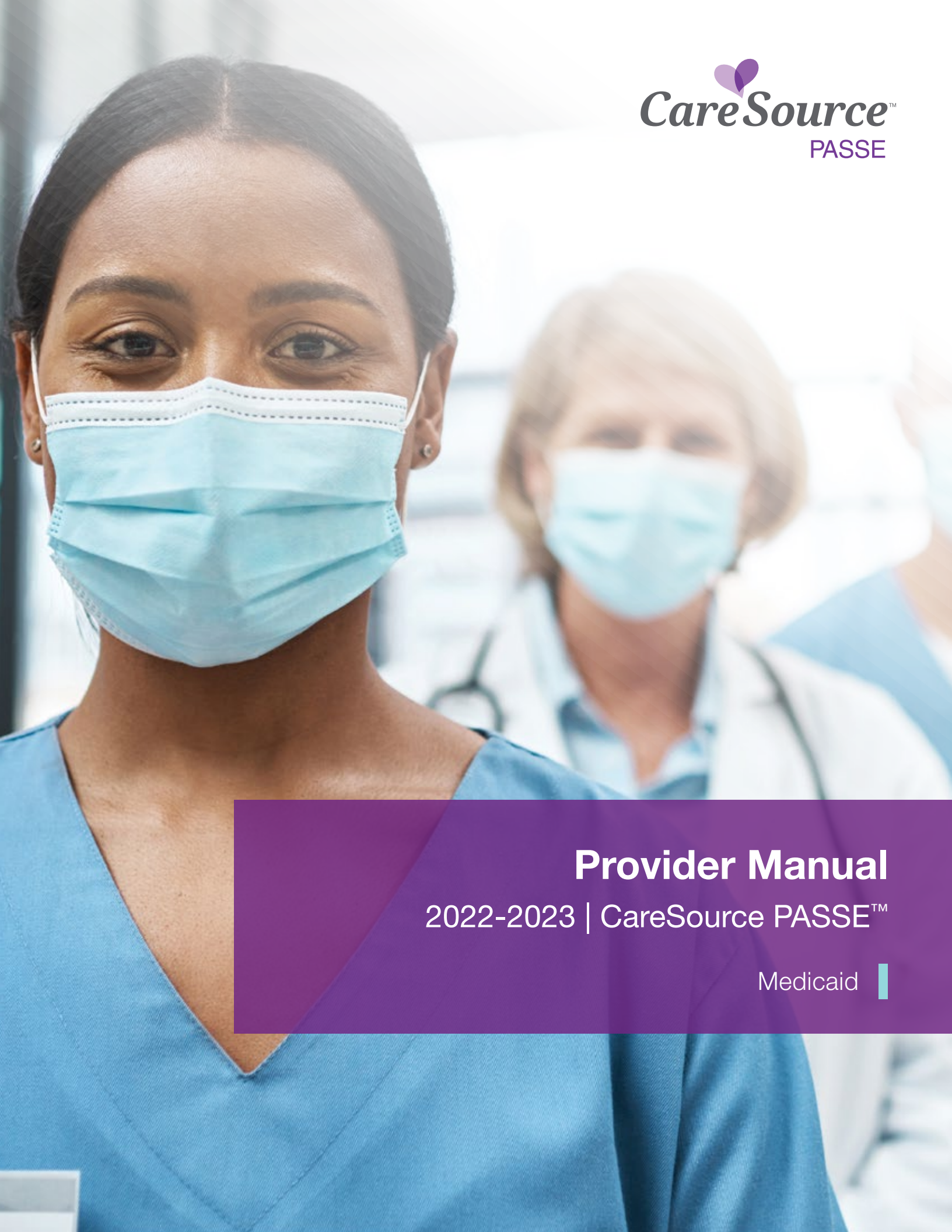
CareSource™
PASSE



# Provider Manual

## 2022-2023 | CareSource PASSE™

Medicaid

This content has been reviewed; however, changes and/or revisions occur frequently. Providers should check our website at **CareSourcePASSE.com** for the most current version of this manual.

# Dear CareSource PASSE™ provider,

Welcome to CareSource PASSE and thank you for your participation. CareSource PASSE values you as a health partner, and we are actively working to make it easier for you to deliver quality care to our members.

The CareSource PASSE Provider Manual is intended as a resource for working with our plan. It communicates policies and applicable PASSE program information. This manual also outlines key information, such as claim submission and reimbursement processes, authorizations, member benefits and more to make it easier for you to do business with us. This manual is available on **CareSourcePASSE.com** > Providers > Tools & Resources > Provider Manual, or you may request a hard copy by calling Provider Services at **1-833-230-2100**.

CareSource PASSE communicates updates with our network regularly through network notifications available on the Updates & Announcements page on **CareSourcePASSE.com** > Providers > Tools & Resources > Updates & Announcements and on our secure Provider Portal at **CareSourcePASSE.com** > Login > Provider.

To better support our providers and offer an immediate response to questions, concerns and inquiries, we offer claim, policy and appeal assistance through our Provider Services call center at **1-833-230-2100**. If you have questions or concerns, you may ask to speak to a member of our Health Partner Engagement Team by calling our toll-free number.

We know great health care begins with you. Together we can help attain better outcomes for our CareSource PASSE members.

Sincerely,

CareSource™
PASSE

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# About CareSource PASSE™, LLC

## Welcome

Welcome, and thank you for participating with CareSource PASSE.

At CareSource PASSE, we refer to health care providers as our health partners. A “health partner” is any health care provider who participates in CareSource PASSE’s provider network. You may find “health partner” and health care provider used interchangeably in our manual, agreements and website.

We work together to ensure that our members – your patients or individuals – can improve their health and well-being. Because you are our partner, we strive to make it simple for you to do business with us. This manual directs you to the solutions you need, whether that’s through convenient online self-service solutions, fast prior authorizations or hassle-free claim payments. It’s our strong partnership that allows us together to facilitate a high-level of care and a respectful experience for our members.

We are a provider-led, community-based health plan that focuses on helping people of all circumstances transform their lives through quality health care and other services. We focus on partnering with local home and community based and health care providers to offer the services our members need to remain healthy.

As a Provider-Led Arkansas Shared Savings Entity (PASSE), we improve the health of our members by utilizing a contracted network of high-quality participating providers.

# About Us

CareSource PASSE was founded on the principles of quality and service delivered with compassion and a thorough understanding of caring for Arkansans dealing with complex behavioral and/or intellectual and developmental disabilities. We are mission-driven, providing quality care to our members. We offer process efficiencies and value-added benefits for our members and participating providers.

## Vision and Mission

**Our vision** is transforming lives through innovative health and life services.

**Our mission** is to make a lasting difference in our members' lives by improving their health and well-being.

At CareSource PASSE, our mission is one we take to heart. In fact, we call our mission our "heartbeat." It is the essence of our company, and our unwavering dedication is the hallmark of our success.

# What is a PASSE?

CareSource PASSE is a Provider-Led Arkansas Shared Savings Entity (PASSE). The CareSource PASSE is a Medicaid program that serves individuals with complex behavioral health, developmental or intellectual disabilities. The CareSource PASSE is a provider-led partnership between providers and CareSource to integrate the care and needs of the CareSource PASSE population through a care coordination model of care.

The goals of the PASSE model are:

- To improve the health of Arkansans who need specialized care for behavioral health issues or intellectual/developmental disabilities
- To link providers of physical health care with specialty providers of behavioral health and intellectual/developmental disabilities services
- To coordinate care for all community-based services for these individuals
- To allow flexibility in the types of services offered
- To increase the number of service providers available in the community to serve these members
- To reduce cost of care by coordinating and providing appropriate and preventive care

CareSource PASSE includes the following provider owners:

## Acadia – Arkansas

Acadia is a leading provider of behavioral health care services across the United States. Acadia operates a network of 227 behavioral health care facilities with approximately 9,900 beds in 40 states and Puerto Rico. With more than 20,000 employees serving approximately 70,000 patients daily, Acadia is one of the largest stand-alone behavioral health companies in the United States. Their network of treatment facilities offers multiple levels of care for various behavioral health and substance use disorders. At Acadia, their primary goal is to meet patients where they're at in their treatment process. They do this by providing a multitude of levels of care, including: detoxification, residential treatment for addiction, residential treatment for dual diagnosis, acute psychiatric inpatient hospitalization, medication-assisted treatment (MAT) service and an array of outpatient programming options, ranging from partial hospitalization programs (PHPs) and intensive outpatient programs (IOPs) to traditional outpatient services. Their expansive network of treatment facilities creates greater access to care, reduces the stigma associated with mental illness and addiction, and offers those in our communities a safe environment in which to receive the treatment they need.

## Ashley County Medical Center

Ashley County Medical Center is a licensed 33-bed critical access hospital located in the town of Crossett in South Arkansas. They presently have six CCU beds, six labor/delivery beds, eight generation beds, 13 med-surg beds, two OR suites, one endoscopy suite, six day surgery suites and nine emergency beds. The hospital has served Ashley County for over 100 years.

## Chenal Family Therapy

Chenal Family Therapy (CFT) is one of the fastest growing behavioral health providers in the United States, according to Inc. Magazine. They've grown from a single clinician in 2010 (Ken Clark, a Licensed Marriage and Family Therapist) to over 125 licensed mental health professionals in various locations throughout the state. CFT's unique model allows therapists, physicians and nurse practitioners to operate in an autonomous private practice-like setting, while also experiencing high-quality support with the back-office administration of insurance, billing, facilities, etc. Utilizing this model, CFT has been able to grow exponentially and begin filling substantial gaps in the Arkansas provider landscape. CFT is deeply committed to serving the Medicaid population and considers it a core value to ensure that the most vulnerable individuals and families in Arkansas receive the highest levels of dignified care.

## Dr. James E. Zini, D.O.

Dr. James E. Zini is an osteopathic physician who has been practicing in Mountain View for 43 years and is affiliated with multiple hospitals in the area. Dr. Zini started his family practice in 1977, providing primary care and community-focused public health for the people of rural Mountain View. He was the first osteopathic physician to be appointed to the Arkansas State Medical Board. His contributions to the field of osteopathic medicine extend well beyond Arkansas as he served as past president of the American Osteopathic Association. In addition, he served as past president of the Arkansas Osteopathic Medical Association and in 2002 the AOMA established the James E. Zini, D.O. "Young Physician Award" given to young physicians for significant contributions to the osteopathic profession. Throughout his career he has served as a teacher and mentor to young medical students, welcoming them to rotate in his family practice clinic and live in his home. Dr. Zini was instrumental in the foundation of the Arkansas College of Osteopathic Medicine in Fort Smith which opened in 2014, the first in-state osteopathic medical school. He is board certified in Osteopathic Family Medicine and affiliated with White River Medical Center, Ozark Health Medical Center, Stone County Medical Center and Unity. Dr. Zini served on the Board of AFMC for 10 years and as past president of the Board of the Arkansas Deportment of Health, where he still serves as a current member. In 2020, he was selected to receive the Dr. Tom Bruce Arkansas Health Impact Award.

## Rehab Net

Rehab Net is a collaborative group of independent therapists (OT/PT/SLP) that work together to provide the highest level of physical therapy, occupational therapy and speech therapy to patients in Arkansas. They support independent therapy clinics through professional and administrative education on best practice, regulatory education and billing education. They also provide support in employee management, insurance contracting, credentialing, lobbying and referral generation. Rehab Net's network provides services to PASSE, Medicaid and most commercial insurance plans with over 1,000 therapists currently in their network across 160 clinics in 42 Arkansas counties. Rehab Net has been focused on outcomes driven care for years and has worked collaboratively with payers in the region to demonstrate high-quality, efficient care.

## Our Services

- Provider services and support
- Life Services® and social determinants of health support for members
- Member eligibility/enrollment information
- Claim processing
- Delegated credentialing and recredentialing
- Decision-support informatics
- Quality improvement
- Regulatory/compliance
- Special investigations for fraud, waste and abuse
- Member services
- CareSource24®, Nurse Advice Line
- Concierge Care Coordination
- Utilization Management
- Service Determination

For more information on these programs, see the Member Support Services & Benefits section.

## Corporate Compliance

At CareSource PASSE, we serve a variety of groups – members, providers, government regulators, community partners and each other. We serve them best by working together with honesty, respect and integrity. Our Standards of Conduct, along with state and federal regulations, outlines the personal, professional, ethical and legal standards we must all follow.

Our Standards of Conduct, as outlined in the Corporate Compliance Plan, are an affirmation of CareSource PASSE's ongoing commitment to conduct business in a legal and ethical environment. They have been established to:

- Formalize CareSource PASSE's commitment to honest communication within the company and within the community
- Develop and maintain a culture that promotes integrity and ethical behavior
- Facilitate compliance with all applicable local, state and federal laws and regulations
- Implement a system for early detection and reporting of noncompliance with laws, regulations or CareSource PASSE policy

Our Standards of Conduct allow us to resolve problems promptly and minimize any negative impact on our members or business, such as financial losses, civil damages, penalties or criminal sanctions.

CareSource PASSE's Standards of Conduct, as outlined in the corporate compliance plan, comprise the formal company policy that outlines how everyone who represents CareSource PASSE should conduct themselves. This includes how we do our work and how we relate to each other in the workplace. It also includes the conduct of those we have business relationships with, such as providers, consultants and vendors.

We expect our providers to.

- Act according to these standards
- Let us know about suspected violations or misconduct
- Let us know if you have questions

Providers are expected to report any potential compliance concern or violation to CareSource PASSE through our anonymous compliance hotline at 1-844-784-9583 or through our anonymous compliance website: http://CareSource PASSE.ethicspoint.com.

For questions about provider expectations, please call Provider Services at **1-833-230-2100**.

The CareSource PASSE Corporate Compliance Plan is posted for your reference on **CareSourcePASSE.com** > About Us > Legal > Corporate Compliance.

The Anti-Fraud Plan is available on the Provider Portal at **CareSourcePASSE.com** > Login > Provider.

**Note:** You will need a username and password to log in to the Provider Portal.

Please let us know if you have questions about the CareSource PASSE Standards of Conduct and the Corporate Compliance Plan. We appreciate your commitment to compliance.

## Consumer Advisory Councils

CareSource PASSE recognizes the importance of engaging members, key constituents and stakeholders in the PASSE program. We developed a Consumer Advisory Council (CAC) to ensure people have the opportunity to provide meaningful feedback and important program information across the state. The CAC also helps guide our mission to empower individuals to lead fuller, healthier lives at home and in their communities.

Members and parents or guardians of children who are members are eligible to join the CAC. By serving on the CareSource PASSE CAC, participants can help improve the quality of service for all members of CareSource PASSE by sharing ideas and concerns.

# Communicating with CareSource PASSE

CareSource PASSE communicates with our network providers through a variety of methods including phone, fax, mail, our website at **CareSourcePASSE.com**, Provider Portal, newsletters, network notifications and in person through our provider orientations.

## Hours of Operation

| **Provider Services** | | |
|---|---|---|
| CareSource PASSE | Monday to Friday | 8 a.m. to 5 p.m.<br>(Central Standard Time) |

| **Member Services** | | |
|---|---|---|
| Care Coordination | Available 24 hours a day, seven days a week,<br>365 days a year | |
| CareSource24® | Available 24 hours a day, seven days a week,<br>365 days a year | |
| CareSource PASSE | Monday to Friday | 8 a.m. to 5 p.m.<br>(Central Standard Time) |
| CareSource PASSE Office | 425 West Capital, Ste 3000<br>Little Rock, AR 72201 | |

## Phone

To help us direct your call to the appropriate professional for assistance, you will be instructed to select the menu option that best fits your need. Please note that our menu options are subject to change. We also provide telephone-based self-service applications that allow you to verify member eligibility.

| | |
|---|---|
| **Provider Services** | 1-833-230-2100 |
| **CareSource PASSE Prior Authorization** | 1-833-230-2100 |
| **Claim Inquiries** | 1-833-230-2100 |
| **Pharmacy** | 1-833-230-2100 |
| **Superior Vision/Versant (Vision)** | 1-888-273-2121 |
| **Grievances & Appeals** | 1-833-230-2100 |
| **Member Services** | 1-833-230-2005 |
| **Care Coordination** | 1-833-230-2005 or CareCoordination@CareSourcePASSE.com |
| **Service Determination** | Servicedeterminations@CareSourcePASSE.com |
| **Incident Reporting** | Incident.reporting@CaresourcePASSE.com |
| **CareSource24® - Nurse Advice Line** | 1-833-687-7305 |
| **Fraud, Waste and Abuse Hotline** | 1-833-230-2100 or Servicedeterminations@CareSourcePASSE.com |
| **TTY for the Hearing Impaired** | 800-285-1131 or 711 |
| **NIA (High Tech Radiology)** | 1-800-424-4313 or www.RadMD.com |
| **Avalon (Lab)** | 1-844-227-5769 |
| **CareBridge (Electronic Visit Verification)** | 844-922-2584 or email: arevv@carebridgehealth.com |

## Regulatory Contacts

| | |
|---|---|
| **Department of Human Services PASSE Provider Line** | 1-888-889-6451 |
| **Arkansas Department of Human Services – PASSE Support** | https://humanservices.arkansas.gov/divisions-shared-services/medical-services/healthcare-programs/passe/ |
| **Office of the PASSE Ombudsman** | **Phone:** 1-844-843-7351<br>Individuals who have a hearing or speech impairment can contact the office by calling toll free, 1-888-987-1200 and selecting option 2.<br>**Online:** Submit issues or complaints by emailing PASSEOmbudsmanOffice@dhs.arkansas.gov<br>**Mail:**<br>Division of Medical Services<br>Office of Ombudsman<br>P.O. Box 1437 Slot S-418<br>Little Rock, AR 72203-1437<br>**Fax:** 501-404-4625 |

| | |
|---|---|
| **Optum (ARIA Independent Assessment)** | **Phone:** 1-844-809-9538 |
| **Arkansas Office of the Medicaid Inspector General (OMIG)** | **Mail:**<br>Office of the Medicaid Inspector General<br>323 Center Street, Suite 1200<br>Little Rock, AR 72201<br>**Phone:** 501-682-8349 or 855-527-6644<br>**Fax:** 501-682-8350 |
| **Arkansas Insurance Department** | 800-282-9134 or 501-371-2600 |

## Fax

| | |
|---|---|
| **Fraud, Waste and Abuse Reporting** | 800-418-0248 |
| **Medical Prior Authorization*** | 937-531-2398 |
| **Service Determination Team** | 844-542-2605 |
| **Provider Appeals and Disputes** | 833-230-2100 |
| **Provider Demographic Changes (e.g., office changes, adding/deleting providers)** | 833-230-2100 |

## Website

Our website, **CareSourcePASSE.com**, is a tool you can use to access important information quickly and easily. On the Provider section of the website, you will find a variety of resources, including:

- Newsletters, updates and announcements
- The provider manual and other plan resources
- Claim information
- Frequently asked questions
- Clinical and preventive guidelines
- Benefit grids
- Behavioral health information
- Authorization requirements and statistical reports
- Waiver service/home and community-based services (HCBS) guidelines

## Provider Portal

**URL:** https://providerportal.caresource.com/GL/SelectPlan.aspx

Our secure online Provider Portal at **CareSourcePASSE.com** > Login > Provider allows 24/7/365 access to valuable information, self-service features, resources and tools. Simply enter your username and password (if already a registered user) or submit your information to become a registered user. Assisting you is a top priority to achieve better health outcomes for our members.

## Portal Registration

If you are not registered with CareSource PASSE's Provider Portal, please follow these easy steps:

1. Go to the Provider Portal at **CareSourcePASSE.com** > Login > Provider, click the "register here" link and complete the three-step registration process. Please note: You will need your Tax ID and CareSource PASSE Provider ID, contained in your Welcome Letter.
2. Click Continue. Note the username and password you create so that you can access the portal's many helpful tools.
3. If you do not remember your username/password, please call Provider Services at **1-833-230-2100**.

## Provider Portal Benefits

The Provider Portal affords you the following benefits:

- An encrypted tool that allows you to easily access time-saving services and critical information
- Available 24 hours a day, 7 days a week, 365 days a year
- Accessible on any PC or device without additional software

## Provider Portal Tools

We encourage you to take advantage of the following time-saving tools:

- **Payment history** – Search for payments by check number or claim number.
- **Claims** – Search for status of claims, submit an online claim, submit attachments needed for proper claims processing, submit appeals and disputes and view claim history.
- **Coordination of benefits (COB)** – Confirm COB for patients.
- **Prior authorization** – Request authorization for medical and behavioral inpatient/outpatient services, Synagis® and Home and Community-Based Services (HCBS).
- **Eligibility termination dates** – View the member's eligibility date spans (if applicable) under the eligibility tab.
- **Benefit limits** – Track benefit limits electronically in real-time before services are rendered.
- **Person-centered service plans (PCSP)** – View person-centered service plans for members.
- **Monthly membership lists** – View and download current monthly membership lists.
- **Member eligibility** – Review the member's eligibility for service, as well as well as clinical alerts, covered benefits and more.
- **Member profile** – Access a comprehensive view of patient medical/pharmacy utilization.
- **Information exchange** – Share relevant member information to facilitate better integration of behavioral health and medical care.
- **CareSource PASSE Clinical Practice Registry** – View and sort CareSource PASSE members into actionable groups for improved focus on preventive care (e.g., well baby visits, diabetes, asthma).

### Demographic Information Changes

Advance written notice of status changes, such as a change in address, phone or adding or deleting a physician to your practice, helps us keep our records current. Your current information is critical for efficient claims processing.

The CareSource PASSE Provider Portal is the preferred method to submit changes. Simply log in to the Provider Portal by visiting **CareSourcePASSE.com** > Log-In > Provider entering your login credentials and selecting "Provider Maintenance" from the left-hand navigation.

**Email:** providermaintenance@CareSourcePASSE.com

### Mail:

CareSource PASSE
Attn. Provider Maintenance
P.O. Box 8738
Dayton OH 45401-8738

### Fax:

937-396-3076

## Mail

CareSource PASSE
P.O. Box 8738
Dayton, OH 45401-8738

### Medical Claim Submissions

CareSource PASSE
Attn: Claims Department
P.O. Box 2308
Dayton, OH 45401

### Pharmacy Claim Submissions

Express Scripts
Attn: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

## Vision Claim Submissions

The Versant/Superior Vision Provider Portal can be located at https://ecp.versanthealth.com/. Once you have signed up, claims can be submitted through a clearinghouse. Versant/SuperiorVision uses Change Healthcare. The payer ID is 41352.

Paper claims can be submitted to Superior Vision at:

Versant Health Claims Department
P.O. Box 967
Rancho Cordova, CA 95741

## Credentialing

CareSource PASSE
Attn: Vice President/Senior Medical Director
P.O. Box 8738
Dayton, OH 45401-8738

## Provider Grievances

CareSource PASSE
Attn: Provider Grievances
P.O. Box 2008
Dayton, OH 45401 – 2008

## Provider Disputes

CareSource PASSE
Attn: Provider Payment Disputes
P.O. Box 2008
Dayton, OH 45401 – 2008

## Provider Appeals

CareSource PASSE
Attn: Provider Appeals
P.O. Box 2008
Dayton, OH 45401 – 2008

## Member Grievances & Appeals

CareSource PASSE
Attn: Member Grievances and Appeals
P.O. Box 1947
Dayton, OH 45401-1947

### Fraud, Waste & Abuse*

CareSource PASSE
Attn. Program Integrity
P.O. Box 1940
Dayton, OH 45401-1940

*Information reported to us can be reported anonymously and is kept confidential to the extent permitted by law.

## Provider Communications

### Newsletters

CareSource PASSE communicates with providers in a variety of ways. Our newsletter is both mailed and posted online at **CareSourcePASSE.com** > Education > Newsletters & Communications, selecting CareSource PASSE from the dropdown menu. It contains operational updates, clinical articles and new initiatives underway at CareSource PASSE.

### Network Notifications

Network notifications are published for CareSource PASSE providers to regularly communicate updates to policies and procedures. Network notifications are found on our website at **CareSourcePASSE.com**> Providers > Tools & Resources > Updates & Announcements.

# Member Enrollment & Eligibility

## PASSE Enrollment

An independent assessment (IA) is required prior to becoming a member of a PASSE. Not all Medicaid enrollees can be enrolled in a PASSE. Individuals must need behavioral health or developmental disabilities services. An IA must be conducted by a qualified individual using an assessment instrument approved by the Arkansas Department of Human Services (DHS).

Beneficiaries who meet the following criteria will be excluded from the PASSE:

- Residents of a human development center (HDC)
- Residents of a skilled nursing facility (SNF)
- Residents of an assisted living facility (ALF)
- Participants of waiver services provided to adults with physical disabilities through the ARChoices in Homecare program or the Arkansas Independent Choices program or any successor waiver for frail, elderly or physically-disabled adults
- Beneficiaries receiving Arkansas Medicaid health care benefits on a medical spenddown basis

# Disenrollment

PASSE disenrollment will be based upon a determination by DHS that a member is no longer eligible to receive PASSE services. A member will be assigned to the same PASSE if re-enrollment occurs within 180 days of previous disenrollment.

Disenrollment may occur because of the following:

- If a member loses Medicaid eligibility.
- If a member is placed in a setting or receives services excluded from the PASSE, e.g. full admission to a Human Development Center, a skilled nursing or assisted living facility, or approval for waiver services provided through the ARChoices in Homecare or Independent Choices programs or successor waiver for the frail, elderly or physically disabled.
- If a member's ARIA re-assessment does not occur within the required timeframes or the reassessment determines that the member no longer has a functional need for PASSE services.

# Reasons for Disenrollment

## Disenrollment Initiated by the Member

A member may voluntarily transition from their assigned PASSE and choose another PASSE within 90 days of initial assignment. A member will not be permitted to change their PASSE more than once within a 12 month period, unless cause for transition, as described in 42 CFR § 438.56, is met.

There will be a yearly open enrollment period when a mandatorily enrolled member may voluntarily transition to a different PASSE. The annual open enrollment period when members can transition their PASSE will be established by DHS and will be for no shorter than 30 days on a yearly basis. If no action is taken by members, they will remain in their current PASSE and will not be permitted to change their PASSE, unless cause for transition, as described in 42 CFR § 438.56, is met for the following year.

Cause for transition, as described in 42 CFR § 438.56, is as follows:

- The member moves out of state;
- The PASSE for which the member is assigned is sanctioned pursuant to Sections I and II of this manual, the PASSE Provider Agreement or any state or federal regulations and laws;
- The PASSE does not, because of moral or religious objections, cover the service the member seeks; or
- Other reasons, including poor quality of care, lack of access to services covered under the PASSE agreement or lack of access to providers experienced in dealing with the member's care needs.

Transition from a PASSE will be processed by DHS after request of change by the member. The effective date of an approved transition must be no later than the first day of the second month following the month in which the member request for transition was received.

To request a transition, a member should contact the Arkansas Department of Human Services, Beneficiary Support Center at 1-833-402-0672.

DHS reserves the right to transition beneficiaries in compliance with 42 CFR 438.56.

### Disenrollment Initiated by CareSource PASSE

The PASSE may not request disenrollment of a member because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity or uncooperative or disruptive behavior resulting from his or her special needs (except when, as determined by DHS, his or her continued enrollment in the PASSE seriously impairs the PASSE's ability to furnish services to either this particular member or other members).

The PASSE cannot transition any assigned member and is responsible for all eligible services provided to that member during the time the member is eligible and a member of CareSource PASSE.

## Eligibility

The following beneficiaries are eligible for mandatory assignment to a PASSE:

A. Beneficiaries identified to meet Tier II or Tier III Level of Care as determined by an independent assessment under criteria established DHS.

1. For beneficiaries with behavioral health (BH) service needs:
    a. Tier II – At this level of need, services are provided in a counseling services setting but the level of need requires a broader array of services.
    b. Tier III – Eligibility for this level of need will be identified by additional criteria, which could lead to inpatient admission or residential placement.
2. For beneficiaries with Developmental Disabilities (DD) service needs:
    a. Tier II – The individual meets the institutional level of care criteria and is eligible to receive paid services and supports.
    b. Tier III – The individual meets the institutional level of care criteria and is eligible for the most intensive level of services, including 24/7 paid services and supports.
3. For beneficiaries who are dually diagnosed (behavioral health and developmental disabilities service needs):
    a. The member meets the institutional level of care criteria by the Division of Developmental Disabilities (DDS) and has received an Independent Assessment and been determined to meet Tier II or Tier III Level of Care.
        i. Individuals who have a primary diagnosis that is a behavioral health or intellectual/developmental disability and a secondary diagnosis that is a behavioral health or intellectual/developmental disability (both diagnoses cannot be behavioral health or developmental disability); and
        ii. Have met the institutional level of care for ICF/IID; and
        iii. Have received an IA and are eligible for Tier II or Tier III behavioral health services.
        iv. The DHS Dual Diagnosis Evaluation Committee must review and approve all members that will be placed into the dually diagnosed category.

## New Member ID Cards and Kits

Each member receives a new member booklet the contains an ID card for CareSource PASSE.

