EMPOWER HEALTHCARE SOLUTIONS

Provider Handbook

PROVIDER SERVICES: 855-429-1028
PROVIDER RELATIONS: Empower Healthcare Solutions (17500 Chenal Pkwy., Suite 300, Little Rock, Arkansas 72223)
ONLINE RESOURCES: www.getempowerhealth.com

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How To Use This Manual

This manual is an extension of the provider agreement and includes necessary information for doing business with Empower Healthcare Solutions, LLC.

Empower is committed to our providers and we strive to make it as easy as possible to work with us. The Provider Manual is your comprehensive source of information on our products, benefits, care coordination, quality of care, operations, and all related policies and procedures. The Provider Manual is considered an extension of your contractual agreement with Empower. This manual should be used as a general guideline by Empower's provider network. It can be found on our website and is updated as needed to reflect updates and changes.

Policy changes will be reflected in the latest version of the Provider Manual. Provider Services will notify providers (within 30 days, when possible) prior to implementation. Whenever appropriate, Provider Services will provide training to network providers and staff regarding updates and policies.

Empower's website includes an extensive amount of provider resources. The website features updates to this manual, provider communication, events, and links to the provider portal that includes tools for authorization, claims, and eligibility. Throughout this manual providers will find links to the website. To access these links click "ctrl" and the link.

The Empower website can be accessed at http://www.getempowerhealth.com

Participating providers may access and download the most up-to-date information and/or forms on the 'Providers' section of the Empower website.

Questions, comments, and suggestions regarding this handbook should be directed to:
Empower Healthcare Solutions Provider Relations:
empowerhealthcaresolutionspr@empowerarkansas.com
(855) 429-1028

Welcome to EMPOWER

Introduction to Empower Healthcare Solutions

Thank you for being a part of our network of physicians, hospitals, agencies, and other healthcare providers. Our number one priority is to *empower* individuals to lead fuller, healthier lives at home and in their communities. Empower is a Provider-Led Arkansas Shared Savings Entity (PASSE) partnering with the Arkansas Department of Human Services Division of Medical Services. Empower also collaborates with providers like you to oversee and deliver health services to our members.

About Us

Empower's model of care ensures individuals with Intellectual and Developmental Disability or behavioral health needs receive the right care, in the right setting, at the right time to improve health outcomes and manage total health care costs. Empower's Care Coordinators manage care across all of the individual providers, including medical, pharmacy, behavioral health, intellectual and developmental disability, and long-term support services. Empower recognizes the importance of engaging individuals, key constituents, and stakeholders in the PASSE program. We developed a Consumer Advisory Council to ensure people have the opportunity to provide meaningful feedback and important program information across the state.

Our Mission and Values

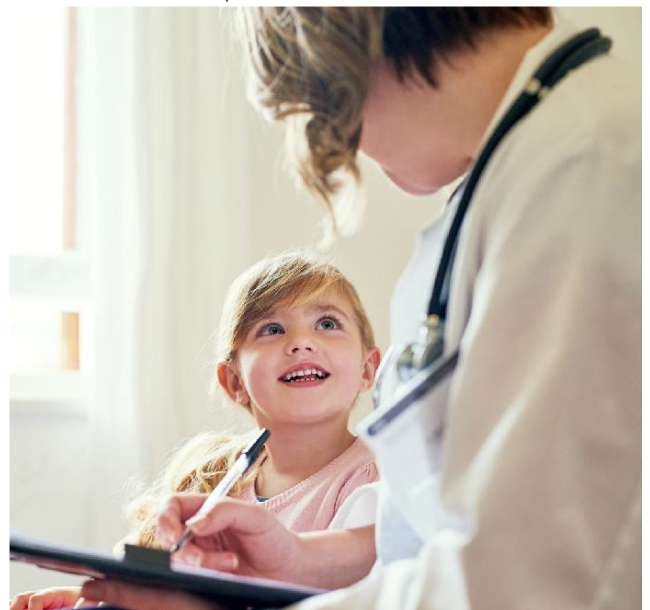
Mission:

We empower individuals to lead fuller, healthier lives at home in their communities.

Keeping members at the center, we partner with providers, advocates, and the community to deliver the right solutions for an improved quality of life.

