ongoing education reinforces our collective responsibility to safeguard the well-being of those we serve and uphold the highest standards of care.

CES waiver compliance (including Community Support Service Provider (CSSP))

All CES waiver services must be delivered in accordance with the waiver requirements and consistent with the applicable Division of Developmental Disability Services provider manual or in our policies.

General provisions for all providers

Interactive voice response system

Summit Community Care provides an automated, interactive voice response (IVR) system to better serve members and participating providers. This IVR technology provides more detailed enrollment, claims and authorization status information, along with self-service features for members. These features allow each member to:

- Update his/her address and telephone number
- Request a new member ID card
- Search for and/or change his/her PCP name

For providers to provide the best service to members, accurate, up-to-date information must be shared and available 24 hours per day, 365 days per year. Please utilize the **Provider Inquiry Line (844-462-0022)** to verify member status, claim status, and prior authorization determination. The inpatient option is available 365/24/7 and the Provider Call Center is available 8:00 a.m. to 5:00 p.m. CST.

Second opinions

A member, parent and/or legally appointed representative, or the member's PCP may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. The second opinion shall be provided at no cost to the member.

The second opinion must be obtained from a network provider (see provider directory) or a non-network provider if there is not a network provider with the expertise required for the condition. Once approved, the PCP will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP will notify the member of the outcome of the second opinion.

Summit Community Care may also request a second opinion at its own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by the member or the provider.
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during its regular course of business.
- Before initiating a denial of coverage of service.
- When denied coverage is appealed.
- When an experimental or investigational service is requested.

When Summit Community Care requests a second opinion, Summit Community Care will make the necessary arrangements for the appointment, payment and reporting. Summit Community Care will inform the member and the PCP of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

Specialty referrals

All specialty referral authorizations will comply with Section 6.3 of the Arkansas Department of Human services PASSE Contract.

Summit Community Care does not require a referral or prior authorization for members to access specialty care. A member, parent, and/or legally appointed representative is allowed to access specialty care for the member at any time, regardless of a PCP referral or an approved prior authorization from Summit Community Care.

Initial health appointments for Summit Community Care members

Summit Community Care members age 21 and over must be offered an initial appointment within 45 days of their date of enrollment with the PCP or within 21 days of request, whichever is sooner, unless one of the following exceptions applies:

- Appointments for initial EPSDT screens shall be offered to new enrollees within 60 days of the enrollee's enrollment date with Summit Community Care, or at an earlier time if 1) an earlier exam is needed to comply with the periodicity schedule or 2) if the child's case indicates a more rapid assessment or 3) a request results from an emergency medical condition. The initial screen shall be completed within three months of the enrollee's enrollment date with Summit Community Care unless we determine the new enrollee is up-to-date with the EPSDT periodicity schedule. To be considered timely, all EPSDT screens, laboratory tests and immunizations shall take place within 30 days of their scheduled due dates for children under the age of two and

within 60 days of their due dates for children aged two and older. Periodic EPSDT screening examinations shall take place within 30 days of a request.

- For pregnant and postpartum women who have not started to receive care, or individuals requesting family planning services, the initial health visit must be scheduled and occur within 14 calendar days of the date the member requests the appointment.

During the initial health visit, the PCP is responsible for documenting a complete medical history and performing and documenting results of an age-appropriate physical exam.

In addition, at the initial health visit, initial prenatal visit, or when physical status, behavior of the member or laboratory findings indicate substance use disorder, refer the member to the Department of Behavioral Health.

Routine urgent appointments for Summit Community Care members

To ensure members receive care in a timely manner, providers must maintain the following appointment availability standards:

Primary care practitioners

Type of visit	Availability standard
Emergency care (life threatening)	Immediately at the nearest facility
Urgent care visits	Within 24 hours of request
Routine, nonurgent care visits	Within 21 calendar days of request
Preventive care visits	Within 30 calendar days of request
Initial appointments for pregnant women or persons needing family planning	Within 14 calendar days of request

Specialist practitioners

Type of visit	Availability standard
Urgent care visits	Within 24 hours of referral
Routine, non-urgent care	Within 60 calendar days of referral

Behavioral health practitioners

Type of visit	Availability standard
Emergency care (life threatening)	Immediately at nearest facility
Care for non-life-threatening emergencies	Within 6 hours of request
Urgent care — behavioral, substance abuse care	Within 24 hours of request
Initial Visit-Routine Care	Within 10 business days of request
Follow-up Visit Routine Care	Within 21 calendar days

As required by both DHS and NCQA to assess member access to network providers, Summit Community Care conducts appointment availability surveys via a third-party vendor. Participating providers are selected on a random basis for the survey. Providers deemed non-compliant with appointment availability standards based on survey results will receive a non-compliance letter and must return the letter within thirty (30) days from receipt including an outline of any action taken in the provider's office to ensure future compliance. Providers deemed non-compliant will remain on future surveys until survey results indicate provider compliance with the availability standards.

The third-party survey vendor will inquire about appointment availability with a specific practitioner. If the practitioner is unavailable to schedule an appointment within the timelines defined in the availability standards, the practitioner will be deemed non-compliant. However, providers may offer an appointment with another practitioner in the group, and if that appointment is available within the timelines defined for the availability standard, the group will be deemed compliant with the survey.

For the Routine, non-urgent care appointment availability, providers may refer a member to the nearest urgent care facility and remain in compliance with the 24-hour urgent care appointment standard.

7. Provider Complaint Process

Summit Community Care maintains a process to resolve provider complaints. Both participating and non-participating providers may file a provider complaint.

Participating Providers must adhere to Summit Community Care's provider complaint process prior to contacting DHS regarding any provider complaint.

To file a provider complaint, a provider may contact via telephone or email their assigned Provider Relations representative, any member of the Summit Community Care Provider Relations team, or Provider Services toll free at (844) 462-0022. Providers contacting the Provider Services toll free line to file a provider complaint should notify the Provider Services representative to escalate the complaint directly to the Arkansas Provider Relations team.

Provider Complaint Process Definitions

An **inquiry** is a request for additional information or clarification regarding an operational issue or interacting with Summit Community Care. An inquiry is an informational request managed at the point of entry, i.e., resolved in the moment, or forwarded to the appropriate operational area for final response. An inquiry is not an expression of any dissatisfaction and not considered a complaint/grievance.

A **complaint** is an expression of dissatisfaction about any matter filed at any time. Complaints may include, but not limited to; adverse decisions/actions other than those excluded below, dissatisfaction with a policy or procedure, the quality of care or services provided, or any aspects of interpersonal relationships such as rudeness of an employee, or failure to conduct business with the provider in a timely or professional manner.

Provider Complaint Process Exclusions

The following scenarios are exclusions from the provider complaint process.

- Disagreement(s) with the outcome of a specific claim or set of claims.
    - For disagreements regarding the outcome of a claim, providers must follow the Claims Payment Dispute Process in this Provider Manual. ***Note: Dissatisfaction with a specific claim policy might be a provider complaint if unrelated to the specific outcome of a claim or set of claims.***
- Disagreement(s) related to an adverse benefit determination.
    - For any disagreement related to an adverse benefit denial, the member, or the provider on the member's behalf, must follow the member appeal process.
- Disputes related to the provider's existing participation agreement, received with provider legal counsel involvement, or written requests for arbitration.
    - Resolution of contractual related disputes are coordinated by the Provider Relations and/or Legal Department.

Provider Complaint Response & Resolution Timelines

Summit Community Care must acknowledge receipt and document follow-up to a provider who files a complaint by close of business the day following receipt of the provider's complaint.

We attempt to resolve provider complaints within thirty (30) days from receipt. Some complaints may be resolved to the provider's satisfaction, while depending on system limitations and other factors, other complaints may be closed without a resolution satisfactory to the provider.

Summit Community Care tracks, trends, resolves, and reports on provider complaints according to periods established by state and federal law and any applicable accreditation standards.

8. Summit Community Care benefits

Overview

Summit Community Care must provide a complete and comprehensive benefit package equivalent to the benefits available to Medicaid participants through the Medicaid fee-for-service delivery system. Carve-out services, which are not subject to capitation and are not a Summit Community Care responsibility, are still available for members. Medicaid will reimburse these services directly on a fee-for-service basis.

Services covered under the Arkansas Medicaid PASSE program include:

- State plan services (example DME, PT/OT/PT, PCP/specialty physician, nursing services, radiology, laboratory)
- Obstetrical/gynecological (excludes newborn coverage)
- Personal care
- Community and Employment Supports (CES) Waiver services (1915c)
- Home- and Community-based services (1915i)
- ADDT/EIDT
- Pharmacy (including transplant-related medication)
- Hospital services
- Family planning
- Inpatient psychiatric services
- Psychiatric Residential Treatment Services/Residential Treatment Unit
- Crisis Stabilization Unit/Acute Crisis Unit
- Behavioral counseling and other outpatient behavioral health services
- Vision and professional medical eyecare (see EyeMed section)

Services **excluded** from the Arkansas Medicaid PASSE program include:

- Non-emergency medical transportation (NET) provided through PAHP
- Transportation to and from an Early Intervention Day Treatment (EIDT) and Adult Development Day Treatment (ADDT) when provided by a contracted transportation broker
- Dental benefits in a capitated program
- School-based services provided by school employees or their contracted vendor when the service is listed on the Individualized Education Plan (IEP), in accordance with the Individuals with Disabilities Education Act (IDEA). When this occurs, the biller must utilize the school district provider number as well as the Local Education Agency (LEA) number
- Skilled nursing facility services – Limited Rehabilitation Stay is not considered an excluded skilled nursing facility service
- Assisted living facility services
- Human Development Center (HDC) services
    - Full admission to HDC
    - Respite stays at HDC's are not excluded services
- Waiver services provided to the elderly and adults with physical disabilities through any other waiver program (example, ARChoices in Home Care program or the Arkansas Independent Choices program), or a successor waiver for the elderly and adults with physical disabilities

- Transplant services as of May 27, 2020, forward and post-transplant services for one (1) year following the date of the transplant *see covered services above for transplant-related pharmacy services
- Abortions, except as allowed by state or federal law

Benefit limitations

- Service is not included as a covered service in the state plan
- Service is of an amount, duration, and scope of the limit in the MCO contract between Arkansas and Summit Community Care
- Service is not medically necessary as defined in the MCO contract between Arkansas and Summit Community Care
- Service is a prescription drug for which Summit Community Care has received prior authorization in writing from DHS to exclude from the *Summit Community Care Formulary*
- Service is cosmetic, except the following services shall not be considered cosmetic:
    - Surgery required correcting a condition resulting from surgery or disease
    - Surgery required to correct a condition created by an accidental injury
    - Surgery required to correct congenital deformity
    - Surgery required correcting a condition that impairs the normal function of a part of the body
    - Surgery to address gender dysphoria as identified in Arkansas State law and/or DHS policy
- Service is sterilization for an enrollee under age 21
- Service is an abortion except as allowed by state or federal law
- Service is described as a non-MCP covered service, which is covered by the Medicaid State Plan but not described as a Summit Community Care covered service (i.e., dental) and, therefore, not the responsibility of Summit Community Care under the contract
- Service is an investigational or experimental treatment if it is a diagnostic or treatment service, in accordance with relevant evidence, is not considered to fall within the range of professionally accepted clinical practice with respect to illness, disability, or condition that is the focus of a coverage determination
- Services are part of a clinical trial protocol. Summit Community Care shall cover all medically necessary inpatient and outpatient services furnished over a clinical trial, but shall not cover the services included in it

Covered services

1915(c) Home and Community Based Waiver (formerly CES waiver services)	
Supportive Living	Supportive living is an array of individually tailored services and activities provided to enable eligible members to reside successfully in their own homes, with their family, or in an alternative living residence or setting. Alternative living residences include apartments, leased or owned homes, or provider group homes. Supportive living services must be provided in an integrated community setting. The services are designed to assist members in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in the home- and community-based setting. It excludes room and board expenses, including general

	maintenance, upkeep, or improvement to the home. The habilitation objective to be served by each activity should be documented in the member's PCSP. Services are flexible to allow for unforeseen changes needed in schedules and times of service delivery. Services are approved as maximum days which can be adjusted within the annual plan year.
Respite	Respite services are provided periodically on a short-term basis to members unable to care for themselves due to the absence of or need for relief of non-paid primary caregivers. Respite services may include the cost of room and board charges when allowable for circumstances under 42 CFR 442.182 (d). Respite should not be furnished to compensate relief or substitute staff for supportive living services. Respite services are not to supplant the responsibility of the parent or guardian.
Supported Employment	Supported employment is a tailored array of services that offers ongoing support to members with the most significant disabilities to assist in their goal of working in competitive integrated work settings for at least minimum wage. It is intended for individuals for whom competitive employment has not traditionally occurred or been interrupted or intermittent due to a significant disability and who need ongoing support to maintain their employment.
Adaptive Equipment	Adaptive equipment is a piece of equipment, or product system used to increase, maintain, or improve functional capabilities of members, whether commercially purchased, modified, or customized. The adaptive equipment services include adaptive, therapeutic, or augmentative equipment that enables a member to increase, maintain, or improve their functional capacity to perform daily life tasks that would not be possible otherwise. Consultation by a medical professional must be conducted to ensure the adaptive equipment will meet the needs of the members. Adaptive equipment includes enabling technology, such as safe home modifications, which empower members to gain independence through customizable technologies that allow them to safely perform activities of daily living without assistance while still providing monitoring and response for those members, as needed. Enabling technology allows members to be proactive about their daily schedule and integrates member choice. Adaptive equipment also includes Personal Emergency Response Systems (PERS), which is a stationary or portable electronic device used in the member's place of residence and enables the member to secure help in an emergency. The system is connected to a response center staffed by trained professionals who respond to activation of the device. PERS services may include the assessment, purchase, installation, and monthly rental fee. Computer equipment, including software, can be included as adaptive equipment. Specifically, computer equipment includes equipment which allows the members increased control of their environment, to gain independence, or to protect their health and safety.

	Vehicle modifications are also included as adaptive equipment. Vehicle modifications are adaptations to an automobile or van to accommodate the special needs of the member. The purpose of vehicle modifications is to enable the member to integrate more fully into the community and to ensure the health, safety and welfare of the member. Vehicle modifications exclude adaptations or modifications to the vehicle that are of general utility and not of direct medical or habilitative benefit to the member; purchase, down payment, monthly car payment or lease payment; or regularly scheduled maintenance of the vehicle.
Environmental Modifications	Modifications made to the member's place of residence deemed necessary to ensure the health, welfare~~,~~ and safety of the member or which enable the member to function with greater independence and without which, the member may require institutionalization. Examples of environmental modifications include the installation of wheelchair ramps, widening doorways, modification of bathroom facilities, installation of specialized electrical and plumbing systems to accommodate medical equipment, installation of sidewalks or pads, and fencing to ensure non-elopement, wandering, or straying of members with decreased mental capacity or aberrant behaviors. Exclusions include modifications or repairs to the home which are of general utility and not for a specific medical or habilitative benefit; modifications or improvements which are of an aesthetic value only; and modifications that add to the total square footage of the home. Environmental modifications which are permanent fixtures to rental property require written authorization and release of current or future liability from the property owner.
Specialized Medical Supplies	Specialized medical equipment and supplies include: 1) Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items. 2) Such other durable and non-durable medical equipment not available under the State plan necessary to address the member's functional limitations and has been deemed medically necessary by the prescribing physician. 3) Necessary medical supplies not available under the State plan. Items reimbursed with Waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items not of direct medical or remedial benefit to the member. All items shall meet applicable standards of manufacture, design, and installation. The most cost-effective item should be considered first. Additional supply items are covered as a Waiver service when they are considered essential and medically necessary for home and community care and may include: 1) Nutritional supplements. 2) Non-prescription medications. Alternative medicines not Federal Drug Administration approved are excluded from coverage. 3)Prescription drugs minus the cost of drugs covered by Medicare Part D when extended benefits available under state plan are exhausted.

Supplemental Support	Supplemental support helps improve or enable the continuance of community living. Supplemental support will be based on demonstrated needs as identified in a member's person-centered service plan as unforeseen problems arise that, unless remedied, could cause disruptions in the member's services, placement, or place him or her at risk of institutionalization.
Consultation Services	Consultation services are clinical and therapeutic services which assist the member, parents, legally responsible persons, responsible individuals, and service providers in carrying out the member's PCSP and any associated plans included in the PCSP. These services are direct in nature. The PASSE will be responsible for maintaining the necessary information to document staff qualifications. Staff who meet the certification criteria necessary for other consultation functions may also provide these activities. These activities include, but are not limited to: 1) Provision of updated psychological and adaptive behavior assessments; allowable providers: psychologist, psychological examiner, speech therapist, physical therapist, occupational therapist with the scope of their practice area. 2) Screening assessing and developing CES Waiver services treatment plans; allowable providers: Qualified Developmental Disabled Professional (QDDP), psychologist, psychological examiner, speech therapist, physical therapist, occupational therapist, dietitian, positive behavior support specialist, licensed clinical social worker, professional counselor, registered nurse, certified communication and environmental control specialist, board certified behavior analyst within the scope of their practice area. 3) Training of direct service staff or family members in carrying out special community living services strategies identified in the member's PCSP as applicable to the consultation specialty. 4) Providing information and assistance to the persons responsible for developing the member's PCSP as applicable to the consultation specialty. 5) Participating on the interdisciplinary team, when appropriate to the consultant's specialty. 6) Consulting with and providing information and technical assistance with other service providers or with direct service staff or family members in carrying out the member's PCSP specific to the consultant's specialty. 7) Assisting direct services staff or family members to make necessary program adjustments in accordance with the member's PCSP and applicable to the consultant's specialty. 8) Determining the appropriateness and selection of adaptive equipment to include communication devices, computers, and software consistent with the consultant's specialty. 9) Training or assisting members, direct services staff, or family members in the set up and use of communication devices, computers, and software consistent with the consultant's specialty. 10) Training of direct service staff or family members by a professional consultant in: a) Activities to maintain specific behavioral management programs applicable to the member.

	b) Activities to maintain speech pathology, occupational therapy, or physical therapy program treatment modalities specific to the member. c) The provision of medical procedures not previously prescribed but now necessary to sustain the members in the community. 11) Training or assisting by advocacy consultants to members and family members on how to self-advocate. 12) Rehabilitation counseling 13) The PASSE is responsible for developing a Risk Mitigation Plan for each client that outlines risk factors and action steps that must be taken to mitigate the risk. CES Waiver clients who are at low risk of displaying behaviors that can lead to harm to self, and/or community members must have a Behavioral Prevention and Intervention Plan that is overseen and implemented by the client's supportive living provider. The goal is to keep the member in his or her place of residence and avoid an acute placement. Supportive living staff developing, overseeing and implementing Behavioral Prevention and Intervention Plans must receive training in verbal de-escalation, trauma informed care, verbal intervention training. Behavioral Prevention and Intervention Plan development must be by staff who meet minimum qualification of a Positive Behavior Support Specialist in accordance with CES Waiver standards. 14) Screening, assessing and developing positive behavior support plans, assisting staff in implementation, monitoring, reassessment and plan modifications; A positive behavior support plan is required when high level of behavioral related risk is identified in the PASSE Risk Mitigation Plan. Allowable providers include Psychologist, Psychological Examiners, Positive Behavior Support (PBS) Specialist, Board Certified Behavior Analyst (BCBA) within the scope of their practice area. licensed clinical social worker and licensed professional counselors 15) Training and assisting members, direct services staff or family members in proper nutrition and special dietary needs
Community Transition Services	Community transition services are non-recurring set-up expenses for members who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the member or his or her guardian is directly responsible for his or her own living expenses.

1915(i) Home and Community Based Waiver (HCBS) services	
Behavioral Assistance	Behavior assistance is an outcome-oriented intervention provided individually or in a group setting with the child/youth member and/or his/her caregiver(s) who will provide the necessary support to attain the treatment plan's goals. Services involve applying positive behavioral interventions and support within the community to foster behaviors that are rehabilitative and restorative in nature. The intervention should result in sustainable positive behavioral changes to improve functioning, enhance quality of life and strengthen skills in many life domains.
Adult Rehabilitative Day Services	A continuum of care is provided to recovering members living in the community based on their level of need. This service includes educating and assisting the member with accessing support and services needed. The service assists the recovering member to direct his or her resources and support systems. Activities

	include training to assist the member to learn, retain, or improve specific job skills, and to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of his or her choosing in the community. In addition, transitional services to assist members adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration. An array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified members aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These rehabilitative day activities are person- and family-centered, recovery-based, culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities assist the member with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with his or her chronic mental illness. The intent of these services is to restore the fullest possible integration of the member as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger; behavioral skills, such as proper use of medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing; community integration skills and any similar skills required to implement a member's master treatment plan.
Peer Supports	Peer support is a consumer-centered service provided by members (ages 18 and older) who self-identify as someone who has or is receiving behavioral health services and thus can provide expertise not replicated by professional training. Peer providers are trained and certified peer specialists who self-identify as being in recovery from behavioral health issues. Peer support is a service to work with members to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Specialists will assist with navigation of multiple systems (housing, supportive employment, supplemental benefits, building/rebuilding natural supports, etc.), which impact members' functional ability. Services are provided on an individual or group basis, and in either the member's home or community environment.
Family Support Partners	Family Support Partners is a service provided by peer counselors, or Family Support Partners (FSP), who model recovery and resiliency for caregivers of children or youth members with behavioral healthcare needs. Family Support Partners come from legacy families and use their lived experience, training~~,~~ and skills to help caregivers and their families identify goals and actions that promote recovery and resiliency. A FSP may assist, teach~~,~~ and model appropriate child-rearing strategies, techniques~~,~~ and household management skills. This service provides information on child development, age-appropriate behavior, parental expectations, and childcare activities. It may also assist the family in securing community resources and developing natural supports.

Supportive Life Skills Development	Supportive life skills development services are designed to assist members in acquiring the skills needed to support an independent lifestyle and promote an improved sense of self-worth. Life skills training is designed to assist in setting and achieving goals, learning independent living skills, demonstrating accountability, and making goal-directed decisions related to independent living (i.e., educational/vocational training, employment, resource and medication management, self-care, household maintenance, health, wellness, and nutrition).
Child and youth Support Services	Child and Youth Support Services are clinical, time-limited services for principal caregivers designed to increase a child's positive behaviors and encourage compliance with parents at home. These services work with teachers/schools to modify classroom environment to increase positive behaviors in the classroom, and increase a child's social skills, including understanding of feelings, conflict management, academic engagement, school readiness, and cooperation with teachers and other school staff. This service is intended to increase parental skill development in managing their child's symptoms of his or her illness and training the parents in effective interventions and techniques for working with the schools. Services might include an In-Home Case Aide~~.~~, which is an intensive, time-limited therapy for youth in the member's home or, in rare instances, a community-based setting. Youth members served may be in imminent risk of out-of-home placement or have been recently reintegrated from an out of-home placement. Services may deal with family issues related to the promotion of healthy family interactions, behavior training~~,~~ and feedback to the family.
Supportive Employment	Supportive employment is designed to help members acquire and maintain meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany members on interviews and providing ongoing support and/or on-the-job training once the member is employed. This service replaces traditional vocational approaches that provide intermediate work experiences (prevocational work units, transitional employment, or sheltered workshops), which tend to isolate members from mainstream society. Service settings may vary depending on individual need and level of community integration and may include the member's home. Services delivered in the home are intended to foster independence in the community setting and may include training about menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.
Partial Hospitalization	Partial hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment equal to an inpatient program but less than 24-hour. The environment at this level of treatment is highly structured and should maintain a staff-to-patient ratio of 1:5 to ensure necessary therapeutic services and professional monitoring, control~~,~~ and protection. This service shall include at a minimum intake, individual therapy, group therapy, and psychoeducation. Partial

	hospitalization shall be at a minimum five hours per day, of which 90 minutes must be a documented service provided by a mental health professional. If a member receives other services during the week but also receives partial hospitalization, the member must receive, at a minimum, 20 documented hours of services on no less than four days in that week.
Mobile Crisis Intervention	Crisis intervention is unscheduled, immediate, short-term treatment activities provided to a member who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the member and his or her family. These services are designed to stabilize the person in crisis, prevent further deterioration and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a member to determine if the need for crisis services is present.)
Therapeutic Communities	Therapeutic Communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the person served. Therapeutic Communities employs community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the members served are assigned responsibilities within the therapeutic community setting. Participants and staff members act as facilitators, emphasizing personal responsibility for one's own life and self-improvement. The service emphasizes the integration of member within his or her community~~,~~ and progress is measured within the context of that community's expectation.
Residential Community Reintegration	The Residential Community Reintegration Program is designed to serve as an intermediate level of care between inpatient psychiatric facilities and Outpatient Behavioral Health Services (OBHS). The program provides twenty-four hour per day intensive therapeutic care provided in a small group home setting for children and youth members with emotional and/or behavior problems which cannot be remedied by less intensive treatment. The program is intended to prevent acute or sub-acute hospitalization of youth, or incarceration. The program is also offered as a step-down or transitional level of care to prepare a youth member for less intensive treatment. Services include all allowable OBHS based on the member's age and any additional interventions to address the member's behavioral health needs.
Planned and Emergency Respite Services	Respite provides temporary direct care and supervision for a member in the member's community and is not facility-based. The primary purpose is relief to the principal caregiver of an individual with a behavioral health need. Respite services de-escalate stressful situations and provide a therapeutic outlet.
Supportive Housing	Supportive housing is designed to ensure members have a choice of permanent, safe~~,~~ and affordable housing. An emphasis is placed on the development and strengthening of natural support in the community. This service assists members in locating, selecting~~,~~ and sustaining housing, including transitional housing and chemical free living; provides opportunities for involvement in the community; and facilitates the member's recovery journey**.**

Disposable medical supplies (DMS)/durable medical equipment (DME)

Authorization

Authorizations for durable medical equipment (DME) and/or disposable medical supplies (DMS) will be provided promptly so as not to adversely affect the member's health. Urgent determinations are made within one business day of receipt of necessary clinical information but no later than 72 hours from the date of the initial request. Non-urgent determinations are made within two business days of receipt of the necessary clinical information but no later than 14 calendar days from the date of the initial request.

For code-specific prior authorization requirements for DME, prosthetics and orthotics ordered by network providers or facilities, use our Prior Authorization Lookup tool at **https://www.summitcommunitycare.com/provider.**

A properly completed and physician signed certificate of medical necessity (CMN) must accompany each prior authorization requests Summit Community Care and the provider must agree on HCPCS and/or other codes for billing covered services. Custom wheelchair prior authorizations may require the medical director's review.

DMS are covered, including disposable incontinence supplies for medical conditions associated with prolonged urinary or bowel incontinence if necessary to prevent institutionalization or infection, and all supplies used in the administration or monitoring of prescriptions by the member.