The new member booklet also contains:

- A quick start guide for how to get started with CareSource PASSE
- Post cards to send in if the member wants to request paper copies of the Member Handbook and/or Provider Directory

The new member kit will also include information on how to reach out to the CareSource PASSE care coordinator. Members are also encouraged to view the handbook online.

**Note:** Members will receive a Provider Directory only if they requested one at the time of enrollment or if they return a request postcard included in new member kits that indicates they would like a printed copy. The new member kits also include the member's CareSource PASSE ID card. The Provider Directory lists participating CareSource PASSE providers and facilities within a certain radius of the member's residence. As the contents of the printed directory are subject to change, we encourage members to call CareSource PASSE or the provider directly to confirm they are in network. The most current list of providers can be found at any time on CareSource PASSE's website using our Find a Doctor/Provider tool.

## Verify Eligibility

Providers may access the Provider Portal at **CareSourcePASSE.com** > Login > Provider to verify member eligibility. After logging in to the Provider Portal, providers can view member eligibility with:

- 24 months of history
- Date of service plus member name, date of birth, case number, Medicaid ID number or CareSource PASSE member ID number
- Multiple member look-up (up to 500)

Providers can also verify eligibility by calling Provider Services at **1-833-230-2100** and using our interactive voice response system.

# Provider Roles & Responsibilities

To make it easier for you, we have outlined key responsibilities of your participation with CareSource PASSE. These key components strengthen our partnership with you and enable us to meet or exceed our commitment to improve the health care of the underserved. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of underserved consumers.

## Provider Responsibilities

- Participating providers, or their designees, are expected to make daily visits to their patients who have been admitted as inpatients to an acute care facility or to arrange for a colleague to visit.
- Participating primary care providers (PCPs) are expected to have a system in place for following up with patients who miss scheduled appointments.
- Participating providers are expected to treat members with respect. CareSource PASSE members should not be treated any differently than patients with any other health care insurance. Please reference our Member Rights & Responsibilities.
- Follow CareSource PASSE's non-discrimination policy.
- Providers shall not distribute information to a potential member about enrolling in a CareSource PASSE or influence members in any way towards enrollment in a CareSource PASSE.
- Providers should participate in the developments of the Person-Centered Service Plans (PCSP).

## Member Required Access to Services

| Service Type | Time Frame |
|---|---|
| **Emergency Care – Medical, Behavioral Health, Substance Abuse** | 24 hours a day, 7 days a week |
| **Behavioral Health Service and Developmental Disability Service Mobile Crisis Response** | 24 hours a day, 7 days a week |
| **Urgent Care – Medical, Behavioral Health, Substance Abuse** | Within 24 hours |
| **Primary Care – Routine, non-urgent symptoms** | Within 21 calendar days |
| **Behavioral Health, Substance Abuse Care – Routine, non-urgent, non-emergency** | Within 21 calendar days |
| **Behavioral Health Care for Non-Threatening Emergency** | 6 hours |
| **Behavioral Health Initial Visit for Routine Care** | |
| **Prenatal Care** | Within 14 calendar days |
| **Primary Care Access to after-hours care** | Office number answered 24 hours/7 days a week by answering service or instructions on how to reach a physician |
| **Preventive visit/well visits** | Within 30 calendar days |
| **Specialty Care – non-urgent** | Within 60 calendar days |

PCPs, are expected to provide 24-hour availability to your CareSource PASSE patients by telephone. Whether through an answering machine or a recorded message used after hours, patients should be provided the means to contact their provider or a back-up physician to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up physician and only recommends emergency room use for after hours.

CareSource PASSE expects participating providers to verify member eligibility and ask for all insurance information before rendering services, except in an emergency. Providers can verify member eligibility and obtain information for other insurance coverage that we have on file by accessing the Provider Portal at **CareSourcePASSE.com** > Login > Provider.

## Provider Status Changes

Advance written notice of status changes, such as a change in address, phone or adding or deleting a physician to your practice, helps us keep our records current. Your current information is critical for efficient claims processing.

The CareSource PASSE Provider Portal is the preferred method to submit changes. Simply log in to the Provider Portal by visiting **CareSourcePASSE.com** > Login > Provider, entering your login credentials and selecting “Provider Maintenance” from the left-hand navigation.

## Email

providermaintenance@CareSourcePASSE.com

### Mail

CareSource PASSE
Attn. Medical Director
P.O. Box 8738
Dayton OH 45401-8738

### Fax

937-396-3076

### Timeline of Provider Changes

Providers should notify CareSource PASSE of intent to terminate 120 calendar days prior to the intended date of termination.

## Primary Care Providers (PCPs)

All CareSource PASSE members choose or are assigned to a PCP upon enrollment in the plan. PCPs should help facilitate a medical home for members. This means that PCPs will help coordinate health care for the member and provide additional health options to the member for self-care or care from community partners.

Members may select a new PCP from our Provider Directory or initiate the change by calling the Member Services department.

CareSource PASSE allows for PCPs to include not only traditional provider types that have historically served as PCPs, but also alternative provider types such as specialists and patient-centered medical homes (PCMH) with documented physician oversight and meaningful physician engagement. A member who has a primary diagnosis of a severe persistent mental illness may be permitted to have any physician, including a psychiatrist, as his or her PCP.

A member may select a PCP as a medical home from the following types of providers:

- Family practice physicians
- General practice physicians
- Pediatricians (for members up to age 19)
- Internal medicine
- Nurse practitioners certified (NP-C) specializing in:
  - Family practice
  - Pediatrics
- Physicians who provide medical services at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).
- Providers who practice at Public Health Department clinics and hospital outpatient clinics when most of their practice is devoted to providing continuing comprehensive and coordinated medical care
- Physician assistants (physician will be listed as member's PCP)

If a member does not select a PCP, CareSource PASSE will assign them one, unless a member has Medicare as their primary insurance. Members who have Medicare may choose to keep their existing PCP.

### Roles and Responsibilities

PCP care coordination responsibilities include at a minimum, the following:

- Assisting with coordination of the member's overall care, as appropriate for the member
- Serving as the ongoing source of primary and preventive care
- Recommending referrals to specialists, as required
- Triaging members
- Participating in the development of the member's person-centered service plan (PCSP)

In addition, CareSource PASSE PCPs play an integral part in coordinating health care for our members by providing:

- Availability of a personal health care practitioner to assist with coordination of a member's overall care, as appropriate for the member
- Continuity of the member's total health care
- Early detection and preventive health care services
- Elimination of inappropriate and duplicate services

PCPs are responsible for:

- Treating CareSource PASSE members with the same dignity and respect afforded to all patients, including high standards of care and the same hours of operation
- Providing preventive care and teaching healthy lifestyle choices
- Assessing the urgency of members' medical needs and directing members to the best place for care
- Identifying members' health needs and taking appropriate action
- Providing phone coverage for handling patient calls 24 hours a day, seven days a week
- Making referrals to medical specialists when necessary
- Following all referral and prior authorization policies and procedures as outlined in this manual
- Complying with the quality standards of our health plan and DHS
- Providing 30 days of emergency coverage to any CareSource PASSE patient dismissed from the practice
- Maintaining clinical records, including information about pharmaceuticals, referrals and inpatient history
- Obtaining patient records from facilities visited by CareSource PASSE patients for emergency or urgent care, if notified of the visit
- Ensuring demographic and practice information is up to date for directory and member use

## Medical Home

To facilitate total care integration for our members, CareSource PASSE encourages a medical home care model. A medical home is a long-term partnership between the PCP/provider team, the patient and the patient's family. The care model focuses on the whole patient, with support and advice focusing on prevention.

The model provides many benefits to the member and provider, including fewer hospital/emergency room visits, higher patient satisfaction, improved access for members in rural environments and higher quality at a lower cost to the health care system.

## Key Contract Provisions

To make it easier for you, we have outlined key components of your contract. These key components strengthen our partnership with you and enable us to meet or exceed our commitment to improve the health care of the underserved. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of underserved consumers.

Participating providers are responsible for:

- Providing CareSource PASSE with advance written notice of any intent to terminate an agreement with us. This must be done 120 days prior to the date of the intended termination and submitted on your organization's letterhead.
- Providing 24-hour availability to your CareSource PASSE patients by telephone (PCPs). Whether through an answering machine or a taped message used after hours, patients should be provided the means to contact their provider or a back-up physician to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up physician and only recommends emergency room use for after hours.
- Submitting clean claims within 365 days of the date of service or discharge.
- Keeping all demographic and practice information up to date.

Our agreement also indicates that CareSource PASSE is responsible for:

- Processing 95 percent of all clean claims submitted within 30 days of receipt.
- Providing you with an appeals procedure for timely resolution of any requests to reverse a CareSource PASSE determination regarding claim payment. Our appeal process is outlined in the Grievances & Appeals section of this manual.
- Offering a 24-hour nurse advice line for members to reach a medical professional at any time with questions or concerns.

These are just a few of the specific terms of our agreement. In addition, we expect participating providers to follow standard practice procedures even though they may not be spelled out in our provider agreement.

## Member/Caregiver Rights and Responsibilities

As a CareSource PASSE provider, you are required to respect the rights of our members. Members and caregivers are informed of member rights and responsibilities via the CareSource PASSE Member Handbook.

All members are encouraged to take an active and participatory role in their own health and the health of their family. Member rights, as stated in the member handbook, are as follows:

- To receive information about CareSource PASSE, its services, its practitioners and providers, and member rights and responsibilities.
- To receive all services that CareSource PASSE must provide.
- To be treated with respect and with regard for their dignity and privacy.
- To be sure that their medical records and personal information will be kept private.
- To be given information about their health. This information may also be available to someone who the member has legally authorized to have the information or who the member has said should be reached in an emergency when it is not in the best interest of the member's health to give it to him/her.

- To candidly discuss any appropriate or medically necessary treatment options for the member's condition, regardless of cost or benefit coverage.
- To participate in decisions regarding his or her health care, including the right to refuse treatment.
- To voice complaints or appeals about the plan or the care it provides.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- To be sure that others cannot hear or see the member when he/she is getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease or revenge as specified in federal regulations.
- To request and receive a copy of his or her medical records and request to amend or correct the record.
- To be able to say yes or no to having any information about himself/herself given out unless CareSource PASSE must by law.
- To be able to say no to treatment or therapy. If the member says no, the provider or CareSource PASSE must talk to him/her about what could happen and a note must be placed in the member's medical record about the treatment refusal.
- To be able to file an appeal, a complaint, a grievance or state hearing, and that the exercise of those rights will not adversely affect the way the member is treated.
- To be able to get all CareSource PASSE written member information from CareSource PASSE:
  - At no cost to the member
  - In the prevalent non-English languages of members in CareSource PASSE's service area
  - In other ways, to help with the special needs of members who may have trouble reading the information for any reason
- To be able to get help free of charge from CareSource PASSE and its providers if the member does not speak English or needs help in understanding information.
- To be able to get help with sign language if the member is hearing impaired.
- To be told if the health care provider is a student and to be able to refuse his/her care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives.
- To know that CareSource PASSE must follow all federal and state laws and other laws about privacy that apply.
- To have choice in the providers rendering the member's care.
- To be able to get a second opinion from a qualified provider on CareSource PASSE's panel. If a qualified provider is not able to see the member, CareSource PASSE must set up a visit with a provider not on its panel.
- To not be held liable for CareSource PASSE's debts in the event of insolvency.
- To not be held liable for the covered services provided to the member for which DHS does not pay CareSource PASSE.
- To not be held liable for covered services provided to the member for which DHS or CareSource PASSE does not pay the provider that furnishes the services.

- To not be held liable for payments of covered services furnished under a contract, referral or other arrangement to the extent that those payments are more than the amount the member would owe if CareSource PASSE provided the services directly.
- To be responsible for cost sharing only in accordance with 42 CRF 447.50 through 42 CRF 447.60.
- To not be billed for any service covered by Medicaid.
- To make recommendations regarding CareSource PASSE's member rights and responsibility policy.
- To contact the United States Department of Health and Human Services Office of Civil Rights at the address below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services.

  Office for Civil Rights
  U.S. Department of Health and Human Services
  Sam Nunn Atlanta Federal Center, Suite 16T70
  61 Forsyth Street, S.W.
  Atlanta, GA 30303-8909

  Customer Response Center: 800-368-1019
  Fax: 202-619-3818
  TDD: 800-537-7697

Members of CareSource PASSE are also informed of the following responsibilities:

- Use only approved providers, except in emergency or other situations approved by CareSource PASSE.
- Keep scheduled doctor appointments, be on time and call 24 hours in advance of a cancellation.
- Follow the advice and instructions for care he/she has agreed upon with his/her doctors and other providers.
- Always carry his/her ID card and present it when receiving services.
- Never let anyone else use his/her ID card.
- Notify his/her county Department of Human Services (DHS) and CareSource PASSE of a change in phone number or address.
- Contact his/her PCP after going to an urgent care center or after getting medical care outside of CareSource PASSE's covered counties or service area.
- Let CareSource PASSE and the county DHS know if he/she has other health insurance coverage.
- Provide the information that CareSource PASSE and his/her providers need to provide care.
- Understand as much as possible about his/her health issues and take part in reaching goals that the member and his/her provider agree upon.

CareSource PASSE distributes the member rights and responsibilities statements to the following groups upon their enrollment and annually thereafter:

- New members
- Existing members
- New practitioners
- Existing practitioners

# Privacy

## Personally Identifiable Information

In the day-to-day business of patient treatment, payment and health care operations, CareSource PASSE and its providers routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, various standards and industry best practices dictate that PII be appropriately protected wherever it is stored, processed and transferred while conducting normal business.

As a provider, you should be taking measures to secure your sensitive data, and you are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to secure protected health information (PHI).

There are many controls you should have in place to protect sensitive PII and PHI. Here are a few important places to start:

- Use a secure message tool or service to protect data sent by email.
- Limit paper copies of PHI and PII left out in the open in your workplace and shred this content when no longer needed.
- Encrypt laptops and other portable media like CD-ROMs and flash drives.
- Ensure conversations involving patient information cannot be overheard by others.
- Ensure all employees complete a HIPAA training program and understand the importance of safeguarding patient information.

CareSource PASSE will share patient information with you on occasion and will ask you to share patient information with us. CareSource PASSE, like you, is a covered entity under HIPAA. It is permissible for covered entities to share patient information when necessary for treatment, payment or health care operations.

# HIPAA Privacy Practices

Members are notified of CareSource PASSE's privacy practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). CareSource PASSE's privacy practices include a description of how and when member information is used and disclosed within and outside of the CareSource PASSE organization. The notice also informs members, in partnership with our providers, on how they may obtain a statement of disclosures or request their medical claim information.

CareSource PASSE takes measures across our organization to protect oral, written and electronic personally identifiable health information, specifically, protected health information (PHI) of members. Please remember that as a covered entity, you are obligated to follow the same HIPAA regulations and only make reasonable and appropriate uses and disclosures of protected health information for treatment, payment and health care operations.

## Care Coordination and HIPAA

Care coordination is an approach to health care in which all a patient's needs are coordinated with the assistance of a primary point of contact. Strong care coordination improves partnerships between the patients/members, providers and CareSource PASSE.

The Code of Federal Regulations (CFR) 42 CFR § 438.208 allows providers to legally share patients' information with CareSource PASSE for care coordination purposes.

- Contract requirements: Contracts between CareSource PASSE and providers require providers to follow federal and state requirements and cooperate with the health plans' quality care delivery guidelines.
- HIPAA-required validation questions: If the identification of the caller is in question, the provider can ask HIPAA-approved validation questions such as date of birth, address or Medicaid ID number.
- Communication among treating providers: Physical and behavioral health providers are required to coordinate care, including sending status reports to each other.

Per 45 CFR § 164.506, a covered entity may, under certain circumstances, use or disclose protected health information without the written consent of the member.

- In general, a provider may share a patient's protected health information with CareSource PASSE for purposes of care coordination and obtaining appropriate health or community-related services without a patient's consent.
- CareSource PASSE may share a member's protected health information without the member's consent in cases of transition from one PASSE to another PASSE for the purpose of coordinating member treatment or care (e.g., during Medicaid open enrollment period when a Medicaid recipient chooses a different managed care plan during an active course of treatment).

## Member Consent to Share Health Information

Consent is the member's written permission to share their information. Not all disclosures require the member's permission. Consent requirements pertain to Sensitive Health Information (SHI) and Substance Use Disorder (SUD) treatment.

- SHI is defined by the state (e.g., HIV/AIDS, mental health, sexually transmitted diseases).
- SUD 42 CFR Part 2 (Part 2), at https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr2_main_02.tpl pertains to federal requirements that apply to all states.

While all member data is protected under the HIPAA Privacy Rules, Part 2 provides more stringent federal protections in an attempt to protect individuals with substance use disorders who could be subjected to discrimination and legal consequences in the event their information is inappropriately used or disclosed. The state requirements provide more stringent protections for the sharing of certain information determined to be SHI.

In an effort to help you efficiently coordinate care for our members, CareSource PASSE has automated the Member Consent/HIPAA Authorization Form available on our member Forms page at **CareSourcePASSE.com** > Providers > Tools & Resources > Forms.

When consent is on record, CareSource PASSE will display all member information on the Provider Portal at **CareSourcePASSE.com** > Login > Provider and any health information exchanges. Please explain to your patients that if they do not consent to let CareSource PASSE share this information, the providers involved in their care may not be able to effectively coordinate their care. When a member does not consent to share this information, a message displays on the Provider Portal to indicate that all the member's health information may not be available to all members.

The Member Consent/HIPAA Authorization Form can also be used to designate a person to speak on the member's behalf. This designated representative can be a physician, an attorney, a relative or some other person that the member specifies.

## Emergency Department Diversion Program

CareSource PASSE is committed to making sure our members access the most appropriate health care services at the appropriate time for their needs. We instruct members to call their PCP or the CareSource24 Nurse Advice Line if they are unsure if they need to go to an emergency room (ER).

Members are advised to call 911 or go to the nearest ER if they feel they have an emergency. CareSource PASSE covers all emergency services for our members and educates members on the appropriate use of urgent care facilities and the urgent care sites they can access.

Member ER utilization is tracked closely by care coordination. Care Coordinators will follow up with members within seven days of discharge via phone or mail. Intervention includes education, as well as assistance with discharge planning and removing any identified health care access barriers. We appreciate your cooperation in educating your patients on the appropriate utilization of emergency services.

## Medical Records

Providers shall prepare, maintain and retain as confidential the health records of all members receiving health care services and members' other personally identifiable health information received from CareSource PASSE, in a form and for time periods required by applicable state and federal laws, licensing requirements, accreditation and reimbursement rules and regulations to which physicians and providers are subject, and in accordance with accepted practices.

Providers are required to maintain member records on paper or in an electronic format. Member medical records shall be timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review.

Complete medical records include, but are not limited to, medical charts, applicable directives, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records and other documentation sufficient to disclose the quantity, quality, appropriateness and timeliness of services provided under the contract. Medical records shall be signed by the provider of service.

The PCP also must maintain a primary medical record for each member that contains sufficient medical information from all providers involved to ensure quality of care.

The medical chart organization and documentation shall, at a minimum, require the following:

- Member/patient identification information, on each page
- Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school name and telephone numbers (if no phone, contact name and number) of emergency contacts, consent forms, identification of language spoken and guardianship information
- Date of data entry and date of encounter
- Provider identification by name
- Allergies, adverse reactions and known allergies noted in a prominent location
- Past medical history, including serious accidents, operations and illnesses [for children, past medical history includes prenatal care and birth information, operations and childhood illnesses (e.g., documentation of chickenpox)
- Identification of current problems

- The consultation, laboratory and radiology reports in the medical record shall contain the ordering provider's initials or other documentation indicating review
- Documentation of immunizations
- Identification and history of nicotine, alcohol use or substance abuse
- Documentation of reportable diseases and conditions submitted to the local health department serving the jurisdiction in which the patient resides or the Department for Public Health
- Follow-up visits provided and (secondary) reports of emergency room care
- Hospital discharge summaries
- Advance medical directives, for adults
- All written denials of service and the reason for the denial
- Record legibility to at least a peer of the writer (records judged illegible by one reviewer shall be evaluated by another reviewer)

A member's medical record shall include the following minimal detail for individual clinical encounters:

- History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's physical/behavioral health, including mental health and substance abuse status
- Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (e.g., Early and Periodic Screening, Diagnostic and Treatment) addressed from previous visits
- Plan of treatment including:
  - Medication history and medications prescribed, including the strength, amount, directions for use and refills
  - Therapies and other prescribed regimen
  - Follow-up plans including consultation and referrals and directions, including time to return

A member's medical record shall include the following minimal detail for hospitals and mental hospitals:

- Identification of the beneficiary
- Physician name
- Date of admission and dates of application for and authorization of Medicaid benefits, if application is made after admission; the plan of care (as required under 42 CFR § 456.172 (mental hospitals) or 42 CFR § 456.70 (hospitals)
- Initial and subsequent continued stay review dates (described under 42 CFR § 456.233 and 42 CFR § 465.234 (for mental hospitals) and 42 CFR 456.128 and 42 CFR § 456.133 (for hospitals)
- Reasons and plan for continued stay if applicable
- Other supporting material the committee believes appropriate to include
- For non-mental hospitals only:
  - Date of operating room reservation
  - Justification of emergency admission if applicable

# Providers of Home and Community-Based Services Under 1915(i) & 1915(c) Waivers

Until PASSE HCBS providers are a registered and fully functional provider type in MMIS, the PASSE is responsible for the annual certification of CES Waiver Providers. All other provisions, except annual certification, outlined in this Agreement apply to all providers providing home and community-based services including the Arkansas Community Independence Program.

## Organizational Requirements

All HCBS providers must be enrolled in Arkansas Medicaid as an HCBS provider. To enroll in Arkansas Medicaid as a PASSE HCBS provider, the HCBS provider must be credentialed as such by the PASSE.

a. The PASSE is required to submit a yearly attestation that all PASSE HCBS providers have been certified on an annual basis. DHS will audit the PASSE's records to ensure compliance with the annual certification requirement. Any PASSE HCBS provider discovered not to have been certified annually will be disenrolled as a Medicaid provider. Failing to annually certify HCBS providers that are enrolled with Medicaid may lead to sanctions by DHS in accordance with Section 14.1.

b. The PASSE's credentialing process must be approved by DHS and include the following, at a minimum, for HCBS providers:
    - Audit requirements;
    - Inspection requirements;
    - Complaint resolution process;

- Performing provider requirements; and
- Any other information required for the PASSE to credential an HCBS provider as such.

1. Provider Governing Documents Available for Inspection: All governing documents, policies, procedures or other equivalent operating documents of a PASSE HCBS provider shall always be readily available for PASSE and DHS inspection and review upon request.
2. Legal Existence and Good Standing: A PASSE HCBS provider shall at all times be duly organized, validly existing and in good standing as a legal entity under the laws of the State of Arkansas, with the power and authority under the appropriate federal, state or local statues to own and operate its business as presently conducted.

# Hiring Procedures & Personnel Record Maintenance

## Hiring Procedures and Required Personnel Records

A. Prior to Employment
   1. The PASSE HCBS Provider must obtain and verify each of the following from an applicant prior to employment:
      a. A completed job application that includes all the applicants' required current and up-to-date credentials
      b. A signed criminal conviction statement
      c. All required criminal background checks, as outlined in A.C.A. § 20-38-101 et. seq. and §20-48-812 or any applicable successor statutes. The PASSE and DHS require criminal background checks for the applicant, their spouse and any children or other adult over the age of eighteen (18) if a beneficiary is to be permitted to stay overnight in an applicant's residence.
      d. A signed declaration of truth statement
      e. Completed reference checks
      f. A successfully passed drug screen
      g. If the applicant is applying for a position where transportation is required, a current and valid driver's license or a commercial driver's license (CDL), as appropriate

# Incident Reporting

## Reportable Incidents

PASSE providers must submit an incident report to the DHS PASSE Quality Assurance unit and the appropriate PASSE, using the reporting form via secure e-mail upon the occurrence of any one of the following events:

1. Death of beneficiary.
2. The use of any restrictive intervention, including seclusion, or physical, chemical or mechanical restraint on a beneficiary.
3. Suspected maltreatment or abuse of a beneficiary.
4. Any injury to a beneficiary that:

   a. Requires the attention of an Emergency Medical Technician, a paramedic or physician
   b. May cause death
   c. May result in a substantial permanent impairment
   d. Requires hospitalization

5. Threatened or attempted suicide by a beneficiary.
6. The arrest of a beneficiary, or commission of any crime by a beneficiary.
7. Any situation in which the whereabouts of a beneficiary is unknown for more than two hours (i.e. elopement and/or wandering), or where services are interrupted for more than two hours.
8. Any event where a staff member threatens a beneficiary.
9. Unexpected occurrences involving actual or risk of death or serious physical or psychological injury to a beneficiary.
10. Medication errors made by staff that cause or have the potential to cause serious injury or illness to a beneficiary, including, but not limited to, loss of medication, unavailability of medication, falsification of medication logs, theft of medication, a missed dose, wrong dose, a dose being administered at the wrong time, by the wrong route and the administration of the wrong medication.
11. Any violation of a beneficiary's rights that jeopardizes the health, safety or quality of life of the beneficiary.
12. Any incident involving property destruction by a beneficiary.
13. Vehicular accidents involving a beneficiary.
14. Biohazard incidents involving a beneficiary.
15. An arrest or conviction of a staff member providing direct care services.
16. Any use or possession of a non-prescribed medication or an illicit substance by a beneficiary.
17. Any other event that might have resulted in harm to a beneficiary or could have reasonably endangered the health, safety or welfare of the beneficiary.

In addition to submitting incident reports for the reportable incidents described above to the DHS PASSE Quality Assurance unit using the reporting form via secure e-mail, PASSE HCBS providers are to also forward a copy of each incident report to the client's assigned PASSE. If the incident involves an employee of a PASSE HCBS provider and you are in network at multiple PASSEs, the incident must be sent all. Incident reports involving unexpected occurrences involving actual or risk of death or serious physical or psychological injury to a beneficiary are considered sentinel events and will be investigated by the DHS.

## Reporting Timeframes

A. Immediate Reporting

Providers must report the following incidents to the DHS PASSE Quality Assurance unit emergency number (501) 371-1329 within one hour of occurrence, regardless of the hour as well as the on-call emergency number for the appropriate PASSE:

1. A death not related to the natural cause of the patient's illness
2. Serious physical or psychological injury to a beneficiary

B. Incidents Involving Potential Publicity

Incidents, regardless of category, that a PASSE HCBS provider should reasonably know might be of interest to the public and/or media must be immediately reported to the DHS PASSE Quality Assurance unit and the appropriate PASSE.

C. All Other Incident Reports
Except as otherwise provided above in subsection A and B, all reportable incidents must be reported to the DHS PASSE Quality Assurance unit and the appropriate PASSE, using the automated PASSE HCBS Incident Report Form via secure e-mail no later than two (2) days following the incident. Any incident that occurs on a Friday is still considered timely if reported by the Monday immediately following.

## Required Incident Report Contents

A. Initial Incident Report
Each initial incident report filed by a PASSE HCBS provider must contain the following information:

1. Date of the incident
2. Detailed description of the accident/injury
3. Time of the incident
4. Location of the incident
5. Persons involved in the accident
6. Other agencies contacted regarding the incident and the name of the individual in the agency that was contacted
7. Whether the guardian was notified of the incident and time of notification
8. Whether the police were involved, and if so, a detailed description of their involvement
9. Any action taken by the provider or staff of the provider, both at the time of incident and subsequent to the incident
10. Any expected follow-up
11. Name of person that prepared the report

When applicable, the PASSE HCBS provider shall notify the parent or legal guardian of the beneficiary any time an incident report is submitted.

B. Follow-Up Incident Reports

Information that is not available at the time of the initial incident report filing must be submitted in follow-up or final incident reports. These reports should be submitted in the same manner as soon as the additional information becomes available.

1. The initial report should be resubmitted with the “follow up” or “final” report areas checked and dated in the appropriate space on the incident form
2. The current date should precede the new information in the text/narrative sections to differentiate follow-up information from the information originally submitted.
3. A new PASSE Incident Report Form should be submitted for follow-up and final reports only when there is insufficient space on the original form. Whenever a new form is submitted, the date of the original written report must be included for cross- referencing.

### Mandated Reporters

The Arkansas Child Maltreatment Act and the Arkansas Adult Maltreatment Act deem all staff of PASSE HCBS providers to be mandated reporters of any suspected adult or child abuse, neglect, exploitation and maltreatment. Failure on the part of a PASSE HCBS provider to properly report suspected abuse, neglect, exploitation and maltreatment to the appropriate hotline is a violation of these minimum standards.

## Beneficiary and Legal Guardian Rights

### Beneficiary/Guardian Rights Policy

Each PASSE HCBS provider must implement policies that enumerate in clear and understandable language each beneficiary's rights and the rights of the legal guardian of each beneficiary. The PASSE HCBS provider must take reasonable steps to ensure beneficiaries and their legal guardians are: (i) informed of their rights; (ii) provided copies of the policies enumerating their rights prior to the initiation of services and at any other time upon request; and (iii) that the information is transmitted in a manner that the beneficiary and their legal guardian are able to read and understand.

