Long-term Service and Supports provider updates and training

LTSS overview

LTSS encompasses a wide array of on-going services delivered over a long period of time, both *paid and unpaid,* and are designed to meet the holistic needs of individuals of any age living with disabilities, chronic health conditions, and/or those who need help with daily activities in a home-, community-based, or institutional setting of choice. Minimum services provided through LTSS programs help people to maintain independence, quality of life, and dignity:

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

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Agenda

- Long-term services and supports networks team and program model
- Provider updates
- Home- and Community-based settings rule
- LTSS provider enrollment
- Member management tools for providers
- Billing and reimbursement
- LTSS Value-based program (VBP)
- Workforce development
- Cultural competency
- Provider resources

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Who are LTSS providers?

LTSS providers include:

- CES waiver providers.
- Personal care providers and residential care facilities.
- Home health and private duty nursing providers.
- Intermediate care facilities (ICFs).
- Adult developmental day treatment (ADDT).
- Early intervention day treatment (EIDT).
- Some agencies may provide LTSS and non-LTSS type services. Those agencies fall under the LTSS provider relations team.

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LTSS provides value to providers and members

Value to providers:

- Training and support on billing and other processes, ensuring timely and accurate claims processing.
- Through incentive payments to the agency, value-based payment models support providers in driving improved health outcomes, improve efficacy, and enhance member safety and service performance.
- Training delivered and designed to support providers in meeting evolving HCBS expectations.

Value to members and families:

- Innovative network capabilities that improve access to care and increase awareness of quality and choice of providers.
- Meaningful participation in the community through integrated competitive employment and civic engagement.
- Supports for independence and exercise of self-direction that promotes self-determination and member self-actualization.
- Family and caregiver supports that strengthen the natural role of family and other member relationships to augment feelings of value and belonging leading to emotional well-being

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LTSS Network Team

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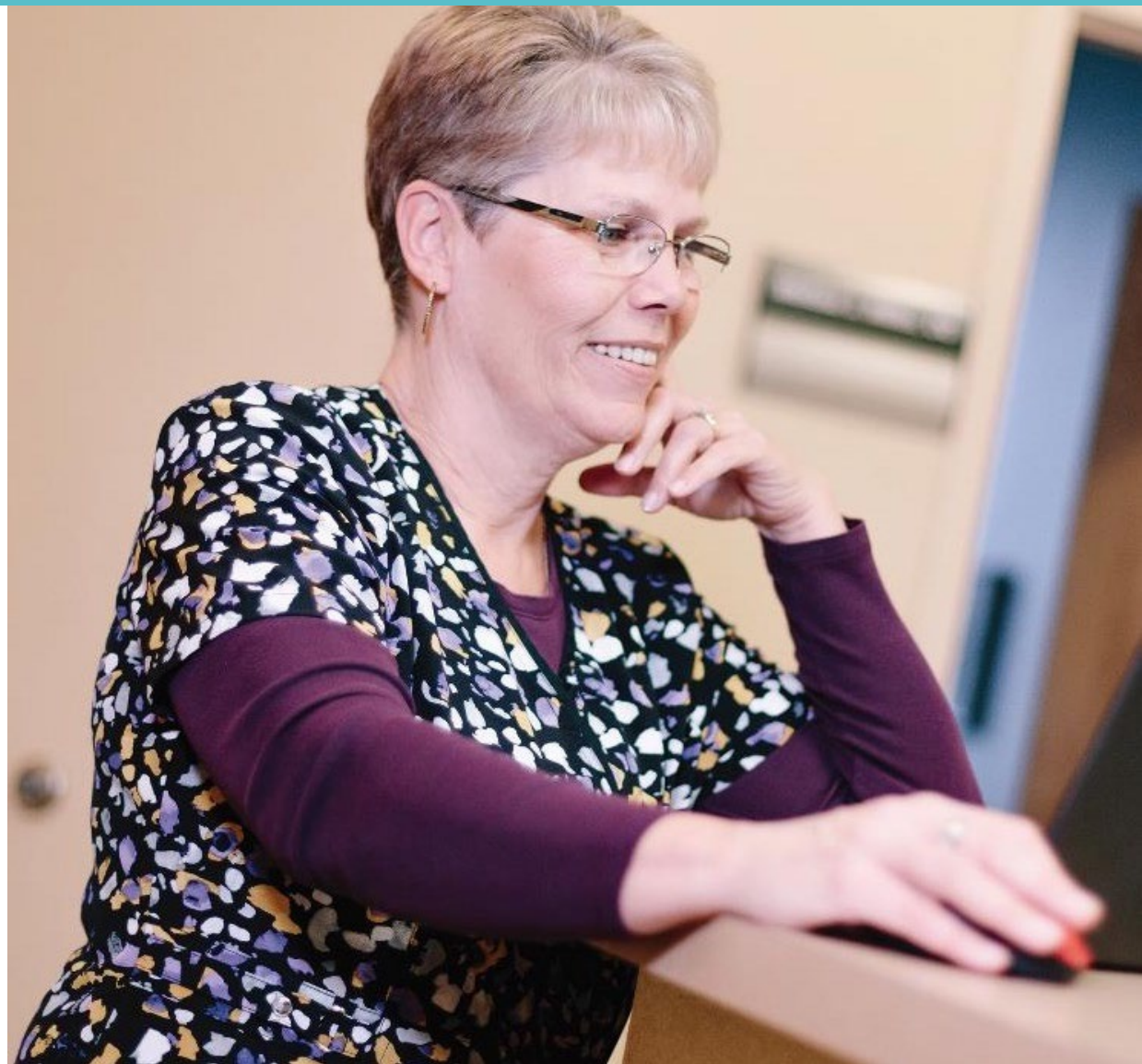
Provider updates

