New care provider orientation

Agenda

- Introduction
- Key contact information
- Public website and Availity Essentials secure website
- Prior authorizations
- Claim information
- Care provider responsibilities
- Additional resources

Summit COMMUNITY CARE

Introduction

- Who are we?
  - We are a joint venture between Summit Community Care and Arkansas Provider Coalition, LLC (APC). It comprises 75 provider investors across the state and maintains a 51% ownership stake. We help coordinate physical and behavioral health services and access to services for people with disabilities. It also offers case management, disease management, care coordination, and various educational programs.
- Our mission:
  - Our mission is to address the physical and behavioral health services of members by offering a wide range of targeted interventions, education, and enhanced access to care to ensure improved outcomes and quality of life for members. We work collaboratively with hospitals, group practices, independent behavioral health services care providers, community and government agencies, human service districts, and other resources to successfully meet the needs of members with mental health, substance use, and intellectual and developmental disabilities.

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Key contact information

- Register for Availity Essentials at **http://Availity.com**. Many of the applications you need, such as eligibility and benefits inquiry, claims submission, claim status inquiry, and authorizations, can now be accessed by logging in to your account on the Availity website.
- Call Provider Services at **844-462-0022** for assistance.
- Care providers unable to resolve their needs through the Availity Essentials website or Provider Services can contact their designated local provider representative.
- Need training? Explore the Availity Essentials and EDI Gateway trainings on the Digital Solutions Learning Hub. This curated resource brings together materials from us and Availity Essentials in one convenient location.

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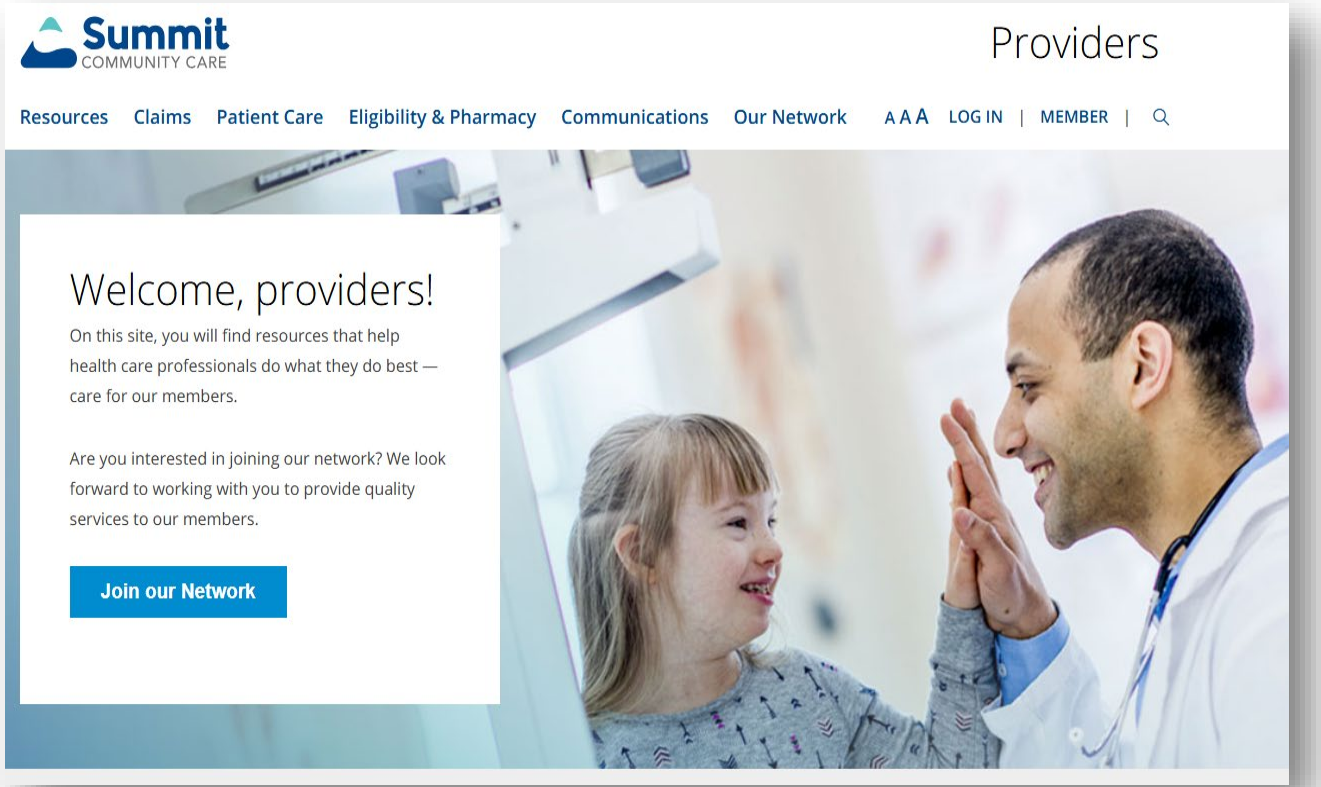
Public website