### Beneficiary Rights

Each PASSE HCBS provider must, at a minimum, ensure the following beneficiary rights:

1. The right to be free from:
    a. Physical or psychological abuse or neglect
    b. Retaliation
    c. Coercion
    d. Humiliation
    e. Financial exploitation
    f. Discrimination

The PASSE HCBS provider must ensure that the application of corporal punishment to beneficiaries is prohibited. "Corporal punishment" refers to the application of painful stimuli to the body to terminate behavior or as a penalty for behavior.

1. The freedom to control their own financial resources.
2. The freedom to receive, purchase, possess and use individual personal property. Any restriction on this right must be supported by an assessed need and justified in the beneficiary's person-centered service plan ("PCSP").
3. The freedom to actively and meaningfully make decisions affecting their life and access pertinent information in a timely manner to facilitate such decision making.
4. The right to privacy. Any restriction on this right must be supported by an assessed need and justified in the PCSP.
5. The right to choose roommate when sharing a bedroom.
6. The freedom to associate and communicate publicly or privately with any person or group of people of the beneficiary's choice at any time. Any restriction on this right must be supported by an assessed need and justified in the PCSP.

7. The freedom to have visitors of their choosing at any time.
8. The freedom of religion.
9. The right to be free from the inappropriate use of a physical or chemical restraint, medication or isolation as punishment.
10. The opportunity to seek employment and work in competitive, integrated settings.
11. Freedom from being required to work without compensation.
12. The right to be treated with dignity and respect.
13. The right to receive due process.
    a. ASSE HCBS providers must ensure beneficiaries have access to legal entities for appropriate and adequate representation, advocacy support services and must adhere to research and ethics guidelines (45 CFR § 46.101 et. seq.).
    b. PASSE HCBS provider rules may not contain provisions that result in the unfair, arbitrary or unreasonable treatment of a beneficiary.
14. The right to and appeal PASSE HCBS provider decisions affecting the beneficiary.
15. The right to request and receive an investigation in connection with an alleged infringement of a beneficiary's rights.
16. The freedom to access their own records, including information regarding how their funds are accessed and utilized and what services were billed for on the beneficiary's behalf. Additionally, all beneficiaries and legal guardians must be informed of how to access the beneficiary's service records and the PASSE HCBS provider must ensure that appropriate equipment is available for them to obtain such access.
    a. Beneficiaries may not be prohibited from having access to their own services records, unless a specific state law indicates otherwise.
17. The right to live in a manner that optimizes, but does not regiment, beneficiary initiative, autonomy and independence in making life choices, including but not limited to:
    a. Choice of HCBS providers
    b. Service delivery
    c. Release of information
    d. Composition of the service delivery team
    e. Involvement in research projects, if applicable
    f. Daily activities
    g. Physical environment
    h. With whom to interact
18. Other legal and constitutional rights

## Financial Safeguards

This Section applies if the PASSE HCBS provider serves as a representative payee of a beneficiary, is involved in managing the funds of the beneficiary, receives benefits on behalf of the beneficiary, or temporarily safeguards funds or personal property for the beneficiary.

A. Financial Safeguards and Procedures

The PASSE HCBS provider must demonstrate that there is a system in place to protect the financial investments of all beneficiaries. PASSE HCBS provider personnel that have any involvement with beneficiary funds and the beneficiary or their legal guardian must receive a copy of the PASSE HCBS provider's Financial Safeguards Policies and Procedures.

1. The PASSE HCBS provider is responsible for ensuring that each beneficiary's funds are used solely for the benefit of the beneficiary.
2. The PASSE HCBS provider must ensure that the beneficiary is able to receive the benefit of those items/services for which they are paying. By way of illustration, if a beneficiary is paying for internet, the beneficiary should have a device with which to access the internet; if the beneficiary pays for a cell phone plan, then the beneficiary should have a functioning cell phone.

B. Access to Financial Records

Beneficiaries and their legal guardians must always have access to financial records concerning the beneficiary's account/funds.

C. Financial Safeguards Policy and Procedures

The PASSE HCBS provider must implement policies that define:

1. How beneficiaries will provide informed consent for the expenditure of their funds.
2. How beneficiary accounts/funds will be segregated and maintained for accounting purposes.
3. The safeguards and procedures in place to ensure that beneficiary funds are used only for designated and appropriate purposes.
4. How interest will be credited to the accounts of the beneficiaries, if applicable.
5. A mechanism that provides evidence that beneficiary funds were expended in the manner authorized.

D. Consent Requirements

The PASSE HCBS provider shall obtain from the beneficiary or their legal guardian prior to implementing the following:

1. Limiting the amount of funds a beneficiary may expend or invest in a specific instance.
2. Designating the amount a beneficiary may expend or invest for a specific purpose.
3. Establishing time frames where a beneficiary is required to or prohibited from expending or investing their funds.
4. Delegating responsibility for expending or investing a beneficiary's funds.

## Restraints and Restrictive Intervention

A. Behavior Management Plan Required

A provider is prohibited from using any restraints or restrictive interventions on a beneficiary unless the beneficiary has a developed and implemented behavior management plan which incorporates alternative strategies to avoid the use of restraints and restrictive interventions, and includes the use of positive behavior support strategies as an integral part of the behavior management plan (See Section 502 "Behavior Management Plans"). There is a limited exception to this requirement when the use of an emergency restraint is necessary (See Section 503 (E) "Emergency Restraint")

B. Definitions of Restraints and Interventions

1. "Physical restraint" or "personal restraint": the application of physical force without the use of any device (manually holding all or part of the body), for the purpose of restraining the free movement of a beneficiary's body. This does not include briefly holding, without undue force, a beneficiary to calm them, or holding a beneficiary's hand to escort them safely from one area to another.
2. "Physical Intervention": the use of a manual technique intended to interrupt or stop a behavior from occurring.
3. "Restrictive intervention": procedures that restrict or limit a beneficiary's freedom of movement, restricts access to their property, prevents them from doing something they want to do, requires them to do something they do not want to do, or removes something they own or have earned. The definition would include the use of "time-out," in which a beneficiary is temporarily, for a specified period of time, removed from positive reinforcement or denied opportunity to obtain positive reinforcement for the purpose of providing the beneficiary with the opportunity to regain self-control. Under no circumstances may a beneficiary be physically prevented from leaving.
4. "Mechanical restraint": any physical apparatus or equipment used to limit or control a challenging behavior. This would include any apparatus or equipment that cannot be easily removed by the beneficiary, restricts the beneficiary's free movement or normal functioning, or restricts normal access to a portion or portions of the beneficiary's body.
5. "Chemical restraint": the use of medication for the sole purpose of preventing, modifying or controlling challenging behavior that is not associated with a diagnosed co-occurring psychiatric condition.

   Under no circumstances are chemical restraints permitted to be used on a beneficiary.
6. "Seclusion": the involuntary confinement of a beneficiary alone in a room or an area from which the beneficiary is physically prevented from having contact with others or leaving. Under no circumstances are chemical restraints permitted to be used on a beneficiary.

C. Use of Restraints and Interventions

Permitted restraints and interventions may be used only when a challenging behavior exhibited by the beneficiary threatens the health or safety of the beneficiary or others. The use of restraints or interventions must be supported by a specific assessed need as justified in the beneficiary's PCSP and only performed as provided in the beneficiary's behavior management plan.

1. Required Prior Counseling: Before a "time out," an absence from a specific social activity, or temporary loss of personal possession is implemented, the beneficiary must first be counseled about the consequences of the behavior and the choices they can make.
2. Direct Observation: A beneficiary must be continuously under direct visual and auditory observation by staff members during any use of restraints or interventions.
3. Specialized Restraint and Intervention Training: All personnel who are involved in the use of restraints or interventions must receive training on and be qualified to perform, implement, and monitor the

particular restraint or intervention as applicable. Additionally, personnel should receive training in behavior management techniques, and abuse and neglect laws, rules, regulations and policies.

4. Restraint and Intervention Identification: The PASSE HCBS provider is required to advise all staff, families and beneficiaries on how to recognize and report the unauthorized use of a restraint or restrictive intervention.

D. Required Restraint and/or Intervention PCSP Information

Any PCSP and behavior management plan permitting the use of restraints or interventions must include the following information:

1. Identify the specific and individualized assessed need for the use of the restraint or intervention.
2. Document the positive interventions and supports used prior to any modifications to the PCSP that permits use of restraint or interventions.
3. Document the less intrusive methods of behavior modification that were attempted but did not work.
4. Include a clear description of the condition that is directly proportionate to the specific assessed need.
5. Include regular collection and review of data to measure the ongoing effectiveness of the modification to the PCSP that permitted the use of a restraint or intervention.
6. Include established time limits for periodic reviews to determine if the use of restraint or intervention is still necessary or can be terminated.
7. Include the informed consent of the beneficiary or legal guardian.
8. Include an assurance that the use of the restraint or intervention will cause no harm to the beneficiary.

E. Emergency Restraint

Personal restraints (use of staff member's body to prevent injury to the beneficiary or another person) are allowed in cases of emergency, even if a behavior management plan incorporating the use of restraints has not been developed and implemented. An "emergency" exists in the following situations:

1. The beneficiary has not responded to de-escalation or other positive behavior support strategies and the behavior continues to escalate
2. The beneficiary is a danger to themselves or others.
3. The safety of the beneficiary and those nearby cannot be assured through positive behavior support strategies.

F. Reporting Each Incident Where Restraint or Interventions Were Used

An incident report must be completed and submitted to DHS PASSE Quality Assurance unit and appropriate PASSE, in accordance with Section 300 herein no later than the end of the second business day following the date any restraint or restrictive intervention is administered. If the use of a restraint or restrictive intervention occurs more than three times in any 30 day period, permitted use of restraints and interventions must be discussed by the PCSP development team, addressed in the PCSP, and implemented pursuant to an appropriate behavior management plan.

Any use of restraint or intervention, whether permitted or prohibited, also must be documented in the beneficiary's daily service log, maintained it their service record and must include the following information:

1. The behavior initiating the use of restraint or intervention.
2. The length of time the restraint or intervention was administered.
3. The name of the personnel that authorized the use of the restraint or intervention.
4. The names of all individuals and outcomes of the use of the restraint or intervention.

Per 4.7.6: Before use of restraints or restrictive interventions, the PASSE must develop a written behavior management plan to ensure the rights of members. The plan must include a provision for alternative methods to avoid the use of restraints and seclusions. The behavior management plan must:

A. Be written and supervised by a qualified professional

B. Be designed so that the rights of the member are protected; and

C. Preclude procedures that are punishing, physically painful, emotionally frightening, involved deprivation or put the member at medical risk.

## Medication Logs

A. Prescription Medications: providers delivering direct care services must maintain medications logs detailing the administration of prescribed medications to the beneficiary. The prescribed medication logs must be readily available review and document the following for each administration of a prescribed medication:
   1. Name and dosage of the medication administered.
   2. Route the medications was administered.
   3. Date and time the medication was administered (recorded at the time of medication administration).
   4. Initials of the staff administering or assisting with the administration of the medication.
   5. Any side effects or adverse reactions to the medication.
   6. Any errors in administering the medication.

B. PRN and Over-the-Counter Medications: PASSE HCBS providers delivering direct care services must also maintain logs concerning the administration of PRN and over-the- counter medications. The logs for the administration of prescription PRN and over- the-counter medications must document the following:
   1. How often the medication is used.
   2. Date and time each medication was administered (recorded at the time of medication administration).
   3. The circumstances in which the medication is used.
   4. The symptom for which the medication was used.
   5. The effectiveness of the medication.

C. Medication Administration Error Reporting/Charting: Any medication administration errors occurring or discovered must be recorded in the medication log and immediately reported to a supervisor. “Medication administration errors” include, but are not limited to, the loss of medication, unavailability of medication, falsification of medication logs, theft of medication, a missed dose, wrong dose, a dose being administered at the wrong time or by the wrong route, the administration of the wrong medication and the discovery of an unlocked medication lock box that is supposed to be locked at all times.
   1. An incident report must be filed with DHS PASSE Quality Assurance unit and appropriate PASSE, in accordance with Section 300 for any medication administration error that caused or had the potential to cause serious injury or illness to a beneficiary.

D. Required Oversight Documentation: Each PASSE HCBS provider delivering direct care services must ensure that supervisory level staff review on at least a monthly basis all beneficiary medication logs to determine if:
   1. All medications were administered accurately as prescribed.
   2. The medication is effectively addressing the reason for which it was prescribed.
   3. Any side effects are noted, reported and being managed appropriately.

## Daily Service Activity Logs

Daily service activity logs must be maintained by all PASSE HCBS providers delivering direct care services in order to provide specific information relating to the individually identified goals and desired outcomes for the beneficiary, so that the care coordinator, PCSP Developer and PCSP development team can measure and record the progress on each of the beneficiary's identified goals and desired outcomes. There is no required format for a daily service activity log; however, the daily service activity logs must document the following:

A. The name and sign-in/sign-out times for each direct care staff member.

B. The specific services furnished.

C. The date and actual beginning and ending time of day the services were performed.

D. Name(s) of the staff/person(s) providing the service(s).

E. The relationship of the services to the goals and objectives described in the beneficiary's individualized PCSP.

F. Daily progress notes/narrative signed and dated by the staff delivering the service(s), describing each beneficiary's progress or lack thereof with respect to each of his or her individualized goals and objectives. This would include any behavior management plan data required to be maintained pursuant to Section 502(E) above.

## Beneficiary Service Records

A. Required Service Record Documentation

Each PASSE HCBS provider delivering direct care services to a beneficiary must establish a service record for the beneficiary. At a minimum, the service record file must contain:

1. A copy of the PCSP
2. Behavior management plan with proper beneficiary/legal guardian approval, if applicable
3. Daily service activity logs
4. Fully approved medication management plan and medication logs, or signed election to self-administer medication if applicable
5. Fully executed copy of lease, residency agreement or other form of written agreement that provides protections that address eviction processes and appeals comparable to those provided under a landlord-tenant law
6. Any documentation providing additional individuals with access to a beneficiary's service record
7. Guardianship order, if applicable

B. Beneficiary Records Maintenance and Storage Retention Requirements

1. Confidentiality

A PASSE HCBS provider shall maintain complete service records/files and treat all information related to beneficiaries as confidential. Access to beneficiary service files must be limited to only those staff members who have a need to know the information contained in the records of the beneficiary. The only individuals that may access a beneficiary's files and records are:

a. The beneficiary
b. The legal guardian of the beneficiary, if applicable
c. Professional staff providing direct care or care coordination services to the beneficiary
d. Authorized provider administrative staff
e. Any other individual authorized by the beneficiary or their legal guardian

Adult beneficiaries who are legally competent shall have the right to decide whether their family will be involved in planning and implementing their PCSP, and a signed release or document shall be present in their service record either granting permission for family involvement or declining family involvement.

A. HIPAA Regulations

Each PASSE HCBS provider shall ensure that information that is used for reporting or billing shall be shared according to confidentiality guidelines that recognize applicable regulatory requirements such as the Health Insurance Portability and Accountability Act ("HIPAA").

B. Electronic and Paper Records/File Maintenance

Electronic service records are acceptable. Paper and electronic service records must be uniformly organized and easily accessible. A list of the order of the service record information shall either be present in each beneficiary's service record or provided to the DHS PASSE Quality Assurance unit and appropriate PASSE upon request. The documents in active service records should be organized in a systematic fashion. An indexing and filing system must be maintained for all service records.

C. Storage Location

The location of the files/service records, and the information contained therein, must be controlled from a central location.

D. Direct Care Staff Access

The PASSE HCBS provider shall ensure all direct care and care coordination staff has adequate access to the beneficiary's file/service record including, current PCSP and other pertinent information necessary to ensure the beneficiary's health, welfare and safety (i.e., name and telephone number of physician(s), emergency contact information, insurance information, etc.).

E. Record/File Retention

Each PASSE HCBS provider must retain all files/services records for five years from the date of service or until all audit questions or review issues, appeals hearings, investigations or administrative or judicial litigation to which the files/services records may relate are finally concluded, whichever period is later. Failure to furnish medical records upon request may result in sanctions being imposed. Federal legislation further requires that any accounting of private health care information ("PHI") or HIPAA polices or complaints must be retained for six years from the date of its creation or the date when it last was in effect, whichever is later.

F. Access Sheets

Access sheets shall be located in the front of the service record to maintain confidentiality according to 5 U.S.C. § 552a. If there is a signed release for a list of authorized persons to review the service record, only those not listed will need to sign the access sheet with date, title, reason for reviewing and signature. If there is not a signed release for authorized persons to review, all persons must sign the access sheet whenever the service record is reviewed or any material is placed in the service record.

## Training Requirements

G. First Aid Training

Within 30 days of hiring, all staff that may be required to provide emergency direct care services to a beneficiary (such as on-call emergency staff or management), shall be required to attend and complete a certified first aid course administered by certified instructors of the course. The course must include instruction on common first aid topics and techniques, including, but not limited to, how to perform CPR, how to apply the Heimlich maneuver, how to stop/slow bleeding, etc.

1. The course must provide a certificate of completion that can be maintained in the staff's personnel file.
2. Any services provided by a staff person prior to receiving the above described First Aid Training can only be performed in a training role, under the supervision of another staff person that has already had the required First Aid Training.
3. Training certification must be maintained and kept up to date throughout the time any staff is providing services.

H. Beneficiary Specific Training

Prior to beginning service delivery, staff must receive the amount of individualized, beneficiary-specific training that is necessary to be able to effectively and safely provide the supportive living services required pursuant to the beneficiary's PCSP, including, but not limited to:

a. General training on beneficiary's PCSP
b. Behavior management techniques/programming
c. Setting-specific emergency and evacuation procedures
d. Appropriate and productive community integration activities and
e. Training specific to certain medical needs

Documentation evidencing that the necessary types and amount of beneficiary-specific training were completed must always be maintained in the personnel file of the supportive living staff member. This type of individualized, beneficiary-specific training shall be required each time a beneficiary's PCSP is updated, amended or renewed.

1. Other Required Training

Staff must receive appropriate training on the following topics at least once every two calendar years:

a. HIPAA Policies and Procedures
b. Procedures for Incident Reporting
c. Emergency and Evacuation Procedures
d. Introduction to Behavior Management
e. Arkansas Guardianship statutes
f. Arkansas Abuse of Adult statutes
g. Arkansas Child Maltreatment Act
h. Nurse Practice Act
i. Appeals Procedure for Individual Served by the Program
j. Beneficiary Financial Safeguards

k. Community Integration Training
l. Procedures for Preventing and Reporting Maltreatment of Children and Adults
m. Other topics where circumstances dictate staff should receive training to ensure the health, safety and welfare of the beneficiary.

Documentation evidencing that training on the topics has been completed must always be maintained in the personnel file of the staff member.

## Beneficiary Accessibility Requirements

PASSE HCBS provider owned/leased/rented residential settings must be fully accessible by the beneficiary, compatible with the services being provided to the beneficiary, and compatible with the needs of each beneficiary and their staff, as provided in the beneficiary's PCSP. Each PASSE HCBS provider owned/leased/rented residential facility must be in compliance with U.S.C. § 12101 et. seq. "American with Disabilities Act of 1990," and 29 U.S.C. §§ 706 (8), 794 – 794(b) "Disability Rights of 1964."

## Emergency and Evacuation Procedures

The PASSE HCBS provider must establish emergency procedures which include detailed actions to be taken in the event of emergency and promote safety. Details of emergency plans and procedures must be in written form and shall be available and communicated to all members of the staff and other supervisory personnel.

A. There shall be written emergency procedures for:
    1. Fires
    2. Natural disasters
    3. Utility failures
    4. Medical emergencies
    5. Safety during violent or other threatening situations

Additionally, the emergency procedures must satisfy the requirements of applicable authorities and contain practices appropriate for the locale (example: nuclear evacuations for those living near a nuclear plant).

B. The PASSE HCBS provider shall maintain an emergency alarm system for each type of drill (fire and tornado).

C. Beneficiaries, as appropriate, must be educated and trained about emergency and evacuation procedures.

D. Evacuation procedures must address:
    1. When evacuation is appropriate
    2. Complete evacuation from the physical facility
    3. The safety of evacuees
    4. Accounting for all persons involved
    5. Temporary shelter, when applicable
    6. Identification of essential services
    7. Continuation of essential services
    8. Emergency phone numbers
    9. Notification of the appropriate emergency authorities

## Safety Equipment

PASSE HCBS providers must maintain the following items in each setting in which beneficiaries reside:

A. Functioning smoke detectors, heat sensors, carbon monoxide detectors and/or sprinklers

B. Functioning fire extinguishers

C. Functioning flashlight

D. Functioning hot water heater

E. Emergency contact numbers (i.e. law enforcement, poison control, etc.)

F. First aid kit

## Required Independence and Integration

Beneficiaries must be safe and secure in their homes and communities, taking into account their informed and expressed choices. Participant risk and safety considerations shall be identified and potential interventions considered that promote independence and safety with the informed involvement of the beneficiary.

A. PASSE HCBS providers must take reasonable steps to ensure that beneficiaries are safe and secure in their homes and communities, taking into account the beneficiary's informed and expressed choices.

B. Participant risk and safety considerations shall be identified and potential interventions considered that promote independence and safety with the informed involvement of the beneficiary.

C. Beneficiaries shall be allowed free use of all space within the group living setting/alternative living site with due regard for privacy, personal possessions of other residents/staff and reasonable house rules.

D. Settings must be able to provide beneficiaries access to community resources and be in a safe and accessible location. Beneficiaries must have access to the community in which they are being served. The site shall assure adequate/normal interaction with the community as a group AND as an individual.

   1. This can be achieved through transportation or through local community resources.

E. The living and dining areas must be provided with normalized furnishings for the usual functions of daily living and social activities.

F. The kitchen shall have equipment, utensils and supplies to properly store, prepare and serve three meals a day. Beneficiaries must have access to food at any time. Any modification to this requirement must be based on an assessed need and documented in the beneficiary's PCSP.

G. Bedroom areas are required to meeting the following:

   1. Shall be arranged so that privacy is assured for beneficiaries. Sole access to these rooms cannot be through a bathroom or other bedrooms. Bedrooms must be equipped with a functioning lock with only appropriate staff having keys.
   2. Beneficiaries must have a choice of roommate when shared by one or more individuals. The PASSE HCBS provider must actively address the need to designate space for privacy and individual beneficiary interests.
   3. Physical arrangements shall be compatible with the physical needs of the individuals.

4. Each beneficiary shall have an individual bed. Each bed must have a clean, adequate, comfortable mattress.
    a. Beds are of suitable dimensions to accommodate the beneficiary who is using it. Mattresses must be waterproof as necessary.
    b. Each beneficiary must have a suitable pillow, pillowcase, sheets, blanket and spread.
    c. Bedding must be appropriate to the season and beneficiary's personal preferences. Bed linens must be replaced with clean linens at least weekly.
5. Bedroom furnishings for beneficiaries shall include shelf space, individual chest or dresser space and a mirror. An enclosed closet space adequate for the belongings of each beneficiary must be provided.
6. 80 square feet per beneficiary in multi-sleeping rooms; 100 square feet in single bedrooms.

H. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

I. Bathroom areas are required to meet the following criteria:
    1. Sole access may not be through another beneficiary's bedroom. Commodes, tubs and showers used by beneficiaries must provide for individual privacy.
    2. A minimum of one commode and sink is provided for every four beneficiaries. Lavatories and commode fixtures are designed and installed in an accessible manner so that they are usable by the beneficiaries living in the residential setting.
    3. A minimum of one tub or shower is provided for every eight beneficiaries.
    4. Must be well-ventilated by natural or mechanical methods.

## Home and Community-Based Services (HCBS) Settings Requirements

All PASSE HCBS providers must meet the Home and Community-Based Services (HCBS) Settings regulations as established by CMS. The federal regulation for the rule is 42 CFR 441.301(c) (4)-(5). All PASSE HCBS provider owned/leased/rented residential settings must have the following characteristics:

1. Be chosen by the beneficiary from among setting options including non-disability specific settings (as well as an independent setting), and an option for a private unit in a residential setting.
    a. Choice must be identified/included in the beneficiary's PCSP.
    b. Choice must be based on the beneficiary's needs, preferences and, for residential settings, resources available for room and board.
2. Ensure a beneficiary's rights of privacy, dignity and respect and freedom from coercion and restraint.
3. Must optimize, but not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.
4. Facilitate beneficiary choice regarding services and supports and who provides them.
5. The setting must be integrated in and support full access to the greater community by the beneficiary, including the opportunity to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving CES Waiver services.

6. The unit or dwelling must be a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the beneficiary receiving services, and the beneficiary has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city or other designated entity.
7. Each beneficiary has privacy in their sleeping or living unit, which must include the following:
    a. Units have entrance doors lockable by the beneficiary, with only appropriate staff having keys to doors.
    b. Beneficiaries sharing units have choice of roommates in that setting.
    c. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
8. Beneficiaries have the freedom and support to control their own schedules and activities and have access to food at any time.
9. Beneficiaries can have visitors of their choosing at any time.
10. The setting is physically accessible to the beneficiary.
11. Any modification of the additional conditions specified in items 6 through 10 above must be justified in the beneficiary's PCSP. The following requirements must be documented in the beneficiary's PCSP:
    a. Identify a specific and individualized assessed need.
    b. Document the positive interventions and supports used prior to any modifications to the PCSP.
    c. Document less intrusive methods of meeting the need that have been tried but did not work.
    d. Include a clear description of the condition that is directly proportionate to the specific assessed need.
    e. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
    f. Include established time limits for periodic review to determine if the modification is still necessary or can be terminated.
    g. Include the informed consent of the beneficiary.
    h. Include an assurance that interventions and supports will cause no harm to the beneficiary.

# Credentialing & Recredentialing

CareSource PASSE credentials and recredentials all licensed independent practitioners, including physicians, facilities and non-physicians with whom it contracts and who fall within its scope of authority and action. Through credentialing, CareSource PASSE checks the qualifications and performance of physicians and other health care practitioners. Our Senior Medical Director is responsible for the credentialing and recredentialing program.

## Credentialing Process

### Council for Affordable Quality Healthcare Application

Please note: All MD and DO providers undergo a separate credentialing process. These providers should be current with CCVS and must submit a release authorization form found at **CareSourcePASSE.com** > Providers > Tools and Resources > Forms.

CareSource PASSE is a participating organization with the Council for Affordable Quality Healthcare (CAQH).

Please make sure that we have access to your provider application prior to submitting your CAQH number:

- Submit a release and authorization to CareSource to start the credentialing process.
- Log on to the CAQH website at www.CAQH.org, utilizing your account information.
- For all non-MD or DO providers, CareSource PASSE is a participating organization with CAQH.
- Select the “Authorization” tab and ensure CareSource PASSE is listed as an authorized health plan (if not, please check the “Authorized” box to add).

Please also include copies of the following documents:

- Malpractice insurance face sheet
- Drug Enforcement Administration (DEA) certificate (current) or Controlled Substance Registration (CSR)
- Clinical Laboratory Improvement Amendment (CLIA) certificate (if applicable)
- Standard care arrangement (if an advanced practice nurse or a physician assistant)

## Debarment and Criminal Conviction Attestation

CareSource PASSE verifies that its providers and the providers' employees have not been debarred or suspended by any state or federal agency. CareSource PASSE also requires that its providers and the providers' employees disclose any criminal convictions related to federal health care programs. "Provider employee" is defined as directors, officers, partners, managing employees or persons with beneficial ownership of more than five percent of the entity's equity.

CareSource PASSE conducts credentialing and recredentialing activities utilizing the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA) and credentialing as defined by the Department of Insurance.

## Providers Credentialed

Contracted providers listed in the Provider Directory and the following are credentialed:

- Providers who have an independent relationship with CareSource PASSE. This independent relationship is defined through contracting agreements between CareSource PASSE and a provider or group of providers and is defined when CareSource PASSE selects and directs its enrollees to a specific provider or group of providers.
- Providers who see members outside the inpatient hospital setting or outside ambulatory free-standing facilities.
- Providers who are hospital-based but see the organization's members because of their independent relationship with the organization.
- Dentists who provide care under the organization's medical benefits.
- Non-physician providers who have an independent relationship with the organization, as defined above, and who provide care under the organization's medical benefits.
- Covering providers (locum tenens).
- Medical directors of urgent care centers and ambulatory surgical centers.

## Providers Who Do Not Need To Be Credentialed

- Providers who practice exclusively within the inpatient setting and who provide care for an organization's members only because of the members being directed to the hospital or other inpatient setting.
- Providers who practice exclusively within free-standing facilities and who provide care for organization members only because of members being directed to the facility and who are not listed separately in the CareSource PASSE Provider Directory.
- Pharmacists who work for a pharmacy benefit management (PBM) organization.
- Providers who do not provide care for members in a treatment setting (e.g., board-certified consultants).

# Provider Selection Criteria

CareSource PASSE is committed to providing the highest quality of care and service to our members. Our providers are critical business partners with us in that endeavor. As a result, we have developed the following provider selection criteria to facilitate this optimal level of care and service, as well as promoting mutually rewarding business partnerships with our providers.