LTSS provider updates

- HCBS Credentialing/Certification for Summit Community Care began in September 2023 and must be completed by April 1, 2024
- Electronic visit verification (EVV) goes live for home health providers January 1, 2024.
- Care Central available to all atypical providers
- Effective October 1, 2023, any practitioner adds must go through digital provider enrollment (DPE) via Availity Essentials.
- Effective October 1, 2023, any changes to an agency's demographics must go through provider data management (PDM) via Availity Essentials.

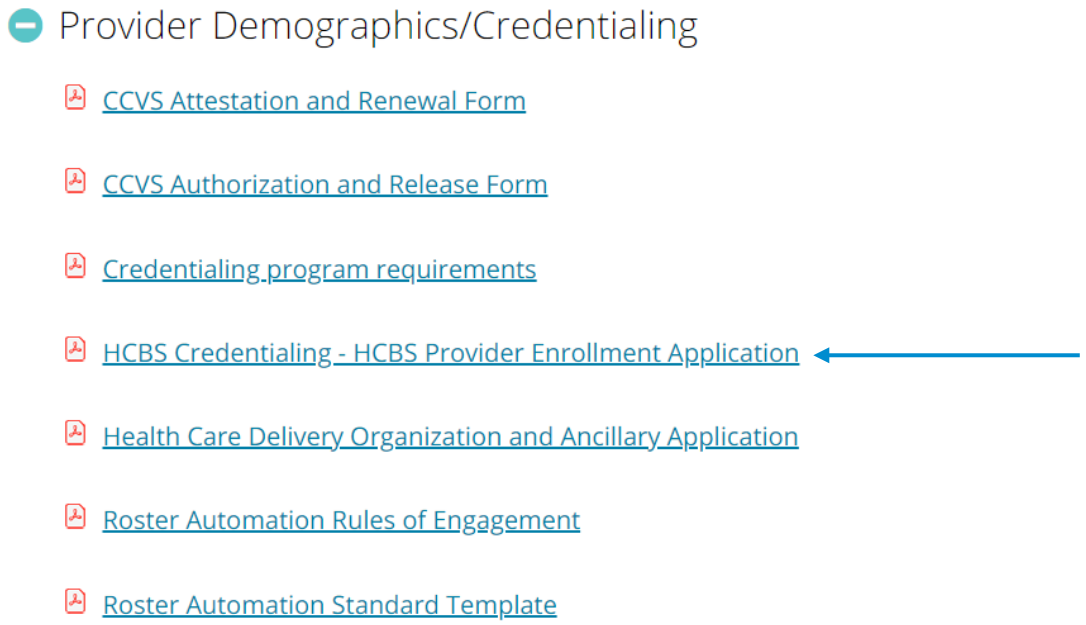


HCBS credentialing

HCBS Provider Enrollment application is in place and should be completed by all HCBS provider-types

The application can be found by visiting our provider website, selecting **Form**s > **Provider Demographics/Credentialing > HCBS Credentialing**

Or you can go to the application directly using this link: *HCBS Credentialing Provider Enrollment Application*



HCBS credentialing timeline

- HCBS providers will receive outreach between September 21, 2023, through April 1, 2024, regarding required credentialing.