Our website

www.summitcommunitycare.com

- Available to all care providers regardless of participation status
- Accessible 24/7
- Multiple resources available without a login, such as the following:
  - Provider manual
  - Forms
  - Quick Reference Guide (QRG)
  - Policies
  - Provider education and training
  - How to sign up for provider newsletters



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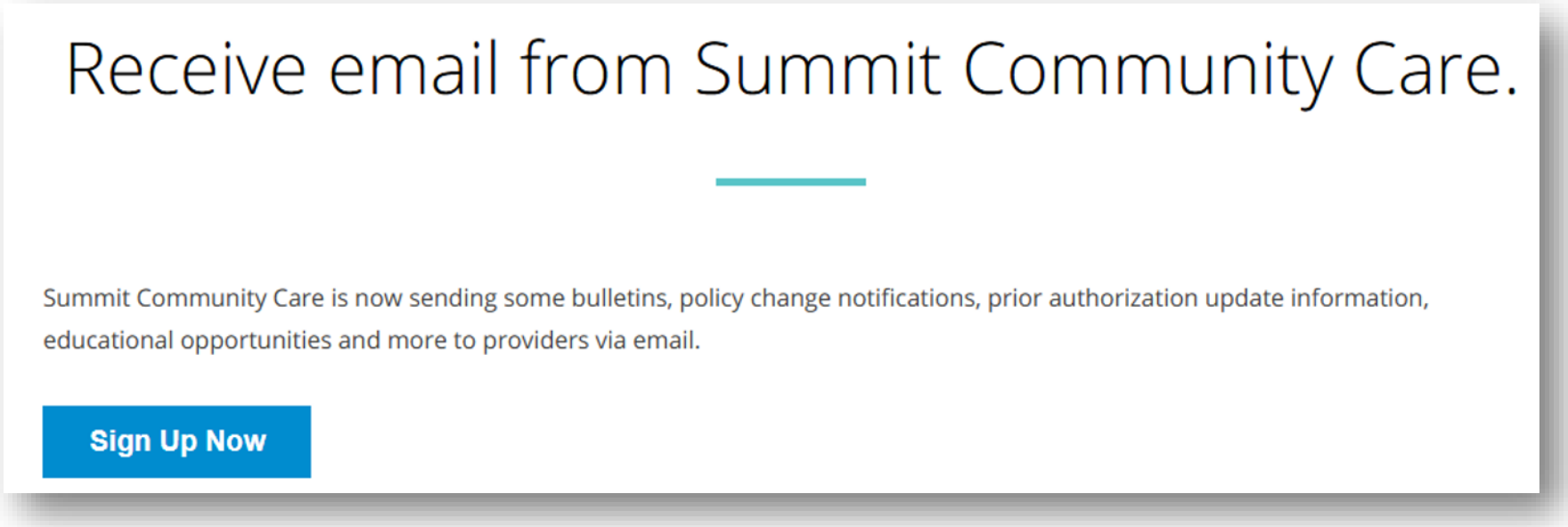
Care provider newsletters and updates

- We want to help declutter your offices by sending provider communications such as bulletins, newsletters, training invitations, policy change notifications, and prior authorization updates to providers via email.



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Availity Essentials secure website

Availity Essentials

- The Availity Essentials secure website has many of the applications you need and may be accessed by logging in to the Availity Essentials website **http://Availity.com**. Features include the following:
  - Eligibility and benefits inquiry
  - Claim submission
  - Claims attachments
  - Claims status inquiry
  - Claims dispute
  - Remittance Inquiry
  - Prior authorization Lookup Tool
  - Prior authorization requests
  - Total Member View (TMV)
- You may chat live via **Payer Spaces** > **Summit Community Care** or contact Availity support at **800-AVAILITY (800-282-4548)**.

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Availity Essentials (cont.)

Availity > Payer Spaces > Summit Community Care

- Applications:
  - Custom Learning Center
  - Care Central
  - Chat with Payer
  - Claim Status Listing
  - Clear Claim Connection
  - Precertification Look-Up Tool
  - Provider Enrollment
  - Provider Online Reporting
  - Remittance Inquiry

Provider enrollment

In direct response to feedback on our annual Provider Satisfaction Survey related to the provider enrollment process, the following automated application is available today on the Availity Essentials secure website:

- Digital Provider Enrollment:
  - Under **Payer Spaces** > **Summit Community Care** in Availity Essentials > **Provider Enrollment** and **Network Management**.
  - This application will improve provider data accuracy, reduce turnaround time on enrollments, and increase visibility into the status of requests submitted.

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Provider Data Management

- The care provider enrollment functionality allows care providers an electronic website to add care providers or request to join our network. Care providers can submit credentialed and non-credentialed care providers using this website. It creates a streamlined process that eliminates the need for enrollment forms or rosters, creates a faster turnaround time, and allows care providers to view the status of applications on a dashboard in Availity Essentials. Currently, this functionality is available only for adding practitioners; ancillary and facility care providers will need to continue to enroll via the existing process.
- Provider data management (PDM) is available to all groups participating in our network and can be found under the My Providers tab in Availity Essentials. Contracted care providers should use Availity Essential's PDM application to request changes to existing practice information. For larger organizations, please use the Upload Roster option to manage change requests in bulk. PDM becomes a one-stop shop for groups to self-manage their data for all payors who use the platform, not just us.