Quality of care delivery, as defined by the Institute of Medicine, states: "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

CareSource PASSE has developed comprehensive care coordination and quality improvement programs to facilitate this level of quality of care delivery, as well as a comprehensive credentialing program to ensure that our providers have the appropriate training and expertise to serve our members from a care delivery and service perspective. CareSource PASSE bases selection on quality of care and service aspects, in addition to business and geographic needs for specific provider types in a nondiscriminatory manner.

The following selection criteria have been put in place and are assessed during the credentialing and recredentialing process in addition to day-to-day monitoring via internal mechanisms and interactions with our members.

## Criteria:

- Active and unrestricted license in the state issued by the appropriate licensing board.
- Current DEA or CSR certificate (if applicable).
- Successful completion of all required education.
- Successful completion of all training programs pertinent to one's practice.
- For MDs and DOs, successful completion of residency training pertinent to the requested practice type.
- For dentists and other providers where special training is required or expected for services being requested, successful completion of training.
- Board certification is not required for primary care specialties. PCPs who are approved by the CareSource PASSE Credentialing Committee will appear in CareSource PASSE Provider Directories.
- Providers approved by the CareSource PASSE Credentialing Committee in non-primary care specialties will be listed in the Provider Directory as specialists if certified by a specialty board, which is recognized by the CareSource PASSE Credentialing Committee.
- Education, training, work history and experience are current and appropriate to the scope of practice requested.
- Malpractice insurance at specified limits established for all practitioners by the credentialing policy.
- Good standing with Medicaid and Medicare.
    - Quality of care and practice history as judged by:
    - Medical malpractice history.
    - Hospital medical staff performance.
    - Licensure or specialty board actions or other disciplinary actions, medical or civil.
    - Lack of member grievances or complaints related to access and service, adverse outcomes, office environment, office staff or other adverse indicators of overall member satisfaction.

  - Other quality of care measurements/activities.
  - Business needs that may dictate policy exceptions require scrutiny of above factors to ensure quality credentialing.
  - Lack of issues on HHS-OIG, SAM/ EPLS or state site for sanctions or terminations (fraud and abuse).
- Signed, accurate credentialing application and contractual documents.
- Participation with care coordination, quality improvement and credentialing programs.
- Compliance with standards of care and evidence of active initiatives to engage members in preventive care.
- Agreement to comply with plan preferred drug list (PDL) requirements or acceptance of PDL as administered through the pharmacy benefit manager.
- Agreement to access and availability standards established by the health plan.
- Compliance with service requirements outlined in the provider agreement and Provider Manual.
- Note: Any pending and/or suspected fraud, waste and abuse investigation(s) or case(s) against the provider may affect the provider's credentialing application.

## Organizational Credentialing and Recredentialing

The following organizational providers are credentialed and recredentialed:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free-standing ambulatory surgery centers
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting
- Providers providing Home and Community Based Services (HCBS) under the 1915(i) and 1915(c) Waivers Hospice providers
- Urgent care facilities, free-standing and not part of a hospital campus
- Dialysis centers
- Physical therapy, occupational therapy and speech language pathology (PT/OT/SLP) facilities
- Free-standing facilities that provide outpatient, non-emergent advanced radiology services (including MRI/ MRA, CT and PET scans)
- Birthing centers
- Long-term acute care
- Rehabilitation facility

The following organizational providers (facilities) are subject to verification of criteria for delivery of clinical services, including, but not limited to compliance with regulatory requirements and/or state or federal contract requirements for provision of such services. They are reviewed for certification, but are not presented to the committee for review:

- Clinical laboratories
- Durable medical equipment

If an urgent care or ambulatory is not accredited or does not have a current site survey, the Medical Director or Senior Provider responsible for medical services will be credentialed using the standard credentialing process.

The following elements are assessed for organizational providers:

- Provider is in good standing with state and federal regulatory bodies.
- Provider has been reviewed and approved by an accrediting body.
- Every three years is still in good standing with state and federal regulatory bodies and is reviewed and approved by an accrediting body.
- Liability insurance coverage is maintained.
- CLIA certificates are current.
- Completion of a signed and dated application.

Providers will be informed of the credentialing committee decision within 60 business days of the committee meeting. Providers will be considered recredentialed unless otherwise notified.

## Provider Credentialing Rights

- Providers have the right to review information submitted to support their credentialing application upon request to the CareSource PASSE Credentialing Department. CareSource PASSE keeps all submitted information locked and confidential.
- Providers have the right to correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the Credentialing Department prior to presenting to the credentialing committee. If any information obtained during the credentialing or recredentialing process varies substantially from the application, the provider will be notified and given the opportunity to correct this information prior to presenting to the credentialing committee.
- Providers have the right to review information submitted from outside sources (e.g., malpractice insurance carriers and state licensing boards) To support their credentialing application upon request to the CareSource Credentialing department. CareSource keeps all submitted information locked and confidential.
- Providers have the right correct incomplete, inaccurate, or conflicting information that was submitted to support their application prior to presenting to the credentialing committee. If any information obtained during the credentialing or recredentialing process varies substantially from the application, CareSource will request that that provider submit written clarification to the Credentialing Department electronically, by -email, fax, or by certified mail, return receipts requested and the provider will be given five business days to respond. Non-response within that timeframe will result in discontinuance on the sixth day.
- Providers have the right to be informed of the status of their credentialing or recredentialing application upon written request to the Credentialing department. An automated email is sent to providers you're your application is submitted via the CareSource Provider Portal. Providers can call Provider Services to obtain application status updates. Provider Service Representatives can inform providers if their application is completed and they are showing as participating in the CareSource network, or if their application is still in process while referencing the state-specific time frames. Practitioners also have the ability to check the status of their application by visiting the CareSource.com website, signing into the Provider Portal, and entering their application and NPI numbers.

## Provider Responsibilities

Providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. CareSource PASSE will initiate immediate action if the participation criteria are no longer met. Providers are required to inform CareSource PASSE of changes in status, such as being named in a medical malpractice suit, involuntary changes in hospital privileges, licensure or board certification or any event reportable to the National Practitioner Data Bank (NPDB).

## Recredentialing

Providers are recredentialed a minimum of every three years. Home and community-based services (HCBS) providers are recredentialed annually. As part of the recredentialing process, CareSource PASSE considers information regarding performance to include complaints and safety and quality issues collected through the quality improvement program, in addition to information regarding sanctions collected from the NPDB, Medicare and Medicaid Sanctions and Reinstatement Report, Medicare Opt-Out and the HHS/OIG. Providers will be considered recredentialed unless otherwise notified.

## Board Certification Requirements

Effective Jan. 1, 2003, physicians applying to become participating providers must be either board certified in their primary specialty or pursuing the pathway to certification as defined by their specialty board, with the exception of general dentists who will have board certification requirements waived in lieu of adequate education and training.

Effective Sept. 10, 2010, PMPs may be exempted from the board certification requirement if they have successfully completed a primary care residency program and their education and training is consistent with their intended scope of practice.

Physicians who are pursuing certification must be certified within the time frame specified by their respective board. Failure to become certified may result in termination as a participating provider.

Physicians whose boards require periodic re-certification will be expected but not required to be re-certified, although failed attempts at re-certification may be reason for termination. At the time of recredentialing, if board certification status has expired, a letter will be sent to the physician to request explanation. If the response indicates quality concerns as a reason, the VP, Senior Medical Director or designated Medical Director will contact the physician and investigate directly.

To be credentialed as a subspecialist, physicians must:

- Complete an approved fellowship training program in the respective subspecialty, and
- Be board certified by a board recognized and approved by the CareSource PASSE Credentialing Committee. If no subspecialty board exists or the board is not a board recognized and approved by the CareSource PASSE Credentialing Committee, then subspecialty recognition will be determined based on education, training and experience requirements of the fellowship training program and/or other suitable board certification recognition.

## Delegation of Credentialing/Recredentialing

CareSource PASSE will only enter into agreements to delegate credentialing and recredentialing if the entity that wants to be delegated is NCQA-accredited for these functions, utilizes an NCQA-accredited Credentials Verification Organization (CVO) and successfully passes a pre-delegation audit demonstrating compliance with NCQA, federal and state requirements.

A pre-delegation audit must be completed prior to entering into any delegated agreement. All pre-assessment evaluations will be performed utilizing the most current NCQA and regulatory requirements. The following will be included (at a minimum) in the review:

- Credentialing and recredentialing policies and procedures
- Credentialing and recredentialing committee meeting minutes from the previous year
- Credentialing and recredentialing provider file review

Delegates must be in good standing with Medicaid and CMS. Monthly reporting will be required from the delegated entity. This will be defined in an agreement between both parties.

CareSource PASSE may also choose to outsource the credentialing and recredentialing function at any time to an NCQA-accredited CVO. Providers will be notified of this and must adhere to the requests from the chosen CVO.

## Reconsideration and Appeals of Credentialing/Recredentialing Decisions

CareSource PASSE may decide that an applying or participating provider may pose undue risk to our members and should be denied participation or be removed from CareSource PASSE's network. If this happens, the applying or participating provider will be notified in writing. Reconsideration and appeal opportunities are available unless an exception applies. Exceptions are set forth in the CareSource PASSE Fair Hearing Plan. To submit a request, the following steps apply:

### Step 1

Submit to the Vice President/Senior Medical Director a reconsideration request in writing, along with any other supporting documentation:

CareSource PASSE
Attn: Senior Medical Director
P.O. Box 8738
Dayton, OH 45401-8738

All reconsideration requests must be received by CareSource PASSE within 30 calendar days of the date the provider is notified of the decision. The request, along with any supporting information, will be presented to the credentialing committee for review at the next meeting. The committee will respond within 30 calendar days of that meeting, and the provider will be notified in writing of the committee's decision.

### Step 2

If the committee maintains the original decision, an appeal may be made consistent with provisions of the CareSource PASSE Fair Hearing Plan unless an exception applies. Any appeal request must be submitted in writing and received by CareSource PASSE within 30 calendar days of the date the provider is notified of the reconsideration decision.

Appeals may be sent to:
CareSource PASSE
Attn: Vice President/Senior Medicaid Director
P.O. Box 8738
Dayton, OH 45401-8738

Applying providers may submit additional documents for reconsideration by the credentialing committee to the address above. An application rejection due to the provider's failure to submit a complete application is not subject to reconsideration or appeal.

If you would like to review the CareSource PASSE Fair Hearing Plan, please visit CareSourcePASSE.com/documents/fhp.

## Provider Disputes

Provider disputes for issues related to quality, professional competency or conduct should be sent to:

CareSource PASSE
Attn: Quality Improvement
P.O. Box 8738
Dayton, OH 45401-8738

Provider disputes for issues that are contractual or non-clinical should be sent to:

CareSource PASSE
Attn: Provider Relations
P.O. Box 8738
Dayton, OH 45401-8738

## Summary Suspensions

CareSource PASSE reserves the right to immediately suspend or summarily dismiss, pending investigation, the participation status of a participating provider who, in the opinion of the CareSource PASSE Vice President/Senior Medical Director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare or safety of our members. Any participating provider that is subject to a suspension or termination may dispute the action and request a hearing through the CareSource PASSE Fair Hearing Plan unless an exception applies. Exceptions are set forth in the CareSource PASSE Fair Hearing Plan.

# Covered Services & Exclusions

This section describes the services and benefit exclusions that are provided to our CareSource PASSE members. CareSource PASSE covers all medically necessary Medicaid-covered services with some exclusions that continue to be covered under Medicaid fee for service.

In addition, for Medicaid individuals under age 21, CareSource PASSE covers medically necessary services to correct or ameliorate physical and behavioral health disorders and defects or conditions identified during Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings or preventive visits, regardless of whether the services are included under the State plan, but are otherwise allowed pursuant to 1905 (a) of the Social Security Act.

Covered services and exclusions for CareSource PASSE members can be found at **CareSourcePASSE.com**.

## Benefit Limits

In general, most benefit limits for services and procedures follow state and federal guidelines. Benefits limited to a certain number of visits per year are based on a calendar year (January through December). Please check to be sure the member has not already exhausted benefit limits before providing services by checking our Provider Portal at **CareSourcePASSE.com** > Login > Provider >, or by calling Provider Services at **1-833-230-2100**.

## Clinical Policies

Medical policies offer guidance on determination of medical necessity and appropriateness of care for approved benefits. CareSource PASSE's medical, reimbursement, administrative and pharmacy policies may be found at **CareSourcePASSE.com** > Providers > Tools & Resources > Provider Policies.

## Prior Authorization

Some services require prior authorization. CareSource PASSE reviews service requests for PASSE members for medical necessity. If a request for authorization is submitted, CareSource PASSE will notify the provider and member in writing of the determination. If the service is not authorized, the letter will include the reason that the service cannot be covered and how to request an appeal if necessary.

Please refer to our website at **CareSourcePASSE.com** > Providers > Provider Portal > Prior Authorization, and the Referrals & Prior Authorization section of this manual for more information about referral and prior authorization procedures.

Please see the Grievances & Appeals section of this manual for information on how to file an appeal.

## Medical Necessity Standards and Practice Guidelines

The Arkansas Division of Medical Services defines medical necessity as "All Medicaid benefits are based upon medical necessity." A service is "medically necessary" if it is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap or cause physical deformity or malfunction and if there is no other equally effective (although more conservative or less costly) course of treatment available or suitable for the beneficiary requesting the service. For this purpose, a "course of treatment" may include more observation or (where appropriate) no treatment at all. The determination of medical necessity may be made by the Medical Director or by the Medicaid Program Quality Improvement Organization (QIO). Coverage may be denied if a service is not medically necessary in accordance with the preceding criteria or is generally regarded by the medical profession as experimental inappropriate or ineffective unless objective clinical evidence demonstrates circumstances making the service necessary.

"Medical necessity" or "medically necessary" means services that are:

- Required to correct or ameliorate a defect, physical or mental illness, or a condition;
- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition;
- Compatible with the standards of acceptable medical practice in the community;
- Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for the convenience of the member or the convenience of the provider or hospital;
- Not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage; and
- Provided when there is no other effective, more conservative or substantially less costly treatment, service or setting is available.

# Emergency Services

CareSource PASSE provides reimbursement for medically necessary emergency services when rendered by a qualified provider with an active Arkansas Medicaid ID, in accordance with the provider's contract with CareSource PASSE.

CareSource PASSE reimburses for all medically necessary emergency services that are provided to stabilize the member. After a member's condition is stabilized, providers must notify CareSource PASSE as soon as reasonably possible for CareSource PASSE to issue any needed authorization.

CareSource PASSE will not:

- Deny or inappropriately reduce reimbursement for a provider's provision of emergency care services for any evaluation, diagnostics or treatment provided to a member who needs emergency medical assistance, or
- Reimburse emergency care services contingent upon on the member or provider providing any notification, either before or after receiving emergency services.
- Reimburse for emergency care until the provider has obtained and Arkansas Medicaid ID. Please see the Member Enrollment & Eligibility section.

# Post-Stabilization Services

Post-stabilization services are covered services that a treating physician views as medically necessary after an emergency medical condition has been stabilized to maintain the member's stabilized condition.

## Participating Providers

Prior authorization is not required for coverage of post-stabilization services when these services are provided in an emergency department or for services in an observation setting by a participating provider. Please call **1-833-230-2100** for any questions related to post-stabilization services.

## Nonparticipating Providers

To request prior authorization for observation services as a non-participating provider or to request authorization for an inpatient admission, please call **1-833-230-2100**. During regular business hours, your call will be answered by our Utilization Management department. If calling after regular business hours, the call will be answered by CareSource24, our Nurse Advice Line. Post-stabilization care services are defined by 42 CFR 438.11.

# EPSDT Program

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit includes a comprehensive array of preventive, diagnostic and treatment services for Medicaid eligible infants, children and adolescents under age 21.

The EPSDT benefit is designed to assure that children receive early detection and care so that health problems are averted or diagnosed and treated as early as possible. The goal of the EPSDT benefit is to assure that individual children get the health care they need when they need it. The EPSDT benefit also covers medically necessary diagnostic services. The program provides reimbursement for preventive health services, periodic visits, developmental screenings, brief emotional/behavioral assessments, hearing and vision screenings, and immunizations under the EPSDT benefit.

## EPSDT Preventive Services

The preventive health exam is a general health assessment and is composed of the following required screening components:

- A comprehensive health, psychosocial and developmental history;
- Documentation of vital signs;
- An unclothed comprehensive physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate examination);
- Assessment of growth and nutritional status;
- Assessment of immunization status and provision of appropriate immunizations according to the Advisory Committee on Immunization Practices (ACIP) schedules;
- Screening for vision, hearing, lead poisoning and development, as per the American Academy of Pediatrics (AAP) guidance;
- Laboratory testing where appropriate to age and exam findings, and in line with AAP guidance;
- Screening for and if suspected, reporting of child abuse and neglect;
- Anticipatory guidance (health education); and
- Referrals/follow-ups where appropriate based on history and exam findings.

## EPSDT Exam Frequency

The recommended schedule for preventive health exams is as follows:

- Birth
- Three to five days
- One month
- Two months
- Four months
- Six months
- Nine months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- At three years, one exam per year until age 21

The American Academy of Pediatrics (AAP) Bright Futures "Recommendations for Pediatric Health Care" Periodicity Schedule is the periodicity schedule used for EPSDT visits and services. The schedule is available at https://www.aap.org/en-us/documents/periodicity_schedule.pdf.

At the beginning of each month, primary care providers (PCPs) receive a list of eligible CareSource PASSE members who have chosen or been assigned to the PCP as of that date. The list includes indicators for patients who appear not to have had their initial preventive health exam and/or who are not in compliance with the EPSDT periodicity schedule. You can find this list on the Provider Portal.

Initial preventive health exams are to be completed within 24 hours of birth for all newborns and within 90 days of the initial effective date of membership for new enrollees. PCPs are required to contact members via phone/mail to encourage them to schedule and keep their preventive health appointment.

### EPSDT Referrals for Further Diagnosis and Treatment

If the PCP is unable to provide all of the components of the preventive health exam, or if screenings indicate a need for evaluation by a specialist, a referral must be made to another participating provider within CareSource PASSE's provider network in accordance with CareSource PASSE's referral procedures. The member's medical record must indicate where the member was referred.

## Immunizations

All members less than 21 years of age shall be provided with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.

Providers must administer immunizations obtained through the Vaccines for Children (VFC) program for all members 18 years of age and younger. CareSource PASSE will not reimburse costs for vaccines obtained outside the VFC program when provided to children under age 19.

Immunizations, flu vaccines and pneumococcal vaccines can be obtained at the retail pharmacy for those members ages 19 and older.

### Vaccines for Children Program

The Vaccines for Children (VFC) program makes designated vaccines available at no cost to VFC participating health care providers to administer to children under the age of 19.

CareSource PASSE encourages providers to participate with the VFC program. Vaccines administered to children 18 years of age and younger must be obtained through the VFC program, which supplies vaccines to program participating providers at no cost. CareSource PASSE will not reimburse costs for vaccines obtained outside the VFC program. CareSource PASSE will pay for the administration of the vaccine only.

### Immunization Schedule

Immunizations are an important part of preventive care for children and should be administered during preventive health exams as needed. CareSource PASSE endorses the same recommended childhood immunization schedule that is approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP). The recommended schedule is updated annually and the most current updates are located at https://www.cdc.gov/vaccines/schedules/hcp/index.html.

### Immunization Codes

Please bill CareSource PASSE with the appropriate CPT and ICD-10 vaccination codes for the immunization(s) being administered and the appropriate administration code. CareSource PASSE requires providers to use ICD-10-CM codes and CPT codes on claims. Billing with the vaccine codes along with the administration codes will help ensure that you are reimbursed properly for administration of the correct vaccine.

## Annual Wellness Exams for Adults

Members may receive an annual wellness exam consisting of the following:

- Routine physical exam by the PCP or OB/GYN
- Screening that consists of the following, as appropriate:
  - Abdominal aortic aneurysm ultrasound (AAA)
  - Alcohol misuse
  - Blood pressure for adults
  - Bone mass measurements
  - Cardiovascular disease
  - Cholesterol for adults
  - Depression for adults
  - Diabetes
  - Hepatitis B
  - Human immunodeficiency virus (HIV)
  - Obesity
  - Colorectal
  - Electrocardiogram (ECG or EKG)
  - Lung
  - Mammogram
  - Pap test
  - Prostate
  - Sexually transmitted infections (STIs)
  - Tobacco/smoking
  - Vision exam for members age 21 and over

Please visit our website at **CareSourcePASSE.com** > Providers > Education > Patient Care, then clicking the Health Care Links page, for up-to-date clinical and preventive care guidelines.

## Reproductive Health Services

CareSource PASSE covers abortions, hysterectomies and sterilizations in very limited circumstances. Please review the information below for specific information.

### Abortion

All abortion services require a prior authorization and must meet the criteria established in Arkansas law.

Before reimbursement for an abortion can be made:

- The provider performing the abortion must certify that one required circumstances has occurred.
- The provider's signature must be in the physician's own handwriting.
- All certifications must contain the patient's name, address and Medicaid ID number.

## Sterilization and Hysterectomy

These requirements are applicable to all sterilizations when the primary intent of the sterilizing procedure is fertility control.

Sterilization procedures are covered only if all the following requirements are met:

- The member is at least 21 years of age at the time of the informed consent.
- The member is mentally competent and not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.
- Sterilization is the result of a voluntary request for services by a member legally capable of consenting to such a procedure.
- The procedure is scheduled at least 30 calendar days, but not more than 180 calendar days, after the consent is signed, except in the case of premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least 30 calendar days before the expected date of delivery. The expected date of delivery must be provided on the consent form.
- The member is given a thorough explanation of the procedure. In instances where the individual is blind, deaf or otherwise handicapped or unable to understand the language of the consent, an interpreter must be provided for interpretation.
- The Informed Consent for Voluntary Sterilization Form (DMA-69) must be completed and attached to the claim.

For hysterectomies, the following additional requirements must also be met:

- A hysterectomy can only be rendered for medical necessity and not for the purpose of family planning, sterilization, hygiene or mental retardation.
- Prior to the hysterectomy, the member must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.
- Informed consent is not obtained while the individual to be sterilized is in labor or childbirth, seeking to obtain or obtaining an abortion or under the influence of alcohol or other substances that affect the individual's state of awareness.
- The hysterectomy is not being performed for the purpose of cancer prophylaxis.
- The Hysterectomy Form (DMA-276) must be completed and attached to the claim.

Providers are required to maintain documentation of all sterilizations, hysterectomies and abortions, as consistent with requirements in 42 CFR 441.200 and 42 CFR 441.208 and 42 CFR 441.250 through 42 CFR 441.259. CareSource PASSE will not accept documentation for informed consent completed or altered after the service was rendered.

# Care Coordination

At CareSource PASSE, we believe in delivering care coordination services that are person-centered, holistic and collaborative. In partnership with our providers, the Care Coordination team will work to enhance member and provider satisfaction to support optimal resource utilization.

CareSource PASSE complies with Conflict Free Case Management rules pursuant to 42 CFR 441.330(c)(1)(iv). Care Coordinators do not replace provider services, but instead partner with providers to facilitate the comprehensive delivery of care to the member.

Every member who participates in the CareSource PASSE program receives care coordination. The Care Coordinator will:

- Assess each member's hopes and dreams, goals and needs
- Develop and implement the PCSP
- Educate the member and their caregiver/family
- Monitor services
- Coordinate and integrate treatment delivery across ALL of the member's providers
- Increase local service capacity to help individuals access quality care and support services within their own communities
- Ensure flexibility in the member's service array to address health care needs long term
- Support member and provider knowledge of the service continuum for maximum resource utilization
- Establish linkage not only to paid providers but free community resources such as family service agencies, court systems, local mental health agencies, food banks, schools, pharmacies, primary care doctors and other appropriate paid and non-paid resources
- Improve whole health outcomes
- Divert inappropriate emergency department utilization
- Foster the creation of health care homes/patient centered medical homes to ensure integration of care
- Deliver quality high-risk case management
- Follow and support members and providers throughout the discharge/transitional care process
- Encourage and coordinate caregiver and companion support

Communication is a priority, and we make certain each member's services are delivered according to the PCSP and that information flows seamless to and from the member and care providers. We stress the importance of identifying barriers, keeping appointments and expressing goals and needs. This one-to-one relationship with individual Care Coordinators is intended to provide a safety net to providers and support members through initial and ongoing assessment activities, coordination of care, education to promote integration of care, self-management when possible and healthy lifestyle decisions.

Our Care Coordination model also utilizes specialty care coordination teams comprised of medical and behavioral health nurses, social workers, licensed professional counselors, community health workers and outreach specialists. We have pharmacists on staff to assist with medication reconciliation and function as a part of the interdisciplinary care team.

Care coordination can provide a broad spectrum of educational and follow-up services for members and primary caregivers and providers. It can reduce admission and re-admission risks, manage planned and unplanned transitions, encourage compliance, reinforce medical instructions and assess social and safety needs.

## Transition of Care and Continuity of Care

CareSource PASSE's Care Coordinators work with members and providers to ensure continuity of care across all services.

The Care Coordination team is responsible for assisting members when they are moving between settings (e.g., from a residential treatment setting to a private home). The Care Coordinator ensures the member has the services and provider he or she needs to be successful in the new setting.

If a member transitions to CareSource PASSE or to another PASSE, our Care Coordination team will ensure the member's necessary documentation is sent to or received from the other PASSE. We will continue to provide care coordination so that the member's services are not interrupted. CareSource PASSE will honor all service authorizations for up to 90 days without the member's consent.

If a member chooses to change a PCP or specialty provider, the care coordinator is available to assist.

## Provider Responsibilities

Your responsibilities as a CareSource PASSE provider for people receiving care coordination are to:

- Actively participate in the PCSP process with others serving the member to develop or enhance a comprehensive plan
- Implement treatment and/or programs in accordance with the PCSP
- Communicate and collaborate with Care Coordinators about the needs of the members you support
- Notify Care Coordinators of any changes, incidents and other information of significance related to the members that you serve
- Submit timely requests for services to the Utilization Management/Service Determination teams that align with the PCSP

### Continuity of Care Responsibilities

CareSource PASSE requires you to play an active role in your patients' care coordination program and to participate in assessment activities and the development of individualized care plans to help meet their needs. For continuity of care, we encourage you to partner and collaborate with our Care Coordinators with member consent when required.

- In general, a provider may share a patient's protected health information with CareSource PASSE for purposes of care coordination and obtaining appropriate health or community-related services without a patient's consent.
- CareSource PASSE may share a member's protected health information without the member's consent in cases of transition from one PASSE to another PASSE for the purpose of coordinating member treatment or care (e.g., during Medicaid open enrollment period when a Medicaid recipient chooses a different PASSE during an active course of treatment).

To preserve continuity of care, you should report specific clinical information to your patient's Care Coordinator as soon as possible. The following should be shared and/or reported in a timely manner:

- Copies of the most up-to-date treatment or service plan
- Prior authorizations
- Updates on progress and/or regression
- Notification of the member's noncompliance with the treatment or service plan
- Results of functional assessments

We strongly recommend that you initiate communication with a member's Care Coordinator first if there is a potential problem or situation that can affect the member's condition, placement or treatment. The Care Coordination team is set up to help navigate unexpected or challenging situations. Examples include:

- A significant change in a member's status that would necessitate an update to the PCSP, such as a change in custody and/or placement
- A request for assistance in identifying resources or to share recommended resources
- Hospital admissions
- Emergency room visits
- Notification that a member moved out of the area or out-of-state

If a CareSource PASSE member transitions to another PASSE, our Care Coordination team will:

- Provide timely notification to the receiving PASSE on the special needs of the transitioning member, ensure timely receipt of medical records, PCSP, treatment plans, care coordination and authorization files
- Provide timely notification to member's service providers

When receiving a transitioning member from another PASSE, we will:

- Engage the member's service providers to develop the member's CareSource PASSE, PCSP
- Assign the member to a Care Coordinator who lives in the member's area
- Continue to provide care coordination so that the member's services are not interrupted
- Coordinate services, including services on an existing PCSP, to ensure a smooth transition and continuity of care for 90 days or until the transition is completed, whichever is longer

Continuity of care is an important part of member-centered care. Individuals who receive continuity have better health care outcomes and higher satisfaction rates, and the care they receive is more cost-effective. Together, we can make a difference.

# Person-Centered Service Planning*

See Prior Authorization section for additional details on BH/HCBS submission

CareSource PASSE Care Coordinators are responsible for creating, monitoring and updating the Person-Centered Service Plans (PCSP) for all enrolled members. The PCSP addresses the member's long-term care needs as an alternative to institutionalization. The plan is updated at least annually, and it identifies the member's hopes, dreams, preferences, strengths, medical concerns, needs for home and community-based services, and desired outcomes or goals. A copy of the member's PCSP and any updates will be maintained by CareSource PASSE. Providers should include a copy of each member's PCSP in their records. The PCSP can be accessed by calling the Care Coordinator directly and asking for a copy to be mailed or emailed or by logging into the Provider Portal and downloading a copy from the site.