- HCBS providers should complete the certification packet located on the Summit Community Care provider website and return to their assigned provider representative within four weeks of outreach.

Electronic visit verification

- EVV is required for providers who deliver care to Medicaid members in HCBS settings through the *21st Century Cures Act*.
- Home healthcare service providers are scheduled to implement the soft launch of EVV on **January 1, 2024**.
- Summit Community Care will implement a soft launch using EVV for home health providers beginning **November 1, 2023,** and anticipate to go live, as scheduled, on January 1, 2024.
- If you have questions, please reach out to your assigned Network Relations Specialist.

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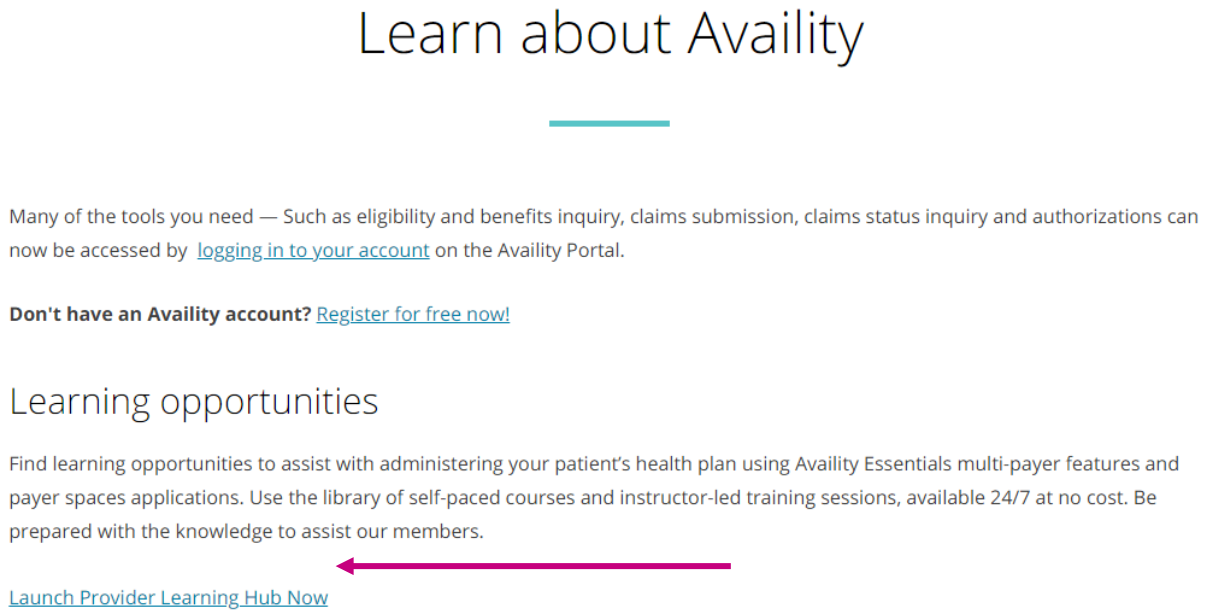
Availity Essentials

- Availity Essentials is used by providers to securely access patient information such as eligibility, benefits, claim status, authorizations, and other proprietary information.
- Additional information about Availity can be found by visiting Learn About Availity and selecting **Launch Provider Learning Hub Now**.

For more information about Availity and its use for reoccurring services, please reach out to your assigned network relations specialist.



Care Central

- Accessible through Availity Essential's *Payer Spaces*, Care Central is a one-stop shop for select LTSS/atypical 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 provider with quick access to information necessary to initiate and maintain member care.
  - Provides clear line of sight into critical data and reporting.