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Provider enrollment (cont.)

- Digital provider enrollment allows a provider to add new practitioners to a contracted group.
- Digital provider enrollment also allows a noncontracted practitioner group to submit a request to enroll as a participating provider in our network.
- For non-physicians (MDs/DOs), the system pulls all professional and practice details from the Council for Affordable Quality Healthcare (CAQH) ProView to populate the information needed to complete the enrollment process, including credentialing, claims, and directory administration. MDs/DOs will complete required CCVS forms during this enrollment.

Please note the following:

- CAQH information must be current and complete or re-attested. The online enrollment application guides providers through the process and displays a digital dashboard with real-time application statuses, eliminating the need to call or email for a status update.
- Submission of a request for an agreement and/or credentialing application is subject to review and is not a guarantee of approval.

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Provider enrollment (cont.)

- The provider enrollment process provides real-time status updates for applications.
- The **My Dashboard** application in Availity Essentials allows care providers to track submissions, including links to view:
  - Recent applications.
  - Incomplete applications.
  - Submitted applications.
- Care providers can select **Begin new Application +** to start the enrollment process by submitting a new application.

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Provider data management (PDM)

PDM allows providers two choices to update existing demographic information:

- Use the standard PDM experience if you are a smaller organization to manage demographic data for your organization.
- Use the Upload Roster feature if you are a medium to large medical organization. This allows you to submit change requests in bulk.

PDM is the **only** means available to providers to update demographic information. Benefits include:

- Consistently updated data.
- Decreased turnaround time for submitted updates.
- Compliance with federal and/or state mandates related to data attestation.
- Improved data quality through standardization.
- Increased provider directory accuracy.
- Reduced claims underpayments or denials.

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PDM (cont.)

To access the PDM tool:

- Log in to your Availity Essentials account.
- Select **My Providers**.
- Select **Provider Data Management.**

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Roster submission through PDM

Rules of engagement for uploading a roster:

- Do not password-protect the submitted roster/Excel file.
- A full roster, with terminations included as a separate tab, is considered best practice.
- Change rosters: Rosters featuring only current updates will also be accepted. This would include adds, changes, and terminations in a separate tab for each request.
- Consistent format month-over-month will allow for programming to run automation.
- Care providers should send rosters one to two times per month versus sending individual changes.

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Provider data attestation

At a glance:

- Care providers contracted with us need to verify and update their demographic data every [90] days using the PDM feature in Availity Essentials.
- Updating and attesting data are critical for maintaining accurate service directories for members, and noncompliance with these requirements can result in removal from the online provider directory.
- Availity Essentials provides digital applications that enable users to monitor submitted demographic updates in real time, review the history of previously verified data, and manage multiple updates within one spreadsheet via the *Upload Roster* feature.
- Individuals registered for their TIN within the Availity Essentials Manage My Organization application on Availity Essentials will receive periodic automated emails and notifications in the *Notification Center* on Availity Essentials reminding them when their attestation is due or overdue.

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Provider data attestation (cont.)

There are two options within Availity Essentials PDM that are available at no cost to care providers:

1. **Multi-payer platform, which includes directory verification and Core PDM:** allows care providers to make required updates using directory verification and changes using Core PDM.
2. **Roster upload:** allows care providers to submit multiple updates within one spreadsheet via the Upload Roster feature. (The Upload Roster feature is currently only available and shared with the health plan.)

Both the multi-payer platform and Roster Upload feature satisfy your 90-day attestation requirement.

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Provider data attestation (cont.)

To attest to your provider data using the multi-payer platform approach:

1. Log in to **https://Availity.com**.
2. Navigate to **My Providers** > **Provider Data Management**.
3. Select the action menu next to the business whose information you want to verify.
4. Select **Verify Directory Listing**.
5. Review each set of data for accuracy.
6. Once complete, select **Submit Verified Profile**.

Organizations with no changes since their last submission may see a **Quick Verify** button that allows for directory verification in one click.