DME is covered when medically necessary, including equipment used in the administration or monitoring of prescriptions by the member.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services

For members under 21 years, all EPSDT services rendered by an EPSDT-certified provider are covered and recorded in accordance with the EPSDT periodicity schedule. The EPSDT provider toolkit is located at **https://www.summitcommunitycare.com/provider** on the Training Academy page under Provider manuals and communications. Providers rendering EPSDT services receive training on these services through the state's program. Services include:

- Annual comprehensive physical examination, health, and developmental history, including an evaluation of both physical and behavioral health development; the implementation of an approved developmental screening tool (e.g., Ages and Stations Questionnaire ASQ or Parents Evaluation of Developmental Status PEDS) should begin at the 9 month, 18 month, and 24 to 30 month visit. The results of the developmental surveillance and screening and the screening tool used should be documented in the member's chart. Children identified as being at risk for developmental delays should have documented counseling and referral for additional evaluation services.
- Immunizations and review of required documentation
- Laboratory tests for at-risk screening including TB risk assessment, hematocrit, and blood lead level test and assessments
- Health education/anticipatory guidance, including a dental referral at 12 months of age

Partial or interperiodic well-child services and healthcare services necessary to prevent, treat, or ameliorate physical, behavioral, or developmental problems or conditions with services in sufficient

amount, duration, and scope to treat the identified condition, and are subject to limitation only based on medical necessity, including:

- Chiropractic services
- Nutrition counseling
- Audiological screening when performed by PCP
- Private-duty nursing
- Durable medical equipment, including assistive devices
- Any other benefits listed in this section

Providers and Summit Community Care are responsible for making appropriate referrals for community resources not covered by Medicaid, such as Women, Infants, and Children (WIC) nutritional program.

Family planning services

Comprehensive family planning services are covered including:

- Office visits for family planning services
- Laboratory tests, including pap smears
- Contraceptive devices such as Mirena, Paraguard, and Implanon
- Voluntary sterilization (including Essure Micro-Insert if done in an obstetrician's office)

Members may see any Arkansas Medicaid provider they choose, without referral, for family planning services, including out of network providers.

Laboratory services

Diagnostic and laboratory services performed by providers who are *Clinical Laboratory Improvement Act of 1998* (*CLIA*)-certified or have a waiver of certificate registration and a *CLIA* identification number are covered. However, viral-load testing, genotypic, phenotypic or drug resistance testing used in treatment of HIV/AIDS are reimbursed directly by DHS and must be rendered by a DHS-approved provider and be medically necessary. Prior authorization is required for genetic testing. All laboratory services furnished by nonparticipating providers require prior authorization by Summit Community Care, except for hospital laboratory services for an emergency medical condition. If a convenient alternative is not available, prior authorization is required for members to access network hospital outpatient departments for blood drawings and/or specimen collection.

To ensure outpatient diagnostic laboratory services are directed to the most appropriate setting, laboratory services should be sent to a Summit Community Care-preferred laboratory vendor (e.g., Lab Corp or Quest Diagnostics). Laboratory services provided in a state hospital will be reimbursed under certain circumstances including:

- Services identified by Summit Community Care as stat laboratory procedures.
- Services rendered in an emergency room setting with an emergency diagnosis.
- Services rendered in conjunction with ambulatory surgery services.
- Services rendered in conjunction with observation services
- Services billed with certain chemotherapy, obstetric and sickle cell diagnosis codes

Physicians may continue to perform laboratory testing in their office but must otherwise direct outpatient diagnostic laboratory tests to a Summit Community Care-preferred laboratory vendor (e.g., LabCorp or Quest Diagnostics).

Clinical Laboratory Improvement Act of 1998 (CLIA) Claim Submission Requirements

We are bound by the *Clinical Laboratory Improvement Amendments* (*CLIA*) of 1988. The purpose of the CLIA program is to ensure laboratories testing specimens in interstate commerce consistently provide accurate procedures and services. As a result of *CLIA*, any laboratory soliciting or accepting specimens in interstate commerce for laboratory testing is required to hold a valid license or letter of exemption from licensure.

Claims that are submitted for laboratory services subject to the *Clinical Laboratory Improvement Amendments* of *1988 (CLIA)* statute and regulations require additional information to be considered for payment.

To be considered for reimbursement of clinical laboratory services, a valid *CLIA* certificate identification number must be reported on a *1500 Health Insurance Claim Form* (*CMS-1500*) or its electronic equivalent for clinical laboratory services. The *CLIA* certificate identification number must be submitted in one of the following manners:

Claim format and elements	*CLIA* number location options	Referring provider name and NPI number location options	Servicing laboratory physical location
***CMS-1500* (formerly *HCFA-1500*)**	Must be represented in field 23	Submit the referring provider name and NPI number in fields 17 and 17b, respectively.	Submit the servicing provider name, full physical address and NPI number in fields 32 and 32A, respectively, if the servicing address is not equal to the billing provider address. The servicing provider address must match the address associated with the *CLIA* ID entered in field 23.
HIPAA 5010 837 Professional	Must be represented in the 2300 loop, REF02 element, with qualifier of X4 in REF01	Submit the referring provider name and NPI number in the 2310A loop, NM1 segment.	Physical address of servicing provider must be represented in the 2310C loop if not equal to the billing provider address and must match the address associated with the *CLIA* ID submitted in the 2300 loop, REF02.

To be considered for reimbursement of reference laboratory services, the referring laboratory must be an independent clinical laboratory. Modifier 90 must be submitted to denote the referred laboratory procedure. Per the Centers for Medicare & Medicaid (CMS), an independent clinical laboratory that

submits claims in paper format may not combine non-referred or self-performed and referred services on the same *CMS-1500* claim form. Thus, when the referring laboratory bills for both non-referred and referred tests, it must submit two separate paper claims: one claim for non-referred tests and the other for referred tests. If submitted electronically, the reference laboratory must be represented in the 2300 or 2400 loop, REF02 element, with qualifier of F4 in REF01.

Providers who have obtained a *CLIA Waiver* or *Provider Performed Microscopy Procedure* accreditation must include the QW modifier when any *CLIA* waived laboratory service is reported on a *CMS-1500* claim form.

Laboratory procedures must be rendered by an appropriately licensed or certified laboratory having the appropriate level of *CLIA* accreditation for the particular test performed. Thus, any claim that does not contain the *CLIA* ID, has an invalid ID, has a lab accreditation level that does not support the billed service code, who render services outside of the effective dates of the CLIA certificate, does not have complete servicing provider demographic information and/or applicable reference laboratory provider demographic information, will be considered incomplete and rejected or denied.

Long-term care facility services/nursing facility services

Long-term care facilities include chronic hospitals, rehabilitation hospitals and nursing facilities. Summit Community Care is responsible for the first 20 days in a long-term care facility. Prior authorization is required for coverage from Summit Community Care.

When a member is transferred to a skilled nursing or long-term care facility and the length of the member's stay is expected to exceed 20 days, medical eligibility approval by the Department of Health for long-term institutionalization must be secured as soon as possible.

Inpatient acute care services provided within the first 30 days following admission to a long-term care facility are **not** considered an interruption of the Summit Community Care – covered 20 continuous days in a long-term care, facility if the member is discharged from the hospital back to the long-term care facility.

A member with serious behavioral illness, intellectual disability or a related condition may **not** be admitted to a nursing facility (NF) unless the state determines NF services are appropriate for coverage. For each member seeking NF admission, a preadmission screening and resident review (PASRR) ID screen must be completed.

The first section of the PASRR ID screen exempts a member if both:

1. NF admission is directly from a hospital for the condition treated in the hospital.
2. The attending provider certifies, before admission to the NF, that the member will likely need less than 30 days of NF services.

Vision benefits

The following route vision services are available to eligible Medicaid beneficiaries and are administered by EyeMed:

- **Age 21 and over**: One comprehensive eye examination including refraction and one pair of prescription eyeglasses every 12 months. Adult members with diabetes are eligible to receive a second pair of eyeglasses within the 12-month period if their prescription changes to more than one diopter. Post-cataract patients are also eligible for a second pair of eyeglasses. Contact lenses are covered only if medically necessary.
- **Under age 21**: One comprehensive eye examination including refraction and one pair of prescription eyeglasses every 12 months. Children/youth members with diabetes are eligible to receive a second pair of eyeglasses within the 12-month period if their prescription changes to more than one diopter. If eyeglasses are lost or broken beyond repair, an additional pair is covered through the state optical laboratory. Contact lenses are covered only if medically necessary.
- All beneficiaries must choose a frame from the state-mandated frame selection. If a member chooses to pay out of pocket for a frame outside of the collection, the member will receive no benefits for the entire pair of eyeglasses. All eyeglasses must be ordered via the EyeMed claim portal.
- For additional information related to routine vision services, including frames and lens restrictions, please review the EyeMed provider manual at **https://www.eyemedinfocus.com/summit/.**

In addition to routine vision services, EyeMed administers medical-surgical eye care services for all eligible beneficiaries. Please review the EyeMed provider manual at **https://www.eyemedinfocus.com/summit/** for additional information related to medical-surgical services, including prior authorization, therapeutic procedures, and injectable drugs.

Verifying member benefits and eligibility

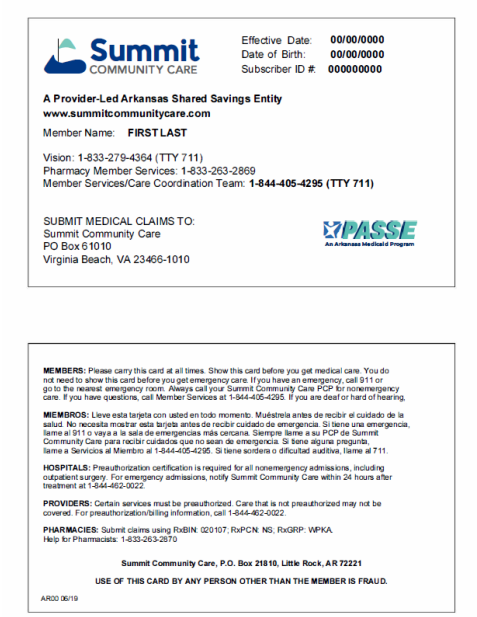
Providers are responsible for verifying member eligibility and covered services. Providers should verify benefits and eligibility each time a Summit Community Care member is scheduled to receive care. Claims will not be paid if it is determined the member is not eligible for services for the dates of service.

Member identification (ID) card

Every Summit Community Care ID card lists the following information:

- Effective date of membership
- Member date of birth
- Subscriber number
- Carrier and group number (RXGRP number) for injectables
- Copays for office visits, emergency room visits, and pharmacy services (if applicable)
- Behavioral health benefit
- Vision service plan telephone number
- Member Services and 24/7 Nurse HelpLine telephone numbers

Sample of member ID card



Providers should verfiy a member's status by inquiring online or via telephone. Online support is available for provider inquiries on the website, and telephone verification may be obtained through the automated Provider Inquiry Line at **844-462-0022**. Presentation of a member ID card does not guarantee eligibility.

Providers should encourage members to protect their ID cards as they would a credit card, to always carry their Summit Community Care ID card, and report any lost of stolen cards as soon as possible.

9. Utilization management

Overview

Summit Community Care, as it relates to Utilization Management (UM) decisions, is governed by the following statements:

- Utilization management decisions are fair, independent, and according to approved criteria and available benefit
- Decisions are based only on appropriate care, service, and coverage
- Practitioners or other individuals are not rewarded for issuing denial of coverage or care. Decisions regarding hiring, promoting, or terminating practitioners or other staff are not based on the likelihood or perceived likelihood they support, or tend to support, denial of benefits.
- Financial incentives for UM decision-makers do not encourage decisions which result in underutilization or create barriers to care and service.

Access to UM is available Monday – Friday, 8 a.m. to 5 p.m. CST by calling **844-429-9630** for inquiries. Clinical professionals are available 24 hours per day, 7 days per week for urgent/emergent inpatient authorizations by calling Provider Services at 844-462-0022.

Criteria and clinical information for medical necessity

Summit Community Care *Medical Policies* and *Clinical UM Guidelines* are available at **https://provider.summitcommunitycare.com/arkansas-provider/manuals-and-guides** and are the primary guidelines used to determine whether services are a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive. A list of these will be posted and maintained on the website and a hard copy may be requested in writing.

Milliman Care Guidelines (MCG) will continue to be used to determine medical necessity for inpatient care. To request a copy of the criteria on which a medical decision was based, please call Provider Services at **844-462-0022**.

Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over clinical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts will supersede MCG and our *Medical Policies* and *Clinical UM Guidelines*. Medical technology is constantly evolving, and Summit Community Care reserves the right to review and periodically update medical policy and utilization management criteria. The UM department reviews the medical necessity of medical services using:

- State guidelines
- Our *Medical Policies* and *Clinical UM Guidelines*
- MCG criteria
- *Carelon Medical Benefits Management Clinical Appropriateness* Guidelines

Established procedures are followed for applying medical necessity criteria based on individual member needs and an assessment of the availability of services within the local delivery system. Please visit the provider website at **https://www.summitcommunitycare.com/provider** or contact Provider Services to learn more about these procedures.

These procedures apply to:

- Prior authorization
- Concurrent review
- Retrospective review

Behavioral health will use MCG crtieria for all levels of care.

Referral/prior authorization process

Referrals to in-network specialists are not required for payment, however, Summit Community Care highly recommends PCPs supply the member with instructions for follow-up care.

Prior authorization and notification — general

Some covered services require prior authorization prior to being rendered, while others require notification.

Notification is a communication received from a provider informing Summit Community Care of the intent to render covered medical services to a member. For emergent or urgent services, notification must be provided within 24 hours after admission. Notifications may be submitted by phone or fax or web portal (please note, voicemails are not acceptable). If the admission or emergency healthcare service occurs on a holiday or weekend, a utilization review entity shall not require notification until the next business day after the admission or provision of the emergency healthcare service.

Prospective means the coverage request occurred prior to the service being provided.

Prior Authorization is the prospective process whereby licensed clinical associates apply specific criteria set against the intensity of services and severity of illness to determine the medical necessity and appropriateness of the request.

Services requiring prior authorization include but are not limited to:

- Elective inpatient admissions
- Select outpatient and specialty care provided outside of the PCP's scope of practice
- High-tech radiology
- Durable medical equipment
- Home health services
- Non-emergent out-of-network services
- CES Waiver services
- Extension of benefits
- BH residential services
- BH Partial Hospitalization services
- BH Intensive Outpatient services

The following information should be provided to the Medical Management department for prior authorization at **844-462-0022**. Please have the following information ready when you call-:

- Member's name
- Member's address

- Member's Summit Community Care ID number
- Member's date of birth
- Member's PCP
- Scheduled date of admission and/or surgery
- Name of hospital
- Ordering and servicing provider NPI
- Ordering and servicing provider address
- Ordering and servicing provider Tax ID
- Member's diagnosis
- Attending provider
- Clinical information (if applicable)

All Summit Community Care members scheduled for inpatient surgery must be admitted to the hospital on the day of the surgery except in preapproved medically necessary cases. Summit Community Care will **not** pay for any costs associated with admissions on the day before surgery unless specific medical justification is provided and approved. Each member's case will be examined individually in this respect.

The following are **not** acceptable reasons for an admission before surgery:

- Member, provider, or hospital convenience
- Routine laboratory or X-ray
- NPO (i.e., nothing by mouth)
- Distance or transportation to the hospital
- Most preps

Upon notification, Summit Community Care reviews the clinical basis for admission and authorizes benefits for the admission. The medical director reviews any potential denial of coverage after evaluating the member's medical condition and medical criteria.

To verify whether a particular outpatient service requires prior authorization, use the Prior Authorization Look Up Tool **https://provider.summitcommunitycare.com/arkansas-provider/prior-authorization-lookup**.

Prior authorization is **not** required for the following services:

- Routine laboratory tests (excluding genetic testing) performed in the PCP's office or contracted laboratory.
- Routine X-rays, EKGs, EEGs or mammograms at a network specialist office, at a freestanding radiology facility, or at some network hospitals.
- Routine outpatient behavioral health therapy services at a network specialist office up to the benefit limit.

The medical director will periodically review and revise this list expecting more services to be added as practice patterns of the network warrants.

Availity Authorization Application

The Summit Community Care Authorization Application on Availity Essentials is the preferred method for the submission of prior authorization requests, offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for Summit

Community Care members. Additionally, providers can use this tool to inquire about previously submitted requests regardless of how they were submitted (phone, fax or another online tool).

- Initiate prior authorization requests online, eliminating the need to fax. The Authorization tool allows detailed text, photo images and attachments to be submitted along with your request.
- Review requests previously submitted via phone, fax, or another online tool.
- Instant accessibility from anywhere, including after business hours.
- Utilize the dashboard to provide a complete view of all your organization's UM requests with real-time status updates.
- Real-time results for some common procedures.
- Access under Patient Registration > *Authorizations and Referrals* via the Availity Essentials.

Access through Availity Essentials at **https://www.availity.com**. You will need to be registered on Availity with your own unique user ID and password and have the appropriate role assignment. To create, submit and update a prior authorization requires the Authorization & Referral Request role. To inquire on a prior authorization, you will need the Authorization Inquiry role assignment. Your organization's Availity Administrator can assign these roles.

For an optimal experience with Summit Community Care Authorization Application, use a browser that supports 128-bit encryption. This includes Chrome, Microsoft Edge, Firefox, or Safari.

Authorizations and Referrals Preference Center
Providers can set preferences for how they receive communication regarding Utilization Management (UM) decisions, choosing between digital or digital and mail. To access the Preference Center, go to Payer Spaces, navigate to Summit Community Care, and select Preference Center. If applicable, choose your organization, and then select Authorizations and Referrals.

Summit Community Care Authorization Application is not currently available for the following:

- Transplant services
- Services administered by vendors (For these requests, follow the same prior authorization process that you use today.)
- CES Waiver services

Prior authorization determination time frames

For services that require prior authorization, Summit Community Care will determine timely so as not to adversely affect the member's health. For standard non-urgent authorization requests, the determination will be made within two business days of Summit Community Care's receipt of all necessary information needed, not to exceed 14 calendar days from the date of the request. For urgent authorization requests, the determination will be made within one business day of Summit Community Care's receipt of all necessary information needed to make the determination, not to exceed 72 hours from the date of the request.

If the request lacks clinical information, the organization may extend the decision time frame up to 14 calendar days for routine requests and for 48 hours for urgent preservice requests.

Failure of Summit Community Care to adhere to the above timeline for responding to a provider's request for prior authorization results in the requested services being "deemed" as approved. Summit Community Care will issue an administrative approval for requests where Summit Community Care did not respond within the turn-around times defined herein.

Inpatient services

Standard inpatient admission notification time frames

All elective admissions must receive prior approval through Provider Services at least 72 hours prior to the admission or scheduled procedure. Failure to comply with notification rules will result in an administrative denial.

The hospital is responsible for notifying Summit Community Care of the birth of a child within one business day of the date of birth. For transfer of a newborn from the nursery to the NICU or to another level of care, or to detain a newborn beyond the OB global period, the hospital must notify Summit Community Care within one business day. These circumstances are considered separate, new admissions and are not part of the mother's admission.

Emergent admissions require notification to Summit Community Care within 24 hours following the admission. Notifications may be submitted by phone or fax or web portal (please note, voicemails are not acceptable). If the admission or emergency healthcare service occurs on a holiday or weekend, a utilization review entity shall not require notification until the next business day after the admission or provision of the emergency healthcare service. Failure to comply with notification rules will result in an administrative denial.

Administrative denial

Administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of prior authorization or member ineligibility. Appeals for administrative denials must address the reason for the denial (i.e., why prior authorization was not obtained).

If Summit Community Care overturns its administrative decision, the case will be reviewed for medical necessity, and if approved, the claim will be reprocessed, or the requestor will be notified of the action that needs to be taken.

Inpatient specialist referrals

Referrals to in-network specialists are not required for payment; however, Summit Community Care highly recommends PCPs supply the member with instructions for follow-up care. Go to **https://www.summitcommunitycare.com/provider** to download the *Personalized* form.

Acute inpatient admission

- All medical inpatient hospital admissions will be reviewed for medical necessity within two business days of the facility notification to Summit Community Care.
- Clinical information for the initial (admission) review will be requested by Summit

Community Care at the time of the admission notification.

- For medical admissions, the facilities must provide the requested clinical information within 24 hours or the next business day of the request.

Inpatient concurrent review

Each network hospital will have an assigned concurrent review clinician. The concurrent review clinician will conduct a review of the medical records electronically or by telephone to determine the authorization of coverage for an admission.

- When the clinical information is received, a medical necessity review will be conducted using applicable nationally recognized clinical criteria, and a determination will be communicated to the facility.
- The Summit Community Care concurrent review clinician will conduct discharge planning review and help coordinate discharge planning needs with the designated facility staff and the attending provider. The attending provider is expected to coordinate with the member's PCP or outpatient specialty provider regarding follow-up care and services after discharge. The PCP or outpatient specialty provider is responsible for contacting the member to schedule all necessary follow-up care.

If the medical director/physician reviewer denies authorization for an inpatient stay based upon applicable guidelines or criteria, a notice of denial will be provided to the facility and to the attending provider.

Upon notification of the medical necessity denial, the member's treating physician can request a physician-to-physician review to provide additional information not previously submitted to Summit Community Care. The request for this review must be made within two business days of the notification of denial. To initiate this request, the physician or a physician representative may contact Summit Community Care at **844-429-9630, option 1** from 8:00 a.m. to 5:00 p.m.

All medical director/physician reviewer and administrative denials will be followed with a written adverse determination.

Inpatient retrospective review

Inpatient admissions may be retrospectively reviewed after the member is discharged. If Summit Community Care is notified of the admission while the member is still in the hospital, the review will be considered concurrent and subject to concurrent time frames and guidelines. For additional questions and a quick reference guide, visit the provider website.

Discharge planning

Discharge planning is designed to assist the provider with coordination of the member's discharge when acute care (i.e., hospitalization) is no longer necessary.

When a lower level of care is necessary, Summit Community Care will work with the provider to help plan the member's discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital setting such as:

- Hospice facility
- Skilled nursing facility
- Long-term acute care hospital (LTACH)
- Residential treatment facilities (RTF)
- Partial hospitalization programs (PHP)
- Intensive outpatient programs (IOP)
- Home healthcare

When the provider identifies medically necessary services for the member, Summit Community Care will assist the provider and the discharge planner in providing timely and effective transfer to the next appropriate level of care.

Discharge plan authorizations follow the applicable prior authorization process and determinations are made using nationally recognized clinical criteria or guidelines. Authorizations include home health, durable medical equipment (DME), follow-up visits to providers or outpatient procedures.

Outpatient services

Administrative denial

Administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of prior authorization or member ineligibility.

Appeals for administrative denials must address the reason for the denial (i.e., why prior authorization was not obtained).

If Summit Community Care overturns its administrative decision, the case will be reviewed for medical necessity, and if approved, the claim will be reprocessed, or the requestor will be notified of the action that needs to be taken.

For code-specific prior authorization requirements performed by a participating provider, visit **https://www.summitcommunitycare.com/provider**.

For prior authorization requirements for behavioral health services, please refer to the Behavioral Health Services chapter in this manual.

In addition, prior authorization is required for all out-of-network care (certain exclusions apply) and for specialty visits (i.e., services beyond the initial evaluation and management) if performed by a nonparticipating provider.

Summit Community Care will review and revise policies when necessary. The most current policies are available on the secure provider website.

Specialist as PCP referral

Under certain circumstances, a specialist may be approved by Summit Community Care to serve as a member's PCP when a member requires the regular care of the specialist. The criteria for a specialist to serve as a member's PCP include the existence of a chronic, life-threatening illness or condition of such complexity whereby:

- The need for multiple hospitalizations exists.
- The majority of care must be provided by a specialist.
- The administrative requirements of arranging for care exceed the PCP's capacity. This would include members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, etc.

The specialist must meet the requirements for PCP participation (including contractual obligations and credentialing), provide access to care 24 hours a day, 7 days a week and coordinate the member's healthcare including preventive care.

Behavioral health prior authorization

We require prior authorization for all elective behavioral health (BH) inpatient admissions and certain outpatient services. We use Milliman Care Guidelines and any applicable state criteria to review for medical necessity of services. The following is a list of services which must be prior authorized:

- Inpatient and residential admissions
- Outpatient BH services (i.e., intensive outpatient)
- All-outpatient BH services for out-of-network providers only
- Partial hospital programs

Cross-discipline coordination

Summit Community Care emphasizes the coordination and integration of physical and behavioral health and developmental disability services wherever possible. Key elements of our model of coordinated care include:

- Ongoing communication and coordination between PCPs and specialty providers and
- LTSS and HCBS providers.
  The expectation that providers screen for co-occurring disorders including:
  - Behavioral health screening by PCPs.
  - Medical screening by behavioral health providers.
  - Screening of mental health members for co-occurring substance use disorders.
  - Screening of members in substance use disorder treatment for co-occurring, mental health and/or medical disorders.
- Referrals to PCPs or specialty providers, including LTSS providers, HCBS providers, and other behavioral health providers, for assessment and/or treatment for members with co-occurring disorders.
- Involving members, as well as caregivers and family members as appropriate, in the development of patient-centered treatment plans and service plans, including case management and condition care programs to support the coordination and integration of care between providers.

- Notification of a member's PCP when a member first enters behavioral healthcare and anytime there is a notable change in care, treatment or need for medical services, provided the provider has secured the necessary release of information. The minimum elements to be included in such correspondence are:
    - Patient demographics.
    - Date of initial or most recent behavioral health evaluation.
    - Recommendation to see PCP, if medical condition identified or need for evaluation by a medical practitioner has been determined for the member (e.g., EPSDT screen, complaint of physical ailments).
    - Diagnosis and/or presenting behavioral health problem(s).
    - Prescribed medication(s).
    - Vital signs.
    - Allergy/drug sensitivity.
    - Pregnancy status.
    - Behavioral health clinician's name and contact information.

We also recognize treatment and recovery can be complicated by comorbid conditions. Essential ambulatory care should continue unabated while a member is hospitalized; therefore, PCPs and specialty providers must communicate directly to ensure continuity of care.

- When a member being treated for a comorbid behavioral health or I/DD condition is admitted for treatment of a physical health condition, the attending physician will try to secure a release of information and review the admission with the PCP. This is necessary to ensure essential treatment will continue unabated.
- When a member, who is being treated for a comorbid physical health condition is admitted for treatment of a behavioral health or I/DD condition, the attending physician will attempt to secure a release of information and review the admission with the behavioral health provider. This is necessary to ensure that essential treatment will continue unabated.

We require PCPs, specialty providers, LTSS and HCBS providers share relevant case information in a timely, useful~~,~~ and confidential manner. We require the specialty providers be notified of the member's physical examination and laboratory and radiological tests within 24 hours of receipt for urgent cases and within five business days in non-urgent cases. This notification will be made by telephone with follow-up in writing. The provider will obtain a release of information from any member or his or her legal representative (e.g., parent, guardian~~,~~ or conservator) before releasing confidential health information. The release of information must contain, at a minimum, the following:

- Name and identification number of the member whose health information is being released.
- Name of provider releasing the information.
- Name of provider receiving the information.
- Information to be released.
- Period for which the authorization is valid.
- Statement informing the signatory that he or she can cancel the authorization at any time.
- Printed name of the signatory.
- Signature or mark of the signatory.
- Date of signature.

A physical health provider who recognizes related behavioral health needs requiring treatment by a behavioral health provider will facilitate the member's access to a behavioral health service. A physical health provider who recognizes needed support or additional services regarding I/DD needs requiring treatment by a specialized I/DD provider will facilitate the member's access to such services. A nonnetwork provider, who recognizes related physical health needs requiring treatment by a physical health provider, is expected to facilitate the member's access to a primary provider by contacting us.