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Digital provider engagement

- Digital provider engagement (DPE) is an application within Availity Essentials secure platform.
- Effective October 1, 2023, providers must use DPE for adding any new practitioners to their group/agency:
  - This applies to all practitioners regardless of in-scope of credentialing (such as, both independently licensed and non-independently licensed practitioners, including physicians).
- The slide deck presentation can be found by visiting the Summit Community Care provider website and selecting DPE Slide Deck.
- Contact your assigned Network Relations Specialist if you would like additional training on DPE.

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Provider data management

Provider data management (PDM) is an application within the Availity Essentials secure platform:

- Effective October 1, 2023, providers must use PDM for updating any demographic information, including but not limited to the following:
  - Terminating a practitioner from the group or agency
  - Updating a telephone or fax number
  - Updating an address or suite number
  - Updating practitioners' last name or licensing level
- Contact your assigned Network Relations Specialist if you would like additional training on PDM.

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Provider enrollment

Credentialing versus certification

- **Credentialing:** All contracted providers, *excluding HCBS providers*, must meet the credentialing guidelines of Summit Community Care to ensure that the quality of care is maintained or improved and that all contracted providers hold current state licensure:
  - Providers may only render services following execution of their contract **and** approval of any credentialing that may be required.
  - Re-credentialing for appliable providers occurs every **three** years.
- **Certification:** For HCBS providers, Summit Community Care validates active registration with Arkansas Medicaid, validates certification by the appropriate state division, and meets all provider qualifications established by the Department of Human Services:
  - We will not be able to offer or extend a contract to any HCBS provider who does not meet the certification standards.
  - Verification of certification occurs every **three** years.

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Provider demographic updates

For waiver providers, many types of updates must first be submitted to the Arkansas Department of Human Services and may require a new *Waiver Certification Letter* before they can be submitted to Summit Community Care, including:

- Name changes.
- Tax identification changes.
- Additional service location addresses.
- Changes to counties served.
- Specialty changes.
- Changes in ownership (CHOW).

Existing providers wishing to make a demographic change, such as updating an address or telephone number, can do so through the PDM application within Availity:

- Promptly notify your LTSS provider relations representative for any changes related to your waiver provider certification.

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Member management tools for providers

Patient360 overview

Patient360 is an interactive dashboard that gives providers instant access to detailed member information:

- Demographic information, Person-centered service plan (PCSP), claim details, authorizations, pharmacy information, and care management activities

Providers may access Patient360 through the Availity platform:

- > Payer Spaces > Applications Tab
- Eligibility & Benefits flow

Additional training can be accessed on our provider website or by contacting Jessica Walker, LTSS Provider Education Specialist:

- Phone: **501-412-0462**
- Email: Jessica.Walker@summitcommunitycare.com

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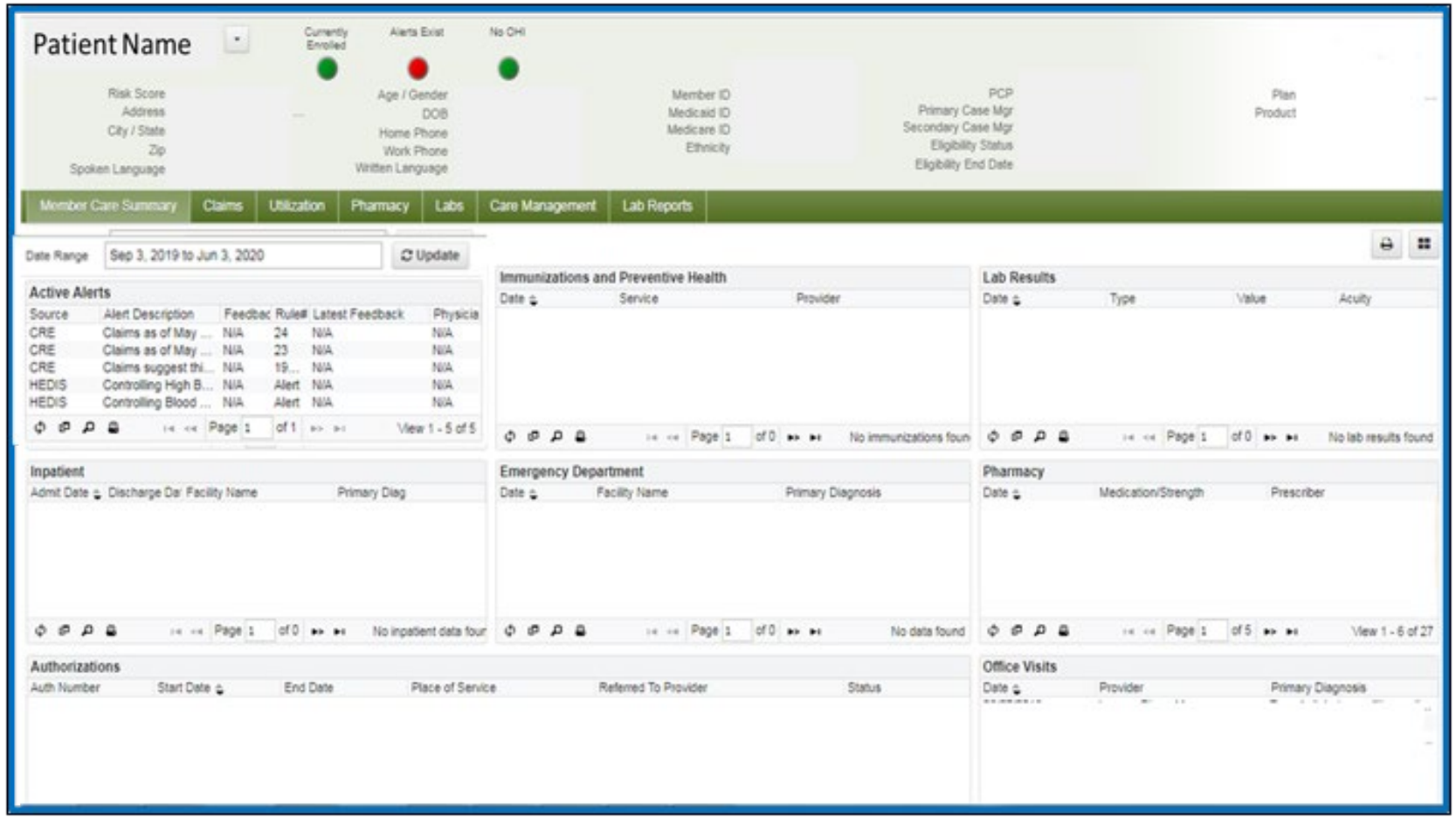
Patient360 overview (cont.)



Billing and reimbursement

Claims submission

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

- **Availity Essentials:**
  - Availity Essentials offers secure access to manage daily transactions with payers:
    - Availity Essentials does not require special software.
  - Within the platform, eligibility can be verified, claims can be submitted, and claims status can be checked.
- **Care Central:**
  - Accessible through Availity's *Payer Spaces*, designed specifically for select LTSS/atypical providers.
  - Streamlines data entry requirements for claim submission.
  - Claims can be submitted for one or more members receiving the same service
  - Offers real-time visibility to claim status.
- **Clearinghouse**:
  - An institution that electronically transmits different types of claim data on behalf of a provider.
  - Typically includes fees charged to the provider for the submissions.

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Claims dispute

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.

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Claim dispute (cont.)

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 if the claim is finalized and you disagree with the outcome.

The provider payment dispute process consists of two internal steps and one external step:

- **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.
- **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.
- **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.

If you reach out directly to DHS, do so only after initiation of the Summit Community Care claims payment dispute process. When reaching out to the state directly, DHS will request providers share the Summit Community Care issued reconsideration or appeal reference number.

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Electronic visit verification

Electronic visit verification (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 provides an accurate account of provider's time while minimizing or eliminating inappropriate claims.
- EVV is required for providers who deliver care to Medicaid members in HCBS settings.
- Required for personal care services (PCS) and home health care services (HHCS) through the *21st Century Cures Act*.

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Care Central: Claims dashboard features

Claims dashboard: Streamlines claims submission and tracking, reducing administrative burden and billing errors by providing the following abilities:

- Create and submit claims:
  - Allows for the submission of claims for one or more members (with same service).
- Upload supporting documentation of a claim.
- Save claims settings for streamlining.
- Review claims and make changes prior to submission.
- Confirmation of submission.
- The ability to sort, filter, and search by member and claims information.
- View the dollar amount of claims that have been billed.