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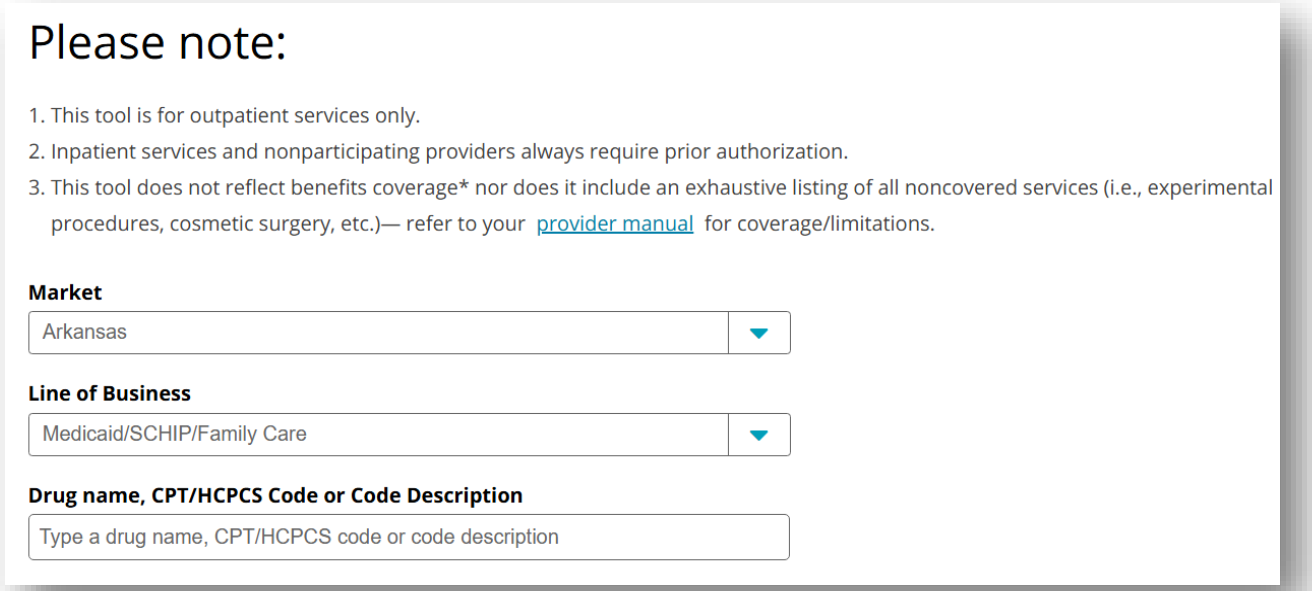
Prior authorizations

Prior authorization

Is prior authorization required?



Note: The prior authorization look-up tool is available in the Availity Essentials application as well.

- Determine if specific outpatient procedures and/or services require prior authorization by searching by CPT®/HCPCS code or code description.
- All inpatient stays require prior authorization.
- All out-of-network service requests require prior authorization.
- All non-emergent ambulance transportation requires prior authorization.

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Availity Essentials prior authorizations

Online prior authorization requests:

- **Interactive care reviewer (ICR)** is a secure, online care provider UM application, accessed via Availity Essentials, that offers a streamlined process to request authorization of inpatient and outpatient procedures/services.
- With this application, your practice can initiate online medical and behavioral health preapproval requests for our members more efficiently and conveniently, as well as locate information on previously submitted requests, regardless of how the original prior authorization was submitted.

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Prior authorization (cont.)

The preferred method for prior authorization is through Availity Essentials at [https://Availity.com].

To request or check the status of a prior authorization request or decision, access our Interactive Care Reviewer (ICR) application via Availity Essentials. Once logged in, select **Patient Registration > Authorizations & Referrals**, then choose **Authorizations or Auth/Referral Inquiry** as appropriate.

Through **Auth/Referral Inquiry**, you can retrieve cases submitted by your organization via both digital and non-digital methods. You can also use the **Pin to Dashboard** feature to keep these cases on the **Auth/Referral Dashboard**, so you don't have to repeat the search in the future.

Get the most recent status of cases submitted by your organization on the **Auth/Referral Dashboard** and view the case details, including decision letters, via **View Details** in the Actions menu. For pinned cases, select the case card to view the latest status and case details.

