Long-term services and supports (LTSS)

Provider orientation 2025

What are long-term services and supports (LTSS)?

Long-term services and supports (LTSS) encompass a wide array of services delivered over a long period of time and are designed to meet the holistic needs of people of any age living with disabilities, chronic health conditions, and/or those who need assistance with daily activities in a home-based, community-based, or institutional setting of choice.

Minimum services provided through LTSS programs help people to maintain independence, quality of life, and dignity.

LTSS are available to people who meet certain medical, functional, and financial criteria determined by the state's eligibility guidelines.

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LTSS: settings, services/care providers

LTSS occurs in two settings:

- Home- and community-based services (HCBS) waiver:
  - Services provided in the member's home or community setting
- Long-term care facility:
  - Intermediate Care Facility for Intellectually Disabled (ICF/ID)

LTSS services include:

- Community and Employment Services (CES) waiver services.
- Personal care in a member's home or in a residential care facility (RCF).
- Home health and private duty nursing.
- Intermediate care facilities (ICFs).
- Adult developmental day treatment (ADDT).
- Early intervention day treatment (EIDT).

Some agencies may provide LTSS and non-LTSS type services. When this occurs, the agency will fall under the LTSS Provider Relations team.

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Community and Employment Services (CES) waiver

CES waiver services may be provided to any Medicaid beneficiary who:

- Is diagnosed with a developmental disability prior to the age of 22:
  - Developmental disabilities may include intellectual disability (IQ below 70), autism, cerebral palsy, epilepsy, Down syndrome, spina bifida
- Meets an institutional level of care
- Scores as a Tier II, III, or IV on the Optum independent assessment

The Division of Developmental Disabilities (DDS) will review the medical records to decide if the level of care meets the waiver requirements. DDS will review:

- Any diagnosis or condition a member may have, and whether it is expected to continue indefinitely.
- Whether a member meets the level of care requirements, showing substantial support is needed in at least three of the five areas of need: self-care, self-direction, understanding and use of language, learning, mobility, and independent living.

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Personal care services

Personal care services are based on the physical dependency need for hands-on services with the following activities:

- Bathing
- Feeding
- Transferring
- Cleaning
- Meal prep
- Dressing
- Toileting
- Walking
- Laundry
- Shopping
- Grooming/routine hair and skin care

Needs are based on a combination of the Optum Independent Assessment, member's Person-Centered Service Plan (PCSP), and the personal care assessment:

- Member's provider(s) will assist with filling in any gaps UM may have; may include the care coordinator, PCP

Personal care services are available to members who are not inpatient or admitted to a hospital, nursing facility, level II assisted living facility, ICF, or institution for mental disease.

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Personal care services (cont.)

Personal care services require prior authorization. Services may be approved up to six months at a time. Services will be approved up to the expiration date of the current personal care assessment.

Procedure code	Modifier	Description
T1019*		20 years and younger
T1019*	U3	21 years and older
T1020**	U1	RCF, less severe needs
T1020**	UA	RCF, more severe needs

*Calculated in 15-minute increments (for example, one hour = four units)
**Calculated per day (for example, one day = one unit)

A blank authorization form can be found at **Personal Care Authorization Form**.

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Home health services

- Typically short-term and include skilled nursing and physical therapy
- Skilled nursing services may require prior authorization and may use the following procedure codes and modifiers:
  - T1021 = nurse's aide
  - T1021 TD = RN
  - T1021 TE = LPN
- Note: Skilled nursing services (T1021 codes) do not require PA for a participating provider for the first 50 visits.
- In-network care providers requesting T1021 codes do not require prior authorization.
- Authorizations may span up to 60 days and correlate to the plan of care completed by the nurse
- Skilled nursing procedure code units are calculated per visit (for example, one visit = one unit)
- Physical therapy services always require prior authorization and may use the following procedure codes and modifiers:
  - S9131
  - S9131 UB
- Authorizations may span up to 60 days and correlate to the plan of care completed by the physical therapist.
- Physical therapy does not have an annual benefit limit.
- Physical therapy procedure code units are calculated per visit (for example, one visit = one unit)

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Private duty nursing services

- Private duty nursing services are nursing services available for members who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility.
- Services must be provided by a registered nurse or licensed practical nurse under the direction of the member's physician and may be provided in the following locations:
  - Member's home
  - Public school
  - DDS community provider facility
- Private duty nursing services are **not** covered in a hospital, nursing facility, residential care facility, or an assisted living facility.
- Private duty nursing services require prior authorization and may utilize the following procedure codes and modifiers:
  - S9123 (different procedure codes are related to supervisory visits)
  - S9124
- Authorizations may span up to 60 days.
- Private duty nursing does not have an annual benefit limit.

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Intermediate care facility (ICF)

- Settings where members reside together, where 24 hours of supervision and support are provided to ensure members' health and safety.
- Members are diagnosed with a developmental disability and meet an institutional level of care.
- ICFs may be available to children (under 22 years) or adults (over 18 years) in different settings.

- ICFs require prior authorization and the submission of supporting documentation.
  - **Initial:**
    - Member history, including behaviors, current living arrangements
    - Completed 703 form
    - Completed 704 form
    - Full-scale IQ assessment, adaptive behavior assessment
    - History of waiver services received (if applicable)
  - **Continued:**
    - Completed 703 form
    - Completed 704 form
- Authorizations may span up to 365 days and correlate to the member's PCSP dates.

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Adult developmental day treatment (ADDT)

- This is a program for adults who are diagnosed with intellectual or developmental disabilities, where habilitative, supervised living, pre-vocational, therapeutic, and educational services are provided.
- The member must have a prescription from a PCP to attend, and should be either at least 21 years old, or between 18 and 21 years with a high school diploma or certificate of completion.
- Habilitative services may include instruction in the following areas:
  - Cognition
  - Communication
  - Social/emotional
  - Motor
  - Adaptive skills
- Members may be eligible to receive the following services:
  - Speech/hearing therapy, evaluation(s) related to speech
  - Therapeutic exercises
  - Physical therapy, evaluation(s) related to physical therapy
  - Occupational therapy, evaluation(s) related to occupational therapy
  - RN, LPN, LVN services (up to 15 minutes)
- ADDT does not require prior authorization for habilitative services. However, a prior authorization is required for nursing services and therapy services provided in an ADDT setting.