For members hospitalized and receiving behavioral and physical health services, primacy (i.e., the primary form of care) will be determined by the principal diagnosis, type of attending physician and location of service. Either type of provider may initiate consultation with the other and coordinate further and/or ongoing care. A physical and behavioral health provider should exchange health information at the following junctures:

- When the member first accesses a physical or behavioral health service.
- When a change in the member's health or treatment plan requires an alteration of the other provider's treatment plan (e.g., when a member who has been taking lithium becomes pregnant).
- When the member is admitted to or discharged from the hospital.
- When the member discontinues care.
- When a member is admitted, and a consultation is warranted.

Information should contain at a minimum:

- Provider's name and contact information.
- Member's name, date of birth, gender, ID number and contact information.
- Reason for referral (initial contact only).
- Current diagnosis.
- History of the presenting illness and other relevant medical and social histories (initial contact only).
- Level of suicide, homicide, physical harm, or threat.
- Current treatment plan.
- Special instructions (e.g., diagnostic questions to be answered, treatment recommendations).

The provider will maintain a copy of the release of information form and document care coordination in the member's medical record. We will coordinate inpatient behavioral health consultations and services and discharge planning and follow-up with the member's behavioral health provider (both network and non-network).

10. Pharmacy

Summit Community Care will maintain drug formularies in compliance with state benefits. The PASSE is required to maintain a drug formulary to meet the unique needs of its members. The PASSE must cover all therapeutic classes of drugs covered by the Arkansas Medicaid pharmacy benefit and must follow the Arkansas Medicaid Preferred Drug List (PDL). The PDL is subject to change on an ongoing basis. For those drugs not on the Arkansas PDL but that are covered by the Social Security Act, the PASSE may require prior authorization. The PASSE must, at a minimum, over the over the counter (OTC) drugs listed in the Medicaid State Plan Amendment.

Coverage may be subject to prior authorization to ensure medical necessity for specific therapies. For formulary drugs requiring prior authorization, a decision will be provided within 24 hours of receipt of necessary clinical information. If a service is denied, Summit Community Care will notify the prescriber and the member in writing of the denial.

Notice: If a generic equivalent drug is not available, a new brand-name drug rated as priority (P) by the Food and Drug Administration (FDA) will be added to the formulary.

Summit Community Care has procedures in place for when nonformulary drug requests are received. The state expects a nonformulary drug to be approved if documentation is provided indicating the formulary alternative is not medically appropriate.

Covered drugs

The Summit Community Care Pharmacy program utilizes a *Preferred Drug List* (*PDL*), which has been reviewed and approved by Arkansas DHS. The *PDL* is a list of the preferred drugs within the most prescribed therapeutic categories. To access the *PDL*, go to **Prime Therapeutics PDL** or visit the Summit Community Care Pharmacy Information and Tools page (**https://provider.summitcommunitycare.com/arkansas-provider/pharmacy**) and click on the link to the *Preferred Drug List (PDL)*. Many over-the-counter (OTC) medications are also covered and may be found on the Summit Community Care Pharmacy Information and Tools page (**https://fm.formularynavigator.com/FBO/4/Summit_Community_Care_OTC_PDL.pdf**).

Vaccines

Summit Community Care covers certain pharmacy vaccines for members as part of the pharmacy benefit. These vaccines include:

- COVID-19
- Hepatitis A
- Hepatitis B
- Haemophilus influenzae type b (Hib)
- Human papillomavirus (HPV)
- Influenza (seasonal flu)
- Meningococcal
- Measles, mumps, rubella (MMR)
- Pneumococcal
- Inactivated polio virus (IPV)
- Shingles
- Tetanus, diphtheria, pertussis (Tdap)
- Varicella (chickenpox)

For members 19 years and older: Vaccines may be obtained from either a prescriber's office or from an in-network pharmacy that offers vaccinations.

For members under 19 years: Vaccines are provided at no cost by the Vaccines for Children (VFC) program. Members may receive vaccines from medical providers enrolled in the VFC program and may also be obtained from an in-network pharmacy that is enrolled in the VFC program.

Monthly limitations

Each prescription may be filled for up to a maximum of 31-day supply. Maintenance medications for chronic illnesses must be prescribed and dispensed in sufficient quantities, not to exceed the maximum 31-day supply per prescription. For drugs that are specially packaged for therapy exceeding 31 days, the days supply limit (other than 31), as approved by the state, will be allowed for claims processing.

Pharmacists may dispense up to a 60-day supply of HIV pre-exposure prophylaxis in accordance with Arkansas state law.

Over-the-counter (OTC) drugs

Over-the-counter drugs are covered in compliance with state benefits. Please refer to the OTC List at **Prime Therapeutics OTC List** or visit the Summit Community Care Pharmacy Information and Tools page (**https://provider.summitcommunitycare.com/arkansas-provider/pharmacy**) for more information and click on the link to the **OTC Drug List**.

Exclusions

Neither the state nor Summit Community Care cover the following:

- Drugs not approved by the FDA
- Drugs not on the OTC Drug Formulary
- Drugs to help members get pregnant
- Drugs used for cosmetic reasons
- Drugs for hair growth
- Drugs used to treat erectile problems
- Drugs used for weight loss
- Experimental or investigation drugs

Pharmacy restriction (lock-in)

The Summit Community Care pharmacy restriction process limits members to a single pharmacy to obtain their medications. The need for restriction is decided following the member's medication claims review. Members identified with uncoordinated care, excessive utilization or suspected patterns of fraud and abuse may also be referred to the pharmacy department.

Using predefined queries, the members are identified and reviewed by Summit Community Care if they meet criteria for lock-in. Members selected for lock-in by Summit Community Care will be notified in advance of the lock-in and may appeal a lock-in decision within sixty (60) days of the date of notice of lock-in either in writing or orally by calling Pharmacy Member Services at 1-833-263-2869. The network

pharmacy provider will also be notified in writing of the decision to lock in the member to a pharmacy within ten (10) business days and prior to the actual lock-in date.

Pharmacy prior authorization

Providers are strongly encouraged to write prescriptions for preferred products as listed on the PDL. If, for medical reasons, a member cannot use a preferred product, providers are required to contact Summit Community Care Pharmacy Services to obtain prior authorization.

Prior authorizations may be requested in the following ways:

- **Phone:** Call **844-462-0022** Monday to Friday from 7 a.m. to 6 p.m. CST or 9 a.m. to 1 p.m. CST on Saturdays.
- **Fax:** Fax prior authorization form and all required information for
    - General pharmacy requests to **844-429-7761**
    - Medical injectable requests to **844-429-7762**
        - Prior authorization forms are located at:
        - **https://provider.summitcommunitycare.com/arkansas-provider/forms or https://provider.summitcommunitycare.com/arkansas-provider/pharmacy**
- **Web:** An electronic prior authorization request via **https://www.covermymeds.com/main/partners/anthem/**

Providers may use the online Prior Authorization Lookup Tool to:

- Submit requests for general pharmacy — medications dispensed directly to a member from retail pharmacy or shipped from a specialty pharmacy.
- Request medical injectables for those medications obtained by your office/facility for onsite infusion or administration.
- Check prior authorization status.
- Appeal denied requests.
- Upload supporting documents and review appeal status.

To access the Precertification Lookup Tool, log in at **https://provider.summitcommunitycare.com/arkansas-provider/prior-authorization-lookup**; you must be a registered user to access the tool. The site also offers tutorials to guide you through the medication prior authorization process and other helpful functions.

The information will be reviewed for medical necessity, and the provider will be notified within 24 hours of receipt of the necessary clinical information.

If the service is denied, the prescriber and the member are notified in writing of the denial. All decisions are based on medical necessity and are determined according to certain established medical criteria. Summit Community Care may not cover brand name medications where there is an FDA-approved therapeutically equivalent generic. Requests for brand name medications when there is a generic available will follow the prior authorization process to determine medical necessity. Some drugs have daily quantity and/or dosage limits and are identified as such on the *PDL*. Request for drugs exceeding the limits will require prior authorization to determine medical necessity.

Examples of medications that may require prior authorization are listed below (this list is not all-inclusive and is subject to change):

- Drugs not listed on the *PDL.*
- Brand-name products for which there are therapeutically equivalent generic products available.
- Self-administered injectable products.
- Drugs that exceed certain limits (for information on these limits please contact the Pharmacy department).

Drug coverage under medical benefit

Drugs only administered to members by healthcare professionals are available under the medical benefit and may be obtained in several ways:

- **Buy and bill**: Physicians may purchase drugs directly through pharmaceutical wholesalers and distributors and submit a claim to Summit. Please refer to the state fee schedule to review a list of services and drugs billable on the medical benefit.
- **Delivery**: Physicians may request delivery of a member specific specialty medication to be administered in their office by calling Summit Community Care's contracted medical specialty pharmacy (MSP), CVS Specialty*.
- **Referral**: Physicians may refer members to infusion suites and outpatient hospital services.

Note: CVS Specialty* is an independent company providing pharmacy services on behalf of Summit Community Care.

Medical specialty pharmacy (MSP)

Summit Community Care is pleased to announce a drug delivery option that enhances medication accessibility to both members and providers. Summit Community Care is contracted with CVS Specialty® as the MSP. CVS Specialty® can deliver member specific medication that is covered under the Summit Community Care medical benefit to your office for administration to the member.

To set up delivery or check a prescription order status, please call **877-254-0015**, and you will be transferred to a pharmacist for a verbal prescription order. Please plan to provide the member's Summit Community Care ID located on the ID card. Staff will obtain additional information necessary to support the delivery of the medication, including the need by date. Please allow up to 10 days for processing and shipping. The staff will then make an outbound call to the member to obtain consent as needed to support the delivery of the medication to your office. Once all necessary information is obtained for shipping, the staff will call your office to confirm delivery.

You may also fax prescription orders to **866-336-8479** and a staff member will call your office to obtain additional information necessary to support the delivery of the medication as described above.

Note: If it is an urgent medication request and the need by date is less than seven days from the order date, please indicate this so the order can be expedited.

Home Delivery

Members can get many prescription drugs shipped directly to your home through an in-network home delivery provider. A prescription drug home delivery form must be completed to set up delivery and are available on the Summit Community Care website at:
https://www.summitcommunitycare.com/arkansas-passe/benefits/pharmacy-benefits.html

11. Care Coordination and Case Management

Care Coordination

The PASSE program defines care coordination as ensuring services are coordinated with specialty providers (BH, DD services as appropriate). The PASSE must provide care coordinators who work with the member's providers to ensure continuity of care across all services. Act 775 of the 2017 Arkansas Regular Session defined care coordination as including the following activities:

- Health education and coaching
- Coordination with other healthcare providers for diagnostics, ambulatory care, and hospital services
- Assist with social determinants of health, such as access to healthy food and exercise
- Promotion of activities focused on the health of a patient and his or her community, including without limitation outreach, quality improvement, and patient panel management
- Coordination of community-based management of medication therapy

Summit Community Care will assign every member a qualified, conflict-free care coordinator who will be responsible for the total plan of care for the member, including but not limited to the following:

- Providing health education and coaching
- Coordinating healthcare providers
- Assisting with social determinants of health
- Promoting community activities focused on health
- Assisting with scheduling Optum independent assessments
- Assisting with referrals for services
- Assisting with eligibility renewals
- Creating person-centered service plan
- Monthly contact
- Quarterly face-to-face visits
- Collaborating with providers
- Being a liaison between other departments

The care coordinator and member's provider are expected to partner to facilitate comprehensive care delivery to the member. The care coordinator is responsible for obtaining copies of all assessments, treatment, and service plans, coordinating related services and supports to prevent duplication of services, and identifying any service gaps for the member, as well as providing any identified health education and health coaching resources.

The care coordinator will also provide case management under the concurrent *1915(c) Home- and Community-Based Services Community and Employment Support (CES) Waiver* for members who are *Waiver* participants, including:

- Coordinating and arranging appropriate and available CES Waiver services and other state plan services
- Identifying and accessing medical, social, educational, and other publicly funded services (regardless of funding source)
- Identifying and accessing informal community supports needed by members and their families

- Monitoring and reviewing services provided to members to ensure all available plan services are being provided, (and if not, seek out those services) and to ensure the health and safety of the member
- Connecting with resources to aid in crisis intervention
- Providing guidance and support to meet generic needs
- Assisting with referrals for resources
- Monitoring services provided to ensure quality of care and case reviews which focus on the member's progress in meeting goals and objectives established on existing case plans
- Providing assistance relative to obtaining Waiver Medicaid eligibility and ICF/IDD level of care eligibility determinations
- Assisting with the submission of timely (advanced) and comprehensive behavior and assessment reports, continued plans of care, and revisions as needs change
- Arranging for access to advocacy services as requested by the member
- Providing assistance upon receipt of DDS or DHS notices or denials, including education regarding the reconsideration and appeal process

The core components of the care coordination model include:

- Matching our members to the right community-based Care Coordinator by carefully considering:
    - Member diagnoses;
    - Complexity of medical, behavioral health or IDD conditions;
    - Intensity of service and support needs

- Identification of a community-based Care Coordinator on our team with appropriate experience, knowledge and skills, person-centered planning through partnership and collaboration with members, their providers, their families and/or natural supports and other member-identified interdisciplinary team participants who will consider members holistically using discovery and assessment results to ensure medical, behavioral, social, vocational, and educational needs are addressed to maximize health, well-being and independence in the development of a comprehensive, person-centered service plan.
- Coordination and collaboration across member systems of care to align resources based on need, integrate services, reduce duplication of efforts, improve continuity of care and services, and increase cost efficiencies.
- The continuous process of delivering, monitoring, and assessing interventions designed to meet the members' goals — defined in person-centered service plans and other care/treatment plans as part of their system of care — to maximize individual health, well-being, and quality of life.
- Technology and innovations to:
    - Improve member and natural support experiences;
    - Expand the tools to enable collaboration among multiple stakeholders;
    - Enhance our members' ability to self-direct services and supports;
    - Provide real-time member information; and
    - Improve provider and system performance.
- Ongoing stakeholder engagement at the member and system levels to build consensus, implement innovative solutions for issues and concerns, and facilitate continuous program improvements to better serve members.

A core responsibility within our model is embracing person-centered service planning. We communicate an array of options available to our members, supporting and promoting their informed decision-making and their well-being. Our approach promotes member engagement in all aspects of care and services, including interdisciplinary team development, use of support, and choice of specific providers. From our experience, we know fully informed members make effective decisions that promote health and safety and are suited to their preferences. This is a cornerstone to improving member experience, adherence to the service plans and overall outcomes.

Risk mitigation planning

All PASSE care coordinators must be trained in the development of PCSPs and will lead the PCSP process with the member and in consultation with the member's representative(s) and provider(s) as applicable. The process will include the identification of the member's goals, strengths, and preferences. It will identify the services and supports, paid and unpaid, to be provided for a period not to exceed 12 months. The PCSP shall reflect the member's daily and weekly activities and routine. It should also reflect planning for future transitions beyond a 12 month period that are age appropriate such as transitioning from the home of the member's parent(s) into a group home with supports for greater autonomy.
The individualized PCSP shall include the risk of institutionalization, risk to personal safety, risk of homelessness, suicide risk, and other health risks. The individualized PCSP shall include the risk mitigation strategies including how the risks are to be monitored and identify the key provider staffs as applicable to be involved.

Providers must document practices and decisions regarding risk assessment and the ongoing management of risks. Providers must specify the tool they use. Members enrolled in the CES Waiver, as they exercise their rights about their services, make choices about the amount of risk they wish to take. In negotiating trade-offs between choice and safety, care coordinators and providers are required to document the concerns of the team members, the negotiation process and the analysis and rationale for the decisions made and the actions taken.

Supportive Living providers must develop and implement Behavioral Prevention and Intervention Plans to address low behavioral risks identified in the client's Risk Mitigation Plan performed by the PASSE.

Case Management

Case management services at Summit Community Care are tailored to members' health needs – from coordinating care to condition care, each of our services helps members to get the most of their benefits. Case managers work alongside care coordinators and focus on the timely, proactive, collaborative, and member-centric coordination of services for individuals. These individuals may be identified with complex medical conditions, repeated admissions for the same condition, or high-risk obstetrics.

The defining features of the case management team are:

- A collaborative process that includes contract with the member, family member, caregiver, and physician or other healthcare provider.
- A process carried out using communication and available resources to promote quality and effective outcomes.

- A process that assists in optimizing the members' healthcare outcomes through plans designed to empower members to use the benefits, services, and options available to meet individual health needs.

Case managers perform the activities of assessment, planning, facilitating, and support throughout the continuum of care and provide evidenced-based, member-centric care planning consistent with recognized standards of case management practice and accreditation requirements.

Case managers consider members' needs for:

- Social services
- Educational services
- Therapeutic services
- Other non-medical support services (personal care, WIC, transportation)

The case management team will also provide education and counseling on member compliance with prescribed treatment programs.

Provider referrals for members who may benefit from case management support are welcome, as well as self-referral or caregiver referrals. Please contact Provider Services at **844-462-0022** and request Case Management. All case managers are licensed RNs and social workers and are available 8 a.m. to 5 p.m. Monday through Friday local time, with confidential voicemail available 24 hours per day. The nurse line is also available 24/7, at 1-844-405-4295.

12.Claims

Reimbursement Policies

These reimbursement policies serve as a guide to assist you with accurate claim submissions and to outline the basis for reimbursement if Summit Community Care plan covered the services for the member's benefit plan. Services must meet authorization and medical necessity guidelines appropriate to the procedures and diagnoses, and Arkansas regulations. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claims submissions. Services should be billed with Current Procedure Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performs, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, Summit Community Care policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Summit Community Care may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Summit Community Care reimbursement policies are based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent loading some policies in the same manner described; however, Summit Community Care strives to minimize these variations.

Reimbursement hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity/clinical criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodology are conditions of payments.

Review schedule and updates to Reimbursement Policies

Reimbursement policies undergo reviews for updates to state contracts, federal or, CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to a Summit Community Care business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policies to our provider website at **https://www.summitcommunitycare.com/provider**.

Medical Coding

The Medical Coding Department ensures that correct coding guidelines have been applied consistently through Blue Cross AR. Those guidelines include but are not limited to:

- Correct modifier use.
- Effective date of transaction code sets (CPT, HCPCS, ICD-10 diagnosis/procedures, revenue codes, etc.)
- Code editing rules, appropriately applied and within regulatory requirements.
- Analysis of codes, code definitions and appropriate use.

Reimbursement by code definition

Summit Community Care allows reimbursement for covered services based on their procedure code definition, or descriptor, as opposed to their appearance under particular CPT categories or sections, unless otherwise noted by state, federal or CMS contracts and/or requirements.

1. Evaluations and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services, or procedures

Claims submission

Claims must be submitted according to the timely filing guidelines and include all necessary information outlined in the following sections. In addition, all codes used in billing must be supported by appropriate medical record documentation. The appropriate CMS billing form is required for paper and electronic data interchange (EDI) claim submissions. The CMS billing forms usage guidelines are CMS 1450 for facilities and CMS 1500 for professionals.

CMS-1500 (08-05) claim form

Healthcare practitioners and other persons entitled to reimbursement must use the *CMS-1500 (08-05)* form and instructions provided by CMS for use of the *CMS-1500 (08-05)* as the sole instrument for filing claims with Summit Community Care for professional services. This does not apply to dental services billed by dentists using the *J 512 Form* or its equivalent or pharmacists or pharmacies filing claims for prescription drugs.

Except for parties to a global contract, Summit Community Care may not require a healthcare practitioner or other person entitled to reimbursement to use any code or modifier to file claims for healthcare services different from, or in addition to, what is required under the applicable standard code set for the professional services provided.

Except as noted, Summit Community Care may not use and may not require a healthcare practitioner or other person entitled to reimbursement to use another descriptor with a code or to furnish additional information with the initial submission of a *CMS-1500 (08-05)* that is different from, or in addition to, the applicable standard code set for the professional services provided.

A healthcare practitioner or other person entitled to reimbursement whose billing is based on the amount of time involved will indicate the start and stop time or number of minutes in Field 24G, currently titled Day or Units, of the *CMS-1500 (08-05)* if it is not used to specify the number of days of treatment.

This form is available at **www.cms.hhs.gov**.

UB-04 claim form

Hospitals or persons entitled to reimbursement must use the *UB-04*, and instructions provided by CMS for use of the *UB-04*, as the sole instrument for filing claims with Summit Community Care for hospital and other healthcare services.

Except for parties to a global contract, Summit Community Care may not use and may not require a hospital or other person entitled to reimbursement to use any code or modifier for the filing of claims for hospital and other healthcare services that is different from, or in addition to, what is required under the applicable standard code set for hospital or other healthcare services provided.

Except as noted, Summit Community Care may not use and may not require a hospital or other person entitled to reimbursement to furnish additional information with the initial submission of a *UB-04* that is different from, or in addition to, the applicable standard code set for the hospital or other healthcare services provided.

This form is available at **www.cms.hhs.gov**.

Summit Community Care follows the CMS billing requirements for paper, EDI, and secure web-submitted claims. Summit Community Care is required by state and federal regulations to capture specific data regarding services rendered to members. Providers must adhere to all billing requirements to ensure timely processing of claims and avoid unnecessary upfront rejections or denials.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Summit Community Care may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Summit Community Care reimbursement policies are based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent loading some policies in the same manner described; however, Summit Community Care strives to minimize these variations.

Paper claim submission

For paper claim submissions, Summit Community Care utilizes optical character recognition (OCR) technology as part of its front-end claims processing procedures. To use OCR technology, claims must be submitted on original, red claim forms that are laser-printed or typed (not handwritten) in large, dark font. Completed claims forms should be submitted within 365 days from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For case of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third-party documents resolution of the claim. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date Summit Community Care receives notification from DHS of the member's eligibility/enrollment.

Claims cannot be accepted with alterations to billing information and Summit Community Care will not accept computer-generated or typewritten claims with information marked through, handwritten, or covered by correction fluid or tape. Claims that have been altered will be returned to the provider with an explanation of the reason for the return.

Paper claims must be submitted to:
Summit Community Care
PO Box 61010
Virginia Beach, VA 23466-1010

Please note: AMA- and CMS-approved modifiers must be used appropriately based on the type of service and procedure code.

Electronic claim submission – Electronic Data Interchange (EDI)

Summit Community Care prefers claims be submitted electronically through Electronic Data Interchange (EDI). Claims must be submitted within 365 days from the date of discharge for inpatient services or from the date of service for outpatient services. Availity is an exclusive partner Summit Community Care uses for managing all EDI transactions, including Electronic Remittance Advices (835) for faster, more efficient, and cost-effective way for providers and employers to do business.

EDI Payer ID - **PASSE**

Use Availity for the following EDI transactions**:**

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

EDI Response Reports

Claims submitted electronically will return response reports that may contain rejections. If using a clearinghouse or billing vendor, please work with them to ensure you are receiving all reports. It is important to review rejections as they will not continue through the process and will require correction and resubmission. For questions on electronic response reports contact your clearinghouse or billing vendor or Availity at **800-AVAILITY (800-282-4548).**

Electronic Funds Transfer (EFT)

Electronic claims payment through electronic funds transfer (EFT) is a secure and fastest way to receive payment reducing administrative processes. EFT deposit is assigned a trace number matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

Use Enroll Safe (https://enrollsafe.payeehub.org/) to register and manage EFT account changes.
Contact Availity
Please contact Availity Client Services with any questions at **800-Availity (800-282-4548)**

Claim form attachments

A **clean claim** refers to a claim for payment of healthcare expenses that is submitted on a CMS 1500 or a UB04 claim form, in the format required by HIPAA, with all required fields completed in accordance with Summit Community Care's published claim filing requirements.

Summit Community Care requires the following attachments for a claim to qualify as a clean claim:

- Explanation of benefits statement from the primary payer to the secondary payer unless an electronic remittance notice has been sent by the primary payer to the secondary payer. For eligible members with dual commercial insurance and Medicaid coverage, Summit Community Care maintains a *Commercial Insurance Bypass List* which identifies service codes for which no third-party liability (TPL) information will be required.
- Medicare remittance notice if the claim involves Medicare as a primary payer, and Summit Community Care provides evidence it does not have a crossover agreement to accept an electronic remittance notice. For eligible members with dual Medicare and Medicaid coverage, Summit Community Care maintains a *Medicare Third Party Bypass List** that identifies service codes for which no TPL information will be required.
- Description of the procedure or service which may include the medical record, if a procedure or service rendered has no corresponding CPT or HCPCS code.
- Operative notes if the claim is for multiple surgeries or includes modifier 22, 58, 62, 66, 78, 80, 81 or 82.
- Anesthesia records documenting time spent on the service if the claim for anesthesia services rendered includes modifiers P4 or P5.
- Documents referenced as contractual requirements in a global contract (if applicable).
- Ambulance trip report if the claim is for ambulance services submitted by an ambulance company licensed by the state Emergency Medical Services Systems.
- Office visit notes if the claim includes modifiers 22.
- Information related to an audit as specified in writing by Summit Community Care if the Summit Community Care audit demonstrated a pattern of fraud, improper billing, or improper coding.

- Admitting notes, if the claim is for inpatient services provided outside of the time or scope of the authorization.
- Physician notes, if the claim for services provided is outside of the time or scope of the authorization or if the authorization is in dispute.
- Itemized bills, if the claim is for services rendered in a hospital, and the hospital claim has no prior authorization for admission or the claim is for services inconsistent with the Summit Community Care concurrent review determination rendered before the delivery of services regarding the medical necessity of the service.

A **non-clean** or **unclean** claim is an incomplete claim that could contain invalid or missing data elements, a claim that has been suspended to get more information from the provider, or a claim that requires manual intervention/processing.

The following are permissible categories of disputed claims for which Summit Community Care may request additional information:

- If there is no authorization or a prior authorization and Summit Community Care disputes the claim is consistent with the basis for denial or because the claim is for services provided outside the time or scope of the authorization and the applicable attachment was not submitted with the claim.
- Eligibility for benefits or coverage.
- Necessity of a service, procedure or DME rendered or provided by a specialist and not requested by a network PCP on a referral form or consultant treatment plan.
- Information necessary to adjudicate the claim consistent with the global contract.
- Reasonable belief of incorrect billing.
- Additional information not obtained by Summit Community Care from the member within 30 days of receipt of the claim.
- Legibility of the claim in a material manner.
- Reasonable belief of fraudulent or improper coding, consistent with the Summit Community Care retroactive denial.
- Reasonable belief a claim for emergency service may not meet the standards for an emergency service.
- Category approved by the commissioner by regulation.

Summit Community Care may not request additional information if an attachment containing the same type of information was submitted with the claim.

Summit Community Care may not request additional information for the following categories of disputed claims:

- Except for global contracts, a description of the procedure or service that is inconsistent with the applicable standard code set.
- Reimbursement for hospital services in accordance with the rates approved by the Health Services Cost Review Commission.
- Services that were prior authorized by Summit Community Care.

An **applicable code set** is defined as the most recent version, as of the date of service, of the following:

- For services rendered by healthcare practitioners, the Current Procedural Terminology
- (CPT) maintained and distributed by the American Medical Association, including its codes and modifiers and codes for anesthesia services.