The Care Coordinator is responsible for coordinating and scheduling the PCSP development meeting. The PCSP development meeting must be attended in person by:

- The member and his or her parent/legal guardian
- The member's primary caregivers; and
- The Care Coordinator
- CareSource, PASSE strongly recommends the provider(s) attend the PCSP meetings

The meeting should include other individuals who may attend in person, by telephone or video conference such as:

- HCBS service providers
- Professionals who have conducted evaluations or assessments
- Anyone else the member desires to attend, including friends and family who support member. If the member objects to anyone's participation in the PCSP development meeting, the Care Coordinator must ensure that they are not allowed to participate.

We encourage you to attend the member's PCSP meeting, as your feedback is important to the process. If you are unable to attend a member's PCSP development meeting, we require you to share your input with the member's Care Coordinator one week in advance of the scheduled PCSP meeting to ensure the information your plan contains is shared with the member and the other team members. Coordination of care is our goal. Ensuring members and care givers understand what each provider is responsible for is key. The PCSP meeting is the time to listen to what the member wants what the team needs and build the comprehensive treatment plan together. This opportunity will allow Care Coordinators and providers to close service gaps and create innovative solutions for CareSource PASSE members.

The member directs the planning process with input from his/her person-centered team comprised of individuals who are aware of the member's strengths and capacities. The PCSP addresses medical, behavioral, and socioeconomic issues, as identified in a culturally and linguistically appropriate manner.

The Care Coordinator is responsible for obtaining copies of all treatment and service plans related to a member. The PCSP is created using information gathered during the initial PCSP development meeting and results from any assessments, such as the Independent Assessment (IA).

The PCSP includes the following:

- The enrolled member's health information, including:
  - Relevant medical and mental health diagnoses
  - Relevant medical and social history
  - PCP and primary provider of behavioral health or developmental disability services
  - The individual who has legal authority to make decisions on behalf of the enrolled member
  - Indication of whether an advance directive or living will has been created for or by the enrolled member
  - The enrolled member's outlined treatment goals and objectives
  - All services necessary for the enrolled member as identified through an assessment of functional need, including services in the community to avoid placement in an institution
  - The provider who will provide each service listed in the PCSP
  - Any specific needs the enrolled member has
  - The enrolled member's strengths and preferences
  - A crisis plan for the enrolled member
  - Unresolved issues

The PCSP must ensure that the member's needs are being met in a manner that is individualized and specific to that member's needs. The PCSP is the fundamental plan to help an individual live safely and successfully in his/her own home or community. The plan should be designed to meet the individual's overarching goals and objectives for the next 12 months. It must reasonably reflect a daily and weekly schedule that is age and

developmentally appropriate. It should also reflect progress towards a future goal (e.g., activities to assist an adult with a developmental disability to plan to transition from an elderly parent's home into a community setting). The listed goals on the PCSP are chosen by the member. Providers will continue to develop their own detailed service/treatment plans of care. These detailed plans should be submitted to the Care Coordinator for inclusion into the Master Treatment Plan (MTP)/PCSP.

Specifically, the PCSP must address any needs identified for the member from the following sources:

- ARIA assessment
- Health questionnaire
- Any psychological testing results
- Any adaptive behavior assessments
- Any social, medical, physical or mental health histories
- Risk assessments
- Case plans for court–involved enrolled members
- Individualized Education Plans (IEP)
- Any other assessment or evaluation used by the PASSE prior to or at the time of PCSP development.

The member's total plan of care may include, but is not limited to, the following:

- Behavioral Health Treatment Plan
- Intellectual/Developmental Disabilities (I/DD) Service Plan
- Primary Care Physician Care Plan
- Individualized Education Plan
- Individual Treatment Plans for developmental clients in day habilitation programs
- Management Plan
- Nutrition Plan
- Housing Plan
- Any existing Work Plan
- Justice System-related Plan
- Child Welfare Plan
- Medication Management Plan

The Master Treatment Plan (MTP) made in accordance with the member as described in 42 CFR 441.30l (c)(l) that indicates the following:

1. Medical services to achieve the goals and desired outcomes as identified through an assessment of functional need in accordance with 42 CFR 441.725;
2. HCBS services including, if appropriate, Long-Term Supports and Services;
3. The member's strengths, needs and preferences; and
4. A crisis plan for the member.

When developing the PCSP, the Care Coordinator will give special attention to the following circumstances that a member may have or experience:

1. Living in their own home with significant conditions or treatments such as pain control, hypertension, enteral feedings, oxygen, wound care and ventilators
2. Receiving ongoing services such as daily in-home care, crisis behavioral health care, dialysis, home health, specialized pharmacy prescriptions, medical supplies, chemotherapy and/or radiation therapy, or who are hospitalized at the time of enrollment
3. Recently received prior authorization for services such as scheduled surgeries, post-surgical follow up visits, therapies to be provided after enrollment or out-of-area specialty services
4. Having significant medical conditions requiring ongoing monitoring or screening
5. Members receiving 24/hour care

All services must be documented in the plan. The listed services on the PCSP do not guarantee authorization of services and do not act as a prescription for services. The development of the PCSP and Utilization Management (UM)/Service Determination (SD) are separate processes. As a provider, you will not have to submit a prior authorization request for most services. The Care Coordinator will create the treatment request and submit it on your behalf at the time the PCSP is created. Your responsibility is to participate in the planning meeting in one of the avenues described in this manual, log into the Provider Portal to acknowledge the information in the PCSP which will generate submission of the treatment request. You will be notified of the approval or denial after the UM or SD teams finish the review within the required turn-around-times.

Although the functional assessment through the independent assessment (IA) identifies areas in which the individual needs services or supports, it is clear under federal guidance that the IA is not the final word, and the responsibility for defining the specific services and supports belong to the PCSP. Even though the need for services were identified in the IA, a particular service may not be needed at all, or the amount of a service may be different when the PCSP is set. In other words, a tier assignment from an IA does not guarantee a specific type or level of service.

The PCSP must be revised if the condition or situation of the individual changes. Members may choose, or not, to include a provider of services on the planning team.

Providers can obtain a copy of the PCSP on the Provider Portal at **CareSourcePASSE.com** > Login > Provider or by calling the CareSource PASSE Provider Services line.

# Home & Community-Based Services (HCBS)

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915I of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide. The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A state has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

## 1915(c) Community and Support Waiver Services

The purpose of Community and Employment Support (CES) Waiver services is to support individuals of all ages who have a developmental disability, meet ICF level of care and require waiver support services to live in the community and prevent institutionalization. The goals of the CES Waiver are to support beneficiaries in all major life activities, promote community inclusion through integrated employment options and community experiences, and provide comprehensive care coordination and service delivery under the 1915(b) PASSE Waiver Program.

| 1915(c) Community and Employment (CES) Waiver Services | |
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| **Adaptive Equipment** | Adaptive equipment is a piece of equipment or product system that is used to increase, maintain or improve functional capabilities of members, whether commercially purchased, modified or customized. The adaptive equipment services include adaptive, therapeutic or augmentative equipment that enables a member to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise.<br><br>Consultation by a medical professional must be conducted to ensure the adaptive equipment will meet the needs of the member.<br><br>Adaptive equipment includes enabling technology, such as safe home modifications, that empower members to gain independence through customizable technologies that allow them to safely perform activities of daily living without assistance while still providing monitoring and response for those members, as needed. Enabling technology allows members to be proactive about their daily schedule and integrates member choice.<br><br>Adaptive equipment also includes Personal Emergency Response Systems (PERS), which is a stationary or portable electronic device used in the member's place of residence and that enables the member to secure help in an emergency. The system is connected to a response center staffed by trained professionals who respond to activation of the device. PERS services may include the assessment, purchase, installation and monthly rental fee.<br><br>Computer equipment, including software, can be included as adaptive equipment. Specifically, computer equipment includes equipment that allows the member increased control of their environment, to gain independence, or to protect their health and safety.<br><br>Vehicle modifications are also included as adaptive equipment. Vehicle modifications are adaptions to an automobile or van to accommodate the special needs of the member. The purpose of vehicle modifications is to enable the member to integrate more fully into the community and to ensure the health, safety and welfare of the member. Vehicle modifications exclude adaptations or modifications to the vehicle that are of general utility and not of direct medical or habilitative benefit to the member; purchase, down payment, monthly car payment or lease payment; or regularly scheduled maintenance of the vehicle. |
| **Caregiver Respite Services** | Caregiver respite services are provided on a short-term basis to members unable to care for themselves due to the absence of or need for relief to the non-paid primary caregiver. Caregiver respite services do not include room and board charges.<br><br>Receipt of respite does not necessarily preclude a member from receiving other services on the same day. For example, a member may receive day services, such as supported employment, on the same day as caregiver respite services.<br><br>When caregiver respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished. Caregiver respite should not be furnished for the purpose of compensating relief or substitute staff for supportive living services. Caregiver respite services are not to supplant the responsibility of the parent or guardian.<br><br>Caregiver respite services may be provided through a combination of basic childcare and support services required to meet the needs of a child. |

| 1915(c) Community and Employment (CES) Waiver Services | |
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| **Community Transition Services** | Community Transition Services are non-recurring set-up expenses for members who are transitioning from an institutional or provider-operated living arrangement, such as an ICF or group home, to a living arrangement in a private residence where the member or his or her guardian is directly responsible for his or her own living expenses.<br><br>Community Transition service activities include those necessary to enable a member to establish a basic household, not including room and board, and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the member's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses.<br><br>Community Transition Services should not include payment for room and board; monthly rental or mortgage expense; regular food expenses, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes. |
| **Consultation Services** | Consultation services are clinical and therapeutic services which assist the individual, parents, legally responsible persons, responsible individuals and service providers in carrying out the member's PCSP. |
| **Crisis Intervention** | Crisis Intervention is delivered in the member's place of residence or other local community site by a mobile intervention team or professional. Intervention shall be available 24 hours a day, 365 days a year. Intervention services shall be targeted to provide technical assistance and training in the areas of behavior already identified. Services are limited to a geographic area conducive to rapid intervention as defined by the provider responsible to deploy the team or professional. Services may be provided in a setting as determined by the nature of the crisis; i.e., residence where behavior is happening, neutral ground, local clinic or school setting, etc., for persons participating in the Waiver program and who are in need of non-physical intervention to maintain or re-establish a behavior management or positive programming plan. |
| **Environmental Modifications** | Modifications made to the member's place of residence that are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence and without which, the member would require institutionalization. Examples of environmental modifications include the installation of wheelchair ramps, widening doorways, modification of bathroom facilities, installation of specialized electrical and plumbing systems to accommodate medical equipment, installation of sidewalks or pads, and fencing to ensure non-elopement, wandering or straying of members with decreased mental capacity or aberrant behaviors. Exclusions include modifications or repairs to the home which are of general utility and not for a specific medical or habilitative benefit; modifications or improvements which are of an aesthetic value only; and modifications that add to the total square footage of the home. Environmental modifications that are permanent fixtures to rental property require written authorization and release of current or future liability from the property owner. |

| 1915(c) Community and Employment (CES) Waiver Services | |
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| **Specialized Medical Supplies** | Specialized medical equipment and supplies include:<br>A. Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items.<br>B. Such other durable and non-durable medical equipment not available under the State plan that is necessary to address the member's functional limitations and has been deemed medically necessary by the prescribing physician.<br>C. Necessary medical supplies not available under the State plan. Items reimbursed with Waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the member. All items shall meet applicable standards of manufacture, design and installation. The most cost-effective item should be considered first.<br>Additional supply items are covered as a Waiver service when they are considered essential and medically necessary for home and community care.<br>D. Nutritional supplements.<br>E. Non-prescription medications. Alternative medicines not Federal Drug Administration approved are excluded from coverage.<br>F. Prescription drugs minus the cost of drugs covered by Medicare Part D when extended benefits available under state plan are exhausted. |
| **Supplemental Support Services** | Supplemental Support Services meet the needs of the member to improve or enable the continuance of community living. Supplemental Support Services will be based upon demonstrated needs as identified in a member's PCSP as unforeseen problems arise that, unless remedied, could cause a disruption in the member's services or placement, or place the member at risk of institutionalization. |
| **Supported Employment** | CES Supported Employment is a tailored array of services that offers ongoing support to members with the most significant disabilities to assist in their goal of working in competitive integrated work settings for at least minimum wage. It is intended for individuals for whom competitive employment has not traditionally occurred or has been interrupted or intermittent as a result of a significant disability, and who need ongoing supports to maintain their employment. |
| **Supportive Living** | Supportive living is an array of individually tailored services and activities to enable members to reside successfully in their own home, with family or in an alternative living setting (apartment or provider owned group home). Supportive living services must be provided in an integrated community setting.<br>Supportive living includes care, supervision and activities that directly relate to active treatment goals and objectives set forth in the member's PCSP. It excludes room and board expenses, including general maintenance, upkeep or improvement to the home.<br>Supportive living supervision and activities are meant to assist the member to acquire, retain or improve skills in a wide variety of areas that directly affect the person's ability to reside as independently as possible in the community. |

# 1915(i) Home and Community Based Services

The purpose of the 1915(i) State Plan Amendment for Home and Community-Based Services is threefold: to improve the health of the population, to improve the experience of care of individuals receiving services and to improve the quality of care while reducing the growth of health care costs.

| 1915(i) Home and Community Based Services | |
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| **Adult Rehabilitative Day Service** | Adult rehabilitative day services are a continuum of care provided to recovering individuals living in the community based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering individual to direct their resources and support systems. Activities include training to assist the person to learn, retain or improve specific job skills, and to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration. An array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified beneficiaries that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These rehabilitative day activities are person- and family-centered, recovery-based and culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the beneficiary as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger; behavioral skills, such as proper use of medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing; community integration skills and any similar skills required to implement a beneficiary's master treatment plan. |

| 1915(i) Home and Community Based Services | |
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| **Behavioral Assistance** | Behavioral assistance is a specific outcome-oriented intervention provided individually or in a group setting with the child/youth and/or his/her caregiver(s) that will provide the necessary support to attain the goals of the treatment plan. Services involve applying positive behavioral interventions and supports within the community to foster behaviors that are rehabilitative and restorative in nature. The intervention should result in sustainable positive behavioral changes that improve functioning, enhance the quality of life and strengthen skills in a variety of life domains. Behavioral assistance is designed to support youth and their families in meeting behavioral goals in various community settings. The service is targeted for children and adolescents who are at risk of out-of-home placement or who have returned home from residential placement and need flexible wrap-around supports to ensure safety and support community integration. The service is tied to specific treatment goals and is developed in coordination with the youth and their family. Behavioral Assistance aids the family in implementing safety plans and behavioral management plans when youth are at risk for offending behaviors, aggressions and oppositional defiance. Staff provides supports to youth and their families during periods when behaviors have been typically problematic – such as during morning preparation for school, at bedtime, after school or other times when there is evidence of a pattern of escalation of problem difficult behaviors. The service may be provided in school classrooms or on school buses for short periods of time to help a youth's transition from hospitals or residential settings but is not intended as a permanent solution to problem difficult behaviors at school. |
| **Child and Youth Support Services** | Child and youth support services are clinical, time-limited services for principal caregivers designed to increase a child's positive behaviors and encourage compliance with parents at home; working with teachers/schools to modify classroom environment to increase positive behaviors in the classroom; and increase a child's social skills, including understanding of feelings, conflict management, academic engagement, school readiness and cooperation with teachers and other school staff. This service is intended to increase parental skill development in managing their child's symptoms of their illness and training the parents in effective interventions and techniques for working with the schools. Services might include an In-Home Case Aide. An In-Home Case Aide is an intensive, time-limited therapy for youth in the beneficiary's home or, in rare instances, a community-based setting. Youth served may be in imminent risk of out-of-home placement or have been recently reintegrated from an out of-home placement. Services may deal with family issues related to the promotion of healthy family interactions, behavior training and feedback to the family. |

| 1915(i) Home and Community Based Services | |
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| **Emergency and Planned Respite** | **Emergency Respite:**<br>Emergency respite is temporary direct care and supervision for a member who is experiencing an acute behavioral crisis or developmental disability need. Emergency respite can in a facility setting, including a Human Development Center. The primary purpose of Emergency respite is to de-escalate stressful situations and return the member back into the community.<br>**Planned Respite:**<br>Temporary direct care and supervision for a beneficiary due to the absence or need for relief of the non-paid primary caregiver. Planned respite can occur at medical or specialized camps, day-care programs, the member's home or place of residence, the respite care provider's home or place of residence, foster homes, a Human Development Center or a licensed respite facility.<br>The primary purpose of Planned respite is to relieve the principal care giver of the member with a behavioral health or developmental disability need so that stressful situations are de-escalated and the care giver and member have a therapeutic and safe outlet. |
| **Family Support Partners** | Family support partners is a service provided by peer counselors, of Family Support Partners (FSP), who model recovery and resiliency for caregivers of children and youth with behavioral health care needs or developmental disabilities. FSP come from legacy families and use their lived experience, training and skills to help caregivers and their families identify goals and actions that promote recovery and resiliency and maintain independence. An FSP may assist, teach and model appropriate child-rearing strategies, techniques and household management skills. This service provides information on child development, age-appropriate behavior, parental expectations and childcare activities. It may also assist the member's family in securing resources and developing natural supports. Family Support Partners serve as a resource for families with a child, youth or adolescent receiving behavioral health or developmental disability services. Family Support Partners help families identify natural supports and community resources, provide leadership and guidance for support groups and work with families on: individual and family advocacy, social support for assigned families, educational support, systems advocacy, lagging skills development, problem solving techniques and self-help skills. |
| **Mobile Crisis Intervention** | Mobile crisis intervention is a short-term, on-site, face-to-face therapeutic response to a member experiencing a behavioral health crisis for the purpose of identifying, assessing, treating and stabilizing the situation and reducing immediate risk of danger to the member or others consistent with the member's risk management/safety plan, if available. This service is available 24 hours per day, seven days per week and 365 days per year; and is available after hours and on weekends when access to immediate response is not available through appropriate agencies. The service includes a crisis assessment, engagement in a crisis planning process, which may result in the development /update of one or more Crisis Planning Tools (Safety Plan, Advanced Psychiatric Directive, etc.) that contain information relevant to and chosen by the beneficiary and family, crisis intervention and/or stabilization services including on-site face-to-face therapeutic response, psychiatric consultation and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services and supports, including access to appropriate services along the behavioral health continuum of care. |

| 1915(i) Home and Community Based Services | |
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| **Partial Hospitalization** | Partial hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less than 24-hour basis. The environment at this level of treatment is highly structured and there should be a staff-to-patient ratio sufficient to ensure necessary therapeutic services. Partial hospitalization may be appropriate as a time-limited response to stabilize acute symptoms, transition (step-down from inpatient), or as a stand-alone service to stabilize a deteriorating condition and avert hospitalization. |
| **Peer Support** | Peer support is a consumer centered service provided by individuals (ages 18 and older) who self-identify as someone who has received or is receiving behavioral health services and thus is able to provide expertise not replicated by professional training. Peer providers are trained and certified peer specialists who self-identify as being in recovery from behavioral health issues. Peer support is a service to work with beneficiaries to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life and empowerment to reach fullest potential. Specialists will assist with navigation of multiple systems (housing, supportive employment, supplemental benefits, building/rebuilding natural supports, etc.) which impact beneficiaries' functional ability. Services are provided on an individual or group basis and in either the beneficiary's home or community environment.<br><br>Peer support may include assisting their peers in articulating their goals for recovery, learning and practicing new skills, helping them monitor their progress, assisting them in their treatment, modeling effective coping techniques and self-help strategies based on the specialist's own recovery experience and supporting them in advocating for themselves to obtain effective services. |
| **Pharmacologic Counseling by a Registered Nurse** | Pharmacologic counseling by registered nurse is a specific, time limited one-to-one intervention by a nurse with a beneficiary and/or caregivers, related to their psychopharmological treatment. Pharmaceutical counseling involves providing medication information orally or in written form to the beneficiary and/or caregivers. The service should encompass all the parameters to make the beneficiary and/or family understand the diagnosis prompting the need for the medication and any lifestyle modification required. |
| **Residential Community Reintegration Program** | The Residential Community Reintegration Program is designed to serve as an intermediate level of care between Inpatient Psychiatric Facilities and home and community-based behavioral health services. The program provides 24 hour per day intensive therapeutic care provided in a small group home setting for children and youth with emotional and/or behavior problems which cannot be remedied by less intensive treatment. The program is intended to prevent acute or sub-acute hospitalization of youth, or incarceration. The program is also offered as a step-down or transitional level of care to prepare a youth for less intensive treatment. A Residential Community Reintegration Program shall be appropriately certified by the Department of Human Services to ensure quality of care and the safety of beneficiaries and staff. A Residential Community Reintegration Program shall ensure the provision of educational services to all beneficiaries in the program. This may include education occurring on campus of the Residential Community Reintegration Program or the option to attend a school off campus if deemed appropriate in according with the Arkansas Department of Education. |

| 1915(i) Home and Community Based Services | |
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| **Substance Abuse Detoxification (Observational)** | Substance abuse detoxification is a set of interventions aimed at managing acute intoxication and withdrawal from alcohol or other drugs. Services help stabilize the member by clearing toxins from his or her body. Detoxification (detox) services are short-term and may be provided in a crisis unit, inpatient or outpatient setting. Detox services may include evaluation, observation, medical monitoring and addiction treatment. The goal of detox is to minimize the physical harm caused by the abuse of substances and prepare the member for ongoing substance abuse treatment. |
| **Supportive Employment** | Supportive employment is designed to help beneficiaries acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany beneficiaries on interviews and providing ongoing support and/or on-the-job training once the beneficiary is employed. Service settings may vary depending on individual need and level of community integration and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen and interacting with the criminal justice system. |
| **Supportive Housing** | Supportive housing is designed to ensure that beneficiaries have a choice of permanent, safe and affordable housing. An emphasis is placed on the development and strengthening of natural supports in the community. This service assists beneficiaries in locating, selecting and sustaining housing, including transitional housing and chemical free living; provides opportunities for involvement in community life; and fosters independence. Service settings may vary depending on individual need and level of community integration and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen and interacting with the criminal justice system. |
| **Supportive Life Skills Development** | (Includes Adult Life Skills Development, Individual Life Skills Development and Group Life Skills Development)<br>Supportive life skills development is a service that provides support and training for youth and adults on a one-on-one or group basis. This service should be a strength-based, culturally appropriate process that integrates the member into their community as they develop their recovery plan or habilitation plan. This service is designed to assist members in acquiring the skills needed to support as independent a lifestyle as possible, enable them to reside in their community (in their own home, with family, or in an alternative living setting) and promote a strong sense of self-worth. In addition, it aims to assist members in setting and achieving goals, learning independent life skills, demonstrating accountability and making goal-oriented decisions related to independent living. Topics may include educational or vocational training, employment, resource and medication management, self-care, household maintenance, health, socialization, community integration, wellness and nutrition. For clients with developmental or intellectual disability, supportive life skills development may focus on acquiring skills to complete activities of daily living (ADLs) and instrumental activities of daily living (IADLs), such as communication, bathing, grooming, cooking, shopping or budgeting. |

| 1915(i) Home and Community Based Services | |
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| **Therapeutic Communities** | Therapeutic communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the person served. Therapeutic communities employs community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling and individual activities, the persons served are assigned responsibilities within the therapeutic community setting. Participants and staff members act as facilitators, emphasizing personal responsibility for one's own life and self-improvement. The service emphasizes the integration of an individual within his or her community, and progress is measured within the context of that community's expectation. |
| **Therapeutic Host Homes** | Therapeutic host homes are homes or family settings that consists of highly-intensive, individualized treatment for the member whose behavioral health or developmental disability needs are severe enough that they would be at risk of placement in a restrictive residential setting. A therapeutic host parent is trained to implement the key elements of the member's PCSP in the context of family and community life, while promoting the PCSP's overall objectives and goals. The host parent should be present at the PCSP development meetings and should act as an advocate for the member. |

# Member Support Services & Benefits

CareSource PASSE provides a wide variety of support and educational services and benefits to our members to facilitate their use and understanding of our plan's services, to promote preventive health care and to encourage appropriate use of available services. We are always happy to work in partnership with you to meet the health care needs of our members.

## Member Services

CareSource PASSE assists members who have questions or concerns about services or benefits. Members can contact our Member Services department by calling **1-833-230-2005** (TTY: 800-285-1131 or 711).

Representatives are available by telephone Monday through Friday, 8 a.m. to 5 p.m. (CT) except on certain holidays, which are listed at **CareSourcePASSE.com** > Members > Contact Us. If the holiday falls on a Saturday, we will be closed on the Friday before. If the holiday falls on a Sunday, we will be closed the Monday after.

## CareSource24®, Nurse Advice Line

Members can call our Nurse Advice Line 24-hours a day, seven days a week. With CareSource24®, members have unlimited access to talk with a caring and experienced staff of registered nurses about symptoms or health questions.

Nurses assess members' symptoms using the Schmitt-Thompson Clinical Content to determine the urgency of the complaint and direct members to the most appropriate place for treatment. Schmitt-Thompson is a leader in telephone triage, offering evidence-based triage protocols and decision support.

CareSource24® nurses educate members about the benefits of preventive care and make referrals to our care coordination programs. The nurses promote the relationship with the primary care provider (PCP) by explaining the importance of their role in coordinating the member's care. For improved care coordination with PCPs, summaries of calls are posted on the Provider Portal, including a record of why the member called and what advice the nurse gave.

Key features of this service include nurses who:

- Assess member symptoms
- Advise of the appropriate level of care
- Answer health-related questions and concerns
- Provide information about other services
- Encourage the PCP-member relationship

Members access CareSource24® anytime night or day. The phone number is on the member's ID card.

## Care Coordination

Members can call **1-833-230-2005** 24 hours a day, seven days a week to access care coordination services. All PASSE members are assigned to a specific care coordinator they will be working with while a part of the PASSE. If, however, a member is unable to reach their assigned care coordinator or have not had contact with them yet, they can call Member Services to receive care coordination services. Additionally, providers may call Member Services to identify who a member's care coordinator is or to speak to a care coordinator supervisor.

## Disease Management Program

Our free Disease Management Program helps our members find a path to better health through information, resources and support.

We help our members through:

- The MyHealth online program for members 18+ to participate in a journey to improve their health
- Newsletters with helpful tips and information to manage their disease, promote self-management skills and provide additional resources
- Coordination with outreach teams such as wellness advocates and health coaches.
- One-to-one care coordination

Members with specific disease conditions such as asthma, diabetes and hypertension are identified by criteria or triggers such as emergency room visits, hospital admissions and health assessment. These members are automatically mailed quarterly condition-specific newsletters. The materials are available in English and Spanish. Any member may self-refer or be referred into the Disease Management program to receive condition-specific information or outreach. If members do not wish to be enrolled in this program, they can call **1-844-438-9498**.

### Benefits to Members and Providers

Members identified in the Disease Management program receive help finding the appropriate level of care for their condition, and they are encouraged to actively participate in the patient-provider relationship. The program improves the percentage of CareSource PASSE members who receive their recommended screenings.

### Disease Management Referrals

If you have a patient with asthma, diabetes or hypertension who you believe would benefit from the Disease Management Program and are not currently enrolled, please call 1-844-438-9498.

## Nonmedical Community Supports and Services

Nonmedical Community Supports and Services (NCSS) are nonmedical in nature and are available under the federal authority of sections 1905, 1915(c), or 1915(i) or under state authority under Act 775 to provide such supports and services through an Arkansas Medicaid-enrolled provider as approved by a PASSE for an individual. NCSS are provided with the intention to prevent or delay entry into an institutional setting or to assist or prepare an individual to leave an institutional setting, meaning the service should assist the individual to live safely and successfully in his/her own home or in the community. The need for these supports and services is established by the functional deficits identified on the Independent Assessment (IA). The IA is an objective assessment that identifies that the need for services exists. However, the types and levels of supports and services needed to achieve his/her goals are beyond the scope of the IA and instead are developed by the PCSP process and ultimately described in the PCSP. The actual supports and services for each member are described in the member's PCSP which must be reviewed by the care coordinator and the member not less than monthly.

## Health Education

CareSource PASSE members receive health information from CareSource PASSE through a variety of communication channels, including easy-to-read newsletters, brochures, phone calls and personal interactions. CareSource PASSE also sends preventive care reminder messages to members via mail and automated outreach messaging.

## Interpreter Services

CareSource PASSE offers over-the phone (OPI) and video remote interpreting (VRI) when appropriate, for medical appointments outside of the surgical, hospital or emergency room setting*. These services are available to CareSource PASSE members who are hearing impaired, do not speak English or have limited English-speaking proficiency. These services are available at no cost to the member or provider. As a provider, you are required to identify the need for interpreter services for your CareSource PASSE patients and offer assistance to them appropriately. To arrange services, please contact our Provider Services department at **1-833-230-2100** or the assigned Care Coordinator. We ask that you let us know of members in need of interpreter services, as well as any members that may receive interpreter services through another resource.