Please refer to the Arkansas DHS website for the current fee schedule.

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Early intervention day treatment (EIDT)

EIDT is a program that offers evaluation as well as therapeutic, developmental, and preventive services to children with developmental disabilities or delays and is offered year-round for children from birth to 6 years and summer months for children 6 to 21 years.

- In order to receive services, a child must:
  - Be under the age of 22 years, have a qualifying diagnosis, and score accordingly on the comprehensive developmental evaluations.
  - Have a documented developmental disability or delay.
  - Have a documented need for at least one of the following:
    - Physical therapy
    - Occupational therapy
    - Speech therapy
    - Nursing services

Note: A PA is required for therapy and nursing services in the EIDT setting.

- Members may be eligible to receive the following services:
  - Speech therapy, evaluation(s) related to speech
  - Physical therapy, evaluation(s) related to physical therapy
  - Occupational therapy, evaluation(s) related to occupational therapy
  - RN, LPN services

Please refer to the Arkansas DHS website for the current fee schedule.
https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/

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Community support system provider (CSSP)

CSSP agencies are certified to provide home- and community-based services to Medicaid beneficiaries with behavioral health and intellectual and developmental disability service needs:

- They are certified to deliver both 1915(c) CES Waiver services and 1915(i) waiver behavioral health services.
- The goal is to improve access to services for Medicaid beneficiaries with complex care needs, including people with both intellectual and developmental disabilities and behavioral health conditions.

CSSPs are categorized into three levels of service, each associated with an increase in requirements.

Although CSSP agencies are certified to provide an array of HCBS services, not all agencies render the same services, and some may only render a single service.

For general questions regarding CSSP agency certification, please email CSSPQuestions@dhs.Arkansas.gov.

Interested in becoming a CSSP agency? Contact the Division of Provider Services and Quality Assurance (DPSQA).

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Home- and community-based services (HCBS)

What are HCBS services?

Home- and community-based services (HCBS) are:

- Federally approved services and/or programs available to individuals who qualify for Medicaid.
- Provided in the member's home or community setting.
- Administered by the state Medicaid agency:
  - Programs may vary from state to state

Home- and community-based waiver programs are available for members who meet certain criteria:

- Level of care
- Income and resource limitations
- Age, disability, and/or medical need
- Need for HCBS waiver services

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Available services

1915(c) waiver services:

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

1915(i) state plan services:

- Behavior assistance
- Adult rehabilitation 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

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Care coordination

Roles — care coordination

Care coordination roles as they relate to LTSS care providers:

- Provide information about member-specific support needs and preferences to facilitate effective referral matches.
- Engage care providers in the development and ongoing revisions of care plans.
- Keep care providers informed about the status of service plan outcomes and changes.
- Facilitate resolution when a member/care provider grievance occurs.

Service plans are the roadmap for how the member should be supported through service delivery. Care providers are critical participants in the interdisciplinary care teams, ensuring services are delivered in alignment with the service plan.

A Person-Centered Service Plan (PCSP):

- Is created by the person's care coordinator in conjunction with the individual, family, guardian, and any other circle-of-support person involved in the individual's life.
- Focuses on the person's needs and goals, as well as housing, medical, social, educational, and a variety of services provided through the PASSE program or other funding sources.
- Actively assists members in completing healthcare indices, ensuring comprehensive care and improved health outcomes.

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PCSP — key components

Key components of the PCSP:

It must be developed through a person-centered planning process, driven by the individual and including people chosen by the individual.

It provides the individual with necessary information and support and ensures that they direct the process to the maximum possible extent.

It is timely and occurs at times/locations of convenience to the individual.

It reflects cultural considerations and uses plain language.

It offers choices to the individual regarding the services and supports they receive and from whom.

It should be updated as needed.

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PCSP — key components (cont.)

It is conducted to reflect what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare:

It identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual.

It includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education, etc.

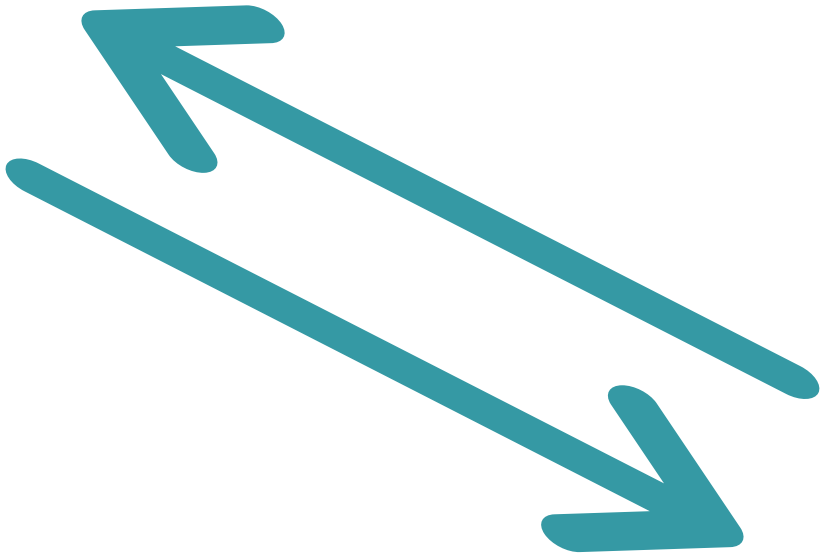
It includes risk factors and plans to minimize them.

The plan is signed by all individuals and providers responsible for its implementation.

A copy of the plan must be provided to the individual and/or guardian.

Ongoing development of the PCSP

- The PCSP is always evolving, just as the individual is evolving.
- Interests and goals may change as the person integrates into the community and is exposed to more options.
- The PCSP will also change as the person's service needs change.
- Care providers play an important role in the evolution of the PCSP.
- Collaboration and communication between the provider and care coordinator are key to ensuring that services and supports reflect the current needs, goals, and interests of the person supported.
- As care providers identify natural supports and/or if services fade, the PCSP will need to be updated to reflect the person's current situation.
- Changes to a person's health must also be reflected in the PCSP.