- For dental services, the Code on Dental Procedures and Nomenclature (CDT), maintained and distributed by the American Dental Association.
- For all professional and hospital services, the International Classification of Diseases, Clinical Modification (ICD-10 CM).
- For all other health-related services, the CMS' HCPCS levels I and II and modifiers, maintained and distributed by the U.S. Department of Health and Human Services.
- For prescribed drugs, the National Drug Codes (NDC), maintained and distributed by the U.S. Department of Health and Human Services.
- For anesthesia services, the codes maintained and distributed by the American Society of Anesthesiologists.
- For psychiatric services, the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-V-TR*) codes, distributed by the American Psychiatric Association.
- For hospital and other applicable healthcare services including home health services, the state *UB-04 Uniform Billing Data Elements Specification Manual.*
- For hospital services pursuant to a Maryland contract or insurance policy, a revenue code approved by the Health Services Cost Review Commission for a hospital located in the state or by the National or State Uniform Billing Data Elements Specifications for a hospital not located in the state.

An **auto code** is defined as an ICD-10 code designed by Summit Community Care as a diagnosis that is an emergency service.

A **modifier** is defined as a code appended to a CPT or HCPCS code to provide more specific information about a medical procedure.

For a paper claim, Summit Community Care will date-stamp the claim with the date received or assign a batch number to the electronic claim that includes the date received. Summit Community Care will maintain a written or electronic record of the date of receipt of a claim. If a provider requests verification, Summit Community Care will provide verification of the date of claim receipt within five working days. The claim is presumed to have been received by Summit Community Care within three working days from the date the provider placed the claim in the U.S. mail if the provider maintains the stamped certificate of mailing for the claim or on the date recorded by the courier if the claim was delivered by courier.

Summit Community Care utilizes auto codes to determine emergency services and provides them to all network practitioners or hospitals rendering emergency services and to all healthcare practitioners or hospitals rendering emergency services who request the auto codes. If the auto codes are updated, the codes will be distributed 30 days prior to implementation.

Encounter data

Providers must submit encounter data within the timely filing periods outlined in the section of this manual through EDI submission methods or *CMS-1500 (08-05)* or *1450/UB04* claim forms. Include the following information in submissions:

- Member name (first and last name)
- Member ID
- Member date of birth
- Provider name according to contract

- Summit Community Care provider number
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (using current procedure codes and modifiers if applicable)
- Provider tax ID number
- NPI/API number

Summit Community Care will not reimburse providers for items received free of charge or items given to members free of charge.

Providers must use HIPAA-compliant billing codes when billing or submitting encounter data. This applies to both electronic and paper claims. When billing codes are updated, providers are required to use appropriate replacement codes for submitted claims or covered services.

Providing after-hours care in an office setting helps reduce inappropriate emergency room use and encourages members to receive appropriate follow-up care. To promote greater access for members, Summit Community Care encourages PCPs to provide efficient quality care in an office setting and will reimburse wellness visits and sick visits billed on the same day.

HEDIS® outcomes are also collected through claim and encounter data submissions. This includes but is not limited to:

- Preventive services (for example, childhood immunization, mammography, and Pap smears).
- Prenatal care (for example, the number and frequency of prenatal visits).
- Acute and chronic illness (for example, ambulatory follow-up and hospitalization for major disorders).

Compliance is monitored by Summit Community Care Utilization and Quality Improvement staff, coordinated with the medical director, and reported to the quality management committee annually. The PCP is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and may result in termination.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Encounter data for capitated providers

Summit Community Care maintains a system to collect member encounter data. All capitated providers and/or sites must report all member encounters. This is a key component of the Summit Community Care information system, and electronic reporting is encouraged. Failure to submit accurate and timely reports may result in corrective action up to and including termination of the *Participating Provider Agreement*.

If a provider is capitated, they will receive a monthly check based on factors (e.g., member's age, gender, number of members in provider's panel) including payment for all capitated services rendered.

Due to reporting needs and requirements, Summit Community Care network providers reimbursed by capitation must send encounter data to Summit Community Care for each member encounter. This is

done through the CMS-1500 (08-05) claim form. Data must be submitted in a timely manner. Failure to provide information can result in delayed capitation payment.

Additional documentation required for I/DD and behavioral health services

Additional documentation may be required for services delivered through the CES waiver, intermediate care facilities and various behavioral health services. Providers must comply with all data collection and reporting requirements promulgated by the Office of Long-Term Care, the Division of Developmental Disabilities and the Division of Behavioral Health.

Summit Community Care appreciates the need for multiple agencies to receive and maintain information for federal program compliance and will collaborate closely with providers and these agencies to simplify documentation requirements and information sharing where feasible.

Claims adjudication/timely filing

Summit Community Care provides timely adjudication of claims. Summit Community Care processes all claims according to accepted claims coding and payment guidelines defined by the CPT-4 and ICD-10 manuals. Providers must use HIPAA-compliant billing codes when billing on paper or electronically. When billing codes are updated, providers are required to use appropriate replacement codes for submitted claims. Summit Community Care will reject claims submitted with noncompliant billing codes. Summit Community Care uses code-editing software to determine which services are considered part of, incidental to, or inclusive of the primary procedure.

Paper and electronic claims must be filed within 365 calendar days. Timely filing periods begin from the date of discharge for inpatient services and from date of service for outpatient/physician services. Secondary and tertiary claims submitted for payment must be submitted within 180 days from the payment date from Medicare or the third-party payer. Timely filing requirements are defined in the provider agreement. Summit Community Care will deny claims submitted after the filing deadline.

Documentation of timely claim receipt

Claims will be considered timely if submitted:

- By United States mail first class, return receipt requested or by overnight delivery service - you must provide a copy of the claim log that identifies each claim included in the submission.
- Electronically - you must provide the clearinghouse-assigned receipt date from the reconciliation reports.
- By hand delivery - you must provide a claim log identifying each claim included in the delivery and a copy of the signed receipt acknowledging the hand delivery.

The claims log maintained by providers must include the following information:

- Name of claimant
- Address of claimant
- Telephone number of claimant
- Claimant's federal tax identification number
- Name of addressee
- Name of carrier

- Designated address
- Date of mailing or hand delivery
- Subscriber name
- Subscriber ID number
- Member name
- Date(s) of service/occurrence
- Total charge
- Delivery method

Good cause

If a claim or claim dispute was filed untimely, you have the right to include an explanation and/or evidence explaining the reason for delayed submission. Summit Community Care will contact you for clarification or additional information necessary to make a good cause determination.

Good cause may be found when a physician or supplier claim filing is delayed due to:

- Administrative error due to incorrect or incomplete information furnished by official sources (e.g., carrier, intermediary, CMS) to the physician or supplier.
- Incorrect information furnished by the member to the physician or supplier resulting in erroneous filing with another care management organization plan or with the state.
- Delay in securing required supporting claim documentation or evidence from one or more third parties despite reasonable efforts by the physician/supplier to secure such documentation or evidence.
- Unusual, unavoidable, or other circumstances beyond the service provider's control that demonstrate the physician or supplier could not be expected to file timely.
- Destruction or other damage of the physician's or supplier's records unless such destruction or other damage was caused by the physician's or supplier's willful act of negligence.

Upfront rejections vs denials

An **upfront rejection** is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the companion guide in **Appendix A** of this manual. A list of common upfront rejections can be found in **Appendix A** of this manual. Upfront rejections will not enter our claims adjudication system, so there will not be an explanation of payment (EOP) for these claims. The provider will receive a letter or a rejection report if the claim was submitted electronically. If a claim is rejected, the identified issue must be corrected and the claim resubmitted as an original claim.

If the claim passes all edits and is accepted, it will then be entered into the system for processing. A **denial** is defined as a claim that has passed edits and is entered into the system, but has been billed with invalid or inappropriate information that causes the claim to deny. An EOP will be sent that includes the denial reason. A list of common delays and denials can be found below with explanations in **Appendix A** of this manual.

Provider claims/payment dispute process

To learn how to submit a claim payment dispute using Availity, listen to a recorded session:

1. Log in to the Availity Essentials > Help & Training > Get Trained.
2. Search the catalog for the term *appeal* to find a listing of the scheduled webinars. Select the date that you wish to register for and then select **Enroll** in the top right-hand corner.
    - To access a recorded session, when you search for the term *appeal*, you'll see the *On-Demand* and *Training Demo* courses at the bottom of the search results. Select the course and then select **Enroll**.

By leveraging Availity for claim payment disputes, providers can:

- Submit disputes through the Availity Essentials any time of the day.
- Send supporting documentation.
- Check the status of a claim payment dispute.
- View claim payment dispute history.
- Download a copy of the dispute outcome letter.
- Indicate there are multiple claims tied to the same issue on one submission, reducing the number of disputes to submit.

Please note: Claim payment disputes that are submitted with multiple claims tied to one issue will be reviewed and processed. If there are multiple claims tied to multiple issues on one dispute submission, the claim payment disputes will be rejected.

Providers claim payment dispute process

If you disagree with the outcome of a claim, you may begin the provider payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized, but you disagree with the outcome.

Please be aware there are three common, claim-related issues that are **not** considered claim payment disputes. To avoid confusion with claim payment disputes, we have defined them briefly here:

1. **Claim inquiry**: a question about a claim but not a request to change a claim payment.
2. **Claims correspondence**: occurs when Summit Community Care requests further information to finalize a claim — typically includes medical records, itemized bills, or information about other insurance a member may have.
3. **Medical necessity appeals**: a pre-service appeal for a denied service in which a claim has not yet been submitted.

The provider payment dispute process consists of two internal steps and a third external step. You will **not** be penalized for filing a claim payment dispute, and no action is required by the member.

1. **Claim payment reconsideration:** This is the first step in the provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
2. **Claim payment appeal:** This is the second step in the provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.
3. **State fair hearing:** Arkansas Medicaid supports an external review process if you have exhausted both steps in the payment dispute process but still disagree with the outcome.

Note: Providers should complete both the dispute and/or appeal defined herein **prior to** filing for a state fair hearing with Arkansas Medicaid.

Providers may submit a claim payment dispute for multiple reason(s), including:

- Contractual payment issues.
- Disagreements over reduced or zero-paid claims.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues. *

* We will consider reimbursement of a claim denied for failure to meet timely filing upon receipt of either 1) documentation the claim was submitted within the timely filing requirements or 2) documentation the claim submission resulted from provider's reasonable efforts to determine the extent of liability.

Claim payment reconsideration

The first step in the claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim.

Note: We cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally and through the Availity Portal within 90 business days from the date on the *EOP* (see below for further details on how to submit). Reconsiderations filed more than 90 business days from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as expected. If a reconsideration requires clinical expertise, the appropriate clinical professional(s) will review.
We will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to decide, the determination date may be extended by 30 additional calendar days. We will mail a written extension letter before the expiration of the initial 30 calendar days.

We will send our decision in a determination letter, which will include:

- A statement of the provider's reconsideration request.
- A statement of what action Summit Community Care intends to take or has taken.
- The reason for the action.

- Support for the action, including applicable statutes, regulations, policies, claims, codes, or provider manual references.

- An explanation of the provider's right to request a claim payment appeal within 30 calendar days of the date of the reconsideration determination letter.
- The address of where to submit the claim payment appeal.
- A statement that the completion of the claim payment appeal process is a necessary requirement before requesting a state fair hearing.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

Claim payment appeal

If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal.

Note: We cannot process a claim payment appeal without a reconsideration on file.

We accept claim payment appeals in writing within 30 calendar days of the date on the reconsideration determination letter.

Claim payment appeals received more than 30 calendar days after the claims reconsideration determination letter will be considered untimely and upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical Summit Community Care professionals.

Summit Community Care will make every effort to resolve the claim payment appeal within 30 calendar days of receipt. If additional information is required to decide, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We will send you our decision in a determination letter, which will include:

- A statement of the provider's claim payment appeal request.
- A statement of what action Summit Community Care intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes, or provider manual references.
- A statement about how to submit a state fair hearing.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

How to submit a claim payment dispute

To file a claim payment dispute:

- **Verbally (for reconsiderations only):** Call Provider Services at **844-462-0022**.
- **Online (for reconsiderations and claim payment appeals):** Use the secure provider Availity Appeal application at

- **https://www.availity.com**.* Through Availity, you can upload supporting documentation and receive immediate acknowledgement of your submission.

Locate the claim you want to dispute on Availity using **Claim Status** from the **Claims & Payments** menu. If available, select **Dispute Claim** to initiate the dispute. Go to **Request**" to navigate directly to the initiated dispute in the appeals dashboard add the documentation and submit.

For Appeals, your Availity Essentials user account will need the Claim Status role. To Send Attachments from Claim Status, you will need the Medical Attachments role.

- **In writing (for reconsiderations and claim payment appeals):** Mail all required documentation (see below for more details), including the *Claim Payment Appeal Form* or the *Reconsideration Form,* to:

Payment Dispute Unit
Summit Community Care
P.O. Box 62429
Virginia Beach, VA 23466-2429

Submit reconsiderations on the *Reconsideration Form* or written claim payment appeals on the *Claim Payment Appeal Form*. To access these forms, visit **https://provider.summitcommunitycare.com/arkansas-provider/forms**.

Required documentation for claims payment disputes
Summit Community Care requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email address, TIN and NPI (or Arkansas Medicaid ID number, **whichever number is registered with Arkansas Medicaid**)
- The member's name and their Summit Community Care or Medicaid ID number
- A listing of disputed claims, which should include the Summit Community Care claim ID number(s) and the date(s) of service(s)
- All supporting statements and documentation

Claim inquiries

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Use Availity Essentials Claim Status application – Log into Availity > Select your state> Under Claims & Payment menu select Claim Status.

Our Provider Experience program helps with claim inquiries. Call **844-462-0022** and choose the *Claims* prompt within our voice portal. We connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact issue resolution rates.

- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim correspondence

Claim correspondence is different than a payment dispute. Claim correspondence occurs when Summit Community Care requires more information to finalize a claim. Typically, Summit Community Care makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, Summit Community Care will use it to finalize the claim.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of issue	**What do I need to do?**
Electronic Data Interchange (EDI) Rejected claim(s)	Please contact Availity Client Services with any questions at **800-Availity (800-282-4548)**, or contact your Clearinghouse Vendor.
EOP requests for supporting documentation (sterilization/ hysterectomy/abortion consent forms, itemized bills and invoices)	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the supporting documentation to: **Claim Correspondence** **Summit Community Care** **P.O. Box 62429** **Virginia Beach, VA 23466-2429**
EOP requests for medical records	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the medical records to: **Claim Correspondence** **Summit Community Care** **P.O. Box 62429** **Virginia Beach, VA 23466-2429**
Need to submit a corrected claim due to errors or changes on the original submission	**Option 1:** Submit the correct claim via the Availity Portal by selecting *7 – Replacement Claim* in the *Billing Frequency* field under *Claims Information*. **Option 2:** Submit a *Claim Correspondence Form* and your corrected claim to: **Claim Correspondence** **Summit Community Care** **P.O. Box 62429** **Virginia Beach, VA 23466-2429**

	Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received in a timely manner, a corrected claim must be received within 180 days from the date of the original Explanation of Payment (EOP). In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Summit Community Care to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI *EOP*.
Type of issue	**What do I need to do?**
Submission of coordination of benefits (COB)/third-party liability (TPL) information	**Option 1:** Dispute the claim via the Availity Portal and include the *EOP* and/or COB/TPL information as an attachment. **Option 2**: Submit a *Claim Correspondence Form*, a copy of your *EOP* and the COB/TPL information to: **Claim Correspondence** **Summit Community Care** **P.O. Box 62429** **Virginia Beach, VA 23466-2429**

Medical necessity appeals

Medical necessity appeals refer to a situation in which an authorization for a service was denied prior to the service. Medical necessity appeals/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the medical necessity appeal process as defined here in Provider Manual.

13.Third-party liability

Coordination of benefits

Summit Community Care follows state-specific guidelines and all federal regulations when coordination of benefits is necessary with other health insurance (OHI), third-party liability (TPL), medical subrogation or estate recovery. Summit Community Care uses covered medical and hospital services whenever available or other public or private sources of payment for services rendered to members.

OHI and TPL refer to any individual, entity or program who may be liable for all or part of a member's health coverage. The state is required to take all reasonable measures to identify legally liable third parties and treat verified OHI and TPL as a resource of each plan member.

Summit Community Care takes responsibility for identifying and pursuing OHI and TPL for members and puts forth best efforts to identify and coordinate with all third parties against whom members may have claims for payments or reimbursements for services. These third parties may include Medicare or any other group insurance, trustee, union, welfare, employer organization or employee benefit organization, including preferred provider organizations or similar type organizations, any coverage under governmental programs, and any coverage required to be provided for by state law.

When OHI or TPL resources are available to cover the costs of trauma-related claims and medical services provided to Medicaid members, Summit Community Care will reject the claim and redirect providers to bill the appropriate insurance carrier (unless certain pay-and-chase circumstances apply — see below). Or, if Summit Community Care does not become aware of the resource until after payment for the service was rendered, Summit Community Care will pursue post payment recovery of the expenditure. Providers must not seek recovery more than the Medicaid payable amount.

Pay-and-chase circumstances include:

- Prenatal care for pregnant women, including services which are part of a global OB package.
- Preventive pediatric services, including Early and Periodic Screening Diagnosis and Treatment (EPSDT) and administration of vaccines to children under the Vaccines for Children (VFC) program.
- Services covered by third-party liability derived from an absent parent whose obligation to pay support is enforced by Child Support Enforcement.

The Summit Community Care subrogation vendor handles the filing of liens and settlement negotiations both internally and externally.

For questions regarding paid, denied, or pended claims, call Provider Services at **844-462-0022**.

14.Member rights and responsibilities

Summit Community Care is committed to ensuring members are treated in a manner that acknowledges their rights and responsibilities.

Summit Community Care members have the right to:

- Be treated with respect and dignity.
- Know when they speak with providers, it's private.
- Have an illness or treatment explained to them in a language they can understand.
- Participate in decisions about their care.
- Receive a full, clear and understandable explanation of treatment options and risks of each option so they may make an informed decision, regardless of cost or whether it is part of covered benefits.
- Refuse treatment or care.
- Be free of physical and chemical restraints except for emergency situations.
- Be free of restraint or seclusion used as coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraint and seclusion.
- See their medical records and request a change if incorrect.
- Choose an eligible primary care provider/primary dental provider (PCP/PDP) from within the Summit Community Care network and change their PCP/PDP.
- Make a grievance (complaint) about the health plan or care provided to them and receive a response.
- Request an appeal or a fair hearing if they believe Summit Community Care was wrong in denying, reducing or stopping a service or item.
- Receive family planning services and supplies from the provider of their choice.
- Obtain medical care without unnecessary delay.
- Receive information on advance directives and choose not to have or continue any life sustaining treatment.
- Receive a copy of the Summit Community Care member handbook and/or provider directory.
- Receive information about our practitioners and other providers.
- Continue treatment they are currently receiving until they have a new treatment plan.
- Receive interpretation and translation services free of charge.
- Refuse oral interpretation services.
- Receive transportation services free of charge.
  Receive an explanation of prior authorization procedures.
- Receive information about the Summit Community Care organization, its services, its practitioners and providers, financial condition, and any special ways we pay providers.
- Receive information on their rights and responsibilities.
- Obtain summaries of customer satisfaction surveys.
- Make suggestions to Summit Community Care about the rights and responsibilities.
- Furnish healthcare services that are available and accessible in a timely manner; coordinated; sufficient in amount, duration, or scope; and provided in a culturally competent manner, in order to meet the member's specific needs.
- Be free to exercise his or her rights as those rights do not
  adversely affect the way Summit Community Care or its network provider, subcontractors, or the state treat the member.

Summit Community Care members have the responsibility to:

- Treat those providing care with respect and dignity.
- Follow the rules of the Medicaid Managed Care Program and Summit Community Care.
- Follow plans and instructions they receive from providers.
- Tell providers about their health conditions.
- Work as a team with providers in deciding what healthcare is best for them and developing mutually agreed-upon treatment goals and following the treatment plans to the best of their ability.
- Go to scheduled appointments.
- Inform providers at least 24 hours before the appointment if they must cancel appointments.
- Ask for additional explanation if they do not understand a provider's instructions.
- Visit the emergency room only if they have a medical emergency.
- Tell their health plan, practitioners, and providers about medical and personal problems that may affect their health.
- Report to Economic Security Administration (ESA) and Summit Community Care if they or a family enrollee have other health insurance or if they have a change in address or phone number.
- Report to ESA and Summit Community Care if there is a change in family (i.e., deaths, births, etc.).
- Help providers to access medical records from providers who have treated them in the past.
- Inform Summit Community Care if they were injured as the result of an accident or at work.

Summit Community Care will provide members with notice of any change that the state defines as significant at least 30 days before the intended effective date of the change.

15. Emergency services and self-referrals

Emergency room medical record review

All emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions while the member is part of the PCP's panel must be noted in the emergency room medical records.

Summit Community Care is only responsible for the hospital admission days incurred while the member is enrolled and eligible with Summit Community Care regardless of the date of admission.

In addition, providers must verify members are assigned to Summit Community Care. To validate member eligibility, call the Summit Community Care Interactive Voice Response (IVR) system at **844-462-0022** or access Availity at: **www.availity.com**.

Self-referred and emergency services

Summit Community Care will reimburse out-of-plan providers for the following services:

- Emergency services provided in a hospital emergency facility.
- Family planning services (except for sterilizations).
- Services related to pregnancy when a member has begun receiving services from an out-of-plan provider prior to enrolling in Summit Community Care.
- Initial medical examination for children in state custody.
- Annual diagnostic and evaluation services for members with HIV/AIDS.
- Renal dialysis provided at a Medicare-certified facility.
- The initial examination of a newborn by an on-call hospital physician when Summit Community Care does not arrange for the service prior to the baby's discharge.
- Services performed at a birthing center including an out-of-state center located in a contiguous state.

Behavioral health and IDD crisis stabilization and post-stabilization

The emergency department's treating provider determines the services needed to stabilize the member's emergency medical condition. After the member is stabilized, the emergency department's provider must contact Summit Community Care for authorization of further services.

The emergency department should send a copy of the emergency room record to the care management team within 24 hours. The PCP should:

- Review and file the chart in the member's permanent medical record.
- Contact the member.
- Schedule a follow-up office visit or a specialist referral, if appropriate.

Special healthcare needs

Children with special healthcare needs are those children who have or are at risk for chronic physical, developmental, behavioral, or emotional conditions that require health and related services of a type or amount beyond that required for children.

Children with special healthcare needs may self-refer to providers outside the Summit Community Care network under certain conditions. Self-referral for children with special needs is intended to ensure continuity of care and appropriate plans of care. Self-referral for children with special healthcare needs will depend on whether the condition that is the basis for the child's special healthcare needs is diagnosed before or after the child's initial enrollment in Summit Community Care.

Medical services related to a special needs child's medical condition may be accessed out-of-network only if the following specific conditions are satisfied:

- For a **new** member: A child who at the time of initial enrollment was already receiving these services as part of a current plan of care may continue to receive these specialty services provided the pre-existing out-of-network provider submits the plan of care to Summit Community Care for review and approval within 30 days of the child's effective date of enrollment into Summit Community Care, and Summit Community Care approves the services as medically necessary.
- For an **established** member: A child who is already enrolled in Summit Community Care when diagnosed as having a special healthcare need that requires a plan of care, including specific types of services, may request a specific out-of-network provider. Summit Community Care is obligated to grant the member's request unless a local, in-network specialty provider with the same professional training and expertise is available to provide the same services and service modalities.

If Summit Community Care denies, reduces, or terminates services, members have an appeal right regardless of whether they are a new or established member. Pending the outcome of an appeal, Summit Community Care may allow for service to continue.

Specialty referrals

Summit Community Care will maintain a complete network of adult and pediatric providers adequate to deliver the full scope of benefits covered by Arkansas Medicaid. If a specialty provider cannot be identified, please contact Summit Community Care for assistance by calling **844-462-0022**

Services for children

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program ensures members under the age of 21 receive comprehensive screening, diagnostic and treatment services as early as possible to identify physical or behavioral health conditions. These services are based on the Periodicity Schedule, which is located at **https://www.summitcommunitycare.com/provider**.

A web based EPSDT provider training was developed by Georgetown University's National Center for Education in Maternal and Child Health in collaboration with the DHS and maintained by Georgetown University. The training module is based on the Bright Futures guidelines and has been tailored to the

needs of the provider community. This training module satisfies the EPSDT and IDEA provider training requirements. Successful completion of the training module is expected of all providers providing EPSDT services within 30 days of joining the Summit Community Care network and every two years thereafter. This training will provide five hours of category one credits toward the AMA Physician's Recognition Award and is paid for by Summit Community Care.

For children under age 21, Summit Community Care shall assign the member to a PCP certified by the state's EPSDT program unless the member or member's parent, guardian or caretaker specifically requests assignment to a PCP who is not EPSDT-certified. In this case, the non-EPSDT-certified provider is responsible for ensuring the child receives well-childcare according to the EPSDT schedule. If a member refuses services, the PCP must document the refusal in the member's health record. During the initial examination and assessment, the provider must perform applicable EPSDT screenings and services, based on the periodicity schedule and any additional assessments needed, with the appropriate tools. If a child is identified to have special healthcare needs or at risk of a developmental delay by the developmental screen required by EPSDT, the provider shall refer the child to specialty care and must make a referral to the Summit Community Care Case Management department.

The EPSDT assessment must include the following:

- Comprehensive health and developmental history assessment including physical, oral and mental health.
- Unclothed comprehensive physical exam.
- Immunizations* (based off the Periodicity Schedule and in accordance with ACIP recommendations).
- Laboratory tests including lead toxicity screenings (if lead level is greater than or equal to 5 ug/dL, provider must make a referral to the Summit Community Care Case Management department).
- Health education and explanation of EPSDT services.
- Vision services (based off the Periodicity Schedule and as needed).
- Hearing services (based off the Periodicity Schedule and as needed).
- Dental services (based off the Periodicity Schedule and as needed).
- Mental health and substance use screening (including a maternal depression screening at the 1month, 2month, 4month and 6month well-child visits. If a mental health issue or substance use is determined, the provider must make a referral to the Summit Community Care Case Management department).
- Any needed diagnostic services for further evaluation and treatment or referrals, as needed to support improving health conditions.

Note: All applicable providers must be enrolled in the Vaccines for Children (VFC) program. Summit Community Care will not reimburse providers for vaccines provided through the VFC program unless the vaccine was unavailable through the VFC program and can be proven through written documentation to Summit Community Care.

For the EPSDT population, members must be offered an initial appointment within 45 days of their date of enrollment with the PCP or within 30 days of request, whichever is sooner, unless the following exception applies:

Appointments for initial EPSDT screens shall be offered to new enrollees within 60 days of the enrollee's enrollment date with Summit Community Care, or at an earlier time if an earlier exam is needed 1) to

comply with the periodicity schedule, or 2) if the child's case indicates a more rapid assessment, or 3) if a request results from an emergency medical condition. The initial screen shall be completed within three months of the enrollee's enrollment date with Summit Community Care unless Summit Community Care determines the new enrollee is up to date with the EPSDT Periodicity Schedule. To be considered timely, all EPSDT screens, laboratory tests and immunizations shall take place within 30 days of their scheduled due dates for children under the age of 2 and within 60 days of their due dates for children aged 2 and older. Periodic EPSDT screening examinations shall take place within 30 days of request.