**CareSource PASSE requires hospitals, emergency rooms and skilled nursing facilities, at their own expense, to offer sign and other language interpreters for members who are hearing impaired, do not speak English, or have limited English-speaking proficiency. This requirement includes providers that perform in-office surgeries. These services should be available at no cost to the member.*

## Telehealth

CareSource PASSE provides telehealth services to ensure our members can have access to health care services, particularly in rural areas where it is difficult to access offices.

Telehealth technology makes health care more accessible and cost-effective, and it can increase patient engagement. CareSource PASSE wants to support your telemedicine program by covering telehealth services you provide to our members. If you do not have a telehealth program or if you need help servicing your patients during busy times, CareSource PASSE partners to provide the convenience of telehealth to all our members.

Telehealth physicians can consult, diagnose and prescribe medications when appropriate (DEA controlled substances excluded) and provide treatment for nonemergency conditions for members two years old and up. Conditions include, but are not limited to allergies, asthma, sore throat, cold and flu, ear infection, urinary tract infection, skin inflammation, joint aches and pains and sinus infections.

# MyResources

The MyResources search engine is a social service and community resource search tool powered by the Aunt Bertha platform. This online directory for CareSource PASSE staff and members provides assistance with locating no-cost or reduced-cost community-based programs and charitable social services.

The MyResources tool is another way CareSource PASSE offers help to our members, target the assistance needed to help address the social determinants of health and provide access to resources that improve their overall health and well-being.

# Claim Submissions

Claims must be submitted within 365 calendar days of the date of service or discharge. We will not pay a claim with incomplete, incorrect or unclear information. Providers have 180 calendar days from the date of service or discharge to submit a corrected claim. Corrected claims should not be submitted through an appeal or dispute.

In general, CareSource PASSE follows the claim reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. It is critical that all addresses and phone numbers on file with CareSource PASSE are up to date to ensure timely claims processing and payment delivery.

You can email providermaintenance@caresource.com to update your information.

## Billing Methods

CareSource PASSE accepts electronic and paper claims. We encourage providers to submit claims electronically to take advantage of the following benefits:

- Faster claim processing
- Reduced administrative costs
- Reduced probability of errors or missing information
- Faster feedback on claim status
- Minimal staff and cost

All claims (electronic and paper) must include:

- Patient (member) name.
- Patient address.

- Insured's ID number: Be sure to provide the complete CareSource PASSE member ID number of the patient.
- Patient's birth date: Always include the member's date of birth. This allows us to identify the correct member in case we have more than one member with the same name.
- Place of service: Use standard CMS (HCFA) location codes.
- ICD-10 diagnosis code(s).
- HIPAA-compliant CPT or HCFA Common Procedure Coding System (HCPCS) code(s) and modifiers when modifiers are applicable.
- Units, where applicable (anesthesia claims require minutes).
- Date of service: Please include dates for each individual service rendered. A date range cannot be accepted, even though some claim forms contain from/to formats. Please enter each date individually.
- Prior authorization number, when applicable: A number is needed to match the claim to the corresponding prior authorization information. This is only needed if the service provided required prior authorization.
- National Provider Identifier (NPI): Please refer to the "Location of Provider NPI, TIN and Member ID Number" section, unless you are an atypical provider. If you are an atypical provider your Medicaid ID must be in the G2 Reference loop.
- Federal Tax ID number or physician Social Security number: Every provider practice (e.g., legal business entity) has a different Tax ID number.
- Signature of physician or supplier: The provider's complete name should be included. If we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.

## Electronic Funds Transfer

CareSource PASSE has partnered with ECHO Health, Inc., to deliver provider payments. ECHO offers three payment options:

1. Electronic fund transfer (EFT) – preferred
2. Virtual Card Payment (QuicRemit) – Standard bank and card issuer fees apply*
3. Paper Checks

**Payment processing fees are what you pay your bank and credit card processor for use of a payment terminal to process payments via credit card.*

Visit our Claims webpage at **CareSourcePASSE.com** > Providers > Provider Portal > Claims, for additional information about getting paid electronically and enrolling in EFT.

If providers do not proactively register with ECHO for EFT payments from CareSource, payments will default to QuicRemit Virtual Care Payment (VCR) or paper check. Simply complete the enrollment form and fax it back to ECHO Health, CareSource PASSE's EFT partner, at **440-835-5656**. ECHO Health will work directly with you to complete your enrollment in EFT.

Providers who elect to receive EFT payment can also choose to receive an EDI 835 (Electronic Remittance Advice) thorough a designated clearinghouse. Providers can download the PDF version of the Explanation of Provider Payment (EPP) from the Provider Portal at **CareSourcePASSE.com** > Login > Provider.

# Electronic Claim Submissions

Electronic Data Interchange (EDI) is the computer-to-computer exchange of business data in standardized formats. EDI transmissions must follow the transaction and code set format specifications required by the Health Insurance Portability and Accountability Act (HIPAA). Our EDI system complies with HIPAA standards for electronic claim submission.

You can submit claims online through our secure online Provider Portal at **CareSourcePASSE.com** > Login > Provider, selecting Arkansas. CareSource PASSE offers this service via our portal at no cost. You can submit claims, check claim status, track payments and more.

CareSource PASSE also partners with Availity to offer electronic claim submission and real-time transactions at no charge through the Availity Portal at www.availity.com/. To sign up, you can use the Availity Portal Registration Guide available on the Claims webpage at **CareSourcePASSE.com** > Providers > Provider Portal > Claims.

## Submit Claims Attachments on the Provider Portal

CareSource PASSE providers may submit claim attachments on the Provider Portal to make processing the claim faster and easier. Supporting documentation can be uploaded on the Claim Information and Attachments page, under the Claims section of the left-hand menu on the portal. Attachment size is limited to 100MB.

To upload documentation, do the following:

- If you have the claim number, search for the claim. After locating the claim, click **View Detail**, and then upload the documentation using the **Document Upload** tab.
- If you do not have the claim number, search for the member record. After searching for the member, enter the correct date of service for the claim you have submitted. Select the appropriate reason for submitting documentation, and then upload your attachments.

Enter your contact information before submitting your attachments.

## Availity Clearinghouse

**CareSource PASSE prefers electronic claim submission.** To submit electronic claims, you may use any clearinghouse (trading partner) that can send claims to CareSource PASSE. If you do not currently use a clearinghouse, please contact the clearinghouse of your choice from our preferred list below or use our free Provider Portal at **CareSourcePASSE.com** > Login > Provider.

Please provide the clearinghouse with the CareSource PASSE payer ID number: ARCS1

| Clearinghouse | Website | Phone |
|---|---|---|
| Availity | www.availity.com | 1-800-282-4548 |

CareSource PASSE accepts electronic professional and hospital claims in the 837 ANSI ASC X12N (005010X ERRATA version) file format.

## 5010 Transactions

In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic health care and pharmacy transactions. This action was taken in preparation to implement ICD-10 CM codes in 2015. The new standard is the HIPAA 5010 format. All trading partners and payers should be 5010 compliant.

## Transactions Covered Under the 5010 Requirements

- 837 health care claim/encounter
- 276/277 health care claim status request and response
- 835 health care claim payments/advice
- 270/271 health care eligibility benefit inquiry and response
- 278 health care services review (prior authorization requests)
- 834 benefit enrollment and maintenance
- 820 group premium payment for insurance products
- NCPDP Version D.0

Please include the full physical address for billing 5010 transactions, P.O. Boxes are no longer accepted for the billing address. However, a P.O. Box or lock box can be used for the pay-to address (Loop 2010AB).

## Procedure and Diagnosis Codes

HIPAA specifies that the health care industry use the following code sets when submitting health care claims electronically.

- International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10- CM). Available from the U.S. Government Printing Office at 202-512-1800, 202-512-2250 (fax) and from many other vendors.
- Current Procedural Terminology, 4th Edition, (CPT-4). Available at www.ama-assn.org/practice-management/cpt-current-procedural-terminology.
- HCFA Common Procedure Coding System (HCPCS). Available at www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html?redirect=/%20MedHCPCSGeninfo/%20 http://www.cms.hhs.gov/default.asp%20.
- Procedures and Nomenclature. 2nd Edition. (CDT-2). Available from the American Dental Association at 1-800-947-4746 or www.ada.org/en.
- National Drug Codes (NDC). Available at www.fda.gov/.

**Please note:** CareSource PASSE also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on providers and health plans. Local or proprietary codes are no longer allowed.

## National Provider Identifier, Tax ID Number and Taxonomy

Your National Provider Identifier (NPI) and Tax Identification number (TIN) are required on all claims. Claims submitted without these numbers will be rejected (except for valid Atypical Providers). Please contact your EDI vendor to find out where to use the appropriate identifying numbers on the forms you are submitting through the clearinghouse.

Provider identifying information and demographic data must match what is registered for Arkansas Medicaid. If your information with Arkansas Medicaid needs to be updated, please reach out to Provider Enrollment at **1-800-457-4454**.

## Location of Provider Information on Professional Claims

Location of Provider NPI, TIN and Member ID Number
On 837P Professional Claims (005010X222A1):

The provider NPI should be in the following location:

- Medicaid: 2010AA Loop – Billing provider name
- Medicare: 2310B Loop – Rendering provider name
- 2010AA Loop – Billing provider name
- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = Billing provider NPI
- 2310B Loop – Rendering provider name
- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = Rendering provider NPI
- Taxonomy
- Providers must include both billing and rendering NPI for HCFA 1500
- Atypical providers will submit their Medicaid ID/PIN in the appropriate billing and/or rendering fields
- Providers must include Attending NPI and Taxonomy on all UB04s

The billing provider TIN must be submitted as the secondary provider identifier using a REF segment, which is either the Employer Identification Number (EIN) for organizations or the Social Security number (SSN) for individuals, see below:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing provider TIN or SSN

## Institutional Claims

On 837I institutional claims (005010223A2):
The billing provider NPI should be in the following location:

- 2010AA Loop – Billing provider name
- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = Billing provider NPI

The billing provider TIN must be submitted as the secondary provider identifier using a REF segment, which is either the EIN for organizations or the SSN for individuals, see below:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing provider TIN or SSN

On all electronic claims, the CareSource PASSE member ID number should go on:

- 2010BA Loop – Subscriber name
- NM109 – Member ID number

On paper claims, the NPI number should be placed in the following boxes based on form type:

- CMS 1500: Box 24J for the rendering provider's NPI 24J and (if applicable) Box 33A for the group NPI
- UB04: Box 56
- ADA: Box 54 for the treating provider's NPI and (if applicable) Box 49 for the group NPI

## Corrected Claims

### Correcting Electronic HCFA 1500 claims:

EDI 837P data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an additional loop in the 2300 loop, segment REF *F8* with the most recent claim number for which the corrected claim is being submitted.

### Correcting Electronic UB-04 claims:

EDI 837I data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an additional loop in the 2300 loop, segment REF *F8* with the most recent claim number for which the corrected claim is being submitted.

**Note:** When billing corrected claims, providers must use the **most recent claim number** in the original claim ID (segment REF *F8) or the claim will be rejected.

## Paper Claim Submissions

For the most efficient processing of your claims, CareSource PASSE recommends you submit all claims electronically. Paper claim forms are only encouraged for services that require clinical documentation or other forms to process.

If you submit paper claims, please use one of the following claim forms:

- CMS 1500
- AMA universal claim form also known as the National Standard Format (NSF)
- HIPAA-compliant ADA Dental Claim Form – J430D (same as J430, J431, J432, J433, J434)
- CMS 1450 (UB-04)

Paper claim submission must be done using the most current form version as designated by the Centers for Medicare and Medicaid Services (CMS), National Uniform Claim Committee (NUCC) and the American Dental Association (ADA).

Detailed instructions for completing each form type are available at following websites:

- CMS 1500 Form Instructions: http://www.nucc.org
- UB-04 Form Instructions: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf UB04 forms (electronic and paper) requires the baby's birthweight.

Please send all paper claim forms to CareSource PASSE at the following address:

CareSource PASSE
Attn: Claims Department
P.O. Box 803
Dayton, OH 45401

CareSource PASSE uses an optical/intelligent character recognition (OCR/ICR) system to capture claim information, which increases efficiency, improves accuracy and results in faster turnaround time. We cannot accept handwritten claims or super bills.

CareSource PASSE also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on providers and health plans. Local or proprietary codes are no longer allowed.

## Instructions for National Drug Code (NDC) on Paper Claims

All the following information is required for each applicable code required on a claim:

- In the shaded area of 24A, enter the N4 qualifier (only the N4 qualifier is acceptable), the 11-digit NDC (this excludes the N4 qualifier), a unit of measurement code (F2, GR, ML or UN are the only acceptable codes) and the metric decimal or unit quantity that follows the unit of measurement code.
- Do not enter a space between the qualifier and the NDC or qualifier and quantity.
- Do not enter hyphens or spaces with the NDC.
- Use three spaces between the NDC number and the units on paper forms.

Include the following on claims that require (NDC):

- NDC and unit of measure: pill, milliliter (cc), international unit or gram
- Quantity administered: the number of NDC units
- NDC unit price: detail charge divided by quantity administered
- HCPCS codes that will require NDCs on professional claims: Submitted on the 837P format

## Tips for Submitting Paper Claims

To upload paper claims on the Provider Portal, go to **CareSourcePASSE.com** > Claims > Online Claims Submission menu option to use the **Upload Claim** option to send your claim to CareSource PASSE.

- Electronic claims are generally processed more quickly than paper claims.
- If you submit paper claims, we require the most current form version as designated by CMS, NUCC and the ADA.
- No handwritten (including printed claims with any handwritten information) claims or super bills will be accepted.
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.

- Fonts should be 10 to 14 point (capital letters preferred) in black ink.
- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps.
- Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- NPI, GNPI (if applicable) and federal Tax ID number or physician SSN is required for all claim submissions.

## Out-of-Network Claims

Nonparticipating providers may submit claims to CareSource PASSE using the Non-Participating Provider Profile Form located on our Forms webpage at **CareSourcePASSE.com** > Providers > Tools & Resources > Claims. Please be sure to attach your W-9 form when you submit this online form. CareSource PASSE is unable to process claims without this information.

## Claim Processing Guidelines

- All providers have an active Arkansas Medicaid ID to cover the date(s) of service reimbursement is being sought.
- Providers have 365 calendar days from the date of service or discharge or 90 days from the EOP date to submit a clean claim. If the claim is not submitted within this timeframe, the claim will be denied for timely filing.
- If you do not agree with the decision of a claim, you can ask us to review the claim again. Please see the Grievance and Appeals section of this manual for additional information.
- If a member has other insurance and CareSource PASSE is secondary, the provider must submit for secondary payment within 90 calendar days of the date on the primary carrier's Explanation of Benefits (EOB), but not more than 12 months from the date of service or discharge. Claims that were filed within this timeframe with a primary carrier, with no response from the carrier despite all reasonable actions taken, must be filed not more than 12 months from the date of service or discharge indicating no response was received.
- If a claim is denied for COB information needed, the provider must submit the primary payer's EOB for paper claims or primary carrier's payment information for electronic claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within 90 calendar days from the primary payer's EOB date, but not more than 12 months from the date of service or discharge. If a copy of the claim and EOP is not submitted within the required time frame, the claim will be denied for timely filing.
- For prenatal or delivery services, the last menstrual period date is required on claims. Participating providers may estimate the last menstrual period date based on the gestational age of the child at birth.
- Claims indicating the provided services were the result of an injury will be considered as a case of possible subrogation. Any third-party liability will be determined. CareSource PASSE will pay the provider for all covered services. Then, we will pursue recovery from any third parties involved.

### Provider-Preventable Conditions

The PASSE must require all providers to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made.

- The PASSE cannot make payments for any provider-preventable conditions in accordance with 42 CFR 483.3 (g). The PASSE must track data and submit a report quarterly that identifies all provider-preventable conditions. This information can be indicated on the POA Indicator where hospitals and ambulatory surgical

centers must utilize the billing system and appropriate diagnosis codes to report conditions present on admission or provider-preventable conditions that occurred during treatment.

- The report must include, at a minimum:
  - Wrong surgical or other invasive procedure performed on an enrolled member; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient
  - Has a negative consequence for the enrolled member

## Electronic Visit Verification (EVV)

Under Section 12006(a) of the 21st Century Cures Act, there is a mandate that states implement EVV for all Medicaid personal care services (PCS) and home health services (HHCS) that require an in-home visit by a provider. This applies to PCS provided under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115; and HHCS provided under 1905(a)(7) of the Social Security Act or a waiver.

CareSource PASSE has partnered with CareBridge for EVV services. To ensure a smooth implementation, shared success and compliance with the 21st Century Cures Act, it is important for you to pick an EVV Provider if you are providing services listed above, as well as ensure your provider is connected to the Payer's provider and State's Provider.

If you would like to connect or utilize CareBridge please contact them at:

**Phone**
1-844-922-2584

**Email**
arevv@carebridgehealth.com

**Data Integration Support Email**
evvintegrationsupport@carebridgehealth.com

## Claim Status

Providers may check claim statuses on the CareSource PASSE Provider Portal at **CareSourcePASSE.com** > Login > Provider.

Claim status is updated daily, and you can check claims that were submitted for the previous 24 months. You can search by member ID number, member name and date of birth or claim number.

You can find the following claim information on the Provider Portal:

- Claim history available up to 24 months from the date of service
- Reason for payment or denial
- Check numbers and dates
- Procedure/diagnostic
- Claim payment date

Claims in a pending status have been entered into our system but have not yet been processed completely. CareSource PASSE, not the provider, is responsible for resolving pended claims. Please do not resubmit pended claims as this may further delay processing.

## Code Editing

CareSource PASSE uses clinical editing software to help evaluate the accuracy of diagnosis and procedure codes on submitted claims to ensure claims are processed consistently, accurately and efficiently.

CareSource PASSE's code editing software finds any coding conflict or inconsistent information on claims. For example, a claim may contain a conflict between the patient's age or gender and diagnosis, such as a pregnancy diagnosis for a male patient. Our software resolves these conflicts or indicates a need for additional information from the provider.

CareSource PASSE's code editing software helps evaluate the accuracy of the procedure code only, not the medical necessity of the procedure.

## Coding and Payment Policies

CareSource PASSE strives to be consistent with all Arkansas Medicaid, federal regulations and national commercial standards regarding the acceptance, adjudication and payment of claims. These standards apply to the code or code set(s) submitted and related clinical standards for claims received either electronically or as a hard copy. We apply HIPAA standards to all electronically received claims.

Accordingly, we accept only HIPAA-compliant code sets (HCPCS, CPT, ICD-10 and NDC). Specific contract language stipulating the receipt, processing and payment of specific codes and modifiers is honored as would be any aspect of a provider contract.

In addition, the Center for Medicare and Medicaid Services (CMS) federal rules for Medicare and Medicaid coding standards are followed.

Finally, generally accepted commercial health insurance rules regarding coding and reimbursement are also used when appropriate. CareSource PASSE strives to follow the prevailing National Correct Coding Initiative (NCCI) edits as maintained by CMS.

To determine unit prices for a specific code or service, please refer to the listed links for details:

- Medicare: www.cms.hhs.gov/home/medicare.asp
- Medicaid: https://medicaid.mmis.arkansas.gov/provider/docs/fees.aspx

CareSource PASSE uses coding industry standards, such as the AMA CPT manual, CCI and input from medical specialty societies to review multiple aspects of a claim for coding reasonableness, including, but not limited to:

- Bundling issues
- Diagnosis to procedure matching
- Gender and age appropriateness
- Maximum units of a code per day
- Currently valid CPT/HCPCS code or modifier usage

CareSource PASSE seeks to apply fair and reasonable coding edits. If a claim is denied for lack of supporting documentation providers should submit a corrected claim with supporting documentation to justify the use of a particular code edit or modifier. All claim reviews take into consideration Arkansas Medicaid, federal regulations and national commercial standards.

To ensure all relevant information is considered, appropriate clinical information should be supplied with the claim submission. This clinical information allows the CareSource PASSE to consider why the code set(s) and

modifier(s) being submitted differ from the usual standards inherent in our edit logic. The clinical information may provide evidence to override the edit logic when the clinical information demonstrates a reasonable exception to the norm.

Specific claims are subject to current CareSource PASSE claim logic and other established coding benchmarks. Consideration of a provider's claim payment concern regarding clinical edit logic will be based upon review of generally accepted coding standards and the clinical information particular to the specific claim in question.

CareSource PASSE maintains reimbursement policies. To view medical, reimbursement, administrative and pharmacy policies, visit **CareSourcePASSE.com** > Providers > Tools & Resources > Provider Policies.

## Explanation of Payment

Explanation of Payments (EOPs) are current claim status statements that have been submitted to CareSource PASSE and entered into our system. EOPs are generated weekly. However, you may not receive an EOP each time they are generated, depending on claim activity. Providers who receive EFT payments will receive an electronic remittance advice (ERA) and can access it on the Provider Portal.

### Information Included on Explanation of Payment

EOPs include paid and denied claims. Denied claims appear on the EOP with a HIPAA-compliant remark code indicating the reason the claim was denied. It is the provider's responsibility to resubmit claims with the correct or completed information needed for processing.

## Coordination of Benefits

CareSource PASSE collects Coordination of Benefits (COB) information for our members. This information helps us to ensure that we are paying claims appropriately and are compliant with federal regulations that Medicaid programs are the payer of last resort.

While we try to maintain accurate information at all times, we rely on numerous sources for information that is updated periodically, and some updates may not always be fully reflected on our Provider Portal. Please ask CareSource PASSE members for all health care insurance information at the time of service.

You can search for COB information on the Provider Portal by:

- Member number
- Case number
- Medicaid number/MMIS number
- Member name and date of birth

You can check COB information for members who have been active with CareSource PASSE within the last 12 months.

Claims involving COB will not be paid until an EOB/EOP or EDI payment information file is received indicating the amount the primary carrier paid. Claims indicating that the primary carrier paid in full (e.g., $0 balance) must still be submitted to CareSource PASSE for processing due to regulatory requirements.

### Coordination of Benefits Overpayment

If a provider receives a payment from another carrier after receiving payment from CareSource PASSE for the same items or services, this is considered an overpayment. Adjustments for an overpayment will be made on subsequent reimbursements to the provider, or the provider can issue a refund check to CareSource PASSE for an overpayment. Providers should not refund money paid to a member from a third party.

## Member Billing

Providers may not bill members for any covered services.

To charge the member for non-covered services, the provider must obtain written acknowledgment that the member is assuming financial responsibility **prior** to the service being rendered. The member's written acknowledgment must come with a clear description of the services the member would be responsible for paying and not include any conditional language.

Providers may not charge members for services which CareSource PASSE denied based on lack of medical necessity or lack of compliance to contractual terms. Providers may not bill members for missed appointments. A member may not be billed for medically necessary emergency services

# Pharmacy

CareSource PASSE covers all medically necessary, Medicaid-covered prescription drugs. For additional information about pharmacy benefits, consult our website at **CareSourcePASSE.com** > Providers > Education > Pharmacy, call Provider Services at **1-833-230-2100**.

## Prescription Drug Coverage

### Medical Supplies

To support member access, certain medical supplies are covered under the pharmacy benefit. Many other medical supplies and durable medical equipment (DME) items are available through a DME provider.

### Medications Administered in the Provider Setting

CareSource PASSE covers many medications that are administered in a provider setting, such as a physician office, hospital outpatient department, clinic, dialysis center or infusion center. Prior authorization requirements exist for many injectables.

### Transition Period

A 90-day transition period applies when members move from another plan to CareSource PASSE. Some medications are excluded from the transition period. After the 90-day transition period has ended, prior authorization may be needed, depending on the medication. Please check our website for which medications require a prior authorization.

## Network Pharmacies

Our pharmacy directory gives you a complete list of our network pharmacies and all the pharmacies that have agreed to fill covered prescriptions for CareSource PASSE members. Members can access our Find a Pharmacy tool from the CareSource PASSE member webpage.

## Drug Formulary

CareSource PASSE uses the Arkansas Medicaid Preferred Drug List (PDL), also known as the drug formulary. Some drugs on the PDL require prior authorization before CareSource PASSE will cover them. The online formulary contains indicators of prior authorizations, quantity limits and step therapy.

Access our Pharmacy webpage at **CareSourcePASSE.com** > Providers > Education > Pharmacy > Drug Formulary, to locate both an online and a PDF version of our formulary.

## Step Therapy and Quantity Limits

Certain medications on the PDL are covered if utilization criteria are met. Step therapy is one such utilization technique that requires a member to try a preferred drug used to treat the same condition before "stepping to" to another cost medication.

Quantity limits are also placed on many medications. Quantity limits are based on several factors such as the manufacturers' recommended dosing frequencies, safety considerations and/or Food & Drug Administration (FDA) recommendations.

## Generic Substitution and Therapeutic Exchange

Generic substitution occurs when a pharmacy dispenses a generic version rather than a prescribed brand-name product. In most instances, when a generic product becomes available, the brand-name version will become non-formulary and replaced with its generic equivalent.

However, it is important to note that the formulary is subject to state-specific regulations and rules regarding generic substitution and mandatory generic rules will apply where appropriate.

Generally, generic drugs are priced lower than their brand-name equivalents and should be considered the first line of prescribing subject to applicable rules. Prescription generic drugs are:

- Approved by the United States Food and Drug Administration (FDA) for safety and effectiveness and are manufactured under the same strict standards that apply to brand-name drugs.
- Tested in humans to assure the generic is absorbed into the bloodstream in a similar rate and extent compared to the brand-name drug (bioequivalence). Generics may be different from the brand in size, color and inactive ingredients, but this does not alter their effectiveness or ability to be absorbed just like the brand-name drugs.
- Manufactured in the same strength and dosage form as the brand-name drugs.

When a generic drug is substituted for a brand-name drug, you can expect the generic to produce the same clinical effect and safety profile as the brand-name drug (therapeutic interchange).

Access our Pharmacy webpage at **CareSourcePASSE.com** > Providers > Education > Pharmacy > Drug Formulary, to locate both an online and a PDF version of our formulary. This page also includes other information about the CareSource PASSE pharmacy program.

# Prior Authorization

A prior authorization is when CareSource PASSE requires that a drug be pre-approved for it to be covered under the member's health benefit. CareSource PASSE processes covered pharmacy outpatient drug prior authorization requests within 24 hours of receipt. If additional information is required from the prescriber but not obtained, we will deny the authorization pending additional information.

The Prior Authorization staff adheres to regulations and determines medical necessity for formulary exception requests based on drug-specific prior authorization criteria or standard non-formulary prescription request criteria.

Providers can submit prior authorization requests electronically, by phone or fax. To ensure timely review, providers are required to submit pertinent medical/drug history.

Access our Pharmacy webpage at **CareSourcePASSE.com** > Providers > Education > Pharmacy, selecting Arkansas from the dropdown menu, for instructions to obtain prior authorization.

CareSource PASSE implements edits in accordance with, and supplementation to, the SUPPORT Act.

## Synagis

CareSource PASSE's clinical policy for Synagis follows the American Academy of Pediatrics (AAP) Guidelines for Respiratory Syncytial Virus (RSV). CareSource PASSE reviews requests per policy in accordance with these guidelines to determine authorization.

Consistent with epidemiologic findings, CareSource PASSE considers RSV season to be November 1 through March 31. Coverage for the RSV season will end March 31 with an extension possible if RSV is still in the community.

# Medication Therapy Management (MTM) Program

CareSource partners with CSS Health to administer our Medication Therapy Management (MTM) program to help members receive the maximum benefit from their medications. CSS Health identifies members with opportunities to prevent or address medication-related problems, gaps in care, duplication of therapies, cost opportunities, nonadherence and numerous other quality-focused interventions. A local pharmacist invites the member to participate in the program, at which time the member has the option to decline participation. A local pharmacist performs interventions in a face-to-face or telephonic interaction to maximize an already existing relationship that the member has established with that clinician. Our CareSource RxInnovations™ pharmacists also engage members in our MTM program.

Elements of our MTM program include:

- Comprehensive Medication Review (CMR) – an interactive, person-to-person medication review and consultation of the patient's medications (including prescriptions, over-the-counter (OTC) medications, herbal therapies and dietary supplements) performed at least annually in real time by a pharmacist with a summary of the results of the review provided to the patient in the standardized format.
- Targeted Medication Review (TMR) – specific recommendations performed at least quarterly sent to prescribers or pharmacists based on type of action that focus on the following categories:
  - Adverse Drug Event – sent to prescribers to identify and resolve an order with a drug interaction risk significant enough to render the therapy unsafe in which the prescriber's approval for a change in therapy is required.