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Person-centered practices

Person-centered

Person-centered language:

- Recognizes the impact of language on thoughts and actions.
- Ensures language does not diminish the uniqueness and intrinsic value of each individual and allows a full range of thoughts, feelings, and experiences to be communicated.
- Emphasizes cultural preferences and communication style when training direct support professionals on the individuals they will support.

Person-centered planning:

- A process whereby the needs and preferences of the person receiving services are described by that person (in collaboration with family, friends, and other circle-of-support individuals) to develop a support plan that ensures they receive the covered services needed in the manner preferred.
- Planning is conducted to reflect what is important **to** the individual while balancing what is important **for** the individual, so delivery of services is provided in a manner reflecting personal preferences and ensuring health and welfare.

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Purpose of person-centeredness

The purpose of person-centered planning is:

- To emphasize the strengths of the individual.
- To assist a person in gaining control over the life of their choosing.
- To increase opportunities for participation in the community in order to achieve a full community life.
- To recognize individual desires, interests, and goals.
- To develop a plan that turns their plans into reality – the ultimate goal through team effort.

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Successful planning

Successful person-centered planning:

- Has a clear and shared appreciation of the skills, strengths, and capabilities of the person supported.
- Meets regularly with the person and their key supports to review methods used or to brainstorm different approaches.
- Makes meaningful connections to the local community.
- Uses the provided person-centered planning tools and creates an individualized path to success.
- Supports the person and their key supports to continue to be motivated to keep moving forward on their journey:
  - Once initial goals are met, make new ones that support what is important to and for the person.
- Is an open process that continues throughout the person's lifetime; it is not a product.

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Provider’s role and responsibilities

Care provider compliance

Core set of policies and procedures based on the services enrolled to provide:

- Compliance with state and federal laws for:
  - Intake
  - Admission
  - Service coordination
  - Discharge
  - Referral
- Compliance with laws and regulations.
- Guidance and training of employees:
  - Identifying processes to ensure services are provided by qualified individuals
  - Completion of child abuse, dependent adult abuse, and criminal background checks pursuant to Arkansas code
  - Screening potential employees and entities for federal program exclusion status

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The care provider's role

When accepting referrals for services, the care provider must review the documentation provided in the referral and determine capacity to meet the person's specific needs.

The care provider must:

- Ensure qualified and trained staff are available and properly matched with the individual needing supports.
- Assess capacity to meet the person's transportation needs (if applicable).
- Review cultural preferences and communication needs.
- Participate in meet-and-greets with the person.
- Attest to and return the PCSP after receiving it to acknowledge they are ready to begin services.
- Accept and begin services in a timely manner.
- Ensure direct support professionals are trained on the PCSP.

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LTSS care provider responsibilities

- Provide all HCBS services in integrated settings.
- Participate in the member's annual person-centered service plan (PCSP) meeting annually, or as needed if the member's needs change.
- Follow all federal rules and regulations as applicable.
- Provide regular updates related to the care of service delivered.
- Participate in discharge planning and promptly provide any requested documentation to the health plan as needed..
- Use the Electronic Visit Verification (EVV) system as required for personal care services and home health services.
- Verify the member is eligible for HCBS services prior to service provision.
- Maintain all licenses, certifications, permits, accreditations, or prerequisites required by Summit Community Care and federal, state, and local laws for providing services.
- Be enrolled and an approved care provider in good standing with the Arkansas Health and Human Services.
- Document service provision as required by state and federal rules.

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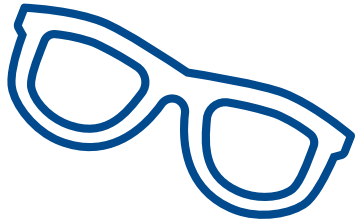
Interdisciplinary team — provider role

Provider expectations as interdisciplinary care team participants:



- Participate in the service planning and revisions.
- Deliver all services using a person-centered approach.
- Ensure all service delivery complies with the HCBS Settings Rule.
- Support each member to achieve their desired outcomes through service delivery as outlined in the service plans and submit status updates according to the agreed upon schedule.
- Notify the care coordinator immediately with any significant change, barrier to progress, social drivers of health (SDOH) needs, or any news that could impact the individual's service outcomes or health and safety.

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Roles and responsibilities for all care providers

Primary care providers must provide preventative health screenings.
Care providers must not discriminate against members with mental, developmental, and physical disabilities and must comply with ADA standards.
Care providers must notify Summit Community Care of any changes such as billing address and name.
Care providers must understand and educate members about advanced directives.
Care providers must comply with HIPAA requirements and recordkeeping standards.
Care providers must recommend preventative care services to all members.
Care providers must identify behavioral health needs.
Care providers must document and bill accurately to avoid fraud, waste, and abuse.
Care providers must provide wheelchair accessibility.
Care providers must have appointment availability and after-hours access.

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Cultural competency

Summit Community Care is dedicated to providing quality, effective, and compassionate care to all members.

We value whole health, a person-centered approach that integrates physical, social, pharmacy, and behavioral health needs to proactively address the wide-ranging factors that contribute to equitable health outcomes.

- Summit Community Care offers translation and interpreter services, cultural competency tips and training, and guides and resources on the Culturally and Linguistically Appropriate Services (CLAS) Standards.
- Cultural competency and member engagement are training resources that increase cultural and disability competency and help effectively support the health and healthcare needs of your diverse members.
- **Caring for Diverse Populations Toolkit** is a resource to help care providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse members.

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HCBS Settings Rule

HCBS Settings Rule requirements: HCBS Settings Rule 42 CFR 441.301

The rule supports enhanced quality in HCBS programs and adds protections for people receiving services. The final rule addresses several sections of Medicaid law under which states may use federal Medicaid funds to pay for HCBS. In addition, this rule reflects CMS' intent to ensure individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and can receive services in the most integrated setting.