Corporate Values:

- **Community** - We encourage involvement. We strive to provide individuals with resources so they can live with purpose and support. We share, partner, and collaborate with others in order to achieve full inclusion for our members at home, at work, and in their communities in the name of mutual goals.
- **Respect** - We respect others. We see the potential in every individual, build upon their strengths, and treat them with dignity and respect. With the right support, all individuals can achieve their goals.
- **Advocacy** - We lead with purpose. We start the conversations that matter. We speak up for others and encourage them to speak up for themselves. We seek out resources and opportunities to help make change.
- **Independence** - We boost self-reliance. We recognize the importance of freedom and personal choice. We use our experience and knowledge to help individuals realize and maintain independence.
- **Collaboration** - We earn trust. We work with individuals and providers to coordinate care. We value member preferences regarding treatment.
- **Recovery** - We promote advancement. We help individuals find the right support to receive the best possible services. We educate, support and collaborate so individuals have the opportunity for continued improvement.



Empower is run by five organizations working together:

1. **Arkansas Community Health Network (ACHN):** ACHN is composed of four health care systems: Baxter Regional Health System, North Arkansas Medical System, Unity Health, and White River Health System.

2. **Independent Case Management (ICM):** ICM is a statewide premier provider of home and community-based supports to individuals with intellectual and developmental disabilities.

3. **Statera:** Statera is an entity comprised of leaders and innovators committed to serving the long-term support services needs of Arkansans, including those with behavioral health and developmental disability diagnoses. Together, the representatives of Statera have vast health care experience, spanning home health, hospice, skilled nursing facilities, assisted living facilities, independent care facilities, institutional pharmacies, retail pharmacies, medical clinics, rural health clinics, non-emergency transportation services; and full-service rehabilitation therapy businesses throughout Arkansas.

4. **The Arkansas Healthcare Alliance, LLC.:** The Alliance is comprised of approximately 22 well-established inpatient and outpatient providers, who strive to provide quality behavioral health, substance use disorder, and intellectual and developmental disability services. Together, the Alliance offers individualized treatment to tens of thousands of Arkansas infants, children, adolescents, adults, and families.

5. **Woodruff Health Group, LLC (ARcare/Pharmacist):** ARcare operates as a Federally Qualified Health Center (FQHC). Also, ARcare is the statewide provider of medical and case management services for the Ryan White HIV/AIDS program. Over the last 30 years, ARcare has created a health care home through a network of 36 primary care clinics, three (3) pharmacies, and four (4) wellness centers to serve underserved communities and provide access to quality health care.

Provider Led Arkansas Shared Saving Entity (PASSE)

PASSE Overview

A Provider-Led Arkansas Shared Savings Entity (PASSE) is a Medicaid program that has been created to improve the health of Arkansans who have Medicaid and require more intensive levels of care for behavioral health and developmental disability needs. The PASSE program is designed to help connect Medicaid members not only to services from their doctors but also to other services in the community they might need. The PASSE allows members to take more active roles in their treatment. The PASSE system is a shift in how a client's care is managed, and how providers bill for services if they serve PASSE clients.

Goals of the PASSE Model

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

Why Should a Provider Join a PASSE?

Providers who join the PASSE enjoy all of the benefits of being an in-network provider. Failing to participate will have a negative impact on payments since the PASSEs are required to reimburse out of network providers below the current Medicaid rates. In addition, out of network providers are required to have services approved and prior authorized before rendering services. Joining the PASSE helps to ensure that providers can continue to serve all of their clients at a better rate of reimbursement and in a timely manner.

Member Services

Member Enrollment in Empower

The State of Arkansas automatically enrolls Medicaid recipients in a PASSE based on their responses on the Arkansas Independent Assessment. These responses help the Department of Human Services to assign individuals to a level, or tier, to best meet their specific needs. If a member has questions about how they were enrolled in Empower, they are encouraged to contact the Arkansas Department of Human Services, PASSE Member Support Center at (833) 402-0672.

Member ID Card

Every member of Empower will receive a Member ID card. The ID card will contain the following information:

- Member's name, Date of Birth, and Gender
- PASSE ID number
- Pharmacy ID number
- Empower contact information
- Claims filing address

Providers should obtain a copy of the member's ID card and should always verify eligibility at the time services are rendered.

FRONT

BACK

Member Services ....866-261-1286 | TTY: 711
Provider Services 855-429-1028
Pharmacy Help Desk...800-364-6331
Website... www.getempowerhealth.com

To Submit Claims & Paper Correspondence: P.O. Box 211446 Eagan, MN 55121
THIS CARD DOES NOT GUARANTEE ELIGIBILITY OR PAYMENT FOR SERVICES

Member Eligibility Verification

- Members should always present their ID card at the time of service. Providers should verify eligibility on every date of service, before rendering services to the member. Eligibility can be quickly and easily verified by logging on to the secure provider portal at **https://bharportal.valence.care/.**

You may search by:

- Member last name and date of birth
  OR
- Empower ID number and date of birth

Providers have the ability to look up multiple members in a single request.