- Care Coordination – sent to prescribers to identify and resolve a gap in care in which the prescriber's approval is required (includes but not limited to health tests, lab monitoring, immunizations).
- Cost-Effective Alternatives – sent to prescribers to identify and resolve an order for a drug product where a more cost-effective therapeutic alternative is available in which the prescriber's approval for a change in therapy is required.
- Inappropriate Therapy – sent to prescribers to identify and resolve an order to initiate or continue drug therapy at a dose or duration unlikely to be safe, effective or not indicated in which the prescriber's approval for a change in therapy is required.
- Patient Adherence Consultations – an interactive, person-to-person consultation between a pharmacist and a patient to identify, resolve and/or prevent the occurrence of medication overuse, medication underuse or inappropriate medication administration.
- Patient Education and Monitoring – an interactive, person-to-person consultation between a pharmacist and a patient to provide education and monitoring under circumstances where the patient has received a new medication or change to an existing medication to identify, resolve and/or prevent the occurrence of one or more medication-related problems.
- Suboptimal Drug Therapy – sent to prescribers to identify and resolve an order to initiate or continue drug therapy with suboptimal efficacy or an untreated indication for prescription therapy in which the prescriber's approval for a change in therapy is required.

## Lock-In Program (LIP)

The CareSource PASSE Lock-In Program (LIP) helps reduce member fraud and abuse by restricting the providers and medications available to the member. The LIP is a regulatory requirement. It is the policy of CareSource PASSE to take appropriate steps to control fraud, abuse and overutilization of medical and pharmacy services by placing or continuing members in the (LIP) which monitors and educates members with the goal of developing positive behavior changes.

The CareSource PASSE LIP team monitors complaints and referrals regarding potential fraud, member abuse, provider abuse or overutilization. The LIP team responds to any complaint or data finding by conducting a utilization review of the member.

A member utilization review includes a review of medical and pharmacy claims to identify if the member utilized Medicaid services at a frequency or amount that exceeds utilization criteria and to determine if the member should be placed in the LIP.

LIP members are restricted to receiving Medicaid services from designated providers, including:

- One or more controlled substance prescribers who will serve as the sole prescriber and manager of controlled substances for the lock-in member; and
- One pharmacy who will serve as the sole establishment to fill the member's prescriptions.

### Eligibility

Potential Lock-In members are scored based on the likelihood that they are engaging in behaviors of abuse or unnecessary use of prescription or non-prescription drugs including, but not limited to:

- Drug therapy that does not correlate with either the primary or secondary diagnosis in claim data
- Prescriptions filled at two or more pharmacies per month, or more than five pharmacies per year
- More than three controlled substances per month

- The number of prescriptions for controlled substances exceeds ten percent of the total number of prescriptions filled by the member
- More than two hospital emergency room visits per year and the recorded diagnosis is not consistent with an emergency medical condition
- Duplicate therapy from different physicians
- Prescriptions from pharmacies or physician visits located outside the member's county of residence
- Purchases of drugs of abuse without utilizing Medicaid prescription benefits
- Diagnosis of narcotic poisoning or drug abuse
- Greater than 120mg MED (morphine equivalent dose) per day

Members may be **excluded** from the Lock-In program if:

- They utilize Medicaid services at a frequency or amount which is medically necessary to treat a complex, life threatening medical condition as determined by the Lock-In Coordinator or with the assistance of a Medical Director and Pharmacist.
- The Lock-In Coordinator, in collaboration with Pharmacy, Behavioral Health and/or Care Coordination staff, determines that not enrolling a member in the Lock-In program is in the best interest of the member.

## Enrollment

Upon identifying a member for the Lock-In program, CareSource PASSE will:

1. Send a written notification to the member including:
    - The reason for enrolling the member in the Lock-In program
    - A description of the Lock-In program
    - The effective date of Lock-In program enrollment
    - Identification of the member's designated provider(s) and/or pharmacy
    - Information relating to the member's right to an appeal
    - Information on how to contact CareSource PASSE for more information about the Lock-In program
2. Enroll the member in the Lock-in program.
3. Refer the member to Care Coordination for management, education and reinforcement of appropriate medication use.

Except for a member who requests an appeal relating to a lock-in determination, CareSource PASSE will enroll the member in the Lock-In program within 30 days of sending the written notification.

## Changing Designated Providers

The member has thirty days from the date of the initial notification of enrollment to select designated provider(s), otherwise the PASSE will select the designated provider(s). A Lock-In member may not transfer to another pharmacy, PCP or care coordination program while enrolled in the Lock-In program within a 12-month period except as indicated below.

The designated controlled substance provider(s) will be the designated provider(s) of a Lock-In member for up to 12 months except if:

- The designated provider contacts CareSource PASSE requesting a release from serving as the member's designated provider. The provider will continue to serve as the member's designated provider until a comparable designated provider is selected.
- A member contacts CareSource PASSE to request a change, or CareSource PASSE requires an alternative selection of a designated provider under the following circumstances:
  - The designated provider's office or location is no longer accessible to the member for one or more of the following reasons:
    - Relocation or closing of the designated provider's office.
    - Relocation or incapacity of the member.
  - The designated provider is no longer an eligible provider.
  - The designated provider chooses to not, or no longer, provide services to the member.
  - The medical or prescription needs of the member are not available from the current designated provider.
  - The medical or prescription needs of the member require a designated provider with a different specialty.
- The CareSource PASSE Lock-In staff or the care coordinator determines that it is in the best interest of the member to change the designated provider.

## Annual Review Process

CareSource PASSE will annually assess the needs for each Lock-In member. Members enrolled in the Lock-In program will either be disenrolled or re-enrolled for an additional 12-month period.

Prior to consideration for disenrollment from the Lock-In program, CareSource PASSE will conduct a utilization review to measure the effectiveness of the member's enrollment in the Lock-In program. CareSource PASSE will provide the Lock-In member with written notification, which includes the findings of the utilization review and the decision to maintain enrollment or discharge the member from the Lock-In program.

# Referrals & Prior Authorization

This section describes the referral and prior authorization processes and requirements for services provided to CareSource PASSE members.

If you have questions about referrals and prior authorization, please call our Utilization Management department at **1-833-230-2100** or the Care Coordinator assigned to the member at 1-833-230-2005.

## Referral Information

Any treating provider can refer CareSource PASSE members for specialty services and evaluation or treatment by most specialists. Other services provided by specialists do not require a referral. Members may schedule self-referred services with participating providers if applicable benefit limits have not been exhausted, or call Provider Services at **1-833-230-2100** and request to speak to the members' Care Coordinator.

### Services That Do Not Require a Referral

Services that do not require a referral include:

- Certified Nurse Practitioner (CNP) services
- Services to treat an emergency
- Family planning services
- Laboratory services (must be ordered by a participating provider)
- Podiatric care
- Psychiatric care at community mental health centers only

- Psychological care from private practitioners or at community mental health centers
- Care at public health clinics
- Care at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Most radiology services (must be ordered by a participating provider)
- Routine eye exams at participating vision centers, within benefit limits
- Speech and hearing services
- Care from obstetricians and gynecologists
- Care at urgent care centers after hours
- Services for children with medical handicaps
- Emergency care
- Care at community mental health centers
- Family planning services provided at qualified family planning providers
- Care at FQHCs and RHCs

## How to Make a Referral to a Specialist

To find a specialist for your CareSource PASSE member, use our Find a Doctor/Provider tool at **CareSourcePASSE.com** > Members > Tools & Resources > Find A Doctor. If you have difficulty finding a specialist, please call our Provider Services department at **1-833-230-2100**.

## Referring Doctor

Document the referral in the patient's medical chart. You are not required to use a referral form or send a copy of it to CareSource PASSE. However, you must notify the specialist of your referral.

## Specialist

Document in the patient's chart that the patient was referred to you for services. Referral numbers are not required on claims submitted for referred services. Generally, specialist-to-specialist referrals are not allowed. However, in some cases, specialists may provide services or make referrals in the same manner as a PCP. Documentation in the medical record should contain the number of visits or length of time of each referral. Medical records may be subject to random audits to ensure compliance with this referral procedure.

## Standing Referrals

A PCP may request a standing referral to a specialist for a member with a condition or disease that requires specialized medical care over a prolonged period. The specialist may provide services in the same manner as the PCP for chronic or prolonged care. The period must be at least one year to be considered a standing referral.

## Referrals to Nonparticipating Providers

A member may be referred to an out-of-plan provider if the member needs medical care that can only be received from a doctor or other provider who is not participating with our health plan. Treating providers must get prior authorization from CareSource PASSE before sending a member to an out-of-plan provider.

### Referrals for Second Opinions

A second opinion is not required for surgery or other medical services. However, providers or members may request a second opinion at no additional cost to the member.

The following criteria should be used when selecting a provider for a second opinion:

- The provider must be a participating provider. If not, prior authorization must be obtained to send the patient to a nonparticipating provider.
- The provider must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.
- The provider must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

## Prior Authorization Information*

*See PCSP section above for specific information regarding the submission of HCBS service reviews.

CareSource PASSE realizes the additional time and effort it takes to ensure the PCSP or MTP containing HCBS services is reviewed properly. We have created a specific team to work directly with providers and care coordinators to ensure that the various waiver requirements and service specifications are complete. The traditional Utilization Management (UM) team will determine medical necessity for all physical health services for members participating in the Care Source PASSE. The teams have internal communication requirements to ensure cohesive treatment is approved.

The Service Determination (SD) team of specialists will focus on all behavioral health inpatient and outpatient requests including HCBS services. This team is diverse and includes, nurses, licensed mental health professionals and staff who have worked with individuals with intellectual and developmental disabilities.

If the BH/HCBS service being requested is documented on the PCSP the Care Coordinator will the treatment request to the Service Determination team on the providers behalf. The Provider has two responsibilities:

A. Log into the Provider Portal to acknowledge the PCSP which will automatically submit the review to the Service Determination Team.

B. Participate in the PCSP meeting by either sending treatment plan specific information one-week in advance of the scheduled PCSP meeting or participate in the meeting face to face, by phone or video.

If the service being requested is an initial behavioral health inpatient request or a continued stay inpatient request the treatment request will be made by utilization the provider portal versus the PCSP process. The PCSP treatment request process is for those services that are planned and are not urgent.

Prior authorization is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and benefit limitations. Services are provided within the benefit limits of the member's enrollment. When prior authorization is requested for a service rendered in the same month, member eligibility is verified at the time the request is received.

When the service is to be rendered in a subsequent month, authorization is given contingent upon member eligibility on the date of service. Providers must verify eligibility on the date of service. CareSource PASSE is not able to pay claims for services provided to ineligible members. It is important to request prior authorization as soon as it is known that the service is needed.

Authorization is not a guarantee of payment. Authorization is based on medical necessity and is contingent on eligibility, benefits and other factors. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

## Prior Authorization Requirements

Providers may use the Procedure Code Lookup Tool to check whether a service requires prior authorization. The online Procedure Code Lookup Tool is available on **CareSourcePASSE.com** > Providers > Provider Portal > Prior Authorization. You can quickly and effortlessly research Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes from an automated search function when submitting PA requests to determine if PA is required. With the PA Procedure Code Look-Up Tool, you will gain access to the following functionality:

- Searching on any CPT or HCPCS code to determine if it requires a prior authorization
- Quick, automated search results
- Up-to-date access to procedure code data

To use the tool, select your state from the tool's drop-down, then enter a CPT/HCPCS code into the tool. The result will include:

- Date
- Code
- Description,
- Y or N, if a PA is required
- Contact a Care Coordinator

## Prior Authorization Procedures

Any provider who is not a participating provider with CareSource PASSE must obtain prior authorization for all non-emergency services provided to a CareSource PASSE member.

| Review Type | Time for Plan to Respond When All Information Is Present | Plan Response Time After Receiving Additional Information |
|---|---|---|
| **Inpatient Initial** | Within one business day | 48 hours with extension request |
| **Inpatient Continued Stay Review (CSR)** | Within one business day | 48 hours with extension request |
| **Outpatient/Elective Non-Urgent** | Within two business days | Determinations made within two business days of obtaining all necessary information |
| **Outpatient/Elective/Hospice Urgent** | Within one business day of obtaining all necessary information | Determinations made within one business day of obtaining all necessary information |
| **Retrospective** | Within 30 calendar days | N/A |

## Prior Authorization Request Procedures

The Provider Portal is the preferred method to request prior authorization for health care services. You can get immediate approval or pend status and can check pending claim statuses. Prior authorization for health care services can be obtained by contacting the CareSource PASSE Utilization Management department online or by phone or fax.

### Online

Access the Provider Portal at **CareSourcePASSE.com** > Login > Provider. Alternate methods include phone, fax or mail.

### Phone

Provider Services: **1-833-230-2100**

Utilization Management: **844-542-2608**

Service Determination Team: **844-542-2605**

### Fax

**844-676-0370**

When requesting authorization, please provide the following information:

- Member/patient name and CareSource PASSE member ID number
- Provider name and NPI
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan provider, if applicable
- Clinical information to support the medical necessity for the service

## Radiology Services

Ordering physicians must obtain prior authorization for the following outpatient, non-emergent diagnostic imaging procedures:

- MRI/MRAs
- CT/CTA scans
- PET scans

Ordering providers can obtain prior authorization from National Imaging Associates (NIA) for an imaging procedure:

**Online:** www1.radmd.com

**Phone:** 1-800-424-4313

Follow the option to obtain prior authorization and select the option for advanced radiology prior authorization, Monday through Friday, from 8 a.m. to 8 p.m. Eastern Standard Time (EST).

**Please note:** Imaging procedures performed during an inpatient admission, hospital observation stay or emergency room visit are not included in this program.

## Decision Timeframes

For standard prior authorization decisions, CareSource PASSE provides notice to the provider and member as expeditiously as the member's health condition requires, but no later than two business days after receipt of the request for service.

Urgent prior authorization decisions are made within one business day of receipt of information needed to complete the review.

If applicable, CareSource PASSE will notify providers and members of prior authorization determination denials via a letter mailed to the address on file.

# Utilization Management*

*See Prior Authorization section for additional details.

Utilization Management (UM) helps maintain the quality and appropriateness of health care services provided to CareSource PASSE members.

The Utilization Management department performs all utilization management activities including prior authorization, preservice/urgent, concurrent/post-service reviews, discharge planning and other utilization activities. We monitor inpatient admissions, observations and outpatient services and procedures to ensure that appropriate medical care is rendered in the most appropriate setting using the most appropriate resources. We also monitor the coordination of medical care to ensure its continuity.

UM criteria is available via the following request methods:

**Fax** 844-542-2608

On an annual basis, CareSource PASSE completes a member satisfaction assessment with the UM process and identifies any areas for improvement opportunities.

## Criteria

CareSource PASSE utilizes nationally recognized criteria to determine medical necessity and appropriateness of inpatient hospital, Intermediate Care Facilities, rehabilitation, skilled nursing facility admissions and select services. This criterion is designed to assist providers in identifying the most efficient quality care practices in use today. They are not intended to serve as a set of rules or as a replacement for a physician's medical judgment about individual patients. CareSource PASSE policies are available at **CareSourcePASSE.com** > Providers > Education > Provider Policies.

CareSource PASSE defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services. CareSource PASSE also has a medical policy developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the criteria, the case is forwarded to a CareSource PASSE Clinical Peer Reviewer for further review and determination.

## Access to Staff

Providers may call our toll-free number, **1-833-230-2100**, to contact UM staff with any UM questions.

- Staff members are available from 8 a.m. to 5 p.m. Central Time for inbound calls regarding UM issues.
- Staff members can receive inbound communication regarding UM issues after normal business hours.
- Staff members can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.
- Staff members are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- Staff members are available to accept collect calls regarding UM issues.
- Staff members are accessible to callers who have questions about the UM process.

Clinical Peer Reviewers from CareSource PASSE are available to discuss individual cases with attending physicians upon request. Criteria are also available upon request by calling our Utilization Management department at **1-833-230-2100** or online at **CareSourcePASSE.com** > Login > Providers.

Utilization review determinations are based only on appropriateness of care and service, benefit limits and existence of coverage. CareSource PASSE does not reward providers or our own staff for denying coverage or services. Staff members do not receive financial incentives for making underutilization decisions.

Our members' health is always our number one priority. CareSource PASSE will provide the clinical rationale or criteria used in making medical necessity determinations. You can also discuss an adverse decision with CareSource PASSE's physician reviewer or request a peer-to-peer conversation. Please call the Utilization Management department at **1-833-230-2100** within five business days of the determination.

If you are dissatisfied with a determination made by our Utilization Management department regarding a member's health care services or benefits, you may request a peer-to-peer conversation or appeal the decision. Please see the Grievances & Appeals section of this manual for information on the peer-to-peer consultation and how to file a clinical appeal.

# Quality Improvement Program

CareSource PASSE is committed to providing evidence-based care in a safe, member-centered, timely, efficient and equitable manner. The scope of our CareSource PASSE Quality Improvement (QI) Program is comprehensive and inclusive of both clinical and non-clinical services as well as health, safety and/or welfare concerns.

CareSource PASSE monitors and evaluates the quality and safety of the care and service delivered to our members, emphasizing:

- Accessibility to care
- Availability of services and practitioners
- Quality of care and member safety
- Medical and behavioral health services
- Internal monitoring, review and evaluation of program areas, including UM, Care Coordination and Pharmacy

Member and provider satisfaction and health outcomes are monitored through:

- Quality improvement activities
- Routine health plan reporting
- Annual Health Effectiveness Data and Information Set (HEDIS®) measures the quality of our health plan
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures patient experience with the health care system
- Member surveys
- Review of accessibility and availability standards
- Utilization trends

CareSource PASSE assesses our performance against goals and objectives that are in keeping with industry standards. We complete an annual evaluation of our QI Program. CareSource PASSE will seek accreditation by the National Committee for Quality Assurance (NCQA).

## Program Scope

CareSource PASSE supports an active, ongoing and comprehensive quality improvement program across the organization. To maintain a robust QI program, our scope includes:

- Advocate for members across settings, including review and resolution of quality of care
- Meet member access and availability needs for physical and behavioral health care
- Determine interventions for HEDIS overall rate improvement to improve preventive care scores and facilitate support of members' acute and chronic health conditions and other complex health, safety or welfare needs
- Conduct an annual member CAHPS survey to capture member perspectives on health care quality and establish interventions based on results to enrich member and provider experience
- Demonstrate enhanced care coordination and continuity across settings
- Meet members' cultural and linguistic needs, encompassing the social determinants of health
- Ensure CareSource PASSE is effectively serving members with complex health needs
- Assess member population characteristics and needs
- Assess geographic availability and accessibility of primary care providers and specialists
- Monitor important aspects of care to ensure the health, safety and welfare of members across health settings
- Determine practitioner adherence to clinical practice guidelines
- Partner collaboratively with network providers, practitioners, regulatory agencies and community agencies
- Ensure regulatory and accrediting agency compliance, including:
  - All federal requirements as outlined in 42CFR Part 438, Managed Care
  - Perform HEDIS compliance audit and performance measurement
  - Ensure compliance with NCQA accreditation standards
- Meet the quality requirements of CareSource PASSE's contract with Arkansas Department of Human Services

On an annual basis, CareSource makes information available about our QI program to providers on our website.

## Quality Strategy

CareSource PASSE seeks to advance a culture of quality and safety that begins with our senior leadership and is cultivated throughout the organization. CareSource PASSE utilizes the Institute of Healthcare Improvement (IHI) framework to optimize health system performance, as well as the Centers for Medicaid & Medicare Services' (CMS) National Quality Strategy, which is a national effort to align public and private sector stakeholders to achieve better health and health care.

### Institute for Healthcare Improvement Triple Aim for Populations

CareSource PASSE aligns with the Institute for Healthcare Improvement Triple Aim (IHI) framework to:

- Improve the member experience of care (including clinical quality and satisfaction)
- Improve the health of populations
- Reduce the per capita cost of health care

## Quality Measures

CareSource PASSE continually assesses and analyzes the quality of care and services offered to our members. This is accomplished by using objective and systematic monitoring and evaluation to implement programs to improve member outcomes.

CareSource PASSE uses HEDIS to measure the quality of care delivered to our members. HEDIS is developed and maintained by NCQA. The HEDIS tool is used by America's health plans to measure important dimensions of care and service and allows for comparisons across health plans in meeting state and federal performance measures and national HEDIS benchmarks. HEDIS measures are based on evidence-based care and address the most significant areas of care.

HEDIS is developed and maintained by NCQA and used by America's health plans to measure important dimensions of care and service and allows for comparisons across health plans in meeting state and federal performance measures and national HEDIS benchmarks.

Potential quality measures include the following:

- Wellness and prevention
  - Preventive screenings (breast cancer, cervical cancer and chlamydia)
  - Well-child care
  - Adolescent care
- Chronic disease management
  - Comprehensive diabetes care
  - Controlling high blood pressure
- Prenatal and postpartum care
- Safety
  - Use of imaging studies for low back pain

Providers can log in to our Provider Portal at **CareSourcePASSE.com** > Login > Provider> to access our Clinical Practice Registry and historical medical and pharmacy data.

CareSource uses Lean Six Sigma tools, when indicated, to focus on improving member experience, member safety and ensuring our processes delver the desired results.

## Patient Safety Program

CareSource recognizes that patient safety is the cornerstone of high quality health care, contributing to the overall health and welfare of our members. Our CareSource Patient Safety Program evaluates patient safety with the goal of reducing avoidable harm. Our patient safety program is developed within the context of our population health management approach and includes regulatory/accreditation, policies/procedures, training/implementation, continuous monitoring, program evaluation and improvement initiatives.

Our CareSource Patient Safety Program has a well-defined health, safety and welfare component. The purpose of the program is to ensure our CareSource network of providers are identifying and remediating those social determinants of health that often contribute to negative member health outcomes.

Safety events are monitored through retrospective review of quality of care concerns and real-time reporting of claims data. Data analysis of our provider and health system networks ensures situational risks can be identified in a timely manner, reviewed and mitigated by proactive corrective action or performance improvement steps.

## Preventive Health and Clinical Practice Guidelines

CareSource PASSE approves and adopts evidence-based nationally recognized standards and guidelines and promotes them to practitioners to help inform and guide clinical care provided to members. Member health resources are available on the website and cover a broad range of wellness, preventive health and chronic disease management tools. Guidelines are reviewed at least every two years or more often as appropriate and updated as necessary. They may be found at **CareSourcePASSE.com** > Providers > Education > Patient Care > Health Care Links.

The use of these guidelines allows CareSource PASSE to measure their impact on member health outcomes. Review and approval of the guidelines are completed by the Market CareSource PASSE Provider Advisory Committee (PAC). The CareSource PASSE Enterprise PAC and Quality Enterprise Committee (QEC) are notified of guideline approval. Topics for guidelines are identified through analysis of member population demographics and national or state priorities. Guidelines may include, but are not be limited to:

- Behavioral health (e.g., depression)
- Adult health (e.g., hypertension and diabetes)
- Population health (e.g., obesity and tobacco cessation)

Guidelines may be promoted to providers through one or more of the following: newsletters, our website, direct mailings, provider manual and through focused meetings with CareSource PASSE Provider Engagement Specialists. Information regarding clinical practice guidelines and other health information are made available to members via member newsletters, the CareSource PASSE member website, or upon request.

## External Quality Reviews

Through our contract with the Arkansas Department of Human Services (DHS), we are required to participate in periodic record reviews. DHS retains an External Quality Review Organization (EQRO) to conduct medical record review for CareSource PASSE members.

You may periodically receive requests for medical record copies from CareSource PASSE or from the DHS-contracted EQRO. Your contract with CareSource PASSE requires that you furnish copies of patient medical records for this purpose.

EQRO and CareSource PASSE reviews are a permitted disclosure of a member's personal health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

CareSource PASSE realizes that supplying medical records for review requires your staff's valuable time, and we appreciate your cooperation with our requests and associated timelines.

If you would like more information about the CareSource PASSE Quality Improvement program, please call Provider Services at **1-833-230-2100.**

## Value-Based Reimbursement

Your success is important to us. At CareSource PASSE, we recognize that not all our provider partners are ready to engage in Value-Based Reimbursement (VBR) arrangements at the same level. Therefore, we offer a continuum of VBR models ranging from rewards and incentives all the way to full risk agreements. CareSource PASSE meets providers where they are in their VBR experience, and together we plan to move forward on the path from volume to value. Our model allows providers to assume more risk at their own pace by tying an increasing percentage of overall medical expenditures to performance thresholds. You are rewarded for providing higher value services and for achieving better health outcomes for our members.

Contact your Provider Contracting Manager for more information about our VBR programs.

## Access Standards

Our comprehensive quality program helps ensure our members receive the best high-quality health care services available. The program includes evaluation of the availability, accessibility and acceptability of services rendered to patients by participating providers.

The access standards outlined below relate to differing levels of care. Participating providers are expected to have procedures in place to see patients within these time frames and to offer office hours to their CareSource PASSE patients that are at least the equivalent of those offered to any other patient. Thank you for adhering to these standards.

| Service Type | Time Frame | Time Frame Goal |
|---|---|---|
| **Emergency Care – Medical, Behavioral Health, Substance Abuse** | 24 hours a day, 7 days a week | Met 100% of the time |
| **Behavioral Health Service and Developmental Disability Service Mobile Crisis Response** | 24 hours a day, 7 days a week | Met 100% of the time |
| **Urgent Care – Medical, Behavioral Health, Substance Abuse** | Within 24 hours | Met 100% of the time |
| **Primary Care – Routine, non-urgent symptoms** | Within 21 calendar days | Met ≥ 90% of the time |
| **Behavioral Health, Substance Abuse Care – Routine, non-urgent, non-emergency** | Within 21 calendar days | Met ≥ 90% of the time |
| **Prenatal Care** | Within 14 calendar days | Met ≥ 90% of the time |
| **Primary Care Access to after-hours care** | Office number answered 24 hours/7 days a week by answering service or instructions on how to reach a physician | Met ≥ 90% of the time |
| **Preventive Visit/Well Visits** | Within 30 calendar days | Met ≥ 90% of the time |
| **Specialty Care – non-urgent** | Within 60 calendar days | Met ≥ 90% of the time |

**A member should be seen as expeditiously as the member's condition warrants based on severity of symptoms. CareSource PASSE expects if a provider is unable to see the member within the appropriate time frame, CareSource PASSE will facilitate an appointment for the member with a participating provider or a non-participating provider, if necessary.*

CareSource PASSE continually assesses and analyzes the quality of care and services offered to our members. This is accomplished by using objective and systematic monitoring and evaluation to implement programs to improve outcomes.

## Quality of Care Reviews

CareSource PASSE ensures the provision of safe and quality care to members by investigating and mitigating potential quality of care concerns, that include:

- Inappropriate or inconsistent treatment
- Delay in receipt of care
- Compromising member health, safety or welfare
- Having the potential to limit functional abilities on a permanent or long-term basis

To properly assess quality of care concerns, CareSource PASSE Enterprise Quality Improvement initiates contact with providers to request medical records using established processes and timelines. As per our policies and provider contracts, we are authorized to ask for protected health information for health care operations, which includes quality issue reviews. Medical record requests are forwarded to providers via mail, e-mail or fax and may be returned to CareSource PASSE via these same mechanisms as detailed in the medical record request document.

All providers are expected to return medical record requests related to quality of care concerns within 14 days from initial receipt of the request, unless otherwise defined by program guidelines or state or federal law requirements. If a state, federal or regulatory agency, or if the health and safety of a member requires that medical records must be submitted under a shorter timeframe, providers are expected to comply with the shorter turnaround time. Providers and facilities that utilize third-party health information management vendors are responsible for providing medical records to CareSource PASSE or facilitating delivery of medical records to CareSource PASSE by the identified contractor. We are legally bound to interact with providers only and CareSource is not subject to any fees charged by health information management companies for medical record retrieval or submission.

Your health partner representative may contact you if medical records are not received within the 14-day timeframe to ensure you received the request. In addition, our market Chief Medical Officer may also be in contact to facilitate and ensure receipt of the required medical records to complete the quality of care reviews. Providers or facilities who repeatedly fail to return requested medical records are reported to the Credentialing Committee and may face other directed intervention or penalties up to and including contract termination.

# Fraud, Waste & Abuse

Health care fraud, waste and abuse hurts everyone, including members, providers, taxpayers and CareSource PASSE. As a result, we have a comprehensive Fraud, Waste and Abuse program in our Program Integrity department. Please help us by reporting questionable activities and potential fraud, waste and abuse situations.

## Definition of Terms

**Fraud** is defined as “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.” (42 CFR, Part 455.2)

**Waste** involves the taxpayers not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by player with control over, or access to, government resources (e.g., executive, judicial or legislative branch employees, grantees or other recipients).

Waste goes beyond fraud and abuse, and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight (Inspector General).

**Abuse** is defined as “provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program” (42 CFR Part 455.2).

**Improper Payment** is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative or other legally applicable requirements. This includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law) and any payment that does not account for credit for applicable discounts (Improper Payments Elimination and Recovery Act [IPERA]).

## Examples of Member Fraud, Waste and/or Abuse

- Inappropriately using services, such as selling prescribed narcotics, or seeking controlled substances from multiple providers or multiple pharmacies
- Altering or forging prescriptions (e.g., changing prescription form to get more than the amount of medication prescribed by their physician)
- Sharing a member ID card
- Non-disclosure of other health insurance coverage
- Changing prescription forms to get more than the amount of medication prescribed by a physician
- Obtaining unnecessary equipment and supplies
- Member receiving services or picking up prescriptions under another person's name or ID (identity theft)
- Providing inaccurate symptoms and other information in order get treatment, drugs, etc.