The rule ensures people receive HCBS in settings fully integrated in the community, supporting full access to the community at large. This includes:

- Opportunities to seek employment and work in competitive and integrated settings.
- Engage in community life.
- Control personal resources.
- Receiving services in the community to the same degree as those individuals who do not receive HCBS.

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HCBS Settings Rule requirements

At a minimum, recredentialing/recertification of providers includes:

- Verification of continued licensure and/or certification (as applicable).
- Compliance with policies and procedures identified during credentialing/certification such as:
  - Background checks and training requirements.
  - Reportable event management.
  - Use of the EVV system.
- Monitoring compliance with the Settings Rule.
- Annual HCBS visits that include evaluating the physical location, policies, procedures, and other written documentation, employee training, and employee files (as appropriate).

This applies to:

- Residential and non-residential settings, including certified and licensed homes.
- Day programs and other day-type services.
- Employment options and work programs.

The HCBS Settings Rule, along with additional guidance and fact sheet is available on the CMS Home and Community-Based Services website.

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LTSS Provider Relations team

LTSS Provider Relations

We are here to support you.

The cornerstone of Summit Community Care's provider promise is to empower providers through education and training to serve members' needs by delivering a superior provider network experience.

We offer:

- A dedicated local team with diverse backgrounds to provide well-rounded care provider support.
- A focus on the Summit Community Care and provider relationship and provider development opportunities, identifying areas of expansion and supporting provider growth.
- Key positions to ensure on-demand expertise on the issues most important to LTSS care providers.

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Provider Relations team

Provider Relations representative	Provider education specialist	Workforce development manager
Provides one-on-one technical assistance and LTSS subject matter experts.	Ensures providers receive comprehensive training and education on key requirements.	Develops and maintains workforce development plan through provider collaboration.
Assists providers with claims-related inquiries.	Engages with other managed care entities to align on training and processes to reduce provider effort.	Serves as a liaison with MCE and providers to implement statewide workforce development initiatives and activities.
Provides onboarding training through site visits, tools, and resources.	Provides on-going training opportunities to ensure providers have up-to-date and accurate information.	Assists providers with online training opportunities through Elsevier.

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LTSS Provider Relations team

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LTSS workforce development

What is workforce development?

A diverse, stable, and well-trained workforce is crucial to providing quality person-centered services and supports.

Investment in direct service workers (DSWs) is essential to serving more members in their homes and communities.

DSWs include the following:

- Certified nursing assistants (CNAs)
- Home health aides
- Direct support professionals (DSPs)
- Personal care aides
- Other non-licensed personnel

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LTSS workforce development

The LTSS Provider Relations team offers workforce development support, ensuring a qualified, competent, and sufficient workforce is established to consistently deliver needed services in a timely manner:

- Summit Community Care is fully dedicated to collaborating with providers to assess their workforce, build capacity, recognize expansion opportunities, offer technical assistance, training, and innovative tools that care providers may leverage to increase provider capacity to support network adequacy.
- Helping providers succeed:
  - Capacity building expansion opportunities
  - Technical assistance
  - Staff recruitment, retention, and development
  - Enhancement of a network that will successfully deliver services in a timely manner

Workforce challenges and WFD expectations

Workforce challenges:

- Low wages
- Feeling unappreciated
- Feeling unprepared and unsupported
- Lack of opportunities for career advancement
- Lack of professional development/training
- Intense demands of the job

Summit Community Care WFD expectations

Workforce initiatives

Summit Community Care	Online training through Elsevier that provides training pathways for frontline supervisors.
Value-based incentives	Performance-based payment strategies that tie payment for care delivery to the quality of care provided. These programs reward providers who prioritize workforce development strategies and HCBS Settings Rule compliance.
On-going support	Monthly provider workforce conversations to discuss challenges, provide resources, strategies, and best practices in the WFD space. Collaboration with providers and DSPs to complete employee surveys to better assist in determining barriers and needs of employees.

Incident reporting

Incident reporting

Reportable incidents:

- Death of a member
- Use of any restrictive intervention, including seclusion or physical, chemical, or mechanical restraint
- Suspected maltreatment or abuse
- Any injury that:
  - Requires the attention of an emergency medical technician, paramedic, or physician
  - May cause death
  - May result in a substantial permanent impairment
  - Requires hospitalization
- Threatened or attempted suicide
- Arrest or commission of any crime
- Any situation in which the whereabouts of the member is unknown for more than two hours (such as elopement or wandering), or where services are interrupted for more than two hours
- Any event where staff threaten, abuse, or neglect a member
- Unexpected occurrences involving actual or risk of death or serious physical or psychological injury

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Incident reporting (cont.)

- Medication errors made by staff that cause or have the potential to cause serious injury or illness to the member; may include loss of medication, unavailability of medication, falsification of medication logs, theft of medication, missed dose, wrong dose, administration of dose at wrong time by the wrong route, administration of the wrong medication
- Any violation of a member's rights that jeopardizes the health, safety, or quality of life
- Any incident involving property destruction
- Vehicular accidents
- Biohazard incidents
- An arrest or conviction of staff providing direct care services
- Any use or possession of non-prescribed medication or an illicit substance
- Any other event that might have resulted in harm or could have reasonably endangered the health, safety, or welfare of the member

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Time frames — incident reporting

Immediate reporting

Care 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 Summit Community Care (**844-462-0022**):

- Death not related to the natural course of the individual's illness
- Serious physical or psychological injury

When a member elopes from service and cannot be located, care providers must report the incident to arkansasquality@anthem.com within two hours of occurrence:

Regular reporting

All other reportable incidents (not listed above) 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 48 hours after the date of the incident. Any incident that occurs on a Friday is still considered timely if reported by the following Monday.