16.Members with special healthcare needs

In general, to provide care to members with special healthcare needs, it is important for providers to:

- Demonstrate their credentials and experience to Summit Community Care for treatment of special populations.
- Collaborate with Case Management staff on issues pertaining to a special needs member's care.
- Document the plan of care and care modalities and update the plan annually.

Summit Community Care members may receive services in the following manner from Summit Community Care and/or Summit Community Care providers:

- Assignment of a case manager trained as a nurse or social worker. The case manager will work with the member's PCP and other providers to plan the treatment and services needed. The case manager will not only help plan for the care but will also help keep track of the healthcare services the member receives during the year and serve as the coordinator of care with the PCP across a continuum of inpatient and outpatient care.
- The PCP and case manager, when required, will coordinate referrals for needed specialty care, including specialists for disposable medical supplies (DMS), durable medical equipment (DME) and assistive technology devices based on medical necessity. PCPs should follow the referral protocols established by Summit Community Care for sending members to specialty care networks.
- All providers are required to treat individuals with disabilities consistent with the requirements of the *Americans with Disabilities Act of 1990 (P.L.101-336 42 U.S.C. §12101 et. seq.)* and regulations disseminated under it.

Services for pregnant and postpartum women

Taking Care of Baby and Me®

Taking Care of Baby and Me® is a proactive case management program for all perinatal members and their newborns. We use several resources to identify pregnancies as early as possible. Sources of identification include, state enrollment files, claims data, and hospital census reports as well as provider and member self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care management services to mitigate risk.

Experienced care managers work with members and providers to establish a care plan for our highest risk pregnant members. They may also collaborate with community partners to facilitate connecting members to local and national agencies who can assist with services and support.

When it comes to pregnancy, we are committed to healthy outcomes for our members and their babies. That is why we encourage all of our pregnant and postpartum members to take part in our <TCOBAM/NBNL> program, a comprehensive program which offers:

- Individualized, one-on-one complex care management support for members with the highest risk
- Care coordination for members who may need just a little extra support
- Digital perinatal educational tools

- Information on community resources
- Incentives to encourage members to keep up with checkups

As part of the program, perinatal members have access to a digital offering. This digital offering is available by smartphone app and provides pregnant and postpartum members with timely, proactive, and culturally appropriate education. Once members are identified as being pregnant, they will receive an invitation to access this program by downloading the app. After the app is installed and the member registers, they are asked to complete a pregnancy screener. The answers provided in the screener allows us to assess their pregnancy risk.

After the risk assessment has been completed, the app delivers gestational-age appropriate education directly to the member. This digital offering does not replace the high-touch, individual care management approach for our highest risk pregnant members; however, it does serve as a supplemental tool to extend our health education outreach. The goal of the expanded outreach is to ensure maternity education is available to all perinatal members and help us to identify members who experience a change in risk acuity throughout the perinatal period.

We request notification of pregnancy at the first prenatal visit and notification of delivery following birth. You may choose to complete the notification of pregnancy and delivery in Availity Essentials or fax the completed forms to **1-800-964-3627**.

We also ask that providers complete the Maternity Application in **Availity Essentials** during the initial E&B request performed on a pregnant member. The information obtained during this process supports our effort to identify pregnancies as early as possible so that we may notify eligible members of various perinatal resources, including the care management program. The steps to complete the Maternity Application are detailed below:

- **Perform an Eligibility and Benefits (E&B) request on the desired member.**
  - **Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.**
  - **If the appropriate conditions apply for payer, user, member and service type, the maternity question screen will display. Conditions include:**
    - **Member is female**
    - **Member is 45 years of age or under**
    - **Member 15 years of age or over**
  - **If member is not pregnant, select no and hit submit to continue to the E&B response screen.**
  - **If member is pregnant, select yes and hit submit. You will be prompted to enter additional dates if known:**
    - **Estimated Due Date**
    - **First Prenatal Appointment Date**
  - **When YES is selected, maternity data entered is saved for this member.**
  - **After submitting your answer, the E&B response screen will display.**

We encourage healthcare providers to share information about the Taking Care of Baby and Me program and the digital parental app with members. Members may access information about the products that are available by visiting the Summit member website.

For more information about the Taking Care of Baby and Me program or the digital maternity tools, reach out to Provider Services at **844-462-0022**, or refer to our website at **https://provider.summitcommunitycare.com/arkansas-provider/maternal-child-services**.

Childbirth-related provisions

There are special rules to determine the length of hospital stay following childbirth:

- A member's length of hospital stay after childbirth is determined in accordance with the ACOG and American Academy of Pediatrics (AAP) guidelines for prenatal care, unless the 48hour (for uncomplicated vaginal delivery) or 96hour (for uncomplicated cesarean section) length of stay guaranteed by state law is longer than that required under the guidelines.
- If a member must remain in the hospital after childbirth for medical reasons, and she requests her newborn remain in the hospital while she is hospitalized, additional hospitalization of up to four days must be provided for the newborn and is covered.
- If a member elects to be discharged earlier than the conclusion of the length of stay guaranteed by state law, a home visit must be provided.
- When a member opts for early discharge from the hospital following childbirth (before 48 hours for vaginal delivery or before 96 hours for cesarean section), one home nursing visit within 24 hours after discharge and an additional home visit, if prescribed by the attending provider, are covered.
- The hospital is responsible for notifying Summit Community Care of the birth of a child within 24 hours or by the next business day.

If a member remains in the hospital for the standard length of stay following childbirth, a home visit, if prescribed by the provider, is covered.

Children with special healthcare needs

Summit Community Care will:

- Provide the full range of medical services for children, including services intended to improve or preserve the continuing health and quality of life, regardless of the ability of services to affect a permanent cure.
- Provide case management services to children with special healthcare needs, as appropriate. For complex cases involving multiple medical interventions, social services or both, a multidisciplinary team must be used to review and develop the plan of care for children with special healthcare needs.
- Refer special needs children to specialists as needed, including specialty referrals for children found to be functioning at one-third or more below chronological age in any developmental area as identified by the developmental screen required by the EPSDT Periodicity Schedule.
- Allow children with special healthcare needs to access out-of-network specialty providers as specified in the special provisions and guidelines in **Self-Referred Services for Children with Special Healthcare Needs**.
- Log any complaints made to the state or to Summit Community Care about a child who is denied services. All denial letters sent to children, or their representatives, must state members can appeal by calling the state at **800-482-8988**.
- Work closely with the schools who provide education and family services programs

to children with special needs.
- Ensure coordination of care for children in state-supervised care. If a child in state supervised care moves out of the area and must transfer to another MCO, the state and Summit Community Care will work together to find another MCO as quickly as possible.

Individuals with HIV/AIDS

Individuals with HIV/AIDS are enrolled in one of the state's MCOs.

The following service requirements apply for persons with HIV/AIDS:

- An HIV/AIDS specialist for treatment and coordination of primary and specialty care must be involved in the patient's care.
- A Diagnostic Evaluation Service (DES) assessment can be performed once every year at the member's request. The DES includes a physical, behavioral, and social evaluation. The member may choose the DES provider from a list of approved locations or can self-refer to a certified DES provider for the evaluation.
- Substance abuse treatment within 24 hours of request.
- The right to ask Summit Community Care to send him or her to a site that performs HIV/AIDS-related clinical trials. Summit Community Care may refer members with HIV/AIDS to facilities or organizations which can provide members access to clinical trials.
- The local health department will designate a single staff member to serve as a contact. In all instances, providers will maintain the confidentiality of member records and eligibility information in accordance with all federal, state, and local laws and regulations and use this information only to assist the member to receive needed healthcare services.
- Summit Community Care case management services are covered for any member diagnosed with HIV. These services must be provided with the member's consent to facilitate timely and coordinated access to appropriate levels of care and to support continuity of care across the continuum of qualified service providers. Case management will link HIV-infected members with the full range of benefits (e.g., primary behavioral healthcare and somatic healthcare services) and referral for any additional needed services including specialty behavioral health services, social services, financial services, educational services, housing services, counseling, and other required support services. HIV case management services include:
    - Initial and ongoing assessment of the member's needs and personal support systems, including using a multidisciplinary approach to develop a comprehensive, individualized service plan. This includes periodic re-evaluation and adaptation of the plan.
    - Coordination of services needed to implement the plan.
    - Outreach for the member and the member's family by which the case manager and the PCP track services received, clinical outcomes and the need for additional follow-up care.

The member's case manager will serve as the member's advocate to resolve differences between the member and providers of care pertaining to the course or content of therapeutic interventions.

If a member initially refuses HIV case management services, the services are to be available at any later time if requested by the member.

17.Culturally and Linguistically Appropriate Services

Patients are increasingly diverse, and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. Summit Community Care wants to help, as we all work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed, how symptoms are described,
- Expectations of care and treatment options,
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine.

Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values, and preferred means of having those needs met.
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

Summit Community Care ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. Summit Community Care encourages providers to access and utilize **MyDiversePatients.com**.

MyDiversePatients.com: The My Diverse Patient website offers resources, information, and techniques, to help provide the individualized care every patient deserves regardless of their diverse backgrounds.

The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.

- **My Inclusive Practice - Improving Care for LGBTQIA+ Patients:** Helps providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients, & develop strategies for providing effective health care to LGBTQIA+ patients.
- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a health care encounter.
- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations & learn techniques to improve patient-centered communication to support needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- **Reducing Health Care Stereotype Threat (HCST): Helps providers understand HCST and the implications for diverse patients and the benefits of reducing HCST to both providers' patients and practices, and how to do so.**

Cultural Competency Training (Cultural Competency and Patient Engagement): A training resource to increase cultural and disability competency to help effectively support the health care needs of your diverse patients.

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients.

Summit Community Care appreciates the shared commitment to ensuring members receive culturally and linguistically appropriate services to support effective care and improve health outcomes.

Interpreter services

Oral interpretive services are available either in-office or telephonically at no cost to you or the member. If you serve a Summit Community Care member with whom you cannot communicate, call Member Services at **844-405-4295** (**TTY 711**) to access an interpreter. For immediate needs, Summit Community Care has Spanish language interpreters available without delay and can provide access to interpreters of other languages within minutes.

Summit Community Care recommends requests for in-office interpreter services be made at least one business day in advance of the appointment. If a member with special needs requires an interpreter to accompany them to a clinic appointment, a case manager/care coordinator can arrange for the interpreter to be present.

Providers are required to offer interpretive services to members who may require assistance. Providers should document the offer and the member's response and reiterate that interpretive services are available at no cost. Family and friends should not be used to provide interpretation services, except at a member's request.

Guidelines for working with an interpreter

Use the following guidelines for better communication when speaking through an interpreter:

- Keep your sentences short and concise — the longer and more complex the sentences, the less accurate the interpretation.
- When possible, avoid using medical terminology, which is unlikely to translate well.
- Ask key questions in several different ways to ensure the questions are fully understood, and you get the information you need.
- Be sensitive to potential member embarrassment, reticence or confusion. It is possible your questions or statements were not understood.
- Ask the member to repeat the instructions given as an effective review of how well the member has understood.

Services for the deaf and hard of hearing

Members have the right to receive assistance through a TTY/TDD line. Summit Community Care can help you telephonically communicate with members with impaired hearing via a translation device. Call the Member Services using the TTY relay service at 711. In-office sign language assistance is also available. Call Member Services at **844-405-4295** (**TTY 711**) to arrange for the service.

Additional communication options for members and providers

Summit Community Care policies are designed to ensure meaningful opportunities for members with limited English proficiency (LEP) to obtain access to healthcare services and to help members with LEP overcome language barriers and fully use services or benefits.

The Summit Community Care provider directory includes a list of languages spoken by participating primary and specialty care providers. Translation assistance options are available at no cost to the member or provider. Upon request, written materials are available in large print, on tape and in languages other than English (dependent upon the plan's population). Member materials are written at a sixth grade reading level per state requirement.

Nondiscrimination statement

Summit Community Care does not engage in, aid or perpetuate discrimination against any person by providing significant assistance to any entity or person who discriminates based on race, color, or national origin in providing aid, benefits or services to beneficiaries. Summit Community Care does not utilize or administer criteria affecting discriminatory practices based on gender or identity. Summit Community Care does not select site or facility locations that exclude individuals from, denying the benefits of or subjecting them to discrimination based on gender or identity. In addition, in compliance with the Age Act, Summit Community Care may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Summit Community Care provides health coverage to members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

Members who contact Summit Community Care with an allegation of discrimination are informed immediately of their right to file. This also occurs when a Summit Community Care representative working with a member identifies a potential act of discrimination. The member is advised to submit a

verbal or written account of the incident and is assisted in doing so if the member requests assistance. Summit Community Care documents, tracks, and trends all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington DC 20201
- By phone at: **800-368-1019** (**TTY/TTD: 800-537-7697**)

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

If you or your patient believes Summit Community Care failed to provide these services or discriminated in any way based on race, color, national origin, age, disability, gender, or gender identity, you may file a grievance with the grievance coordinator via Provider Services at **844-462-0022**.

Equal program access based on gender

Summit Community Care gives individuals equal access to health programs and activities without discriminating based on gender. Summit Community Care must also treat individuals consistently with their gender identity and is prohibited from discriminating against any individual or entity based on a relationship with, or association with, a member of a protected class (i.e., race, color, national origin, gender, gender identity, age or disability).

Summit Community Care may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual since a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

18.Member Grievances (Complaints) and appeals

Member Grievances (Complaints) & Appeals Overview

Summit Community Care's Grievances (Complaints) and appeals process meets all requirements of state and federal law and accreditation agencies. We encourage members to seek resolution of issues through our Grievance (Complaint) and appeals process.

Providers are prohibited from penalizing a member in any way for filing a Grievance (Complaint) or appeal. Summit Community Care will not take any punitive action against a member or provider for filing or participating in a Grievance (Complaint), or appeal.

Summit Community Care will resolve any Grievance (Complaint) or appeal, internal or external, at no cost to the member.

Member Grievances (Complaints) and appeals include, but are not limited to, the following:

- Access to healthcare services
- Care and treatment by a provider
- Issues having to do with how we conduct business

Summit Community Care will ensure all Grievance (Complaint) decisions and appeal resolutions are made by qualified personnel. For Member appeals, the decision maker will be a qualified healthcare professional with the appropriate clinical expertise is treating the member's condition or disease if:

- The decision involves an appeal of a denial based on lack of medical necessity.
- The decision involves a grievance regarding denial of an expedited resolution of an appeal, or
- The decision involves a grievance or appeal involving clinical issues.

Summit Community Care will ensure decision makers on Grievances (Complaints) and appeals are not:

- Involved in any previous level of review or decision-making, and
- Subordinate(s) of anyone involved in a previous level of review or decision-making.

Summit Community Care will also ensure the decision maker considers all comments, documents, records, and other information submitted, without regard to whether such information was submitted or considered in the initial adverse decision.

Confidentiality

All grievances (complaints) and appeals are handled in a confidential manner.

Non-discrimination

Summit Community Care does not discriminate against a member for filing a Grievance (Complaint), appeal, or for requesting a State fair hearing. A member who contacts us with an allegation of discrimination is informed immediately of his/her right to file a Grievance (Complaint). The member is advised to submit a verbal or written account of the incident and may request assistance in filing the Grievance (Complaint) as needed. Summit Community Care documents, tracks, and trends all alleged acts of discrimination through its Grievances (Complaints) process.

Member Grievances (Complaints) Definitions

An **authorized representative/appellant** is any person or entity acting on behalf of a member, with the member's written consent. The following individuals may serve as an Authorized Representative:

- The member; or
- The member's parent or legal guardian; or
- An attorney authorized to represent the member; or
- Another authorized representative of the member, including the representative of the member's estate if the member is deceased; or
- A provider who is the subject of the adverse action/adverse decision, or the provider's legal representative or attorney.

If the member is a minor or is incompetent or incapacitated, the member's Authorized Representative may submit the Grievance (Complaint) on the member's behalf.

An **inquiry** is a request for additional information or clarification regarding benefit coverage or how to access medical care/covered benefits. An inquiry is an informational request handled at the point of entry or forwarded to the appropriate operational area for final response. An inquiry is not an expression of any dissatisfaction.

A **Grievance (Complaint)** is an expression of dissatisfaction about any matter filed at any time, either in writing (formally) or verbally (informally), to Summit Community Care by a member, or by a guardian or provider on the member's behalf, about any aspect of our operation or the activities or behaviors other than an adverse benefit determination as defined in this chapter. If a member is dissatisfied for any reason, other than an adverse benefit determination described below, the member may file a Grievance (Complaint). Grievances are tracked and trended, resolved within established time frames established by state and federal law and accreditation standards. ***Note: A member's or provider's disagreement with an adverse benefit determination is considered an appeal***.

How To File a Member Grievance (Complaint)

If a member or Authorized Representative would like to file a grievance (complaint), he/she may file via mail, fax, or phone as follows:

Via phone: 844-405-4295 (TTY 711)
Via fax: 844-400-3465
Via mail to the following address:

Summit Community Care
Attn: Grievance and Appeals Department
P.O. Box 62429
Virginia Beach, VA 23466-2429

The Member or Authorized Representative should provide the following:

- Who is part of the Grievance (Complaint)?
- What happened?
- When the incident happened?

- Where the incident happened?
- Why they were not happy with the healthcare services received?

Timelines for Member Grievance (Complaint)

Upon receipt of a member's Grievance (Complaint), Summit Community Care will send the member an acknowledgment letter within five (5) business days by mail. The acknowledgement letter will include the receipt date and contact information for Member Services. Summit Community Care will send a Grievance (Complaint) resolution letter to the member within (30) thirty calendar days after receiving the grievance.

A member Grievance (Complaint) received by DHS and forwarded to Summit Community Care must be treated as a Grievance (Complaint), unless related to an adverse benefit determination, and shall be considered as filed with Summit Community Care upon the day received by Summit Community Care from DHS. All Grievances (Complaints) must be followed up by the close of business on the business day after receipt. If the Grievance (Complaint) is not resolved within 10 business days, the Grievance (Complaint) must be entered as a grievance and complete the grievance process to resolve the matter.

Extension for a Member Grievance (Complaint)

The thirty (30) day standard time limit to resolve a Grievance (Complaint) may be extended up to an additional 14 days if the member, or individual who submitted the Grievance (Complaint) on behalf of the member, asks for an extension – or Summit Community Care documents additional information is necessary to resolve the Grievance (Complaint), the information cannot be obtained within the 30-day time limit, and it is in the member's best interest to extend the time limit.

If the time limit is extended, Summit Community Care must:
- Provide the member with verbal notice of the reason for extension by close of business on the day of the determination to extend the Grievance (Complaint) time limit, and
- Provide written notice of the extension within two calendar days of the determination.

Member Appeal Definitions

An **authorized representative/appellant** is any person or entity acting on behalf of a member, with the member's written consent. The following individuals may serve as an Authorized Representative:
- The member; or
- The member's parent or legal guardian; or
- An attorney authorized to represent the member; or
- Another authorized representative of the member, including the representative of the member's estate if the member is deceased; or
- A provider who is the subject of the adverse action/adverse decision, or the provider's legal representative or attorney.

  If the member is a minor or is incompetent or incapacitated, the member's Authorized Representative may submit the appeal on the member's behalf.

An **adverse benefit determination (also referred to as adverse decision/action)** is any of the following:

- A denial or limited authorization of a requested service, including determinations based on the type, level of service, medical necessity, appropriateness, setting or effectiveness of a covered benefit.
- A reduction, suspension, or termination of a previously authorized service.
- A denial, in whole or in part, of a payment for a service.
- Failure to provide services in a timely manner, as defined by the State.
- Failure to adhere to the required time frames for standard resolution of Grievance (Complaint)s and appeals.
- For a resident of a rural area with only one PASSE, the denial of the member's request to obtain services outside the network.
- The denial of the member's request to dispute financial liability.

An **appeal** is the procedure by which a member or Authorized Representative/Appellant may challenge an adverse benefit determination by requesting Summit Community Care review the adverse benefit determination. Members receive information about the appeal process with the notice of an adverse benefit determination following any of the above actions. Members may request a translated version in a language other than English. Appeals for these adverse actions are treated as member appeals and follow the member appeal process. Summit Community Care also offers members an expedited appeal process for decisions involving urgently needed care.

An **expedited appeal** is an appeal when Summit Community Care determines, or the provider indicates in making the request on the member's behalf or supporting the member's request, that taking the time for a standard appeal could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

A **notice of Adverse Benefit Determination (ABN)** is a written explanation to the member and/or to member's Authorized Representative and/or provider of an Adverse Benefit Determination.

A **State Fair Hearing (SFH)** is a formal proceeding where an impartial Hearings Officer, assigned through a state's administrative process, listens to all the facts of a case (appeal or grievance). Witnesses are sworn in by the Hearings Officer. All proceedings are tape recorded and are on the record. The Hearings Officer decides within a state's mandated timeframe.

How To File a Member Appeal

Members have the right to appeal any adverse benefit determinations defined herein. Members receive information about the appeal process with the notice of an adverse benefit determination following any of the actions identified under the definition of adverse benefit determination. Members may request a translated version in a language other than English.
If a member of Authorized Representative would like to file an appeal, he/she may file via mail, fax, or phone as follows:

Via phone: 844-405-4295 (TTY 711):

Via fax: 844-400-3465

Via mail to the following address:

Summit Community Care
Attn: Grievance and Appeals Department
P.O. Box 62429
Virginia Beach, VA 23466-2429

The member or Authorized Representative should provide the following:

- Who is part of the appeal?
- What happened?
- When the incident happened?
- Where the incident happened?

The date of the verbal filing constitutes the date of receipt of the appeal.

An appeal filed for a member by an Authorized Representative requires written consent from the member. If the member is a minor or is incompetent or incapacitated, the member's representative may submit the grievance or complaint on the member's behalf.

When submitted the appeal in writing, the individual filing the appeal must attach documents that will help us investigate the problem and mail those documents to the address noted above.

Timelines for Standard Appeal

A Member or Authorized Representative, with written consent, must file an appeal within sixty (60) calendar days of the date on the adverse benefit determination notice. A Member or Authorized Representative may request an appeal verbally or in writing.

After an appeal request is received, the case is taken into consideration and investigated by Summit Community Care's Grievances and Appeals department. The member or his or her representative and the provider are given the opportunity to submit written comments and documentation relevant to the appeal. Summit Community Care may request medical records, or a provider explanation of the issues raised in the appeal by:

- Phone.
- Fax, with a signed and dated letter.
- Mail, with a signed and dated letter.

Providers must comply with the request for additional information within ten (10) calendar days. When the appeal is the result of a medical necessity determination, a healthcare professional who was not involved in the initial decision reviews the case. The healthcare professional contacts the provider, if needed, to discuss alternatives.

Upon request of an appeal, members or their authorized representatives are provided with a copy of their case file free of charge and sufficiently before the appeal's resolution. The appellant will also be provided with an opportunity to present evidence and testimony and make allegations of fact or law, either in person or in writing, as requested by the appellant.

Standard appeals are acknowledged in writing within five (5) business days of receipt and resolved within thirty (30) calendar days of receipt of the initial written or verbal request. Members are notified in writing of the appeal resolution which will include details regarding their right to request a State Fair Hearing should the member disagree with the outcome of the appeal.

Extension for a Members Appeal

If Summit Community Care is unable to resolve the appeal within the standard thirty (30) days for a standard appeal or seventy-two (72) hours for an expedited appeal, the resolution time frame for an appeal not related to an ongoing hospitalization or emergency may be extended up to fourteen (14) calendar days if:

- The appellant requests an extension.
- Summit Community Care demonstrates there is a need for additional information, and the delay is in the member's best interest.
- If the time frame is extended other than at the appellant's request, Summit Community Care must provide verbal notice of the reason for the delay to the appellant by close of business on the day of the determination and written notice of the reason for the delay to the appellant. The appellant will also be informed of the right to file a grievance if he or she disagrees with the decision.
- The appeal will be resolved as expeditiously as the member's health condition requires and no later than the date the extension expires.

Response Timelines for Expedited Appeal

If the amount of time necessary to participate in a standard appeal process could jeopardize the member's life, health, or ability to attain, maintain or regain maximum function, the appellant may request an expedited appeal. Summit Community Care will resolve each expedited appeal and provide notice to the appellant as quickly as the member's health condition requires not to exceed seventy-two (72) hours after receipt of the appeal. Summit Community Care will inform the appellant of the limited time available to present evidence and allegations of fact or law. Members may request an expedited appeal by calling our Member Services at **844-405-4295**.

If Summit Community Care denies the request for an expedited appeal, Summit Community Care will transfer the appeal to the time frame for standard resolution and immediately notify the appellant of the transfer.

Summit Community Care may also extend the time frame for expedited appeals resolution by 14 calendar days if:

- The appellant requests the extension.
- Summit Community Care demonstrates there is a need for additional information and the delay is in the member's best interest.

If the time frame is extended other than at the appellant's request, Summit Community Care must provide verbal notice of the reason for the delay to the appellant by close of business on the day of the determination and written notice of the reason for the delay to the appellant within two calendar days of the determination. The appellant will also be informed of the right to file a grievance if he or she disagrees with the decision.

The appeal will be resolved as expeditiously as the member's health condition requires and no later than the date the extension expires.

Response Timelines for Expedited Appeals

Members have the right to request an expedited appeal within 60 calendar days from the date on the initial notice of action letter. Expedited appeals are acknowledged by telephone, if possible. Summit Community Care must inform the appellant of the limited time available to present evidence and allegations of fact and law and ensure the appellant understands any time limits that may apply.

If Summit Community Care denies a request for an expedited appeal, we must:

- Transfer the appeal to the time frame for standard resolution.
- Provide verbal notice of the resolution to the appellant by close of business on the day of resolution and follow up within two calendar days with written notice.

Summit Community Care resolves expedited appeals as quickly as the member's health condition requires, not to exceed 72 hours after receipt of the expedited appeal. The member is notified by telephone of the resolution, if possible. Summit Community Care follows up with a written resolution letter within 72 hours of the expedited appeal decision.

Summit Community Care may request medical records, or a provider explanation of the issues raised in an expedited appeal by:

- Phone.
- Fax, with a signed and dated letter.
- Mail, with a signed and dated letter.

Providers are expected to comply with the request for additional information within 24 hours.

Members: continuation of benefits during appeal

Upon request by the member or his or her parent or legal guardian, Summit Community Care must continue the member's benefits while his or her appeal is pending, in accordance with federal regulations, when all the following requirements are met:

- The request for appeal is timely in accordance with 42CFR Part 438.420.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- Services were ordered by an authorized provider.
- The period covered by the original authorization has not expired.
- The member or his or her parent/legal guardian timely files for continuation of benefits.

If, at the member's request, Summit Community Care continues or reinstates the benefits while the appeal is pending, the benefits must continue until one of the following occurs:

- The appellant withdraws the appeal.
- The member or the member's parent/legal guardian withdraws the request for continuation of benefits. The appellant fails to request a fair hearing and continuation of benefits within 10 calendar days after Summit Community Care send the appeal resolution notice that is not in the member's favor.