## Examples of Provider Fraud, Waste and/or Abuse

- Prescribing drugs, equipment or services that are not medically necessary
- Failing to provide patients with medically necessary services due to lower Medicaid/Medicare reimbursement rates
- Billing for services not provided
- Requiring members to pay for CareSource PASSE covered services
- Billing more than once for the same service
- Intentionally using improper medical coding to receive a higher rate of reimbursement
- Prescribing high quantities of controlled substances without medical necessity
- Unbundling services to obtain higher reimbursement
- Not checking member IDs, resulting in claims submitted for non-covered persons
- Scheduling more frequent return visits than are needed
- Billing for services outside of your medical qualifications
- Using member/enrollee lists for the purpose of submitting fraudulent claims
- Billing drugs billed for inpatients as if they were outpatients
- Accepting payments stemming from kickbacks or Stark violations
- Retaining overpayments made in error by CareSource PASSE
- Preventing members from accessing eligible or covered services resulting in underutilization of services offered

## Examples of Pharmacy Fraud, Waste and/or Abuse

- Dispensing prescription drugs that are inconsistent with the written order
- Submitting claims for a more expensive brand name drug when a less expensive generic prescription is dispensed
- Dispensing less than the prescribed quantity without arranging for the additional medication to be received with no additional dispensing fees
- Splitting prescriptions into two orders to seek higher reimbursement
- Dispensing expired, fake, diluted, tainted or illegal drugs
- Billing prescriptions not filled or picked up

It is also important for you to tell us if a CareSource PASSE employee acts inappropriately.

## Examples of Employee Fraud, Waste and/or Abuse

- Receiving gifts or kickbacks from vendors for goods or services
- Inappropriately marketing our company to potential members
- Behaving in an unethical or dishonest manner while performing company business

## Examples of Vendor Fraud, Waste and/or Abuse

- Falsifying business data or reports
- Not reporting or taking action on employees that are debarred
- Billing for services not rendered
- Billing for a more expensive service, but providing a less expensive service

## Corrective Actions

The CareSource PASSE Program Integrity (PI) department routinely monitors for potential fraud, waste and abuse. PI reviews claim data and medical records to look for billing discrepancies. When found, an investigation is initiated and, if warranted, a corrective action is taken.

Corrective actions can include, but are not limited to:

- Member and/or provider education
- Written corrective action plan
- Provider termination with or without cause
- Provider summary suspension
- Prepayment review of claims
- Recovery of overpaid funds
- Member disenrollment
- Reporting to one or more applicable state and federal agencies
- Contract termination
- Employee disciplinary actions
- Legal action

Refer to your Provider Agreement for specific information on each type of provider termination/suspension. Access the Fair Hearing Plan at CareSourcePASSE.com/documents/fhp/ for information about the appeal process.

## The Federal and Arkansas False Claims Acts Laws

Using the False Claims Act, you can help reduce fraud against the federal government. The act allows everyone to bring "whistleblower" lawsuits on behalf of the government – known as "qui tam" suits – against businesses or other individuals that are defrauding the government through programs, agencies or contracts.

The False Claims Act addresses those who:

- Knowingly* present, or cause to be presented, a false or fraudulent claim for payment or approval
- Knowingly* make, use or cause to be made or used, a false record or statement material to a false or fraudulent claim
- Conspire to commit a violation of any other section of the False Claims Act
- Have possession, custody or control of property or money used, or to be used, by the government and knowingly deliver, or cause to be delivered, less than all of that money or property
- Are authorized to make or deliver a document certifying receipt of property used, or to be used by the government, and intending to defraud the government, makes or deliver the receipt without completely knowing that the information on the receipt is true
- Knowingly* buy, or receive as a pledge of an obligation or debt, public property from an officer or employee of the government, or a member of the armed forces, who lawfully may not sell or pledge property
- Knowingly* make, use or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the government.

** Knowingly means acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information.*

An example would be if a provider, such as a hospital or a physician, knowingly "upcodes" or overbills, resulting in overpayment of the claim using Medicaid and/or Medicare dollars.

### Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are designed to reduce program spending. As an entity that offers Medicaid and Medicare coverage, CareSource PASSE is required to comply with certain provisions of the DRA.

One such provision prompted this communication, as it requires us to provide you with information about the federal False Claims Act, state False Claims Acts and other state laws regarding Medicare and Medicaid fraud. In addition, the DRA requires you and your contractors and agents to adopt our policy on fraud, waste and abuse when handling CareSource PASSE business.

The period for a claim to be brought under the False Claims Act is the later of:

- Within six years from the date of the illegal conduct, or
- Within three years after the date the government knows or should have known about the illegal conduct, but in no event later than 10 years after the illegal activity

## Protection for Whistleblowers

Federal and state law and CareSource PASSE's policy prohibit any retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she has been subject to any such retribution or retaliation should also report this to our Program Integrity department using one of the reporting methods outlined at the end of this section.

Individuals bringing the suit may receive a percentage of the proceeds of the action or settlement. Additional information on the False Claims Act and our fraud, waste and abuse policies can be found at **CareSourcePASSE.com** > Providers > Education > Fraud, Waste & Abuse.

## Anti-Kickback Statute

Under the Federal Anti-Kickback Statute, and subject to certain exceptions, it is a crime for anyone to knowingly and willfully solicit or receive, or pay anything of value, including a kickback, bribe or rebate in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a federal health care program (42 U.S.C. §1320a-7b).

## Stark Law

Under the Federal Stark Law, and subject to certain exceptions, providers are prohibited from referring federal health care program patients for certain designated health services to an entity with which the physician or an immediate family member has a financial relationship. The Stark Law imposes specific reporting requirements on entities that receive payment for services covered by federal health care programs (42 U.S.C. §1395nn).

## Health Insurance Portability and Accountability Act (HIPAA)

As part of the Health Insurance Portability and Accountability Act (HIPAA), the United States Criminal Code was amended, and it is a crime to knowingly and willfully execute, or attempt to execute a scheme or artifice to defraud any federal health care program or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any federal health care program. (18 U.S.C. §1347).

## Prohibited Affiliations

CareSource PASSE is prohibited by its federal and state contracts from knowingly having relationships with persons who are debarred, suspended or otherwise excluded from participating in federal procurement and non-procurement activities (42 C.F.R. § 438.610). Relationships must be terminated with any trustee, officer, employee, provider or vendor who is identified to be debarred, suspended, or otherwise excluded from participation in federal or state health care programs. If you become aware that your corporate entity, those with more than five percent ownership in your corporate entity, your office management staff or you are a prohibited affiliation, you must notify us immediately utilizing the contact information in the "How to Report Fraud, Waste or Abuse" reporting section below.

# How to Report Fraud, Waste or Abuse

It is CareSource PASSE's policy to detect and prevent any activity that may constitute fraud, waste or abuse, including violations of the federal False Claims Act or any state Medicaid fraud laws.

If you have knowledge or information that any such activity may be or has taken place, please contact our Program Integrity department. Reporting fraud, waste or abuse can be anonymous or not anonymous.

Options for reporting anonymously:

**Write**
CareSource PASSE
Attn: Program Integrity Department
P.O. Box 1940
Dayton, OH 45401-1940

**Options for Reporting That Are Not Anonymous:**

**Fax**
1-800-418-0248

**Email***
fraud@CareSourcePASSE.com

**Most email systems are not protected from third parties. Please do not use email to send confidential information. If you will be sending confidential or health information, please use the form or phone number to report your concerns to help protect your privacy.*

Arkansas Office of Medicaid Inspector General
(855) 527-6644
Omig.arkansas.gov

Or you may choose to use the Fraud, Waste and Abuse Reporting Form located on our Forms webpage at **CareSourcePASSE.com** > Providers > Tools & Resources > Forms.

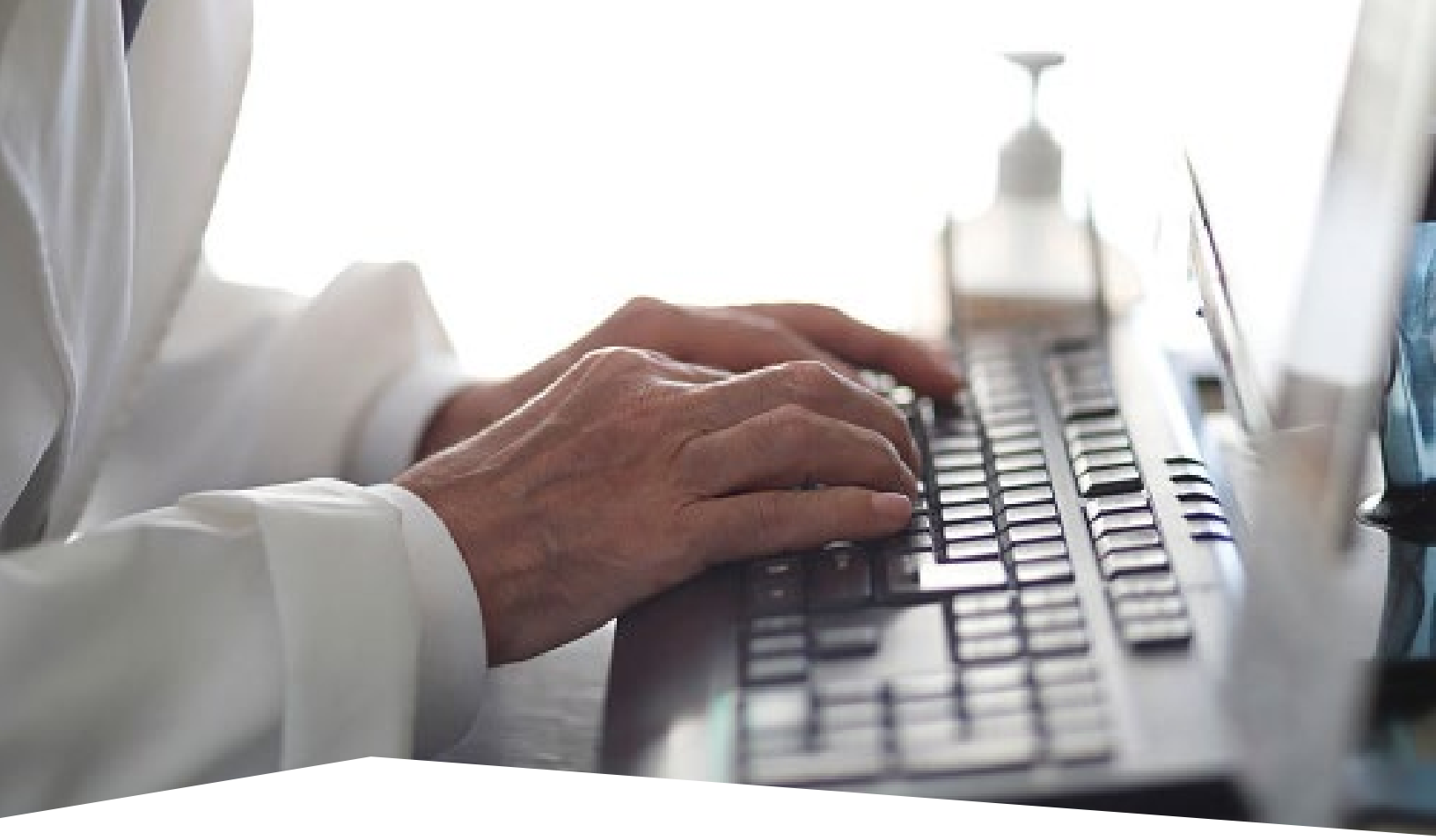
When you report fraud, waste or abuse, please give as many details as you can, including names and phone numbers. You may remain anonymous, but if you do, we will not be able to call you back for more information. Your reports will be kept confidential to the extent permitted by law.

# Physician Education Materials

## A Roadmap to Avoid Medicare and Medicaid Fraud and Abuse

The Office of the Inspector General (OIG) has created free materials for providers to assist you in understanding the federal laws designed to protect Medicaid and Medicare programs and program beneficiaries from fraud, waste and abuse. This brochure can be found on the OIG website at: https://oig.hhs.gov/compliance/physician-education/roadmap_web_version.pdf.

Thank you for helping CareSource PASSE keep fraud, waste and abuse out of health care.



# Grievances & Appeals

CareSource PASSE provides members with reasonable assistance in completing forms and taking other procedural steps for complaints, grievances and appeals. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY and interpreter capability.

## Member Complaints

Members have the right to file a complaint at any time. Complaints may be filed by the member, a member's parent if the member is a minor or the member's legal guardian. If the complaint is not resolved within 10 business days, the complaint can be transferred to the grievance process.

## Member Grievances

Members have the right to file a grievance at any time.

Any time a member informs us that they are dissatisfied with CareSource PASSE or one of our providers, it is a grievance. A grievance is an expression of dissatisfaction about any matter other than an adverse decisions/ adverse actions.

Grievances may include, but are not limited to, the following:

- Quality of care or services provided
- Aspects of interpersonal relationships such as rudeness of a provider or employee
- Failure to respect the enrollee's rights, regardless of whether remedial action is requested
- A dispute of an extension of time proposed by CareSource PASSE to make an authorization decision

Members are encouraged to call or write to CareSource PASSE to let us know of any complaints regarding CareSource PASSE or the health care services they receive. Detailed grievance and appeal procedures are available in the CareSource PASSE Member Handbook. Members can contact CareSource PASSE at **1-833-230-2005** (TTY: 800-285-1131 or 711) to learn more about these procedures.

### Timeframes and Requirements for Member Grievances

CareSource PASSE will acknowledge receipt of a grievance within five business days of receipt. CareSource PASSE investigates all grievances. As a CareSource PASSE provider, we may contact you to obtain documentation. If the grievance is about a provider, we may contact the provider's office to gather information for resolution.

CareSource PASSE ensures that the individuals who make decisions on grievances that involve clinical issues are health care professionals, under the supervision of CareSource PASSE's Medical Director, who have the appropriate clinical expertise in treating the member's condition or disease and who were not involved in any previous level of review or decision-making.

CareSource PASSE has procedures to ensure all members are notified of the grievance resolution in their primary language.

CareSource PASSE responds to all grievances as soon as possible, but no later than 30 calendar days from receipt.

If members are not satisfied with our response to a grievance, they can ask us to reconsider it by sending us a letter within 60 calendar days.

## Member Appeals

A member appeal is a request for reconsideration of an adverse decisions/adverse actions. CareSource PASSE notifies members in writing when an adverse decisions/adverse actions has been made. This can include:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or part, of payment for a service
- Failure to provide services in a timely manner
- Failure of CareSource PASSE to act within the appropriate time frame
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other enrollee financial liabilities

Members have the right to appeal an adverse decisions/adverse actions if they contact CareSource PASSE within 60 calendar days from the date on their adverse decisions/adverse actions notice. Members can contact CareSource PASSE at **1-833-230-2005** (TTY: 800-285-1131 or 711) to learn more about appeal procedures.

### Submissions

A member, the member's authorized representative or a provider acting on behalf of the member may file an appeal orally or in writing. All oral appeal requests must be followed by a written, signed appeal within 10 calendar days of the oral request, unless an expedited resolution is requested.

Appeals will be expedited when a provider indicates, or CareSource PASSE determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

CareSource PASSE will provide the member, the member's authorized representative or provider acting on behalf of the member, a reasonable opportunity to present evidence and allegations of fact or law, in-person, as well as in writing, and to examine the member's case file, including medical records and any other documents and records considered during the appeal process. CareSource PASSE will inform the member of the limited time available to provide this in case of an expedited review.

CareSource PASSE will ensure that the individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making and who are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following:

- An appeal of a denial that is based on lack of medical necessity
- An appeal that involves clinical issues

## Notification of Resolution or Adverse Action

CareSource PASSE will respond to the appeal in writing as expeditiously as the member's health condition requires, but not later than 30 calendar days of when it was received for a standard appeal or within 72 hours for an expedited appeal.

CareSource PASSE will verbally notify the appellant of an expedited appeal determination and will send written notification of the appeal decision within two calendar days of the expedited appeal determination.

## Extensions

A member or the authorized representative can verbally request that CareSource PASSE extend the time frame to resolve a standard or expedited appeal up to 14 calendar days. CareSource PASSE may also extend the time frame to resolve a standard or expedited appeal up to 14 calendar days if there is a need for additional information and that the delay is in the member's best interest. CareSource PASSE will provide oral notice of the reason for the delay to the appellant by close of business on the day of the determination, and written notice of the reason for the delay to the appellant within two calendar days of the determination.

## State Fair Hearings

CareSource PASSE members can request a State Fair Hearing. A provider can request a State Fair Hearing on behalf of a member.

Members must request State Fair Hearing within 90 calendar days of the date of CareSource PASSE's notice to uphold its decision in response to a member's appeal. CareSource PASSE will comply with the decisions reached because of the State Fair Hearing.

The PASSE must timely notify the appellant that a request for a Fair Hearing must be filed with the appropriate office within 90 calendar days of receipt of resolution of the Appeal.

To file a request for State Fair Hearing:

## Beneficiary Appeals

DHS Office of Appeals and Hearings
P.O. Box 1437, Slot N401
Little Rock, AR 72203-1437
Phone: 501-682-8622
Fax: 501-404-4628

## Provider Appeals

ADH Office of Medicaid Provider Appeals
4815 West Markham Street, Slot 31
Little Rock, AR 72205
Phone: 501-683-6626
Fax: 501-661-2357

## Continuation of Benefits

CareSource PASSE will continue the member's benefits while an appeal or State Fair Hearing is pending:

- If the member or the member's authorized representative files the appeal within the required timeframe
- If the appeal involves the termination, suspension or reduction of a previously authorized course of treatment
- If the services were ordered by an authorized provider
- If the original period covered by the original authorization has not expired; and
- If the member or his or her parent/legal guardian timely files for continuation of benefits in accordance with CareSource PASSE polices

Providers may not request the continuation of benefits on behalf of a member.

Required timeframes for filing are on or before the later of the following:

- Within ten calendar days of CareSource PASSE mailing the notice of adverse decisions/adverse actions (the appeal decision)
- The intended effective date of CareSource PASSE's proposed adverse decisions/adverse actions

If, at the member's request, CareSource PASSE continues or reinstates the member's benefits while the appeal or State Fair Hearing is pending, the benefits will be continued until one of the following occurs:

- The member withdraws the appeal or request for the State Fair Hearing
- The member of the member's parent/legal guardian withdraws the request for extension of benefits
- The member fails to request a State Fair Hearing and the continuation of benefits within 10 calendar days after CareSource PASSE sends the notice of adverse decisions/adverse actions
- The Hearing Officer issues a hearing decision adverse to the member
- The period or service limits of a previously authorized service have been met

### Final Resolutions

If the final resolution of an appeal is adverse to the member and upholds CareSource PASSE's appeal decision, CareSource PASSE may recover from the member the cost of the services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section.

If CareSource PASSE or the Hearing Officer reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, CareSource PASSE will authorize or provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours after receiving the decision.

If CareSource PASSE or the Hearing Officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, CareSource PASSE will pay for those services.

## Provider Complaints

Providers have the right to file a complaint within 30 calendar days of the date of the incident. A complaint can be filed by a direct service provider whether they are participating or not.

## Provider Grievances

Providers are permitted to submit grievances to CareSource PASSE regarding CareSource PASSE's policies, procedures or any aspect of CareSource PASSE's administrative functions. Issues involving claim payment or claim payment denial should be submitted through the dispute or appeal process. All provider grievances should be clearly documented.

Providers have 30 calendar days from the date of the incident to file a provider grievance:

CareSource PASSE
Attn: Provider Grievances – CareSource PASSE
P.O. Box 2008
Dayton OH 45401-2008

Grievances can be filed orally or in writing. Provider can also submit grievances using the Provider Portal at **CareSourcePASSE.com**. CareSource PASSE will strive to resolve all provider grievances within 30 days.

CareSource PASSE will thoroughly investigate each grievance using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties and applying CareSource PASSE policies and procedures.

## Peer-to-Peer Consultations

Providers are notified of their right to a peer-to-peer conversation in the notification that is distributed to communicate a medical necessity decision. You have five business days from the receipt of the denial notification to request a peer-to-peer consultation and only one per denied service/procedure is allowed. We will schedule the consultation within one business day or within a reasonable time frame at the provider's request.

If a denial is upheld through a peer-to-peer consultation, the provider can request a clinical appeal. Review the Provider Appeals section below for further instruction on how to submit a clinical appeal. If a denial is upheld on appeal, a peer-to-peer consultation is no longer an option. In addition, the following adverse decisions are not eligible for peer-to-peer consultations:

- Retroactively denied services/procedures (denied for timely filing reasons)
- Administratively denied services/procedures

## Claim Disputes

If you believe your claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim. If you have new information to be considered for your claim, you should submit a corrected claim. Corrected claims should not be submitted through the claim dispute process.

If you believe your claim was denied incorrectly or underpaid, you can submit a claim payment dispute. Claim payment disputes must be submitted in writing.

The dispute must be submitted within 25 calendar days of the date of denial or the date of payment.

At a minimum, the dispute must include:

- Sufficient information to identify the claim(s) in dispute
- A statement of why you believe a claim adjustment is needed
- Pertinent document to support the adjustment

Incomplete requests will be returned with no action taken.

Payments disputes can be submitted to CareSource PASSE through the following methods:

**Provider Portal:** https://providerportal.CareSourcePASSE.com/AR

**Fax:** 937-531-2398

**Mail:** CareSource PASSE
Attn: Provider Appeals Department
P.O. Box 2008
Dayton, OH 45401

CareSource PASSE will render a dispute decision within 30 calendar days of receipt. If the decision is to uphold the original claim adjudication, providers will receive a letter including the right to request an appeal. If the dispute is approved, payment will reflect on the Explanation of Payment (EOP).

## Claim Appeals

Providers may submit a claim appeal to request reconsideration of a claim denial or a clinical appeal for a medical necessity decision.

If you believe a claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim. You do not need to file an appeal in this situation. If you have new information to be considered for your claim, you should submit a corrected claim. Corrected claims should not be submitted through the appeal process.

You have 60 calendar days from the date the adverse action, denial of payment, remittance advice or initial review determination was mailed to you to submit a claim appeal. If the appeal is not submitted in the required time frame, it will not be considered. You will be notified of the dismissal in writing.

## Clinical Appeals

After receiving a letter from CareSource PASSE denying coverage, the provider or the member can submit a clinical appeal. Providers must have a member's written consent to file a pre-service appeal on behalf of a member. The consent must be specific to the service being appealed, is only valid for that appeal and must be signed by the member. You can use the Consent for Provider to File an Appeal on Patient/Member's Behalf form, available on our Forms webpage at **CareSourcePASSE.com** > Providers > Tools & Resources > Forms. The appeal must be submitted within 60 calendar days of the notice of adverse decisions/adverse actions.

The appeal request should include all grounds for appeal and be accompanied by supporting documentation and an explanation of why you disagree with our decision.

## Submissions

Providers may submit appeals through our secure Provider Portal or in writing:

- Provider Portal: **CareSourcePASSE.com** > Login > Provider, selecting Arkansas from the drop-down menu. Click the Claims Information and Attachments > Claim Appeals option.
- Writing: Use the Provider Claim Appeal Request Form available on our Forms webpage at **CareSourcePASSE.com** > Providers > Tools & Resources > Forms.
- Please include:
  - Member's name and CareSource PASSE member ID number
  - Provider's name and ID number
  - Code(s) and why the determination should be reconsidered
  - For a timely filing appeal, proof of original receipt of the appeal by fax or Electronic Data Information (EDI)
  - For a clinical edit denial, all the supporting clinical documentation as to the justification of reversing the determination

    CareSource PASSE
    Attn: Provider Appeals – CareSource PASSE
    P.O. Box 2008
    Dayton, OH 45401-2008
    Fax: 937-531-2398

## Resolutions

Appeals may be reviewed by the CareSource PASSE Appeals staff, Medical Directors, Claims staff, Provider Relations staff and any department that may have reason to assist in resolving a grievance, dispute or appeal.

If the outcome of the review of the claim appeal is adverse to the provider, CareSource PASSE will provide a notice of adverse action. The notice of adverse action will state that you may request a State Fair Hearing.

If the appeal is approved, payment will show on your Explanation of Payment (EOP).

## State Fair Hearings

CareSource PASSE requires exhaustion of the provider appeal process prior to requesting a State Fair Hearing.

If you have new information to be considered for your claim, you should submit a corrected claim. Corrected claims should not be submitted through the claim dispute process, the appeals process or the State Fair Hearing process.

A request for a State Fair Hearing must include the following information:

- A clear expression by the provider that he or she wishes to present his or her case to a State Fair Officer
- Identification of the action being appealed and the issues that will be addressed at the hearing
- A specific statement of why the provider believes CareSource PASSE's action is wrong
- A statement of the relief sought

Providers should send all requests for State Fair Hearings to the Arkansas Department of Health at:

ADH Office of Medicaid Provider Appeals
4815 West Markham St., Slot 31
Little Rock, AR 72205
Phone: 501-683-6626
Fax: 501-661-2357

Reference the CareSource PASSE Family of Companies Fair Hearing Plan below for more information about your rights to a fair hearing.

# CareSource PASSE Commitment to Health Equity & Cultural Competency

CareSource PASSE has a long-standing commitment to addressing the need for culturally competent care in our member populations, including exploring the social determinants of health that impact member health outcomes and quality of life. CareSource PASSE considers providing equitable and culturally competent care and services a core value of our organization. CareSource PASSE is committed to promoting health equity principles and developing programs, which focus on identifying and addressing health disparities.

## Cultural Competency

We recognize language and cultural differences have a significant impact on member health care experience and outcomes. Consistent with federal mandate 42 CFR 438.206 (2), Access and Cultural Considerations, CareSource PASSE participates in efforts to promote the delivery of services in a culturally competent manner to all members. Participating providers must also meet the requirements of this mandate and any applicable state and federal laws or regulations pertaining to provision of services and care.

In addition to our focus on health disparities and their impact on member health outcomes, it is important for our providers and CareSource PASSE team members to understand how a lack of cultural competency may negatively impact member health outcomes. The goal of culturally competent health care services is to provide the highest quality of care to every patient, regardless of race, ethnicity, cultural background, English proficiency or literacy.

We offer staff education and training through our CareSource PASSE University learning management system. Available courses include: the social determinants of health, CLAS standards (Culturally and Linguistically Appropriate Standards, and patient safety). In addition, CareSource PASSE developed an Equity Council to promote diversity within the organization, including the development of Employee Resource Groups to foster a diverse and inclusive workplace.

CareSource PASSE maintains a Cultural Competency Plan which is distributed to providers, to ensure members receive care in a culturally competent manner.

CareSource PASSE encourages our participating providers to visit the Office of Minority Health, Cultural Competency Resources website found at: www.ThinkCulturalHealth.hhs.gov for toolkits and educational resources. Included on the site is a free nine-credit Continuing Medical Education (CME) course, *A Physician's Practical Guide to Culturally Competent Care*. This self-directed e-learning program equips providers to better understand and treat diverse populations. In addition, CareSource PASSE encourages its participating providers to complete the U.S. Department of Health and Human Services Physician's Practical Guide to Culturally Competent Care, which is a free online accredited educational program.

## CLAS Standards: National Culturally and Linguistically Appropriate Standards

The Office of Minority Health (United States Department of Health & Human Services, 2018), created National Culturally and Linguistically Appropriate Standards (CLAS) to provide a blueprint for implementing culturally and linguistically appropriate services for health and health care organizations to:

- Advance health equity
- Improve quality
- Help eliminate health disparities

CareSource PASSE recognizes language and cultural differences have the potential to negatively impact interactions between providers, members and employees. CareSource PASSE adheres to the CLAS, which consists of 15 standards that encompass the following topic areas:

- Principal standard: provision of effective, equitable, understandable and respectful quality care and services that are a response to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs
  - Governance, Leadership and Workforce
  - Communication and Language Assistance
  - Engagement, Continuous Improvement and Accountability

Network providers must ensure that:

- Members understand that they have access to free medical interpreter services in their native language, including Sign Language. No cost TDD/TTY services are available to facilitate communication with hearing impaired members.
- Health care is provided with consideration of the members' cultural background, encompassing race/ethnicity, language and health beliefs. Cultural considerations may impact/influence member health decisions related to preventable disease or illness.
- The provider office staff makes reasonable attempts to collect race-and language-specific member data. Staff is available to answer questions and explain race/ethnicity categories to a member, to assure accurate identification of race/ethnicity for all family members.

- Treatment plans are developed based on evidence-based clinical practice guidelines with consideration of the member's race, country of origin, native language, social norms, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process.
- Participating providers must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care.

CareSource PASSE prohibits its providers or partners from refusing to treat, serve or otherwise discriminate against an individual because of race, color, religion, national origin, sex, age, gender orientation (i.e. intersex, transgendered and transsexual) or disability. In consideration of cultural differences, including religious beliefs and ethical principles, CareSource PASSE will not discriminate against providers who practice within the permissions of existing protections in provider conscience laws, as outlined by the United States Department of Health and Human Services (HHS).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