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Contents — incident reporting

- Date of the incident
- Detailed description of the accident/injury
- Time of the incident
- Location of the incident
- Person(s) involved in the incident
- Name of the person who prepared the report
- Other agencies contacted regarding the incident and the name of the individual at the agency who was contacted
- Whether guardian was notified and time of notification
- Whether police were involved, and if so, detailed description of their involvement
- Action taken by the provider, both at the time of the incident and after the incident
- Any expected follow-up

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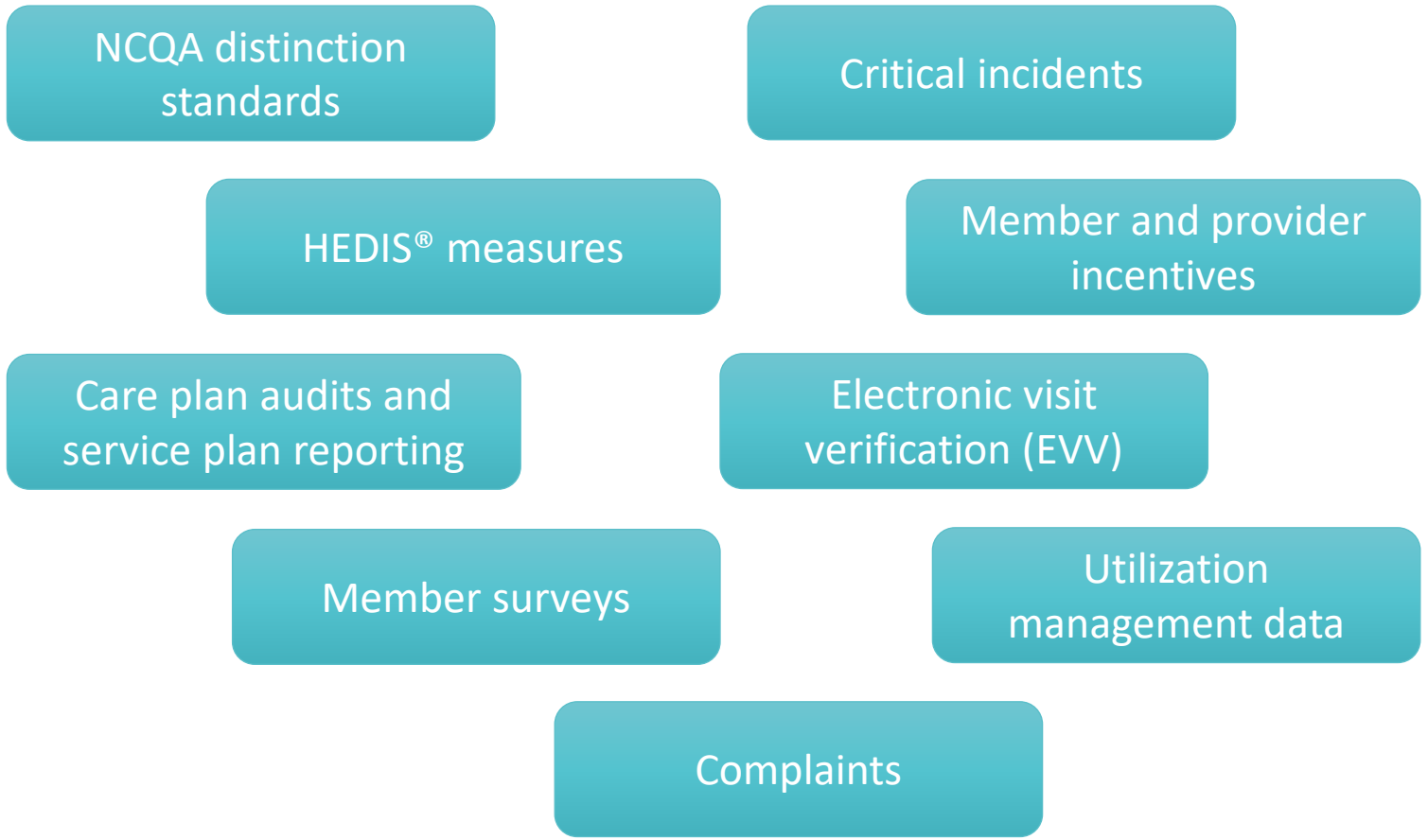
Quality in LTSS service provision

LTSS quality management

There are multiple elements used to measure, monitor, and improve the quality of LTSS service provision, such as, but not limited to:



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LTSS quality service provision (cont.)

What are some ways care providers can contribute to quality service provision?

- Person-centered services and supports: Communicate clearly and timely with care and service coordinators, support the development of the service plan, and deliver services that are person-centered, participant-driven, holistic, and involve caregivers. Look for opportunities to identify and address SDOH needs, communicating any needs to the care coordinator.
- Ensuring smooth transitions: Be proactive in planning for transitions to ensure continuity of care and seamless experiences for participants. Communicate clearly and often with the member, family, and care coordinators and share and mitigate concerns.
- Access to services (member choice): Engage members in selecting staff that meet their preferences and enable participants to live in their setting of choice and promote their well-being and quality of life.

Addressing social drivers of health (SDOH)

LTSS care providers are often the first to encounter a member's SDOH needs because they are visiting the member in their home to provide support and may identify, without the member voicing a problem, that a concern exists. Care providers may notice challenges almost immediately upon entering a member's home, such as:

- Issues with cleanliness or disrepair to the home.
- Physical barriers for the person to navigate their home environment (may cause falls and other risks).
- Lack of transportation.
- Lack of basic resources such as food, water, electricity, or clothing.
- Safety issues, both interior and exterior, including exposure to crime.

Care providers can support addressing SDOH by developing community partnerships and linking members to resources, communicating SDOH needs to the member's care coordinator, and training direct support professionals on how to identify and respond when issues are discovered. Timely identification of needs and closed-loop referrals are key to ensuring the member is connected to the appropriate resources.

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Provider feedback and Provider Relations assistance

Summit Community Care is committed to ensuring members are receiving quality services and our contracted care providers are successful. Our Provider Relations team will work directly with care providers through technical assistance and training to help care providers improve the quality of services delivered:

- Support care providers to understand reports that include feedback around quality, supporting care providers to build capabilities to improve and meet performance targets.
- Provide training to help care providers understand and assess SDOH and how to connect members with social services care providers to address member and informal caregiver SDOH needs.
- Provide training and technical assistance to help engagement with VBP programs.
- Target training around specific quality improvement initiatives and input from care providers.
- Support workforce development efforts in coordination with the state.