If the final resolution of the appeal or fair hearing is adverse to the appellant, Summit Community Care may recover the cost of services furnished to the member while the appeal or fair hearing was pending to the extent they were furnished solely because of the requirements for continuation of benefits.

Requesting a State Fair Hearing

If a member is dissatisfied with the appeal decision after exhausting Summit Community Care's internal grievance and appeal process, the member has the right to file an appeal with the Arkansas Department of Human Services (DHS) and request a State Fair Hearing within 90 calendar days from the date of the resolution letter.

The appellant may also request a fair hearing if Summit Community Care fails to adhere to the notice and timing requirements applicable to the appeal process. If the appeal is considered adverse, the appellant may request a fair hearing. The written request must be sent to:

DHS Office of Appeals and Hearing
P.O. Box 1437, Slot N401
Little Rock, AR 72203-1437
Phone: **501-682-8622**
Fax: **501-404-4628**
dhs.appeals@dhs.arkansas.gov

The process is as follows:

- DHS sends a notice of the hearing request to Summit Community Care.
- Within two business days, Summit Community Care must provide the Adverse Benefit Determination Notice and Appeal Resolution Notice that is the subject of the Fair Hearing.
- Within 10 business days of receipt of the request, Summit Community Care must provide an evidence packet to the Fair Hearing officer and the appellant.
- DHS notifies all parties of the date, time, and place of the hearing. Representatives from Summit Community Care's administrative, medical, and legal departments may attend the hearing to present testimony and arguments. Summit Community Care's representatives may cross-examine the witnesses and offer rebutting evidence.
- A fair hearing officer renders a decision.
- If the fair hearing officer overturns Summit Community Care's decision and finds in favor of the appellant and Summit Community Care did not furnish services while the appeal and fair hearing was pending, Summit Community Care must authorize or provide the disputed services promptly and expeditiously as the member's health condition requires, but no later than 72 hours from the date Summit Community Care receives the fair hearing decision.
- If the member files for continuation of benefits within 10 calendar days of receipt of the appeal resolution notice, Summit Community Care must continue the member's benefits while the fair hearing is pending and until one of the following occurs:
    - The appellant withdraws the fair hearing request; or
    - The member withdraws the request for continuation of benefits; or
    - The fair hearing officer issues a hearing decision averse to the member.

Quality assurance performance improvement

Summit Community Care embraces quality assurance and improvement. The Summit Community Care Quality Assurance Performance Improvement Program is embedded across all aspects of operation. The program develops goals to improve our members' health outcomes, access to care and services, health equity, quality of life and satisfaction with care services. Summit Community Care standards and goals are based on state and federal rules and regulations, other regulatory requirements, and NCQA standards. Overall performance is measured using HEDIS®, CAHPS® and other industry standard methods of measurement. As providers, you play a vital role in achieving quality improvement.

As part of its Quality Assurance activities, Summit Community Care may conduct a random sampling of provider medical records to assess documentation in accordance with established standards. Summit Community Care may also review quality metrics by provider and communicate specific opportunities for improvement.

For more information about the Summit Community Care Quality Management program, call Provider Services at **844-462-0022**.

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

Patient safety

Summit Community Care provides information and resources for providers regarding healthcare safety and standards. An example of a resource is **www.hospitalcompare.hhs.gov**, a CMS website providing specific information on hospitals. This user-friendly site compiles quality indicators for all Medicare certified hospitals and provides a comparison of quality indicators for services rendered by the selected hospital.

Summit Community Care Member Hotline

The Member Hotline can be reached at **844-405-4295** (**TTY 711**), Monday to Friday from 8 a.m. to 6 p.m. This unit handles, resolves and/or properly refers members' inquiries and complaints to other departments. Additionally, Summit Community Care provides members with information about how to access the Member Services department and Consumer Services Hotline to obtain information and assistance.

Quality management committee

The quality management committee's purpose is to maintain quality as a cornerstone of our culture and to be an instrument of change through demonstrable improvement in care and service.

The quality management committee's responsibilities are to:

- Establish strategic direction and monitor and support implementation of the Quality Management program.
- Establish processes and structure to ensure NCQA compliance.
- Review planning, implementation, measurement, and outcomes of clinical/service quality improvement studies.
- Coordinate communication of quality management activities throughout the health plans.
- Review HEDIS® data and action plans for improvement.

- Review and approve the annual quality management program description.
- Review and approve the annual work plans for each service delivery area.
- Provide oversight and review of delegated services.
- Provide oversight and review of subordinate committees.
- Receive and review reports of Utilization Review decisions and act when appropriate.
- Analyze member and provider satisfaction survey responses.
- Monitor the plan's operational indicators through the plan's senior staff.

Medical advisory committee

The medical advisory committee (MAC) has multiple purposes:

- Assesses levels and quality of care provided to members and recommends, evaluates, and monitors standards of care.
- Identifies opportunities to improve services and clinical performance by establishing, reviewing, and updating clinical practice guidelines based on review of demographics and epidemiologic information to target high-volume, high-risk, and problem-prone conditions.
- Oversees the peer review process that provides a systematic approach for the monitoring of quality and the appropriateness of care.
- Conducts a systematic process for network maintenance through the credentialing/recredentialing process.
- Advises the health plan administration in any aspect of the health plan policy or operation affecting network providers or members.
- Approves and provides oversight of the peer review process, the Quality Management program, and the Utilization Review program.
- Oversees and makes recommendations regarding health promotion activities.

The MAC's responsibilities are to:

- Use an ongoing peer review system to monitor practice patterns to identify appropriateness of care and to improve risk prevention activities.
- Approve clinical protocols/guidelines to help ensure the delivery of quality care and appropriate resource utilization.
- Review clinical study design and results.
- Develop action plans/recommendations regarding clinical quality improvement studies.
- Consider and act in response to provider sanctions.
- Provide oversight from credentialing committee decisions to credential/recredential providers for participation in the plan.
- Approve credentialing/recredentialing policies and procedures.
- Oversee member access to care.
- Review and provide feedback regarding new technologies.
- Approve recommendations from subordinate committees.

19.Regulatory matters

Critical incident reporting

We have a critical incident/quality of care reporting and management system for incidents and quality of care concerns that occur where a member is receiving services. As a participating provider, you must participate in critical incident and quality of care reporting. Immediate action will be taken to ensure the member is protected from further harm. Critical incidents and quality of care concerns will be tracked and presented to our quality improvement committee for review.

A critical incident, also known as a major incident or a quality-of-care concern, means an occurrence that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital.
2. Results in the death of any person.
3. Requires emergency mental health treatment for the member.
4. Requires the intervention of law enforcement.
5. Requires the use of restrictive interventions.
6. Requires a report of child abuse pursuant to *§ 12-18-102, § 12-18-103(7), 12-18-402(b)* or a report of abuse or maltreatment of an at-risk person pursuant to *ACA 12-12-1708*.
7. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in 1, 2 or 3.
8. Involves a member's location being unknown by provider staff who are assigned protective oversight.

Providers must report critical incidents and quality of care concerns to Summit Community Care in accordance with applicable requirements. The maximum time frame for reporting an incident to Summit Community Care is 24 hours. The initial report of an incident within 24 hours may be submitted verbally, in which case the person, agency or entity making the initial report will submit a follow-up written report within 48 hours. The report should be made verbally to Provider Services at **844-462-0022** with follow-up written report to **Arkansas Quality** or the DHS Incident Management System. The *Incident Report Form* may be located in the **Appendix** section.

Suspected abuse, neglect and exploitation of adult members must be immediately reported to the Arkansas Adult Abuse Hotline at 800-482-8049. Suspected brutality, abuse or neglect of members who are children must also be immediately reported. Reports of suspected child abuse and dependent abuse must be made by calling the Department of Human Services' Child Abuse Hotline at **800-482-5964**. Providers must immediately (i.e., within 24 hours) take steps to prevent further harm to all members and respond to any emergency needs of members. We request that all providers strictly adhere to statutes related to maltreatment, abuse, and exploitation. To ensure compliance and enhance the protection of vulnerable individuals, it is crucial that providers conduct annual staff training on the recognition and prevention of exploitation, abuse, and neglect. Providers may be required to submit an annual attestation confirming that the training has taken place, along with the percentage of staff who have completed it. This commitment to ongoing education reinforces our collective responsibility to safeguard the well-being of those we serve and uphold the highest standards of care.

The following occurrences require submission of an incident report to Summit Community Care:

a. Death of a member – requires immediate reporting* within one (1) hour of Summit Community Care becoming aware of the occurrence;
b. The use of restrictive interventions;
c. Suspected maltreatment or abuse of a member;
d. Injury to a member that requires emergency room care or a paramedic;

e. Injury to a member that may result in a substantial permanent impairment – requires immediate reporting* within one (1) hour of Summit Community Care becoming aware of the occurrence;
f. Injury to a member that requires hospitalization;
g. Threatening or attempting suicide;
h. Arrest;
i. Any situation where the member eloped from a service and cannot be located withing two (2) hours;
j. Any event where a PASSE HCBS provider staff threatens, abuses or neglects a member; and
k. Medication errors that cause serious injury to the member.

All incidents, other than the immediate reporting occurrences* referenced above, must be reported within twenty-four (24) hours of Summit Community Care becoming aware of the occurrence. Incident reports must contain the following information:

a. Date of incident;
b. Time of incident;
c. Member's name and date of birth;
d. Member's Medicaid ID;
e. Location of incident;
f. Person(s) involved;
g. Person(s) notified – including APS, CPS, guardian/next of kin, law enforcement and other agencies;
h. Incident description;
i. Any action taken by the provider, staff or Summit Community Care;
j. Any expected follow-up related to the incident; and
k. Name of person who prepared the report with contact information.
l. Any other information required by DHS upon request.

Providers must conduct an internal critical incident/quality of care investigation and submit a report on the investigation by the end of the next business day. Summit Community Care will review the provider's report and follow up with the provider, as necessary, to ensure an appropriate investigation was conducted and corrective actions were implemented within applicable times.

Providers must cooperate with any investigation conducted by Summit Community Care or outside agencies (e.g., Adult Protective Services, Child Protective Services, and law enforcement).

For Summit Community Care HCBS providers and CES Waiver providers, see.

Medical records documentation standards

Member records

Summit Community Care requires medical records to be maintained in a current, detailed and organized manner that permits effective and confidential patient care and quality review.

Providers must maintain medical records that conform to professional medical practice and appropriate health management. A permanent medical record must be maintained at the primary care site for every member and be available to the PCP and other providers. Medical records must be kept in accordance with Summit Community Care and state standards as outlined below.

Member visit data

Documentation of individual encounters must provide adequate evidence of, at a minimum:

1. History and physical exam: Appropriate subjective and objective information must be obtained for the presenting of complaints.
2. For members receiving behavioral health treatment, documentation must include at-risk factors (e.g., danger to self-and/or others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social health) and efforts to coordinate care with all behavioral health providers after obtaining the appropriate release(s) of information.
3. Admission or initial assessment must include current support systems or lack of support systems.
4. For members receiving behavioral health treatment, an assessment must be completed for each visit relating to client status and/or symptoms of the treatment process. Documentation may indicate initial symptoms of the behavioral health condition as decreased, increased or unchanged during the treatment period.
5. Plan of treatment must include the activities, therapies, and goals to be carried out.
6. Diagnostic tests.
7. Therapies and other prescribed regimens: For members who receive behavioral health treatment, documentation must include evidence of family involvement, as applicable, and include evidence the family was included in therapy sessions when appropriate.
8. Follow-up: Encounter forms or notes must have a notation when indicated concerning follow-up care, calls or visits. The specific time to return must be noted in weeks, months or as needed. Unresolved problems from previous visits are addressed in subsequent visits.
9. Referrals, results thereof and all other aspects of member care, including ancillary services.

Summit Community Care will systematically review medical records to ensure compliance with standards and will institute actions, as appropriate, for improvement when standards are not met. Access to or copies of medical records must be provided, free of charge, within fourteen (14) calendar days of our request.

Summit Community Care policies are designed to maintain an appropriate record-keeping system for services to members. This system will collect all pertinent information related to the medical management of each member and make that information readily available to appropriate health professionals and state agencies. All records will be retained in accordance with the record retention requirements of 45 CFR 74.164 (i.e., records must be retained for ten years from the date of service). Records will be made accessible upon request to agencies of the state and federal governments.

Medical record standards

The records reflect all aspects of patient care, including ancillary services. Documentation of each visit must include:

1. Date of service.
2. Purpose of visit.
3. Diagnosis or medical impression.
4. Objective finding.
5. Assessment of members findings.
6. Plan of treatment, diagnostic tests, therapies, and other prescribed regimens.
7. Medications prescribed.
8. Health education provided.
9. Signature and title or initials of the provider rendering the service:
    a. If more than one person documents the medical record, there must be a record on file as to what signature is represented by which initials.

These standards shall, at a minimum, meet the following medical record requirements:

1. Member identification information: Each page or electronic file in the record must contain the member's name or ID number.
2. Personal/biographical data: The record must include the members age, gender, address, employer, home and work telephone numbers and marital status.
3. All entries must be dated, and the author identified with credentials.
4. Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one provider reviewer.
5. Allergies: Medication allergies and adverse reactions must be prominently noted on the record. When clinically appropriate, the note of *No Known Allergies* (i.e., the absence of allergies) must be documented in an easily recognizable location.
6. Past medical history (for members seen three or more times): Past medical history must be easily identified, including serious accidents, operations and illnesses. For children, past medical history relates to prenatal care and birth.
7. Immunization~~s~~: For pediatric records of children aged 13 and under, a completed immunization record or a notation of prior immunization must be recorded, including vaccines and dates given when possible.
8. Diagnostic information: Information used to arrive at a diagnosis, such as in-office examinations, laboratory and radiology reports~~,~~ or specialist consultation, must be documented.
9. Medication information: Medication information and/or instructions to members are included.
10. Identification of current problems: Significant illnesses, medical and behavioral health conditions and health maintenance concerns must be identified in the medical record.
11. Condition specific education: The members must be provided with basic teaching and instruction regarding physical and/or behavioral health conditions.
12. Smoking/alcohol/substance abuse: A notation concerning cigarette and/or alcohol use or substance abuse must be stated if present for members aged 12 and older. Abbreviations and symbols may be appropriate.
13. Consultations, referrals, and specialist reports: Notes from referrals and consultations

must be included in the record. Consultation, laboratory and X-ray reports filed in the chart must have the ordering provider's initials or other documentation signifying review. Consultation and any abnormal laboratory and imaging study results must have an explicit notation in the record of follow-up plans.

14. Emergency care: All emergency care provided directly by the contracted provider or through an emergency room and the hospital discharge summaries for all hospital admissions while the member is enrolled.
15. Hospital discharge summaries: Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the member is enrolled with the provider's panel and for prior admissions, as necessary. Prior admissions pertain to admissions which may have occurred prior to the member being enrolled and are pertinent to the member's current medical condition.
16. Advance directive: For medical records of adult members, the medical record must document whether the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for healthcare relating to the provision of healthcare when the individual is incapacitated.
17. Documentation of evidence and results of medical, preventive and behavioral health screenings must be included.
18. The record must include documentation of all treatment provided and the results of such treatment.
19. The record must include documentation of the team of providers involved in the multidisciplinary team of a member needing specialty care.
20. The record must include documentation in the physical and behavioral health records of clinical care integration. Documentation should include:
    a. Screening for behavioral health conditions, including those which may affect physical healthcare and vice versa, and referral to behavioral health providers when problems are indicated.
    b. Screening and referral by behavioral health providers to PCPs, when appropriate.
    c. Receipt of behavioral health referrals from physical medicine providers and the disposition and/or outcome of those referrals.
    d. A summary of the status and/or progress from the behavioral health provider to the PCP at least quarterly or more often if clinically indicated.
    e. A written release of information permitting specific information sharing between providers.
    f. Documentation indicating behavioral health professionals are included in the primary and specialty care service teams described in this contract when a member with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder.

Provider notification to Summit Community Care

The provider must notify Summit Community Care in writing within five days, unless otherwise stated below, following the occurrence of any of the following events:

- The provider's license to practice in any state is suspended, surrendered, revoked, terminated or subject to terms of probation or other restrictions. Notification of any such action must be furnished in writing to Summit Community Care immediately.
- The provider 1) learns he or she has become a defendant in any malpractice action

relating to a member who also names Summit Community Care as a defendant or receives any pleading, notice or demand of claim or service of process relating to such a suit, or 2) is required to pay damages in any such action by way of judgment or settlement. Notification must be furnished in writing to Summit Community Care immediately.

- The provider is disciplined by a state board of medicine or a similar agency.
- The provider is sanctioned by or debarred from participation with Medicare or Medicaid.
- The provider is convicted of a felony relating directly or indirectly to the practice of medicine. Notification must be furnished in writing to Summit Community Care immediately.
- There is a change in the provider's business address or telephone number.
- The provider becomes incapacitated in such a way that the incapacity may interfere with patient care for 21 consecutive days or more.
- There is no change in the nature or extent of services rendered by the provider.
- There is any material change or addition to the information and disclosures submitted by the provider as part of the application for participation with Summit Community Care.
- The provider's professional liability insurance coverage is reduced or canceled. Notification must be given in writing to Summit Community Care at least five days before such a change.
- There is any other act, event, occurrence or the like that materially affects the provider's ability to carry out his or her duties under the *Participating Provider Agreement*.
- The provider's member panel is reaching capacity according to the established capacity standards set in the *Standards and Measures for Appropriate Availability to Provider Policy*. At least 30 days advance notice must be given.
- There is a change to hours of operation or staffing levels.
- There is an inability to meet timely access to care and services according to the established appointment access standards set in the *Appointment Guidelines Policy*.

20.Relevant legislation

Federal False Claims Act (FCA)

We are committed to complying with all applicable federal and state laws, including the federal *False Claims Act* (*FCA*). The *FCA* is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the *FCA*, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of $5,500-$11,000 per false claim.

The *FCA* also contains *Qui Tam,* or *whistleblower*, provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under *Qui Tam* provisions in the *FCA* and may be entitled to a percentage of the funds recovered by the government.

HIPAA

The *Health Insurance Portability and Accountability Act* (*HIPAA*) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in healthcare fraud, and simplifies the administration of health insurance.

Our company strives to ensure both Summit Community Care and contracted participating providers conduct business in a manner that safeguards member information in accordance with the privacy regulations enacted pursuant to *HIPAA*. Contracted providers shall have the following procedures implemented to demonstrate compliance with the *HIPAA* privacy regulations:

- Our company recognizes its responsibility under *HIPAA* privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose; conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting us; however, privacy regulations allow the transfer or sharing of member information. Our company may request information to conduct business and make decisions about care, such as a member's medical record, authorization determinations or payment appeal resolutions. Such requests are considered part of the *HIPAA* definition of treatment, payment, or healthcare operations.
- Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to us, verify the receiving fax number is correct, notify the appropriate staff at our company and verify the fax was received.
- Internet email (unless encrypted and/or transferred by another secure service) should not be used to transfer files containing member information, e.g., Excel spreadsheets with claim information; such information should be mailed or faxed.
- Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked "confidential" and addressed to a specific individual, P.O. Box, or department at our company.
- Our company voice mail system is secure, and password protected. When leaving messages for any of our associates, leave only the minimum amount of member information required to accomplish the intended purpose.

When contacting us, please be prepared to verify the provider's name, address, and tax identification number (TIN) or member's provider number.

Fraud, waste, and abuse

Our goal is to make sure our health care program works well and that we catch any problems like fraud, waste, or abuse. We start by learning about these issues and being aware of them.

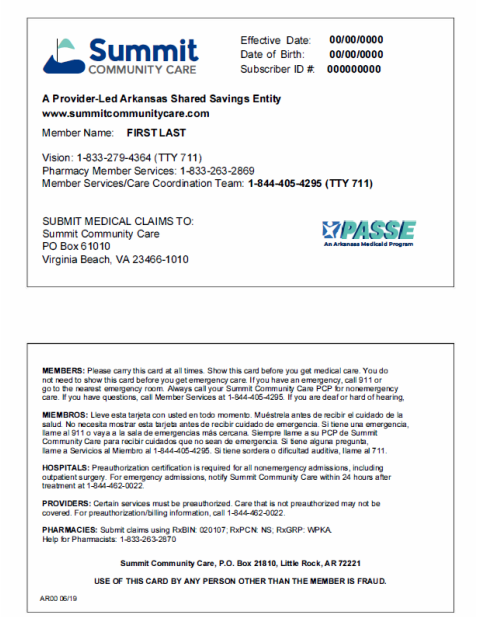
- **Fraud**: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it -- or any other person. This includes any act that constitutes fraud under applicable Federal or State law.
- **Waste:** Includes overusing services, or other practices that, directly or indirectly, result in excessive costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** behaviors that are inconsistent with sound financial, business and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet professionally recognized standards for health care. This includes any member actions that result in unnecessary costs.

To help prevent fraud, waste or abuse, providers can educate members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the Summit Community Care member identification card. It is the first line of defense against fraud. Summit Community Care may not accept responsibility for the costs incurred by providers supplying services to a person who is not a member, even if that person presents a Summit Community Care member identification card. Providers should take measures to ensure the cardholder is the person named on the card.

Every Summit Community Care member ID card lists the following:

- Effective date of Summit Community Care membership
- Member date of birth
- Subscriber number (Summit Community Care identification number)
- Carrier and group number (RXGRP number) for injectables
- PCP name, telephone number and address
- Copays for office visits, emergency room visits, and pharmacy services (if applicable)
- Behavioral health benefit
- Vision service plan telephone number
- Member Services and 24/7 Nurse HelpLine telephone numbers

Summit Community Care member identification card sample:



Presentation of a member identification (ID) card does not guarantee eligibility; providers should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries on the website, and telephonic verification may be obtained through the automated Provider Inquiry line at **844-462-0022**.

Providers should encourage members to protect their ID cards as they would like a credit card, to always carry their Summit Community Care card and report any lost or stolen cards to us as soon as possible. Understanding the numerous opportunities for fraud and working with members to protect their health benefit ID card can help prevent fraudulent activities. If you or a patient suspects ID theft, call our Compliance Hotline at **877-725-2702**. Providers should instruct their patients who suspect ID theft to watch the *Explanation of Benefits* (*EOBs*) for any errors and then contact Member Services if something is incorrect.

21. Fraud, waste, and abuse

Reporting

If you suspect a provider (e.g., provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste, or abuse, you have the right to report it. One of the most important steps to help prevent Member fraud is as simple as reviewing the Member identification card to ensure that the individual seeking services is the same as the Member listed on the card. It is the first line of defense against possible fraud. Learn more at **www.fighthealthcarefraud.com**.

You can report your concerns by:

- Visiting **https://provider.summitcommunitycare.com**, scrolling to the bottom footer and click on **Report Waste, Fraud or Abuse**
- Calling our Special Investigations Unit (SIU) fraud hotline at **866-847-8247**

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. No individual who reports violations or suspects fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators. We appreciate your time in referring suspected fraud but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of provider fraud, waste, and abuse

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Overutilization
- Soliciting, offering, or receiving kickbacks or bribes
- Unbundling — when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding — when a provider bills a health insurance payer using a procedure code for a more expensive service than was performed

When reporting concerns involving a ***provider*** (a doctor, dentist, counselor, medical supply company, etc.), please include:

- Name, address, and phone number of provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.).
- Medicaid number of the provider and facility if you have it.
- Type of provider (doctor, dentist, therapist, pharmacist, etc.).
- Names and phone numbers of other witnesses who can help in the investigation.
- Dates of events.
- Summary of what happened.

Examples of member fraud, waste, and abuse

- Forging, altering, or selling prescriptions
- Letting someone else use the member's ID (Identification) card
- Relocating to out-of-service plan area
- Using someone else's ID card

When reporting concerns involving a ***member***, please include:

- The member's name.
- The member's date of birth, member ID or case number if you have it.
- The city where the member resides.
- Specific details describing fraud, waste, or abuse.

Investigation process

Our Special Investigations Unit (SIU) reviews all reports of provider or member fraud, waste and abuse for all services. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste or abuse, which may include, but is not limited to:

- *Written warning and/or education*: We send secure/trackable communications to the provider documenting the issues and the need for improvement. Correspondence may include education or requests for recoveries or may advise of further action.
- *Medical record review*: We review medical records in context to previously submitted claims and/or to substantiate allegations.
- *Prepayment Review*: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- *Recoveries*: We recover overpayments directly from the Provider. Failure of the provider to return the overpayment may result in reduced payment on future claims and/or further legal action.

If you are working with the SIU all checks and correspondence should be sent to:

Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, case number

Instructions for sending paper medical records and/or claims when working with the SIU is found in correspondence from the SIU. If you have questions, contact your investigator. Delays for claim and/or medical record review, and ultimately resolution of an investigation may be delayed if SIU-supplied instructions are not followed. An opportunity to submit claims and medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at 800-AVAILITY (282-4548) for more information.

About Prepayment Review
One method we use to detect fraud, waste, or abuse is through prepayment claim review. Through a variety of means, certain providers (facilities or professionals), or certain claims submitted by providers, may come to our attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or claims activity that indicates the provider is an outlier compared to his/her/its peers.

Once a claim, or a provider, is identified as an outlier or has otherwise come to our attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination the provider's action(s) may involve fraud, waste, and abuse, unless exigent circumstances exist, the provider is notified of their placement on prepayment review and given an opportunity to respond.

When a provider is on prepayment review, the provider will be required to submit medical records and any other supporting documentation with each claim so the SIU can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation in accordance with this requirement will result in a denial of the claim under review. The provider will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, we may review coding, documentation, and other billing issues. In addition, one or more clinical utilization management guidelines may be used in the review of claims submitted by the provider, even if those guidelines are not used for all providers delivering services to plan members.

The provider will remain subject to the prepayment review process until the health plan is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the provider could face corrective measures, up to and including termination from the network at the direction of the State.

Providers are prohibited from billing a member for services the health plan has determined are not payable as a result of the prepayment review process, whether due to fraud, waste, or abuse, any other coding or billing issue or for failure to submit medical records as set forth above. Providers whose claims are determined to be not payable may make appropriate corrections and resubmit such claims in accordance with the terms of their provider agreement, proper billing procedures and state law. Providers also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Acting on Investigative Findings

If, after investigation, the SIU determines a provider appears to have committed fraud, waste, or abuse the provider:

- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination
- Will be referred to other authorities as applicable and/or designated by the State
- The SIU will refer all suspected criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily dis-enrolled from our health care plan, with state approval.

Offset

Summit Community Care shall be entitled to offset claims and recoup an amount equal to any overpayments ("Overpayment Amount") or improper payments made by the health plan to provider or facility against any payments due and payable by Summit Community Care to provider or facility with respect to any Health Benefit Plan under any contract with Summit Community Care regardless of the cause. Provider or facility shall voluntarily refund the overpayment amount regardless of the cause, including, but not limited to, payments for claims where the claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by the Summit Community Care that an overpayment amount is due from provider or facility, provider or facility must refund the overpayment amount within the timeframe specified in letter notifying the provider or facility of the overpayment amount. If the overpayment amount is not received by Summit Community Care within the timeframe specified in the notice letter, Summit Community Care shall be entitled to offset the unpaid portion of the overpayment amount against other claims payments due and payable by Summit Community Care to provider or facility under any Health Benefit Plan in accordance with Regulatory Requirements. Should provider or facility disagree with any determination by Summit Community Care, provider or facility shall have the right to appeal such determination under Summit Community Care procedures set forth in this provider manual, on condition that that such appeal shall not suspend Summit Community Care's right to recoup the overpayment amount during the appeal process unless required by Regulatory Requirements. Summit Community Care reserves the right to employ a third-party collection agency in the event of non-payment.