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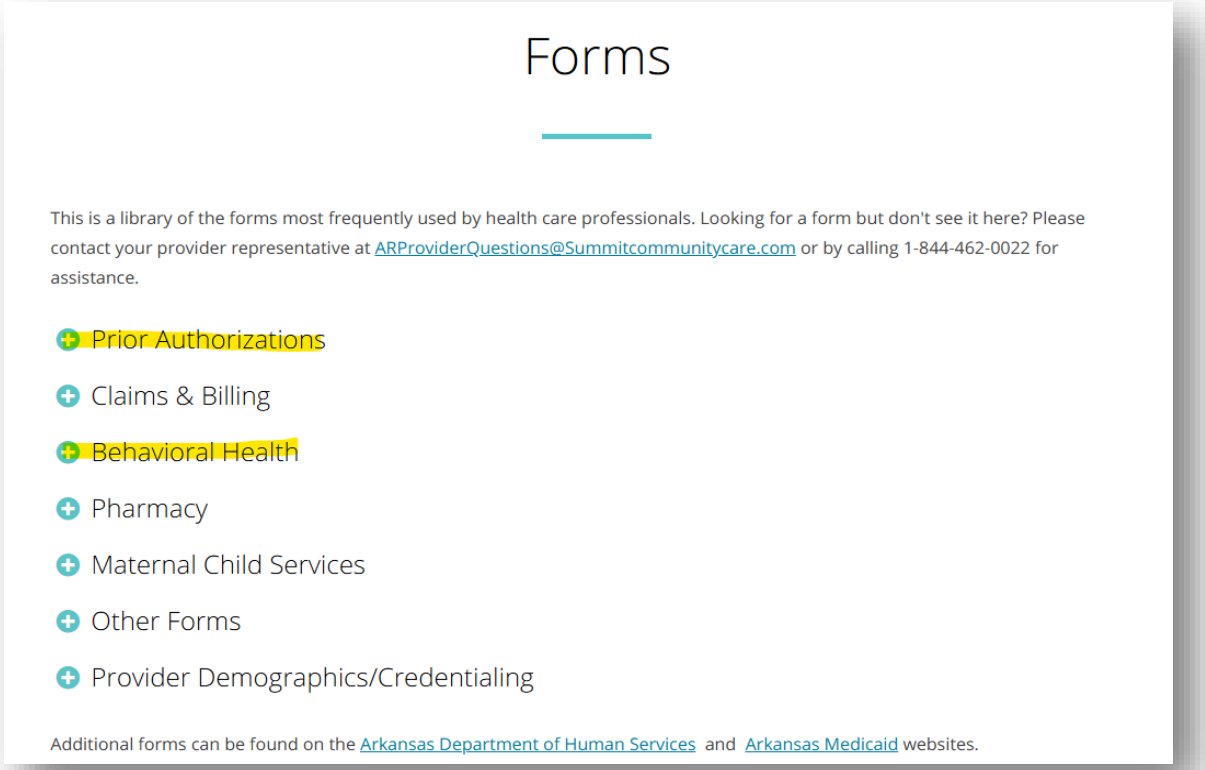
Prior authorization (cont.)

If unable to submit the request online through the Availity website, please fax requests by using the prior authorization forms on our website at https://provider.summitcommunitycare.com/arkansas-provider/forms.

Please select the **Authorizations** tab and note that prior authorization forms for medical services are listed under **Prior Authorizations,** and prior authorization forms for Behavioral services are listed under the **Behavioral Health** link.



Planned/elective admissions

Care providers must submit a prior approval request at least 72 hours before the admission or scheduled procedure to ensure that the proposed care is a covered benefit, medically necessary, and performed at the appropriate level of care. Prior authorization requests can be submitted via:

Availity Essentials: **https://Availity.com**

Fax:

- Inpatient physical health (IP PH): **800-964-3627**
- Inpatient behavioral health (IP BH): **844-452-8068**

Phone: **844-462-0022**

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Emergency admissions

Emergent inpatient admissions require notification within one business day following admission. Authorizations can be submitted via:

- Availity Essentials: **https://Availity.com**
- Fax:
  - IP PH: **800-964-3627**
  - IP BH: **844-452-8068**
- Phone: **844-462-0022**

Emergent inpatient admissions will be reviewed within the prescribed timeframes. Expedited requests are reviewed within one business day, and standard requests within two business days of notification to us. Noncompliance with notification rules may lead to administrative complications.

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Notification requirements

Notification is required for the following services; however, for these services, clinical information is not needed since they do not require a medically necessary review:

- Observation: only needed for nonparticipating facilities
- Maternity admits: medically necessary review required for anything over a 48-hour stay for vaginal delivery (uncomplicated) and 96-hour stay for Cesarean section (uncomplicated)

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Denial management (service does not meet medical necessity)

- **Outpatient**: If medically necessary requirements are not met, the case is forwarded to the medical director for review. Additional clinical information can also be submitted to support the request. If a denial is issued, the provider may request peer review for reconsideration within two business days of the issuance of the denial for standard requests and within one business day for urgent requests.
- **Inpatient**: If medically necessary requirements are not met, the case is forwarded to the medical director for review. A paper **or** peer review may be requested by the provider. If denial is issued after paper review, peer-to-peer reconsideration can be requested, to be requested within two business days of the issuance of the denial for standard requests and within one business day of issuance of denial for urgent requests.

If denials are upheld and the peer-to-peer reconsideration timeline is exhausted, the case may move to the Appeals process, which is outlined in the denial letters.

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Denial management (administrative)

- There are instances in which a prior auth request may be administratively denied. Examples of administrative denials include:
  - Failure to timely notify of an emergent inpatient admission.
  - Failure to pre-certify a service that requires PA.
  - Services rendered by any provider who is not actively registered with the Arkansas Medicaid program.
  - Ineligibility of member on date of service.
  - Benefit exhaust for members in an IMD (Institute for Mental Disease).
- Administrative denials are not eligible for peer/reconsideration review; however, care providers and/or members can request an appeal as outlined in the written denial notification.

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Claim information

Claim submission options

- Electronic Data Interchange (EDI)
- Availity Essentials
- Paper
- Timely filing is 365 days from the date of service.