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Member management tools for providers

Availity Essentials

- Availity Essentials offers secure access to manage daily transactions with payers.
- Availity Essentials does not require special software, and is accessible with high-speed internet, using Google Chrome/Microsoft Edge/Firefox browsers.
- Availity Essentials features:
  - **Electronic transactions:** Provide a secure platform where care providers can perform eligibility and benefit inquiries, check claim status, and track remittance.
  - **Multi-payer website:** Ensure a consistent workflow for all participating health plans, allowing care providers the same experience.
  - Through this multi-payer portal, care providers can access Summit Community Care's **Care Central** application, a one-stop shop for LTSS care providers.
- Availity Essentials can be found at **https://Availity.com**.
- Availity Essentials can be contacted directly at **800-AVAILITY (800-282-4548)**.

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Availity Essentials — getting started

- To initiate registration, navigate to **Availity Essentials Registration** at the top right-hand corner of the screen, select **New to Availity? Get Started.**
- Care providers must first register with Availity Essentials, specific to the option that best describes the situation:
  - **Healthcare provider** – care providers who are part of a physician's practice, mental health provider, or a non-physician provider. These providers typically have a National Provider Identifier (NPI) and are also known as medical providers.
  - **Caregiver or atypical care provider** – This category would include Summit Community Care's LTSS providers and are often referred to as *atypical* or *non-medical* providers.
- **Need help?** Join Availity Essentials for a live webinar or explore options on the **training site**.

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Availity Essentials — what's needed?

What's needed to get started?

- All organization types – only the person who will be designated as the administrator needs to register. The following information is needed:
  - Physical and billing addresses
  - Tax ID (EIN or SSN)
  - NPI (if applicable)
  - Primary specialty/taxonomy

Atypical care providers

Some provider types are not required to have an NPI. If you are **registered with Arkansas Medicaid as** an atypical care provider **without an NPI**, in the **Organization Setup** step, look for this verbiage and the associated button: **This organization does not have an NPI. It is an atypical provider and does not provide healthcare, as defined in 45 Code of *Federal Regulations (CFR) Section 160.103.*** ***Registration in Availity must match your registration with Arkansas Medicaid.***

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Availity Essentials — next steps

Once the Availity registration form is complete and sent, the submitter will receive an application ID used for tracking the status of the registration:

- Keep this ID in a safe place if you need to follow up on the status of your registration.
- Visit the **Manage My Organization** page to check the status of the registration:
  - Approved – You are ready to submit transactions on Availity Essentials
  - Pending – You are not quite ready to submit transactions. Be sure to stay updated on your application by visiting the Manage My Organization page and follow up on any actions needed.
  - Rejected – Be sure to review the Organization Activity section to review the notes on why the application was rejected and next steps. Registrations may get rejected when the organization with duplicate information already exists on Availity Essentials.

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Availity Essentials — administrators

Once the organization’s administrator has registered and verified their identity, the administrator can:

- Add users — Add users one at a time, use a spreadsheet to upload multiple users at once, and copy a user from one organization to another.
- Explore roles and permissions — Assign roles to users in the organization based on each user’s job function.
- Assign a backup administrator — This person will be able to help manage users and roles.
- Enroll for additional features.
- Add additional tax IDs — include the business details, as applicable.

Once you've registered and are ready to get started, Availity’s Reference Guide for Users and Reference Guide for Administrators are available through the Availity Notification Center.

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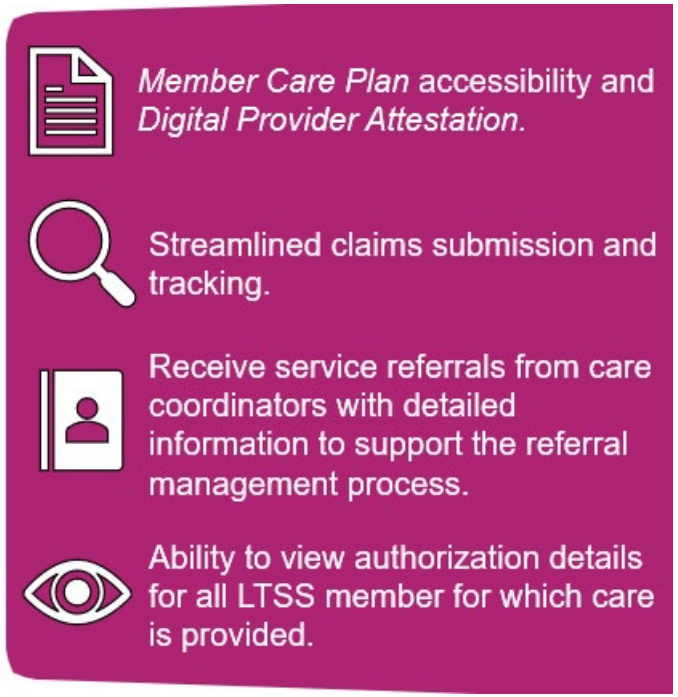
Care Central

Accessible through Availity Essentials **Payer Spaces**, Care Central is a one-stop shop for LTSS/atypical care providers, with tailored billing, referral, and multiple dashboards to support member management, which:

- Enables a simplified, seamless, and tailored online experience, reducing administrative burden.
- Reduces errors, manual processes, and obsolete technology.
- Empowers the care provider with quick access to information necessary to initiate and maintain member care.
- Provides a clear line of sight into critical data and reporting.



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Care Central — authorization dashboard features

Authorization Dashboard: This dashboard showcases all a care provider's authorizations for the past 365 days, with the ability to view real-time authorization details for all LTSS members for which care is provided:

- Ability to sort, filter, and search authorizations by the authorization number, member name, member ID, authorization start and end date, and authorization status.
- Ability to view authorization details for a selected authorization, including:
  - Member details (member name, member ID, date of birth).
  - Authorization details (diagnosis code, request date and type, service, and plan).
  - Service details (procedure code, modifiers, description, units, start and end dates).
- Authorizations will stay on the care provider's authorization dashboard for one year after expiration.
- Ability to export Authorization Dashboard views to Excel.