Translator and Interpreter Services

Providers should assist in the coordination of interpreter services for members by contacting Empower's Member Services to arrange appropriate assistance. Members may receive interpreter services at no cost when necessary to access covered services. Interpreter services available include verbal translation and sign language for the hearing impaired.

The Member Handbook is available in alternative formats for members with visual impairments. Additionally, for members with hearing impairments who use a Telecommunications Device for the Deaf, Empower's TDD/TTY number for Member Services is (866) 261-1286 | TTY 711.

Member Choice of PASSE

Members may change to a different PASSE for any reason for 90 days after joining a PASSE. There is an open enrollment period every year for members who want to change their PASSE for any reason. Empower members may switch to a different PASSE at any time if there is cause.

This can happen if Empower:

- Does not follow certain DHS rules
- Does not cover needed services because of moral or religious reasons
- Provides poor quality of care
- Does not provide access to needed services

PASSE changes may occur for other reasons as well. Members with questions, concerns, or who believe there is cause, are encouraged to contact Empower Member Services at (866) 261-1286. To request a transition to another PASSE, members may contact the Arkansas Department of Human Services, PASSE Member Support Center at (833) 402-0672.

Charges that are the Responsibility of the PASSE Member as a Medicaid Beneficiary

The beneficiary is responsible for:

- Charges incurred during a time of ineligibility
- Charges for non-covered services, including services received in excess of Medicaid benefit limitations, if the beneficiary has chosen to receive and agreed to pay for those non-covered services
- Charges for services which the beneficiary has chosen to receive and agreed to pay for as a private pay patient
- Spend down liability on the first day of spend down eligibility
- Any applicable cost-sharing amounts such as premiums, deductibles, coinsurance, or co-payments imposed by the Medicaid Program pursuant to 42 C.F.R. §§ 447.50 – 447.60 (2004)

The beneficiary is **not responsible** for insurance cost share amounts if the claim is for a Medicaid-covered service by a Medicaid-enrolled provider who accepted the beneficiary as a Medicaid patient. Arkansas Medicaid pays the difference between the amount paid by private insurance and the Medicaid maximum allowed amount. Medicaid will not make any payment if the amount received from the third party insurance is equal to or greater than the Medicaid allowable rate.

Dis-enrollment from the PASSE

Only DHS can dis-enroll a member from Empower. This could happen if DHS determines that the member is no longer eligible for a PASSE for the following reasons:

- The member is no longer eligible for Medicaid.
- The member requires services that are not provided by Empower.
  - Full admission to a Human Development Center, a skilled nursing, or assisted living facility
  - Approval for waiver services provided through the ARChoices in Homecare or Independent Choices programs or successor waiver for the frail, elderly, or physically disabled.
- The member was re-assessed and determined to no longer meet the level of need for the PASSE program. The member's needs are required to be rated as a Tier 2 or Tier 3 by the independent assessment organization.
  - Once the member has been dis-enrolled they will no longer receive the ARIA re-assessment

Empower may not request that a member be dis-enrolled, except in circumstances that involve fraud or other gross misuses of coverage. All requests for dis-enrollment must be submitted to DHS Member Support.

Reinstatement into the PASSE

Members who lose their Medicaid eligibility may not automatically lose PASSE coverage, as long as the member is reinstated within the month. To do so the member must provide DHS proof of Medicaid eligibility and ensure that their information is entered into the DHS system by the last day of the month.

- Members who re-enroll within 180 days will automatically be re-assigned to Empower.
- Members who re-enroll after 180 days must complete a new Independent Assessment (ARIA) and will be automatically assigned to a new PASSE if they qualify.

Member Rights & Responsibilities

Empower distributes the Rights and Responsibilities statement to new members upon enrollment and to existing members upon request. We also provide the information to practitioners when joining the network upon request and always available within this manual.

Member Rights

RESPECT

- Members must always be treated with respect, dignity, and privacy, no matter what.
- Members have the right to receive services in a physically and therapeutically safe environment.
- A copy of the member rights and responsibilities must be provided.
- Members have a right and are encouraged to provide feedback regarding what they believe their rights and responsibilities as a member should be.
- Members have the right to understand their Person-Centered Service Plan (PCSP) and receive the services listed therein.
- Members must be a part of decisions made about their care plans, including the right to refuse treatment.
- Members have the right to execute advance directives and exercise their rights without being treated unfairly or having their quality of care affected.
- Members may elect to have anyone of their choosing to speak on their behalf and are entitled to decide who will make medical decisions for them if they are unable.
- No form of restraint or seclusion may be used as a means of coercion, discipline, convenience, or retaliation.
- Members have the right to live in an integrated and supported setting in the community and have control over aspects of their life.
- Members have the right to be safe and feel safe where they receive services
- Members have the right to be protected in their community.