Paper submissions	Electronic submissions
Mail: Summit Community Care P.O. Box 61010 Virginia Beach, VA 23466	Availity Essentials: https://Availity.com EDI submissions Payer name: Summit Community Care Payer ID: PASSE

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Electronic remittance advice (ERA) and electronic funds transfer (EFT) enrollment

Electronic remittance advice (835):

- The 835 eliminates the need for paper remittance reconciliation.
- Use Availity Essentials to register and manage ERA account changes with these easy steps:
  - Log in to Availity Essentials (https://Availity.com).
  - Select **My Providers** > **Enrollment Center** > **ERA Enrollment**.

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERAs.

Electronic funds transfer (EFT):

- Electronic claims payment through electronic funds transfer (EFT) is a secure and fast way to receive payment, reducing administrative processes. EFT deposits are assigned a trace number that is matched to the [835] electronic remittance advice (ERA) for simple payment reconciliation:
  - Use enrollsafe.payeehub.org to register and manage EFT account changes.

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Third-party liability

Submitting claims where third-party liability (TPL) exists:

- When a member has dual coverage through Medicare and Medicaid, Medicare will be primary. For Medicare primary claims, we cover the full deductible, copay, and/or coinsurance as indicated in the coordination of benefits (COB), regardless of the Medicaid allowed amount. We may choose not to cover the deductible, copay, or coinsurance if the claim is denied for reasons such as duplication, member termination, timely filing, or similar issues.
- For inpatient Medicare primary claims, we are responsible for paying the difference between the Medicaid allowed and the Medicare payment as listed on the COB. No payment is required if the Medicare payment exceeds the Medicaid allowed amount.
- For eligible members with dual Medicare and Medicaid coverage, we maintain a Medicare Third Party Bypass List that identifies service codes for which no TPL information will be required. Care providers may access the complete list of service codes included on the Medicare Third-Party Bypass List via our website > **Resources** > **Provider Education**.

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Third-party liability (cont.)

- When a member has dual coverage through a Commercial insurance entity and Medicaid, the Commercial insurance will be primary. For Commercial primary claims, we are responsible for paying the difference between the Medicaid allowed and the Commercial payment as listed on the COB. No payment is required if the Commercial payment exceeds the Medicaid allowed amount. We may choose not to cover the deductible, copay, or coinsurance if the claim is denied for reasons such as duplication, member termination, timely filing, or similar issues.
- For eligible members with dual Commercial insurance and Medicaid coverage, we maintain a Commercial Insurance Bypass List that identifies service codes for which no TPL information will be required. Providers may access the complete list of service codes included on the Commercial Third-Party Bypass List via our **website** > **Resources** > **Provider Education**.

Select the following links for a summary of services included on the **Medicare** and **Commercial** insurance TPL bypass lists.

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TPL submission requirements

When submitting claims for services not included on the TPL bypass list, we require TPL verification. Care providers may submit any of the following as verification of the primary insurance adjudication decision:

- Certificate of Benefits (COB) from the primary insurer
- Denial letter or Explanation of Payment (EOP) showing no payment from the primary insurer
- EOP showing payment to the provider from the primary insurer

Note: Documentation of the primary insurance denial via the COB or EOP with no payment will satisfy the TPL requirements for one year from the date of the denial or letter.

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Rejected versus denied claims

What is the difference between a rejected and a denied claim?

- Rejected:
  - Does not enter the adjudication system due to missing or incorrect information
  - Resubmission subject to the timely filing deadline
- Denied:
  - Does go through the adjudication process, but is not approved for payment
  - Appeal deadline of 90 days from the EOP date applies
- For claim inquiries, care providers may call Provider Services at **844-462-0022**.

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Top 10 reasons for front-end rejections

1. Billing provider NPI or Medicaid ID must be present and registered with the state
2. Billing provider address should not be P.O. Box
3. Rendering care provider NPI or Medicaid ID must be present and registered with the state
4. Ordering provider not eligible during the claims dates of service
5. Referring provider not eligible during the claims dates of service
6. Medicaid ID submitted as billing secondary ID not found on state file/invalid
7. Billing and servicing facility location NPI links to multiple Medicaid IDs
8. Invalid or blank rendering provider NPI
9. Invalid or blank billing provider NPI
10. Billing provider NPI must be registered with billing Medicaid ID

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Payment dispute process

If you disagree with the outcome of a claim, you may begin the provider payment dispute process. Please be aware that there are [three] common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, we've defined them briefly here:

- Claim inquiry: a question about a claim, but not a request to change a claim payment
- Claims correspondence: occurs when we request further information to finalize a claim — typically includes provision of medical records, itemized bills, or information about other health insurance a member may have
- Medically necessary appeals: a pre-service appeal for a denied service in which a claim has not yet been submitted

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Payment dispute process (cont.)

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:

- Reconsideration: This is the first step in the provider payment dispute process and must occur **within 90 business days** from the date on the explanation of payment (EOP). 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 and must occur **within 30 calendar** days after the date on the Reconsideration determination letter. 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. The appeal determination letter will outline the timeline and process for requesting a State Fair Hearing.