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Care Central — claims dashboard features

Claims dashboard: Streamlined claims submission and tracking, reducing administrative burden and billing errors:

- Create and submit claims — allows for submission of claims for one or members (with the same service).
- Allows for the upload of supporting documentation for a claim.
- Can save claims settings for streamlining.
- Can review claims and make changes prior to submission.
- Confirmation of submission.
- The ability to sort, filter, and search by member and claims information.
- The ability for the care provider to see the dollar amount of claims that have been billed.
- Allows care providers to see fee schedule/contracted rates.

- View Claims Dashboard with claims status reasons:
  - **Submitted:** The claim is submitted, awaiting claim number
  - **Pending:** The claim is pending review, may take up to 30 days
  - **Finalized:** The claim has been paid
  - **Denied:** This claim has been denied

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Electronic visit verification (EVV)

EVV is the use of technology to record the time and location of paid caregivers during a scheduled visit check-in and check-out. This method of verification has been proven to be an accurate account of the provider's time while minimizing or eliminating inappropriate claims.

EVV information collected during visits includes:

- Date of service provided.
- Start time and end time of service provided.
- Type of healthcare service performed.
- Location of the service provided.
- Information about the service provider.

EVV is required for care providers who deliver care to Medicaid members in HCBS settings through the 21st Century Cures Act.

Personal care services implemented EVV on December 1, 2022, and home health providers are scheduled to be implemented in March 2025.

Summit Community Care works with CareBridge for EVV. For more information, visit **www.carebridgehealth.com** or **http://resourcelibrary.carebridgehealth.com/arevv**.

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Billing and reimbursement

Reimbursement requirements

An authorization does not guarantee payment. Reimbursement requires the following:

- The member must be eligible for the service at the time services were provided.
- Appropriate services must be authorized.
- Claim must be submitted with the correct code and modifier combination, if applicable.
- Claim must be submitted with the care provider's NPI or atypical provider ID number.
- Claims may be submitted electronically or on paper.
- Dates of service on a claim form cannot span multiple months:
  - A new claim form must be used for services provided in a different calendar month.

Care providers must accept reimbursement based on established rate methodology:

- Care providers ~~may not request additional payment from the~~ **bill or collect any cost share amounts from an Arkansas Medicaid** member (known as balance billing).

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Claims submissions

Claims can be submitted via Availity Essentials, the Care Central application, or a clearinghouse.

Availity Essentials:

- Offers secure access to manage daily transactions with payers.
- Does not require special software.
- Eligibility can be verified; claims can be submitted, and claims status can be checked.

Care Central:

- Accessible through Availity's **Payer Spaces**, an application designed specifically for LTSS care providers
- Reduces the fields within an LTSS claim to only those required for the type of service being provided
- Real-time visibility into claim status

Clearinghouse:

- An institution that electronically transmits different types of medical claims data on behalf of a care provider.
- Typically includes fees charged to the care provider for the submissions.

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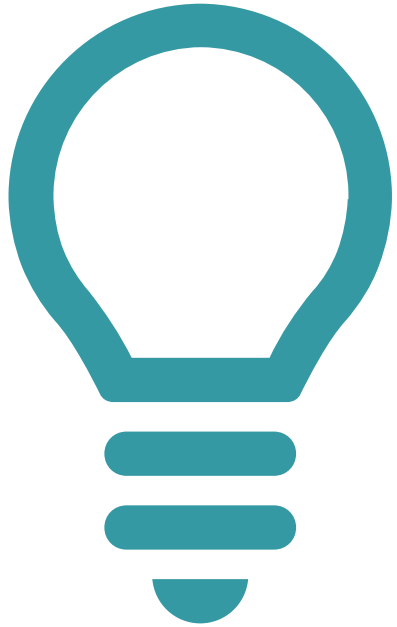
Billing and reimbursement — tips

Summit Community Care accepts electronic and paper claim submissions, although we do encourage care providers to submit electronic claims:

- Clean electronic claims will be processed within seven business days of receipt.
- Paper claims will be processed within 30 calendar days of receipt.

Timely filing is within 365 days from the date of service, and corrected claims must be filed within 180 days of the date of the remittance notice.

Care providers should verify a member's eligibility prior to submitting a claim. Care providers can view real-time eligibility information and details through Care Central via Availity Essentials, including eligibility dates, ID numbers, member demographics, and other important information.



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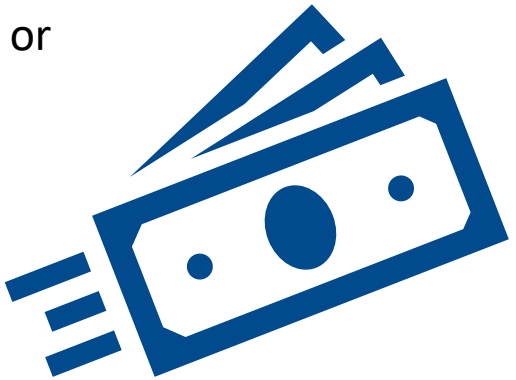
Electronic payment services

If you sign up for electronic remittance advice (ERA) or electronic funds transfer (EFT), you can:

- Start receiving ERAs and import information directly into your patient management or patient accounting system.
- Route EFTs to the bank account of your choice.
- Create custom reports within your office.
- Access reports 24 hours per day, seven days per week.



EFT enrollments are through EnrollSafe:

- EnrollSafe at **enrollsafe.payeehub.org**.
- EnrollSafe is the only option for care providers to enroll or make changes for EFT payment.

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Enrollment for EFTs

Enrollment for EFTs is facilitated through EnrollSafe. You can start the process online by visiting **https://enrollsafe.payeehub.org/**.

For your reference, please review the link to a flyer that provides some general information about EFT enrollment: **EFT Enrollment Flyer**.

Please take note of the following:

- You will need to have an Availity Essentials account set up. If you don't have one already, you can register for free **here**.
- During the EFT enrollment process, several outreach efforts are conducted to verify the taxpayer identification number (TIN) and banking details. For a successful and smooth setup, it is important to provide a contact number where you can be reached reliably. Calls from unfamiliar numbers often go unanswered, but responding to these calls is key to completing your EFT setup.