22.Marketing policies

We want our members to make the best healthcare decisions possible, and when members ask for our assistance, we want to provide assistance, so they make those decisions without undue influence. We recognize providers occupy a unique trusted, and respected part of people's lives. Given the complexity of modern-day healthcare and the inherent difficulties communicating with some of the populations we serve, there are potentially serious pitfalls when providers try to assist in the decision-making process. For that reason, we are committed to following strict enrollment and marketing guidelines and honoring the rules for all state healthcare programs.

Summit Community Care providers are prohibited from making marketing presentations and advising or recommending to an eligible individual that he or she select membership in a particular plan. The state marketing practice policies prohibit network providers from making any of the following false or misleading claims:

- The provider's office staff are employees or representatives of the state, county, or federal government.
- Summit Community Care is recommended or endorsed by any state or county agency, or any other organization.
- The state or county recommends a prospective member enroll with a specific health plan.
- A prospective member or medical recipient loses Medicaid or other welfare benefits if the prospective member does not enroll with a specific Medicaid MCO.

These policies also prohibit network providers from taking the following actions:

- Making marketing presentations, advising or recommending to an eligible individual they select membership in a specific Medicaid MCO.
- Offering or giving away any form of compensation, reward, or loan to a prospective member to induce or procure member enrollment in a specific Medicaid MCO.
- Engaging in direct marketing to members is designed to increase enrollment in a particular health plan. The prohibition should not constrain providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.
- Using any list of members originally obtained for enrollment purposes from confidential state or county data sources, or from the data sources of other contractors.
- Employing marketing practices that discriminate against potential members other than persons specifically excluded from coverage under our contract. Providers may not discriminate based on marital status, age, religion, sex, national origin, language, sexual orientation, ancestry, or pre-existing psychiatric problems or medical conditions, such as pregnancy, disability, or AIDS.
- Reproducing or signing an enrollment application for the member.
- Displaying materials only from the provider's contracted managed healthcare organizations and excluding others.

23.Agreement outlining minimum standards for PASSE HCBS providers

Ensuring the health and safety of individuals who are enrolled in the Arkansas Medicaid PASSE program and are served through the Arkansas Community Employment Supports (CES) 1915(c) waiver and state plan amendment authority under 1915(i) Arkansas Community Independence Services is a shared responsibility among the Arkansas Department of Human Services (DHS), each PASSE, and each provider of home- and community-based services.

Accordingly, DHS has developed the attached Agreement for use by each PASSE and their PASSE HCBS providers to be placed in their manuals for those performing home- and community-based services. This agreement is based on former requirements under the CES waiver. Each PASSE must include the content of each of the sections, although they may modify the format according to their individual manual specifications. These are minimum standards in addition to federal, state, and local statutes, acts and regulations that apply, and any other qualifications established by the PASSE. All other provisions, except other certification, outlined in this agreement apply to all providers providing home- and community-based services, including the Arkansas Community Independence Program.

SECTION 100 ORGANIZATIONAL/MANAGEMENT REQUIREMENTS OF PASSE HCBS PROVIDERS AND ANNUAL CERTIFICATION REQUIREMENTS SECTION
SECTION 200 HIRING PROCEDURES AND PERSONNEL RECORD MAINTENANCE SECTION
SECTION 300 INCIDENT REPORTING SECTION
SECTION 400 EMERGENCY RESPONSE REQUIREMENTS FOR CSSP PROVIDERS SECTION
SECTION 500 BENEFICIARY AND LEGAL GUARDIAN RIGHTS

Section 100 Organizational/Management Requirements and Solicitation

Organizational Requirements

The PASSE is responsible for the credentialing of PASSE HCBS providers. All HCBS providers must be enrolled in Arkansas Medicaid as an HCBS provider. To enroll in Arkansas Medicaid as a PASSE HCBS provider, the HCBS provider must be credentialed as such by the PASSE.

- The PASSE must submit to DHS for approval the method by which the PASSE will credential HCBS providers.
- The PASSE is required to submit a yearly attestation that all PASSE HCBS providers have been certified on an annual basis. DHS will audit the PASSE's records to ensure compliance with the annual certification requirement. Any PASSE HCBS provider discovered not to have been certified annually will be disenrolled as a Medicaid provider. Failing to annually certify HCBS providers that are enrolled with Medicaid may lead to sanctions by DHS.
- The PASSE's credentialing process must be approved by DHS and include the following, at a minimum, for HCBS providers:
    - Audit requirements
    - Inspection requirements
    - Complaint resolution process
    - Performing provider requirements
    - Any other information required for the PASSE to credential an HCBS provider
- Provider governing documents available for inspection: All governing documents,

policies, procedures, or other equivalent operating documents of a PASSE HCBS provider shall at all times be readily available for PASSE and DHS inspection and review upon request

- Legal existence and good standing: A PASSE HCBS provider shall at all times be duly organized, validly existing and in good standing as a legal entity under the laws of the state of Arkansas, with the power and authority under the appropriate federal, state, or local statues to own and operate its business as presently conducted.

Management Requirements

- Point of contact: Each PASSE HCBS provider must appoint a single member of management as the point of contact for all quality assurance matters. The DHS PASSE unit, in conjunction with the PASSE, will oversee compliance with the below minimum standards.
- Executive Director: Each PASSE HCBS provider must appoint an executive director or other titled officer position that is vested with the authority and responsibility of overseeing all day-to-day operations.

300 Incident Reporting

Reportable Incidents

PASSE HCBS providers must submit an incident report to the DHS PASSE quality assurance unit and the appropriate PASSE, using the reporting form via secure email upon the occurrence of any one of the following events:

- Death of beneficiary
- The use of any restrictive intervention, including seclusion or physical, chemical, or mechanical restraint on a beneficiary
- Suspected maltreatment or abuse of a beneficiary
- Any injury to a beneficiary that:
    - Requires the attention of an Emergency Medical Technician, a paramedic, or a physician
    - May cause death
    - May result in a substantial permanent impairment
    - Requires hospitalization
- Threatened or attempted suicide by a beneficiary
- The arrest of a beneficiary, or commission of any crime by a beneficiary
- Any situation in which the whereabouts of a beneficiary is unknown for more than two hours (e.g. elopement and/or wandering), or where services are interrupted for more than two hours
- Any event where a staff member threatens, abuses, or neglects a beneficiary
- Unexpected occurrences involving actual or risk of death or serious physical or psychological injury to a beneficiary
- Medication errors made by staff that cause or have the potential to cause serious injury or illness to a beneficiary, including, but not limited to, loss of medication, unavailability of medication, falsification of medication logs, theft of medication, a missed dose, a wrong dose, a dose being administered at the wrong time by the wrong route, and the administration of the wrong medication

- Any violation of a beneficiary's rights that jeopardizes the health, safety, or quality of life of the beneficiary
- Any incident involving property destruction by a beneficiary
- Vehicular accidents involving a beneficiary
- Biohazard incidents involving a beneficiary
- An arrest or conviction of a staff member providing direct care services
- Any use or possession of a non-prescribed medication or an illicit substance by a beneficiary
- Any other event that might have resulted in harm to a beneficiary or could have reasonably endangered the health, safety, or welfare of the beneficiary

In addition to submitting incident reports for the reportable incidents described above to the DHS PASSE quality assurance unit using the reporting form via secure email, PASSE HCBS providers are also to forward a copy of each incident report to the client's assigned PASSE. If the incident involves an employee of a PASSE HCBS provider and the provider is in multiple PASSE networks, the incident must be sent to all.

Incident reports involving unexpected occurrences involving actual or risk of death or serious physical or psychological injury to a beneficiary are considered sentinel events and will be investigated by DHS. In addition to sentinel events, DHS will investigate if the network provider and/or network provider staff is suspected to be at fault. All other incidents will be investigated by the appropriate PASSE.

Reporting Time Frames

Immediate reporting – Providers must report the following incidents to the DHS PASSE quality assurance unit emergency number (501-371-1329) within one hour of occurrence, regardless of time of day, as well as the on-call emergency number for the appropriate PASSE:

- A death not related to the natural course of the patient's illness
- Serious physical or psychological injury to a beneficiary

The provider must report the following incidents to arkansasquality@anthem.com or the DHS Incident within two hours of occurrence:

- Member elopes from service and cannot be located

Incidents involving potential publicity – Incidents, regardless of category, that a PASSE HCBS provider should reasonably know might be of interest to the public and/or media must be immediately reported to the DHS PASSE quality assurance unit and the appropriate PASSE.

All other incident reports, except as otherwise provided in the above subsections, all reportable incidents must be reported to the DHS PASSE quality assurance unit, and the appropriate PASSE, using the automated PASSE HCBS Incident Report Form via secure email no later than two days following the incident. Any incident that occurs on a Friday is still considered timely if reported by the Monday immediately following.

Required Incident Report Contents

Initial Incident Report – Each initial incident report filed by a PASSE HCBS provider must contain the following information:

- Date of the incident
- Detailed description of the accident/injury
- Time of the incident
- Location of incident
- Person(s) involved in the incident
- Other agencies contacted regarding incident, and the name of the individual in the agency that was contacted
- Whether the guardian was notified of the incident and time of notification
- Whether the police were involved, and if so, a detailed description of their involvement
- Any action taken by provider or staff of provider, both at the time of the incident and subsequent to the incident
- Any expected follow-up
- Name of the person who prepared the report

When applicable, the PASSE HCBS provider shall notify the parent or legal guardian of the beneficiary any time an incident report is submitted.

Follow-up Incident Report – Information that is not available at the time of the initial incident report filing must be submitted in follow-up or final incident reports. These reports should be submitted in the same manner as soon as the additional information becomes available.

- The initial report should be resubmitted with the "follow-up" or "final" report areas checked and dated in the appropriate space on the incident report form.
- The current date should precede the new information in the text/narrative sections to differentiate follow-up information from the information originally submitted.
- A new PASSE Incident Report Form should be submitted for follow-up and final reports only when there is insufficient space on the original form. Whenever a new form is submitted, the date of the original written report must be included for cross-referencing

Mandated Reporters

The Arkansas Child Maltreatment Act and the Arkansas Adult Maltreatment Act deem all staff of PASSE HCBS providers to be mandated reporters of any suspected adult or child abuse, neglect, exploitation, and maltreatment. Failure on the part of a PASSE HCBS provider to properly report suspected abuse, neglect, exploitation, and maltreatment to the appropriate hotline is a violation of these minimum standards.

Incident Reporting Requirements for Children's Residential & Acute Psychiatric Providers

Providers of children's psychiatric residential, sub-acute, and psychiatric acute services are required to provide information to Summit Community Care for critical incidents as outlined below. These providers are required to submit critical incident reports to Summit Community Care via the outlined incident reporting process. These critical incident reports are required to be submitted to Summit Community Care within the timeframe required by the provider's licensing body:

- Death of a member
- Suspected maltreatment of a member
- Injury to a member that requires emergency room care or a paramedic

- Injury to a member that may result in a substantial permanent impairment
- Injury to a member that requires hospitalization
- Arrest
- Any situation in which the member eloped from a service and cannot be located within two hours
- Any significant peer-on-peer or member-on-staff incidents or assault

The following elements must be included in the incident report:

- Member name
- Member date of birth (DOB)
- Member Summit Community Care and/or Medicaid ID
- Overview of incident, including details such as date, time, antecedents, actions taken, etc.
- All follow-up action items

400 Emergency Response Requirements for CSSP Providers

Emergency Response Services

Applicants/providers must establish, implement, and maintain a site-specific emergency response plan, which must include:

- A 24-hour emergency telephone number available to all members
- The applicant/provider must:
    - Provide the 24-hour emergency telephone number to all members
    - Post the 24-hour emergency number on all public entries to each site
    - Include the 24-hour emergency phone number on answering machine greetings
    - Identify local law enforcement and medical facilities within a 50-mile radius that may be emergency responders to member emergencies
- Direct access to a mental health professional within 15 minutes of an emergency/crisis call and face-to-face crisis assessment within two hours
- Response strategies are based on the following:
    - Time and place of occurrence
    - Individual's status (client/non-client)
    - Contact source (family, law enforcement, healthcare provider, etc.)
- Requirements for a face-to-face response to requests for emergency intervention received from a hospital or law enforcement agency regarding a current client.
- All face-to-face emergency responses shall be:
    - Available 24 hours a day, seven days a week
    - Made by a mental health professional within two hours of the request (unless a different time frame is within clinical standards guidelines and mutually agreed upon by both the requesting party and the MHP responding to the call)
- Emergency services training standards to ensure emergency services are age-appropriate and comply with accreditation requirements. Providers shall maintain documentation of all emergency services training in each trainee's personnel file.

- Requirements for clinical review by the clinical supervisor or emergency services

director within 24 hours of each afterhours emergency intervention, with such additional reporting as may be required by the provider's policy
- Requirements for documentation of all crisis calls, responses, collaborations, and outcomes
- Requirements that emergency responses not vary based on the client's funding source. If a client is eligible for inpatient behavioral healthcare funded through the community mental health centers, and the provider is not a community mental health center with access to these funds, the provider must:
    - Determine whether the safest, least restrictive alternative is psychiatric hospitalization; and
    - Contact the appropriate community mental health center (CMHC) for consult and request that the CMHC access local acute care funds for those over the age of 21

Required Incident Report Contents

Initial Incident Report – Each initial incident report filed by a PASSE HCBS provider must contain the following information:

- Date of the incident
- Detailed description of the accident/injury
- Time of the incident
- Location of incident
- Persons involved in the incident
- Other agencies contacted regarding incident, and the name of the individual in the agency that was contacted
- Whether the guardian was notified of the incident and time of notification
- Whether the police were involved, and if so, a detailed description of their involvement
- Any action taken by provider or staff of provider, both at the time of the incident and subsequent to the incident
- Any expected follow-up
- Name of the person who prepared the report

When applicable, the PASSE HCBS provider shall notify the parent or legal guardian of the beneficiary any time an incident report is submitted.

Follow-up Incident Reports – Information that is not available at the time of the initial incident report filing must be submitted in follow-up or final incident reports. These reports should be submitted in the same manner as soon as the additional information becomes available.

- The initial report should be resubmitted with the follow-up or final report areas checked and dated in the appropriate space on the incident report form.
- The current date should precede the new information in the text/narrative sections to differentiate follow-up information from the information originally submitted.
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Mandated Reports

The Arkansas Child Maltreatment Act and the Arkansas Adult Maltreatment Act deem all staff of PASSE HCBS providers to be mandated reporters of any suspected adult or child abuse, neglect, exploitation, and maltreatment. Failure on the part of a PASSE HCBS provider to properly report suspected abuse, neglect, exploitation, and maltreatment to the appropriate hotline is a violation of these minimum standards.

Incident Reporting Requirements for Children's Residential & Acute Psychiatric Providers

Providers of children's psychiatric residential, sub-acute, and psychiatric acute services are required to provide information to Summit Community Care for critical incidents as outlined below. These providers are required to submit critical incident reports to Summit Community Care via the outlined incident reporting process. These critical incident reports are required to be submitted to Summit Community Care within the time frame required by the provider's licensing body:

- Death of a member
- Suspected maltreatment of a member
- Injury to a member that requires emergency room care or a paramedic
- Injury to a member that may result in a substantial permanent impairment • Injury to a member that requires hospitalization
- Arrest
- Any situation in which the member eloped from a service and cannot be located within two hours
- Any significant peer-on-peer or member-on-staff incidents or assaults

The following elements must be included in the incident report:

- Member name
- Member date of birth (DOB)
- Member Summit Community Care and/or Medicaid ID
- Overview of incident, including details such as date, time, antecedents, actions taken, etc.
- All follow-up action items

500 Beneficiary and Legal Guardian Rights

Beneficiary/Guardian Rights Policy

Each PASSE HCBS provider must implement policies that enumerate in clear and understandable language each beneficiary's rights and the rights of the legal guardian of each beneficiary. The PASSE HCBS provider must take reasonable steps to ensure beneficiaries and their legal guardians are (1) informed of their rights; (2) provided copies of the policies enumerating their rights prior to the initiation of services and at any other time upon request; and (3) that the information is transmitted in a manner that the beneficiary and their legal guardian are able to read and understand.

Beneficiary Rights

Each PASSE HCBS provider must, at a minimum, ensure the following beneficiary rights:

- The right to be free from:
    - Physical or psychological abuse or neglect

    - Retaliation
    - Coercion
    - Humiliation
    - Financial exploitation

The PASSE HCBS provider must ensure that the application of corporal punishment to beneficiaries is prohibited. “Corporal punishment” refers to the application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior.

- The freedom to control their own financial resources
- The freedom to receive, purchase, possess, and use individual personal property. Any restriction on this right must be supported by an assessed need and justified in the beneficiary’s PCSP
- The freedom to actively and meaningfully make decisions affecting their life and access pertinent information in a timely manner to facilitate such decision making
- The right to privacy. Any restriction on this right must be supported by an assessed need and justified in the PCSP
- The right to have a choice of roommate when sharing a bedroom
- The freedom to associate and communicate publicly or privately with any person or group of people of the beneficiary’s choice at any time. Any restriction on this right must be supported by an assessed need and justified in the PCSP
- The freedom to have visitors of their choosing at any time
- The freedom of religion
- The right to be free from the inappropriate use of a physical or chemical restraint, medication, or isolation as punishment
- The opportunity to seek employment and work in competitive, integrated settings
- Freedom from being required to work without compensation
- The right to be treated with dignity and respect
- The right to receive due process
    - PASSE HCBS providers must ensure beneficiaries have access to legal entities for appropriate and adequate representation, advocacy support services, and must adhere to research and ethics guidelines (45 CFR § 46.101 et. seq.).
    - PASSE HCBS provider rules may not contain provisions that result in the unfair, arbitrary, or unreasonable treatment of a beneficiary.
- The right to contest and appeal PASSE HCBS provider decisions affecting the beneficiary
- The right to request and receive an investigation in connection with an alleged infringement of a beneficiary’s rights
- The freedom to access their own records, including information regarding how their funds are accessed and utilized and what services were billed for on the beneficiary’s behalf. Additionally, all beneficiaries and legal guardians must be informed of how to access the beneficiary’s service records and the PASSE HCBS provider must ensure that appropriate equipment is available for them to obtain such access.
    - Beneficiaries may not be prohibited from having access to their own service records, unless a specific state law indicates otherwise.
- The right to live in a manner that optimizes, but does not regiment, beneficiary initiative, autonomy, and independence in making life choices, including but not limited to:
    - Choice of HCBS providers

    - Service delivery
    - Release of information
    - Composition of the service delivery team
    - Involvement in research projects, if applicable
    - Daily activities
    - Physical environment
    - With whom to interact
- Other legal and constitutional rights

Financial Safeguards

This section applies if the PASSE HCBS provider serves as a representative payee of a beneficiary, is involved in managing the funds of the beneficiary, receives benefits on behalf of the beneficiary, or temporarily safeguards funds or personal property for the beneficiary.

Financial Safeguards and Procedures. The PASSE HCBS provider must demonstrate that there is a system in place to protect the financial interests of all beneficiaries. PASSE HCBS provider personnel that have any involvement with beneficiary funds and the beneficiary, or with the beneficiary's legal guardian, must receive a copy of the PASSE HCBS provider's Financial Safeguards Policies and Procedures.

- The PASSE HCBS provider is responsible for ensuring that each beneficiary's funds are used solely for the benefit of the beneficiary.
- The PASSE HCBS provider must ensure that the beneficiary is able to receive the benefit of those items/services for which they are paying. By way of illustration, if a beneficiary is paying for internet, the beneficiary should have a device with which to access the internet. If the beneficiary pays for a cell phone plan, then the beneficiary should have a functioning cell phone.

Access to Financial Records. Beneficiaries and their legal guardians must have access to financial records concerning the beneficiary's account/funds at all times.
Financial Safeguards Policy and Procedures. The PASSE HCBS provider must implement policies that define:

- How beneficiaries will provide informed consent for the expenditure of their funds
- How beneficiaries will access their financial records
- How beneficiary accounts/funds will be segregated and maintained for accounting purposes
- The safeguards and procedures in place to ensure that beneficiary funds are used only for designated and appropriate purposes
- How interest will be credited to the accounts of the beneficiaries, if applicable
- A mechanism that provides evidence that beneficiary funds were expended in the manner authorized

Consent Requirements. The PASSE HCBS provider shall obtain consent from the beneficiary or their legal guardian prior to implementing the following:

- Limiting the amount of funds a beneficiary may expend or invest in a specific instance
- Designating the amount a beneficiary may expend or invest for a specific purpose
- Establishing time frames where a beneficiary is required to or prohibited from expending or investing their funds
- Delegating responsibility for expending or investing a beneficiary's funds

Restraints & Restrictive Intervention

Behavior Management Plan Required. A provider is prohibited from using any restraints or restrictive interventions on a beneficiary unless the beneficiary has a developed and implemented behavior management plan which incorporates alternative strategies to avoid the use of restraints and restrictive interventions, and includes the use of positive behavior support strategies as an integral part of the behavior management plan (see Section 502 "Behavior Management Plans"). There is a limited exception to this requirement when the use of an emergency restraint is necessary (see Section 503 (E) "Emergency Restraint").

Definitions of Restraints and Interventions:

- "Physical restraint" or "personal restraint": The application of physical force without the use of any device (manually holding all or part of the body), for the purpose of restraining the free movement of a beneficiary's body. This does not include briefly holding, without undue force, a beneficiary in order to calm them, or holding a beneficiary's hand to escort them safely from one area to another.
- "Physical intervention": The use of a manual technique intended to interrupt or stop a behavior from occurring
- "Restrictive intervention": Procedures that restrict or limit a beneficiary's freedom of movement, restricts access to their property, prevents them from doing something they want to do, requires them to do something they do not want to do, or removes something they own or have earned. The definition would include the use of a "time out" in which a beneficiary is temporarily, and for a specified period of time, removed from positive reinforcement or denied opportunity to obtain positive reinforcement for the purpose of providing the beneficiary with the opportunity to regain self-control. Under no circumstances may a beneficiary be physically prevented from leaving.
- "Mechanical restraint": Any physical apparatus or equipment used to limit or control a challenging behavior. This would include any apparatus or equipment that cannot be easily removed by the beneficiary, restricts the beneficiary's free movement or normal functioning, or restricts normal access to a portion or portions of the beneficiary's body.
    - Under no circumstances are mechanical restraints permitted to be used on a beneficiary.
- "Chemical restraint": The use of medication for the sole purpose of preventing, modifying, or controlling challenging behavior that is not associated with a diagnosed co-occurring psychiatric condition.
    - Under no circumstances are chemical restraints permitted to be used on a beneficiary.
- "Seclusion": The involuntary confinement of a beneficiary alone in a room or an area from which the beneficiary is physically prevented from having contact with others or leaving.
    - Under no circumstances is seclusion permitted to be used on a beneficiary.

Use of Restraints and Interventions. Permitted restraints and interventions may be used only when a challenging behavior exhibited by the beneficiary threatens the health or safety of the beneficiary or others. The use of restraints or interventions must be supported by a specific assessed need as justified in the beneficiary's PCSP, and only performed as provided in the beneficiary's behavior management plan.

- Required prior counseling: Before a "time out," an absence from a specific social activity, or a temporary loss of personal possession is implemented, the beneficiary must first be counseled about the consequences of the behavior and the choices they can make.
- Direct observation: A beneficiary must be continuously under direct visual and auditory observation by staff members during any use of restraints or interventions.
- Specialized restraint and intervention training: All personnel who are involved in the use of restraints or interventions must receive training on and be qualified to perform, implement, and monitor the particular restraint or intervention as applicable. Additionally, personnel should receive training in behavior management techniques and abuse and neglect laws, rules, regulations, and policies.
- Restraint and intervention identification: The PASSE HCBS provider is required to advise all staff, families, and beneficiaries on how to recognize and report the unauthorized use of a restraint or restrictive intervention.

Required Restraint and/or Intervention PCSP Information. Any PCSP and behavior management plan permitting the use of restraints or interventions must include the following information:

- Identify the specific and individualized assessed need for the use of the restraint or intervention.
- Document the positive interventions and supports used prior to any modifications to the PCSP that permits use of restraint or interventions.
- Document the less intrusive methods of behavior modification that were attempted but did not work.
- Include a clear description of the condition that is directly proportionate to the specific assessed need.
- Include regular collection and review of data to measure the ongoing effectiveness of the modification to the PCSP that permitted the use of a restraint or intervention.
- Include established time limits for periodic reviews to determine if the use of restraint or intervention is still necessary or can be terminated.
- Include the informed consent of the beneficiary or legal guardian.
- Include an assurance that the use of the restraint or intervention will cause no harm to the beneficiary.

Emergency Restraint. Personal restraints (use of staff member's body to prevent injury to the beneficiary or another person) are allowed in cases of emergency, even if a behavior management plan incorporating the use of restraints has not been developed and implemented. An emergency exists in the following situations:

- The beneficiary has not responded to de-escalation or other positive behavior support strategies and the behavior continues to escalate.
- The beneficiary is a danger to themselves or others.
- The safety of the beneficiary and those nearby cannot be assured through positive behavior support strategies.

Reporting Each Incident Where Restraint or Intervention Was Used. An incident report must be completed and submitted to the DHS PASSE quality assurance unit and appropriate PASSE, in accordance with Section 300 herein, no later than the end of the second business day following the date any restraint or restrictive intervention is administered. If the use of a restraint or restrictive intervention occurs more than three times in any 30-day period, permitted use of restraints and

interventions must be discussed by the PCSP development team, addressed in the PCSP, and implemented pursuant to an appropriate behavior management plan. Any use of restraint or intervention, whether permitted or prohibited, also must be documented in the beneficiary's daily service log, maintained in their service record, and must include the following information:

- The behavior initiating the use of restraint or intervention
- The length of time the restraint or intervention was administered
- The name of the personnel that authorized the use of the restraint or intervention
- The names of all individuals involved and outcomes of the use of the restraint or intervention

Medication Logs

Prescription Medications – Providers delivering direct care services must maintain medications logs detailing the administration of prescribed medications to the beneficiary. The prescribed medication logs must be readily available review, and document the following for each administration of a prescribed medication:

- Name and dosage of the medication administered
- Route the medication was administered
- Date and time the medication was administered (recorded at the time of medication administration)
- Initials of the staff administering or assisting with the administration of the medication
- Any side effects or adverse reactions to the medication
- Any errors in administering the medication

PRN and Over-the-Counter Medications – PASSE HCBS providers delivering direct care services must also maintain logs concerning the administration of PRN and OTC medications. The logs for the administration of prescription PRN and over-the-counter medications must document the following:

- How often the medication is used
- Date and time each medication was administered (recorded at the time of medication administration)
- The circumstances in which the medication is used
- The symptom for which the medication was used
- The effectiveness of the medication

Medication Administration Error Reporting/Charting – Any medication administration errors occurring or discovered must be recorded in the medication log and immediately reported to a supervisor. "Medication administration errors" include, but are not limited to, the loss of medication, unavailability of medication, falsification of medication logs, theft of medication, a missed dose, wrong dose, a dose being administered at the wrong time or by the wrong route, the administration of the wrong medication, and the discovery of an unlocked medication lock box that is supposed to be locked at all times.