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

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How to submit a claim payment dispute

- **Online (for reconsiderations and claim payment appeals):** Use the secure provider Availity Essentials payment appeal tool. Through the Availity Essentials **website**, you can upload supporting documentation and receive immediate acknowledgment of your submission.
- **Verbally (for reconsiderations only):** Call Provider Services at **844-462-0022**.
- **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

Care providers must submit the following with a claim payment dispute (reconsideration or claim payment appeal):

- Name, address, phone number, email address, TIN, and NPI (or Arkansas Medicaid ID number, whichever number is registered with Arkansas Medicaid)
- The member name and Summit Community Care subscriber ID, or member Medicaid ID number
- List of disputed claims must include the Summit Community Care claim ID #(s) and date(s) of service(s)
- All supporting statements and documentation

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Provider responsibilities

Provider responsibilities

- To provide preventive health screenings
- To comply with Americans with Disabilities Act standards and not discriminate against members with mental, developmental, and physical disabilities
- To not discriminate on the grounds of age, race, color, religion, sex, national origin, or any of the protected classes that fall under federal law
- To provide notification of changes such as name and billing address
- To educate members on advance directives
- To comply with HIPAA recordkeeping standards for medical records
- To provide preventive care services recommended to all members
- To identify behavioral health needs
- To document fraud, waste, and abuse
- To meet access standards (such as wheelchair accessibility)
- To comply with after-hours access requirements (PCP only) and appointment availability standards (all care providers)
- To attest to the accuracy of their provider data on the Availity Essentials platform every 90 days (participating care providers)

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Provider Satisfaction Survey (PSAT)

Your satisfaction is important to us:

- Provider Satisfaction Surveys are conducted annually. We rely on your feedback to improve and strengthen our processes and operations. Our provider satisfaction survey is an important application, enabling us to make evaluations that will help us improve our service to you. We strive for provider satisfaction.
- Based on the feedback we received from past surveys, we have made some improvements, such as digital options (to reduce turnaround times), Quick Reference Guides, a more simplified after-hours and appointment availability process, and Provider Relations representatives returning to the field.
- In our previous survey, care providers who submitted timely responses were entered into a drawing to win a VISA gift card as a thank you for their time in completing the survey. We rely on your survey responses to help us identify opportunities for improvement. Please remember to complete the survey if you receive one!

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Appointment availability and after-hour standards

- To ensure members maintain timely access to care, the Arkansas Department of Human Services (DHS) contractually requires us to ensure participating care providers adhere to specific appointment availability standards. Adherence to appointment availability standards is also required to maintain NCQA accreditation. As a result, we have agreed to make these standards an obligation for our participating practitioners. Our provider manual also outlines the requirement to adhere to these standards and lists the specific appointment standard by provider or service type. Please note that where there is a variance between the DHS and NCQA standards, we adopt the more stringent standard.
- We use a third-party vendor to conduct two surveys throughout the year to assess a practitioner's ability to schedule appointments within the defined timelines. Practitioners are obligated to participate in the Appointment Availability Survey if chosen in the random selection. We will notify any practitioners deemed noncompliant with appointment-scheduling standards following a review of survey findings.
- Noncompliant practitioners will receive a written letter outlining any areas of noncompliance. Care providers who receive the letter must complete the attached form describing the action(s) taken or to be taken to remedy the areas of noncompliance. While the survey protocol ensures random selection of care providers, any care provider noncompliant in the prior survey is included in the next survey.

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Appointment availability and after-hour standards (cont.)

Appointment availability standards are as follows:

Primary care providers	
Routine care *(non-urgent)*	Within 21 calendar days
Preventive or well-visits	Within 30 calendar days
Urgent care	Within 24 hours
Emergency care	Within 24 hours
Specialty care providers (non-OB/GYN)	
Routine care *(non-urgent)*	Within 60 calendar days
Preventive or well-visits	Within 30 calendar days
Urgent care	Within 24 hours
Emergency care	Within 24 hours

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Appointment availability and after-hour standards (cont.)

Appointment availability standards are as follows:

Obstetrical/gynecological providers	
Routine care *(non-urgent)*	Within 60 calendar days
Preventive or well-visits	Within 30 calendar days
Prenatal care	Within 14 calendar days
Urgent care*	Within 24 hours
Emergency care	Within 24 hours
Behavioral providers	
Initial visit — Routine care *(non-urgent)*	Within 10 *business* days
Follow-up visit — Routine *(non-urgent)*	Within 21 calendar days
Non-life-threatening emergency care	Within 6 hours
Urgent care — behavioral and substance abuse	Within 24 hours
Emergency care	Within 24 hours
Behavioral health & DDS providers	
Mobile crisis response	24/7

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Appointment availability and after-hour standards (cont.)

Tips for complying with standards:

- **For routine appointments:** Offering an appointment with a different practitioner in the group or agency constitutes compliance if an appointment can be scheduled within the timelines defined by the standards.
- **For urgent care appointments:** Referral to the nearest urgent care center constitutes compliance.
- **For emergency appointments:** Referral to the nearest emergency room constitutes compliance.

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Appointment availability and after-hour standards (cont.)