If you have any more questions or need additional assistance regarding the enrollment process, feel free to contact the EnrollSafe Support Team at **877-882-0384**.

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Submitting your first claim

Whatever method is chosen for claims submission, your Summit Community Care LTSS Provider Relations representative will provide the following support to you when submitting your first claim:

- Confirm registration with Availity Essentials/Care Central and ensure you are properly set up across Summit Community Care systems, including registered through EnrollSafe for reimbursement.
- Provide step-by-step instructions through your first claim submission.
- Review the dashboard within Care Central to check claim status for successful submission.

Rejected claim:

- Does not enter the adjudication system due to missing or incorrect information
- Will not have an Explanation of Payment (EOP)
- Will result in a letter or a rejection report (if the claim was submitted electronically), which the provider will receive
- Must be resubmitted as an original claim once the identified issue is corrected.

Denied claim:

- Goes through the adjudication process but is denied for payment.
- An EOP will be sent and will include the reason for the denial.

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Claim status inquiries

Claim status is available through Availity Essentials or by calling Provider Services.

Availity Essentials:

- Submit a 276-277 EDI transaction using the payer ID PASSE:
  - Tip: If a claim status transaction is not submitted with the payer ID PASSE, the claim will not be found. Providers will need to correct the payer ID and resubmit the transaction.
- Perform a claim status inquiry by selecting *Claim Status Inquiry* and selecting Summit Community Care as the payer from the drop-down menu:
  - Tip: Start from an eligibility and benefits response (member card), select **Claims**, then select **Claim Status Inquiry** (or **Claims and Payments***).*
- For questions related to Availity Essentials, call **800-AVAILITY (800-282-4548)**.

Provider Services:

- Call **844-462-0022** Monday to Friday, 8 a.m. to 5 p.m. CT

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Claim payment disputes

A claim payment dispute may be submitted for multiple reasons, including:

- Disagreements over reduced or zero-paid claims.
- Post-service authorization issues.
- Other health insurance denial issues.
- Contractual payment issues.
- Timely filing issues.

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

- **Reconsideration** (within 90 days of EOP): This is the first step in the provider payment dispute process. The reconsideration represents the initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
- **Appeal** (reply within 30 days): 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.
- **State fair hearing**: Arkansas Medicaid supports an external review process if you have exhausted both previous steps in the payment dispute process and still disagree with the outcome.

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

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Filing a claim payment dispute

Verbally:

- Reconsiderations only
- Call Provider Services at **844-462-0022**.

Online:

- Reconsiderations and claim payment appeals
- Availity Essentials, payment appeal tool — will need to include supporting documentation

Written:

- Reconsiderations and claim payment appeals
- Mail required documents, 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

Required documentation includes:

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

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Member grievances and appeals

Summit Community Care encourages members, or a guardian or provider on a member's behalf, to seek resolution of member issues through our grievances and appeals process. These issues may involve dissatisfaction or concern about another provider or the plan.

Grievance:

- A grievance 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.
- **Note:** A member's or provider's disagreement with an adverse benefit determination is considered an appeal.

Appeals:

- Medical appeals — An appeal is the procedure by which a member or authorized representative/appellant may challenge an adverse benefit determination by requesting that Summit Community Care review the adverse benefit determination.

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Member grievances and appeals (cont.)

Member grievances and appeals are classified as follows:

- Grievances related to the operation of the plan, including benefit interpretation, claim processing, and reimbursement
- Care provider appeals related to adverse determinations

Member grievances and appeals can include, but are not limited to, the following:

- Access to healthcare services
- Care and treatment by a care provider
- Issues with how Summit Community Care conducts business

Members or care providers should refer to the denial letter issued to determine the correct appeals process:

- Via telephone: **844-405-4295 (TTY 711)**
- Via fax: **501-372-1871**

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Member grievances and appeals (cont.)

Written:

- Must include:
  - Who is part of the grievance?
  - What happened?
  - When did the incident happen?
  - Where did the incident happen?
  - Why is the member unhappy with the healthcare services received?
- Mail to:

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

Please refer to the provider manual for more details on member grievances and appeals.

Provider resources and information

Resource/topic	Description	Website/phone number
Arkansas Department of Human Services	Home page for programs and services available to Arkansas residents, includes agencies, elected officials, news, county offices	http://www.humanservices.arkansas.gov/
Summit Community Care Provider Manual	Details Summit Community Care provider regulations and standards.	https://provider.summitcommunitycare.com/arkansas-provider/manuals-and-guides
Summit Community Care Website	Home page for Summit Community Care — choose provider access at top of the page for more information on claims, patient care, eligibility & pharmacy, communications, and our network	https://provider.summitcommunitycare.com/arkansas-provider/home
Email address for providers to directly submit questions to provider relations		ARProviderQuestions@SummitCommunityCare.com
Provider Services	Connect with a provider services representative to assist with common questions and concerns	**844-462-0022**
CareBridge Training Guide	CareBridge Provider Portal, Electronic Visit Verification (EVV)	http://www.carebridgehealth.com/
24/7 Nurse Line	Talk with a registered nurse when you have health questions or need medical advice	**844-405-4295 (TTY 711)**

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Member rights and responsibilities

Member rights and responsibilities

These rights include:

- The right to receive information, which relates to the managed care program and plan in which the member is enrolled.
- The right to be treated with respect and with due consideration for the member's dignity and privacy.
- The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- The right to participate in decisions regarding the member's healthcare, including the right to refuse treatment.
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
- The right to request and receive a copy of the member's medical records, and request they be amended or corrected, as specified in the HIPAA Privacy Rule, which addresses security and privacy of individually identifiable health information.

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Member rights and responsibilities (cont.)

- The right to be furnished healthcare services that are related to service availability, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.
- The right to review their care plan.
- For those members who are receiving home- and community-based long-term services and supports:
  - The right to have and review their PCSP.
  - The right to request a fair hearing when an individual is:
    - Not given the choices of HCBS waiver services as an alternative to an institutional level of care.
    - Denied the services of their choice or the care provider of their choice.
    - Denied, suspended, reduced, or terminated from services.

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Questions?

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https://provider.summitcommunitycare.com