View the claims dashboard using claim status:

- **Submitted**: The claim has been submitted and you are awaiting a claim number.
- **Pending**: The claim is pending review. This may take up to 30 days.
- **Finalized**: The claim has been paid.
- **Denied**: The claim has been denied.

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Value-based programs

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Value-based programs – coming soon

- Value-based care joins payments for care delivery to the quality of care provided and rewards providers for both efficiency and effectiveness.
- Value-based payment models are only going to increase in importance in the coming years as the healthcare industry continues to evolve.
- Using claims data, we will identify providers who are ready to enter value-based arrangements based on overall provider performance. We will also use Care Central to identify provider collaboration opportunities to develop innovative VBP programs.
- Currently piloting phase 2 for the SLQIP value-based program for supportive living waiver providers.

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HCBS Settings Rule

HCBS Settings Rule requirements: *HCBS Settings Rule 42 CFR 441.301*

The purpose of the *Home- and Community-based Settings* (*HCBS*) *Rule* is to ensure individuals receive services in settings that are integrated in and support full access to the greater community. These include:

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

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Workforce development

What is workforce development?

Workforce development is:

- A diverse, stable, and well-trained workforce, crucial to providing quality person-centered services and supports.
- Investment in direct service professionals (DSPs),essential to serving more members in the homes and communities.
- DSPs include:
  - Certified nursing assistants.
  - Home health aides.
  - Personal care aides.
  - ADDT/EIDT aides.
  - Other non-licensed personnel.

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What you can expect

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Workforce challenges

What factors may contribute to an understaffed workforce?

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

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Workforce development and retention training for providers

- We are offering **free** access to the online training platform Elsevier for our in-network providers.
- This training platform will allow LTSS providers access to several trainings focused on workforce development and retention.
- For more information on Elsevier and how to access their training, please contact our Workforce Development Manager, Ashley Riedmueller, at:
  - Phone: **501-289-9297**
  - Email: Ashley.Riedmueller@SummitCommunityCare.com.

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Cultural competency

Cultural competency

- Providers are expected to provide fair, accurate, and impartial information and services in a manner that is culturally and linguistically appropriate to meet the needs of consumers, including those with disabilities and limited English proficiency (LEP) in accordance with all applicable federal laws.
- Providers are required to follow culturally and linguistically appropriate services (CLAS) standards set forth in Centers for Medicare & Medicaid Services (CMS) regulations (45 CFR 155.215(c)).
- Providers may use the cultural competency training free through the provider website and Elsevier platforms:
  - Summit Community Care - Cultural Competency Training
  - CMS Resource - Training for Cultural Competence

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Provider resources

Provider resources

- The provider manual is available on the Summit Community Care provider website and includes additional education materials, including but not limited to:
  - Information regarding members and benefits
  - Processes and procedures governing provider interaction with Summit Community Care
  - Provider Manuals and Guides (summitcommunitycare.com)

Quick reference card

Service	Phone number
Provider Services/Member Services	1-844-462-0022 1-844-405-4295
Behavioral health services	1-844-462-0022
PA	1-844-462-0022
24/7 NurseLine	1-844-405-4295
Pharmacy services — member/provider	1-844-462-0022
IngenioRx — effective October 1, 2019	833-262-1726
Interpreter/translation services	1-844-405-4295 (TTY 711)
Fraud, waste and abuse	1-800-422-6641
Availity Portal (https://www.availity.com)	1-800-282-4548

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Quick reference card (cont.)

Service	Phone number/website
Availity client services	1-800-282-4548
EFT — CAQH	1-844-815-9763 https://solutions.caqh.org/bpas/Default.aspx
Electronic claims submission and ERA	https://www.availity.com
Paper claims: Summit Community Care P.O. Box 61010 Virginia Beach, VA 23466-1010	365 calendar days from the Date of Service
Transportation (NET)	1-888-987-1200
Grievance and Medical Appeals: Summit Community Care P. O. Box 62429 Virginia Beach, VA 23455-2429	60 calendar days from Summit Community Care's notification postmark date

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https://provider.summitcommunitycare.com