Appointment wait times:

- Wait times at the behavioral health practitioner's office should not exceed 45 minutes from the scheduled appointment time, except when the provider is unavailable due to an emergency.
- Care providers may experience delays attempting to meet scheduled appointment times when working on an urgent case, when encountering a serious problem, or when a member has an unknown need requiring more services or education than described when scheduling the appointment.

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Total Member View (previously Patient360)

Total Member View (TMV), previously Patient360 (P360), is a dashboard you can access through Payer Spaces in the Availity Essentials platform that gives you a full 360-degree view of your patient's health and treatment history to help you facilitate care coordination.

You can drill down to specific items in a patient's medical record to retrieve demographic information, care summaries, claims details, authorization details, pharmacy information, and care management-related activities. The TMV user interface is purple and displays **Total Member View** in the upper-right corner.

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Balance billing

- Participating care providers may not balance bill members for covered services. This means that participating care providers may not bill a member directly for any amount not paid by us for covered services provided. Care providers may not bill for or take recourse against a member for denied or reduced claims for covered services that are within the amount, duration, and scope of benefits of the Medicaid PASSE program.
- The only instance in which a participating or non-participating provider may charge a member is for a non-covered service or services. The provider must obtain advance written agreement from the member or the member's guardian acknowledging that the member recognizes their financial responsibility and obligation to pay for such service(s). The provider must obtain this written acknowledgment in advance of rendering the non-covered service. The member's written acknowledgment must include a clear description of the specific service(s) or procedure(s) the member would be responsible for paying and not include any conditional language.

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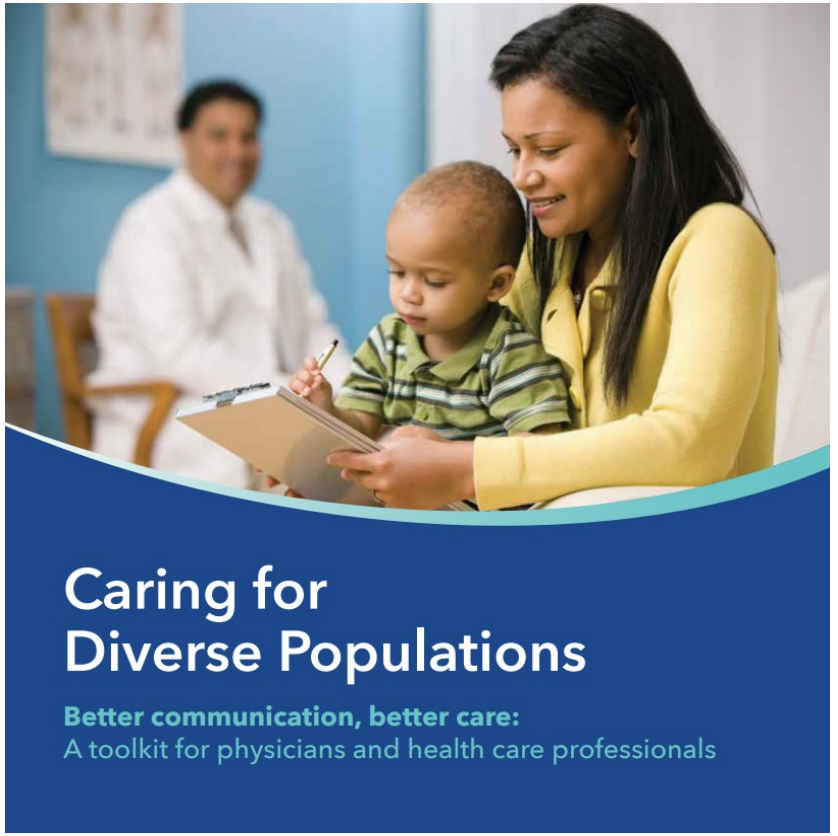
Cultural competency

We believe we must recognize and thoroughly understand the roles played by culture and ethnicity in the lives of our members to ensure everyone receives equitable and effective healthcare:

- Expectations are that care providers and their staff share our commitment.
- Resources, training material, and information are available online, including:
  - Caring for Diverse Populations Toolkit
  - Cultural Competency Training
  - Development Disability Provider Webinar



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Provider communications/training resources

We offer curated trainings and provider communications to ensure you and your staff are aware of updates, trainings, and onboarding resources that every care provider, new or experienced, can use to further their education. All training resources are accessible through the Training Academy.

For more information, visit **https://tinyurl.com/4fnxwk89**.

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Additional resources

- Quick Reference Guide: **Summit Community Care QRG**
- Provider manual: **Summit Community Care Provider Manual**
- PLUTO: **Prior Authorization Lookup Tool**
- Provider enrollment guidelines: **Provider Enrollment Presentation**
- Provider digital engagement: **Provider Digital Engagement**
- Claims payment dispute process: **Claims Dispute Process**
- Top 10 reasons for front-end claim rejections: **Top 10 reasons for front-end claim rejections — Provider News**
- **Digital Solutions Learning Hub**

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Thank you!

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