- An incident report must be filed with DHS PASSE quality assurance unit and appropriate PASSE, in accordance with Section 300, for any medication administration error that caused or had the potential to cause serious injury or illness to a beneficiary.

Required Oversight Documentation – Each PASSE HCBS provider delivering direct care services must ensure that supervisory level staff review on at least a monthly basis all beneficiary medication logs to determine if:

- All medications were administered accurately as prescribed.
- The medication is effectively addressing the reason for which it was prescribed.
- Any side effects are noted, reported, and being managed appropriately.

Daily Service Activity Logs

Daily service activity logs must be maintained by all PASSE HCBS providers delivering direct care services to provide specific information relating to the individually identified goals and desired outcomes for the beneficiary, so that the care coordinator, PCSP developer, and PCSP development team can measure and record the progress on each of the beneficiary's identified goals and desired outcomes.

There is no required format for a daily service activity log; however, the daily service activity logs must document the following:

- The name and sign-in/sign-out times for each direct care staff member
- The specific services furnished
- The date and actual beginning and ending time of day the services were performed
- Name(s) of the staff/person(s) providing the service(s)
- The relationship of the services to the goals and objectives described in the beneficiary's individualized PCSP
- Daily progress notes/narrative signed and dated by the staff delivering the service(s), describing each beneficiary's progress or lack thereof with respect to each of his or her individualized goals and objectives. This would include any behavior management plan data required to be maintained pursuant to Section 502(E) above.

Beneficiary Service Records

Required Service Record Documentation. Each PASSE HCBS provider delivering direct care services to a beneficiary must establish a service record for the beneficiary. At a minimum, the service record file must contain:

- A copy of the PCSP
- Behavior management plan with proper beneficiary/legal guardian approval, if applicable
- Daily service activity logs
- Fully approved medication management plan and medication logs, or a signed election to self-administer medication if applicable
- Fully executed copy of lease, residency agreement, or other form of written agreement that provides protections that address eviction processes and appeals comparable to those provided under a landlord-tenant law
- Any documentation providing additional individuals with access to a beneficiary's service record
- Guardianship order, if applicable

Beneficiary Records Maintenance & Storage Retention Requirements:

- Confidentiality. A PASSE HCBS provider shall maintain complete service records/files and treat all information related to beneficiaries as confidential. Access to beneficiary service files must be limited to only those staff members who have a need to know the information contained in the records of the beneficiary. The only individuals that may access a beneficiary's files and records are:

- The beneficiary
- The legal guardian of the beneficiary, if applicable
- Professional staff providing direct care or care coordination services to the beneficiary
- Authorized provider administrative staff
- Any other individual authorized by the beneficiary or their legal guardian

Adult beneficiaries who are legally competent shall have the right to decide whether their family will be involved in planning and implementing their PCSP, and a signed release or document shall be present in their service record either granting permission for family involvement or declining family involvement.

- HIPAA Regulations. Each PASSE HCBS provider shall ensure that information that is used for reporting or billing shall be shared according to confidentiality guidelines that recognize applicable regulatory requirements such as HIPAA. 3. Electronic and Paper Records/File Maintenance.
- Electronic service records are acceptable. Paper and electronic service records must be uniformly organized and easily accessible. A list of the order of the service record information shall either be present in each beneficiary's service record or provided to the DHS PASSE quality assurance unit and appropriate PASSE upon request. The documents in active service records should be organized in a systematic fashion. An indexing and filing system must be maintained for all service records.
- Storage Location. The location of the files/service records, and the information contained therein, must be controlled from a central location.
- Direct Care Staff Access. The PASSE HCBS provider shall ensure all direct care and care coordination staff has adequate access to the beneficiary's file/service record, including current PCSP and other pertinent information necessary to ensure the beneficiary's health, welfare, and safety (e.g. name and telephone number of physician(s), emergency contact information, insurance information, etc.).
- Record/File Retention. Each PASSE HCBS provider must retain all files/services records for five years from the date of service, or until all audit questions or review issues, appeals hearings, investigations, or administrative or judicial litigation to which the files/services records may relate are finally concluded, whichever period is later. Failure to furnish medical records upon request may result in sanctions being imposed. Federal legislation further requires that any accounting of private healthcare information or HIPAA polices or complaints must be retained for six years from the date of its creation or the date when it last was in effect, whichever is later.
- Access Sheets. Access sheets shall be located in the front of the service record to maintain confidentiality according to 5 U.S.C. § 552a. If there is a signed release for a list of authorized persons to review the service record, only those not listed will need to sign the access sheet with date, title, reason for reviewing, and signature. If there is not a signed release for authorized persons to review, all persons must sign the access sheet whenever the service record is reviewed or any material is placed in the service record.

Training Requirements

First Aid Training – Within 30 days of hiring, all staff that may be required to provide emergency direct care services to a beneficiary (such as on-call emergency staff or management), shall be required to

attend and complete a certified first aid course administered by certified instructors of the course. The course must include instruction on common first aid topics and techniques, including, but not limited to, how to perform CPR, how to apply the Heimlich maneuver, how to stop/slow bleeding, etc.

- The course must provide a certificate of completion that can be maintained in the staff's personnel file.
- Any services provided by a staff person prior to receiving the above described first aid training can be performed only in a training role, under the supervision of another staff person that has already had the required first aid training.
- Training certification must be maintained and kept up to date throughout the time any staff is providing services.

Beneficiary Specific Training – Prior to beginning service delivery, staff must receive the amount of individualized, beneficiary-specific training that is necessary to be able to effectively and safely provide the supportive living services required pursuant to the beneficiary's PCSP, including but not limited to:

- General training on beneficiary's PCSP
- Behavior management techniques/programming
- Medication administration and management
- Setting-specific emergency and evacuation procedures
- Appropriate and productive community integration activities
- Training specific to certain medical needs

Documentation evidencing that the necessary types and amount of beneficiary-specific training were completed must be maintained in the personnel file of the supportive living staff member at all times. This type of individualized, beneficiary-specific training shall be required each time a beneficiary's PCSP is updated, amended, or renewed.

Other Required Training – Staff must receive appropriate training on the following topics at least once every two calendar years:

- HIPAA policies and procedures
- Procedures for Incident Reporting
- Emergency and evacuation procedures
- Introduction to behavior management Arkansas guardianship statutes Arkansas abuse of adult statutes
- Arkansas Child Maltreatment Act
- Nurse Practice Act
- Appeals procedure for individuals served by the program
- Beneficiary financial safeguards
- Community integration training
- Procedures for preventing and reporting maltreatment of children and adults
- Other topics where circumstances dictate staff should receive training to ensure the health, safety, and welfare of the beneficiary

Documentation evidencing that training on the topics has been completed must be maintained in the personnel file of the staff member at all times.

Beneficiary Accessibility Requirements

PASSE HCBS provider owned/leased/rented residential settings must be fully accessible by the beneficiary, compatible with the services being provided to the beneficiary, and compatible with the needs of each beneficiary and their staff, as provided in the beneficiary's PCSP. Each PASSE HCBS provider owned/leased/rented residential facility must be in compliance with U.S.C. § 12101 et. seq. American with Disabilities Act of 1990, and 29 U.S.C. §§ 706 (8), 794–794(b) Disability Rights of 1964.

Safe and Comfortable Environment

The PASSE HCBS provider must ensure each PASSE HCBS provider owned/leased/rented residential settings provide a safe and comfortable environment tailored towards the needs of the beneficiary, as provided for in their PCSP. This shall include, but not be limited to, the following:

- All PASSE HCBS provider owned/leased/rented residential settings must meet all local and state building codes, regulations and laws.
- The temperature must be maintained within a normal comfort range for the climate.
- The interior and exterior of the residential setting must be maintained in a sanitary and repaired condition.
- The residential setting must be free of offensive odors.
- The residential setting must be maintained free of infestations of insects and rodents.
- All materials, equipment, and supplies must be stored and maintained in a safe condition. Cleaning fluids and detergents must be stored in original containers with labels describing contents.

Emergency and Evacuation Procedures

The PASSE HCBS provider must establish emergency procedures that include detailed actions to be taken in the event of emergency and promote safety. Details of emergency plans and procedures must be in written form, and shall be available and communicated to all members of the staff and other supervisory personnel.

There shall be written emergency procedures for:

- Fires
- Natural disasters
- Utility failures
- Medical emergencies
- Safety during violent or other threatening situations

Additionally, the emergency procedures must satisfy the requirements of applicable authorities, and contain practices appropriate for the locale (example: nuclear evacuations for those living near a nuclear plant).

The PASSE HCBS provider shall maintain an emergency alarm system for each type of drill (fire and tornado).

Beneficiaries, as appropriate, must be educated and trained about emergency and evacuation procedures.

Evacuation procedures must address:

- When evacuation is appropriate

- Complete evacuation from the physical facility
- The safety of evacuees
- Accounting for all persons involved
- Temporary shelter, when applicable
- Identification of essential services
- Continuation of essential services
- Emergency phone numbers 9. Notification of the appropriate emergency authorities

Safety Equipment

PASSE HCBS providers must maintain the following items in each setting in which beneficiaries reside:

- Functioning smoke detectors, heat sensors, carbon monoxide detectors and/or sprinklers
- Functioning fire extinguishers
- Functioning flash light
- Functioning hot water heater
- Emergency contact numbers (law enforcement, poison control, etc.)
- First-aid kit

Required Independence and Integration

Beneficiaries must be safe and secure in their homes and communities, taking into account their informed and expressed choices. Participant risk and safety considerations shall be identified and potential interventions considered that promote independence and safety with the informed involvement of the beneficiary.

- PASSE HCBS providers must take reasonable steps to ensure that beneficiaries are safe and secure in their homes and communities, taking into account the beneficiary's informed and expressed choices.
- Participant risk and safety considerations shall be identified and potential interventions considered that promote independence and safety with the informed involvement of the beneficiary.
- Beneficiaries shall be allowed free use of all space within the group living setting/alternative living site with due regard for privacy, personal possessions of other residents/staff, and reasonable house rules.
- Settings must be able to provide beneficiaries access to community resources and be located in a safe and accessible location. Beneficiaries must have access to the community in which they are being served. The site shall assure adequate/normal interaction with the community as a group and as an individual. This can be achieved through transportation or through local community resources.
- The living and dining areas must be provided with normalized furnishings for the usual functions of daily living and social activities.
- The kitchen shall have equipment, utensils, and supplies to properly store, prepare, and serve three meals a day. Beneficiaries must have access to food at any time. Any modification to this requirement must be based on an assessed need and documented in the beneficiary's PCSP.
- Bedroom areas are required to meet the following:
    - Bedrooms shall be arranged so that privacy is assured for beneficiaries. Sole

access to these rooms cannot be through a bathroom or other bedrooms. Bedrooms must be equipped with a functioning lock with only appropriate staff having keys.
    - Beneficiaries must have a choice of roommate when shared by one or more individuals. The PASSE HCBS provider must actively address the need to designate space for privacy and individual beneficiary interests.
    - Physical arrangements shall be compatible with the physical needs of the individuals.
    - Each beneficiary shall have an individual bed. Each bed must have a clean, adequate, and comfortable mattress.
        - Beds are of suitable dimensions to accommodate the beneficiary who is using it. Mattresses must be waterproof as necessary.
        - Each beneficiary must have a suitable pillow, pillowcase, sheets, blanket, and spread.
        - Bedding must be appropriate to the season and beneficiary's personal preferences.
        - Bed linens must be replaced with clean linens at least weekly.
        - Bedroom furnishings for beneficiaries shall include shelf space, individual chest or dresser space, and a mirror.
        - An enclosed closet space adequate for the belongings of each beneficiary must be provided.
    - The space is 80 square feet per beneficiary in multi-sleeping rooms, and 100 square feet in single bedrooms.
- Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- Bathroom areas are required to meet the following criteria:
    - Sole access may not be through another beneficiary's bedroom. Commodes, tubs, and showers used by beneficiaries must provide for individual privacy.
    - A minimum of one commode and sink is provided for every four beneficiaries. Lavatories and commode fixtures are designed and installed in an accessible manner so that they are usable by the beneficiaries living in the residential setting.
    - A minimum of one tub or shower is provided for every eight beneficiaries.
    - Must be well ventilated by natural or mechanical methods.

HCBS Setting Requirements

All PASSE HCBS providers must meet the HCBS setting regulations as established by CMS. The federal regulation for the rule is 42 CFR 441.301(c) (4)–(5). All PASSE HCBS provider-owned/leased/rented residential settings must have the following characteristics:

- Be chosen by the beneficiary from among setting options including non-disability specific settings (as well as an independent setting), and an option for a private unit in a residential setting.
    - Choice must be identified/included in the beneficiary's PCSP.
    - Choice must be based on the beneficiary's needs, preferences, and, for residential settings, resources available for room and board.
- Ensure a beneficiary's rights of privacy, dignity, and respect and freedom from coercion and restraint.

- Must optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, including daily activities, physical environment, and with whom to interact.
- Facilitate beneficiary choice regarding services and supports and who provides them
- The setting must be integrated in and support full access to the greater community by the beneficiary, including the opportunity to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as beneficiaries not receiving CES waiver services.
- The unit or dwelling must be a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the beneficiary receiving services, and the beneficiary has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity
- Each beneficiary has privacy in their sleeping or living unit, which must include the following:
    - Units have entrance doors lockable by the beneficiary, with only appropriate staff having keys to doors.
    - Beneficiaries sharing units have a choice of roommates in that setting.
    - Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
    - Beneficiaries have the freedom and support to control their own schedules and activities and have access to food at any time.
    - Beneficiaries are able to have visitors of their choosing at any time.
    - The setting is physically accessible to the beneficiary.
    - Any modification of the additional conditions specified in items above must be justified in the beneficiary's PCSP.

The following requirements must be documented in the beneficiary's PCSP:

- Identify a specific and individualized assessed need.
- Document the positive interventions and supports used prior to any modifications to the PCSP.
- Document less intrusive methods of meeting the need that have been tried but did not work.
- Include a clear description of the condition that is directly proportionate to the specific assessed need.
- Include regular collection and review of data to measure the ongoing effectiveness of the modification
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Include the informed consent of the beneficiary.
- Include an assurance that interventions and supports will cause no harm to the beneficiary

24.Appendix

APPENDIX A – FORMS

The rest of this page is intentionally left blank.

Living Will

You can make a living will by completing this form. You can choose another form or use the one your doctor gives you. If you make a living will, give it to your Summit Community Care network provider. If you need help to understand or complete this form, call Member Services at 844-405-4295 (TTY 711).

I, (*Print your name here*) _____, am of sound mind. I want to have what I indicate here followed. I am writing this in the event something happens to me, and I cannot make decisions about my medical care. These instructions are to be used if I am not able to make decisions. I want my family and doctors to honor what I say here. These instructions will tell what I want to have done if 1) I am in a terminal condition (going to die), or 2) I am permanently unconscious and have brain damage that is not going to get better. If I am pregnant and my doctor knows it, then my instructions here will not be followed during the time I am still pregnant, and the baby is living.

TREATMENT I DO **NOT** WANT
I do not want (put your initials by the services you do not want):
_____Cardiac resuscitation (start my heart pumping after it has stopped)
_____Mechanical respiration (machine breathing for me if my lungs have stopped)
_____Tube feeding (a tube in my nose or stomach that will feed me)
_____Antibiotics (drugs that kill germs)
_____Hydration (water and other fluids)
_____Other (indicate what it is here)

TREATMENT I **DO** WANT
I want (put your initial by the services you do want):
_____Medical services
_____Pain relief
_____All treatment to keep me alive as long as possible
_____Other (indicate what it is here)
_____

What I indicate here will happen unless I decide to change it or decide not to have a living will at all. I can change my living will anytime I wish. I just have to let my doctor know I want to change it or forgo a living will entirely.
Signature: _____
Date: _____
Address: _____

Statement of witness
I am not related to this person by blood or marriage. I know that I would not get any part of the person's estate when he or she dies. I am not a patient in the healthcare facility where this person is a patient. I am not a person who has a claim against any part of this person's estate when he or she dies. Furthermore, if I am an employee of a health facility in which this person is a patient, I am not involved in providing direct patient care to him or her. I am not directly involved in the financial affairs of the health facility.

Witness: _____
Date: _____
Address: _____

Durable Power of Attorney

You can name a durable power of attorney by filling out this form. You can use another form or use the one your doctor gives you. If you name a durable power of attorney, give it to your Summit Community Care network provider. If you need help to understand or complete this form, call Member Services at 844-405-4295 (TTY 711).

I, (*Name*) **_____, want**
_____
_____,
(*Name of person I want to carry out my wishes*) (*Person's address*)

to make treatment decisions for me if I cannot. This person can make decisions when I am in a coma, not mentally able to or so sick I just cannot tell anyone. If the person I named is not able to do this for me, then I name another person to do it for me. This person is
_____
_____.
(*Name of second person I want to carry out my wishes*) (*Second person's address*)

TREATMENT I DO **NOT** WANT
I do not want (put your initials by the services you do not want):
_____Cardiac resuscitation (start my heart pumping after it has stopped)
_____Mechanical respiration (machine breathing for me if my lungs have stopped)
_____Tube feeding (a tube in my nose or stomach that will feed me)
_____Antibiotics (drugs that kill germs)
_____Hydration (water and other fluids)
_____Other (indicate what it is here)
_____

TREATMENT I **DO** WANT
I want (put your initial by the services you do want):
_____Medical services
_____Pain relief
_____All treatment to keep me alive as long as possible
_____Other (indicate what it is here)

What I indicate here will happen unless I decide to change it or decide not to have a durable power of attorney at all. I can change my durable power of attorney anytime I wish. I just must let my doctor know if I want to change it or not have it at all.
Signature: _____
Date: _____

Address: _____

Statement of witness
I am not related to this person by blood or marriage. I know that I would not get any part of the person's estate when he or she dies. I am not a patient in the healthcare facility where this person is a patient. I am not a person who has a claim against any part of this person's estate when he or she dies. Furthermore, if I am an employee of a health facility in which this person is a patient, I am not involved in providing direct patient care to him or her. I am not directly involved in the financial affairs of the health facility.

Witness: _____ Date: _____
Address: _____

APPENDIX B – CLINICAL GUIDELINES

As part of its quality improvement process, Summit Community Care adopts Non preventive and preventive clinical practice guidelines for acute and chronic medical and behavioral health conditions that are scientific and evidenced-based. This is determined by scientific evidence, review of government research sources, review of clinical or technical literature, involvement of board-certified practitioners from appropriate specialties or professional standards. Recognized sources of the evidenced-based guidelines include national organizations such as the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH), professional medical-specialty organizations such as the American Academy of Pediatrics (AAP), American College of Obstetrics and Gynecologists (ACOG), American Academy of Family Practice (AAFP) and voluntary health organizations as the American Diabetes Association (ADA) and American Cancer Society (ACS). The American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), Texas Implementation of Medication Algorithm (TIMA) and Texas Medicaid Algorithm Project (TMAP) are currently more specific sources recognized for behavioral health guidelines. Other sources that may be referenced in developing or updating behavioral health guidelines include organizations such as the Substance and Mental Health Services Administration (SMHSA) and National Institute of Mental Health (NIMH). The guidelines are based on valid and reliable clinical evidence, a consensus of healthcare professionals in a particular field and the needs of the members. The guidelines are adopted and approved in consultation with network healthcare professionals. They are reviewed and updated periodically as appropriate, but at least every two years. Summit Community Care will disseminate the guidelines to all affected providers and, upon request, to members and potential members. The Summit Community Care decisions regarding condition care, case management, utilization management, member education, coverage of services and other areas included in the guidelines, will be consistent with Summit Community Care guidelines. Data is gathered and monitored using HEDIS, ad hoc medical records review and other sources to measure performance against the guidelines and improve the clinical care process.

For a copy of the guidelines, visit **https://www.summitcommunitycare.com/provider** to print them from the website, or you can contact Provider Services at **844-462-0022** to receive a copy.

APPENDIX C – INCIDENT REPORT

DHS QA Incident Report Form **Effective: 05/24/2023**

ARKANSAS PASSE Incident Report Form

Type of Report ☐ **Initial Written** **Date/Time:** _____
☐ **Follow-Up** **Date:** _____
☐ **Final** **Date:** _____

☐ **APC LLC** (DBA Summit) 1-844-462-0022 ArkansasQuality@anthem.com
☐ **Empower** 866-261-1286 Incident.Reporting@EmpowerArkansas.com
☐ **Arkansas Total Care** 866-282-6280 Incident@ArkansasTotalCare.com
☐ **CareSource PASSE** 833-230-2005 Incident.Reporting@CareSourcePASSE.com

Incident Date: _____ Incident Time: _____
Injured Person's Name: _____
Address: _____
Phone Number(s): _____
Date of Birth: _____ Age: _____
Gender: _____ Race: _____
Legal Status: _____ Medicaid#: _____ Member ID#: _____

Incident Type:
☐ Death; Suspected Cause? _____
☐ Suicidal Behaviors ☐ Rape
☐ Maltreatment/Abuse/Exploitation:
☐ Neglect ☐ Verbal ☐ Physical ☐ Sexual ☐ Other; _____
☐ Missing Client ☐ Injury ☐ Disturbance ☐ Property Destruction ☐ Theft ☐ Arrest
☐ Other; _____

Does Incident/Injury Require Medical Attention? ☐ Yes ☐ No
Physician/Hospital Name: _____
Address: _____
Phone Numbers: _____

Designation of Incident:
☐ Member to Member ☐ Member to Staff ☐ Self-inflected ☐ Member to Public ☐ Public to Member
☐ Other; _____

Roles (Relationship to Subject) and Names of Others Involved:

Role	Name	Address and Phone

(Continue, if needed, in the Additional Information as Needed section. on the next page.)

Notifications (Enter method, date and time when communicated as appropriate.)
☐ Adult Protective Services Hotline (1-800-482-8049): _____
☐ Child Abuse Hotline (1-800-482-5964): _____
☐ DHS PASSE Incident report line (501-910-7828 Fax 501-682-8380): _____
☐ DHS PASSE Ombudsman: _____
☐ Next of Kin: _____
☐ Responsible Party (if different from above): _____
☐ Law Enforcement: _____
☐ Other: _____

ARKANSAS PASSE Incident Report Form

Type of Report	☐ **Initial Written**	**Date of Incident:** _____
	☐ **Follow-Up**	**Time of Incident:** _____
	☐ **Final**	**Place of Incident:** _____

Clear, Concise Description of Incident:

Should/Could Incident Have Been Prevented/Anticipated? ☐ Yes ☐ No (If yes, please explain.):

Findings/Outcome/Disposition (When appropriate include corrective action or preventive plans for future.)

☐ Pending Investigation

☐ Investigated with Appropriate Action/Preventive Plan Attached

Additional Information as Needed:

Person Submitting Form: _____ Title: _____

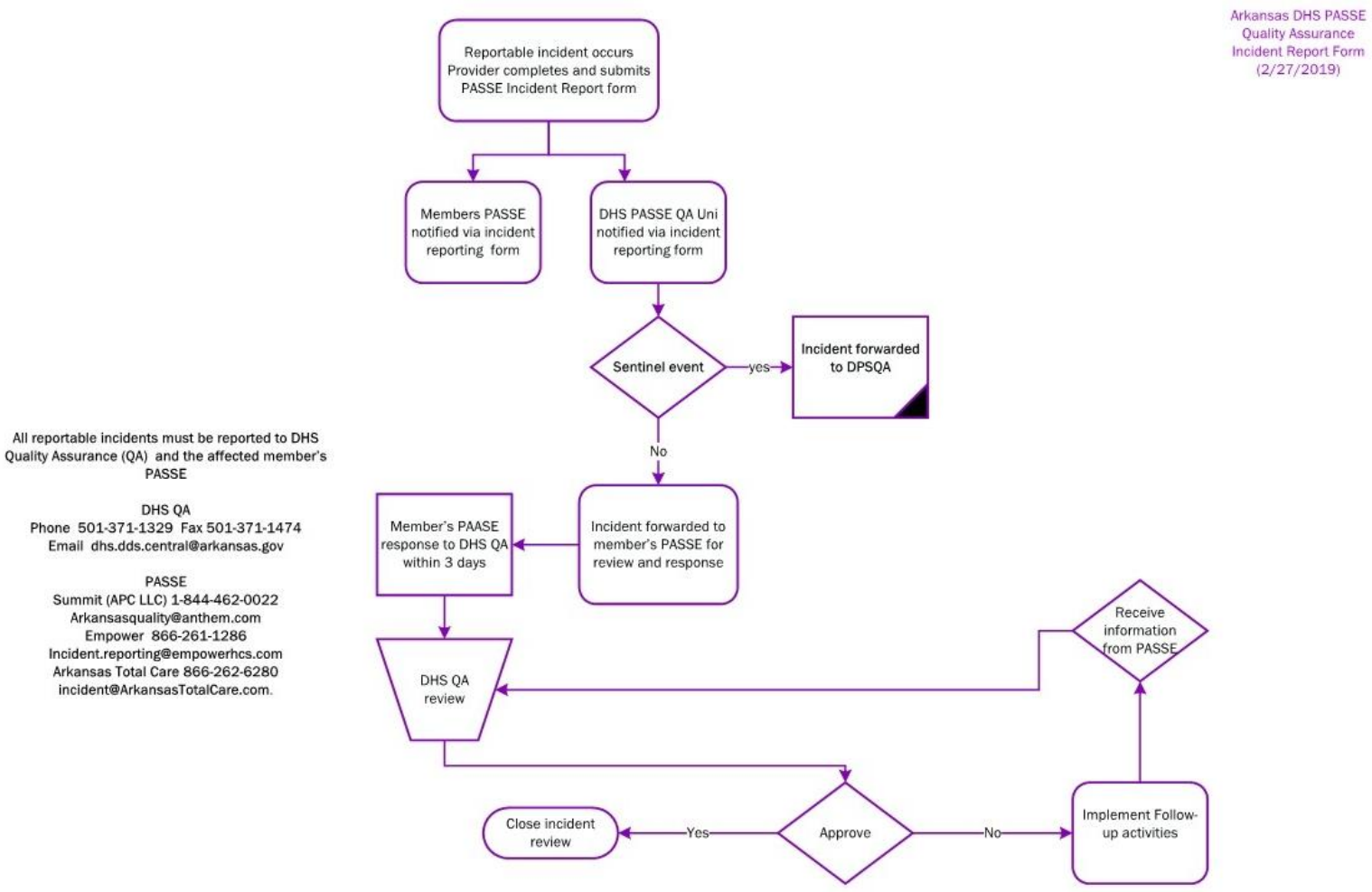
PASSE: _____ Phone Number: _____ Email: _____

HCBS Provider: _____ Contact: _____

Phone Number: _____ Email: _____

APPENDIX D – INCIDENT REPORT FLOW CHART

Division of Medical Services
Innovation and Delivery System Reform
P.O. Box 1437, Slot S401 · Little Rock, AR 72203-1437
501-682-8292 · Fax: 501-682-1197




Summit
COMMUNITY CARE