COMMUNICATION

- Receive information about Empower, including services, benefits, practitioners, providers, member rights and responsibilities and clinical guidelines
- Receive written notice of changes regarding their Care Coordinator within seven days
- Receive a member handbook and provider directory soon after enrollment
- Communicate with providers regarding treatment options without factoring in cost or coverage
- Understand covered services, benefits, and decisions about health care payments, as well as how to obtain services
- Obtain information regarding their treatment record promptly, with signed consent
- Receive a copy of medical records and request that they be amended or corrected
- Request that the provider change or amend information in their medical or billing record if the member thinks the information in the record is incorrect. If the provider does not agree to the request, the member has the right to submit a statement of disagreement that must be added to the record. Receive information regarding available treatment options and alternatives, and have this information given in an understandable and appropriate way
- Receive oral interpretation services free of charge for any Empower materials, in any language

Grievance Resolution

- Submit grievance either verbally or in writing regarding staff, services, or the care given by providers
- Appeal decisions about their care. Empower administers member appeal rights as stipulated under their benefits plan

Confidentiality

- Keep communication about health information private
- Access to care, Services, & Benefits
- Receive timely care consistent with his/her need for care
- Choose a participating provider for any service for which a member is eligible and authorized to receive under a PCSP, including a primary care provider (PCP)
- Obtain needed, available, and accessible health care services covered under Empower

Claims & Billing

- Know all of the facts about any charge or bill that they receive

Member Responsibilities*

Members have the responsibility to the best of their ability:Provide information, to the best of their ability, which Empower or a provider may need to plan treatment

- Learn about their condition and work with providers to develop a plan for care
- Follow the plans and instructions for care agreed to with providers
- Gain an understanding of their benefits including what is covered and what is not covered
- Understand that they will be responsible for payment of services they receive which are not included in the Covered Services List for their coverage type
- Notify Empower and their providers of changes such as changes to address, phone number, or insurance
- Contact a Behavioral Health provider if they experience a mental health or substance use emergency
- If required by their benefits, members are responsible for choosing a primary care provider and site for the coordination of all their medical care

*Member or Legal Guardian

Empower Provider Support Services

Empower aims to furnish you and your staff with all of the tools and information that will enable you to successfully partner with us and to provide the highest quality of healthcare to our members.

Provider Services support is available Monday through Friday from 8:00 a.m. to 5:00 p.m. CST.

Empower Provider Training

Visit our website to register for upcoming webinars that will cover Empower related information including provider responsibilities, provider resources, member rights, and responsibilities, eligibility, covered services, utilization management, care coordination, claims submission, quality improvement, the empower portal and so much more.

https://www.getempowerhealth.com/providers/ and then click "Provider Training"

Past trainings are found under Educational Opportunities near the bottom of the Empower Provider Training page of the website. Empower also offers Provider trainings upon request.

Online Resources

Empower Website:
https://www.getempowerhealth.com/

Providers can access the Empower website 24 hours a day, 7 days a week. Utilizing our website can significantly reduce the need for making telephone calls regarding coverage. The following information is found on the Empower website:

- Billing Resources & Guidelines
- Clinical guidelines
- The latest Empower news
- Critical incident reporting guidelines
- Fraud, waste, and abuse reporting guidelines
- Provider portal
- Provider directory
- Provider manual and forms
- Preferred Drug List (or formulary)
- Prior authorization Reference Document
- Wellness information
- Member communications
- Member benefits

Provider Portal:
https://bharportal.valence.care/

The Empower Provider Portal allows providers to access the in-network Provider Directory, submit claims and check claim status and history, verify member eligibility, submit a prior authorization request, and view important documents and forms.

Registration for the Provider Portal is required for most resources. Please see the Provider Portal User Guide for instructions and contact a Provider Relations Manager to request a tutorial of the secure provider site.

You may reach Provider Relations by email at empowerhealthcaresolutionsPR@empowerarkansas.com or by phone at (855) 429-1028.

Credentialing

Empower conducts a rigorous credentialing process for our network providers prior to care delivery to our members based on The Centers for Medicare and Medicaid Services (CMS), The National Committee for Quality Assurance (NCQA), and other accreditation and regulatory guidelines. All providers must be credentialed by Empower or our delegates to participate in the network. Providers must also comply with re-credentialing standards by submitting all requested information within the specified timeframe. Private, solo, and group practice clinicians are individually credentialed, while facilities are credentialed as organizations. The processes for both are described below. To request additional credentialing information and application(s), please email empower.network@empowearkansas.com

Empower credentials the following individuals or group health care practitioners who are contracted directly with Empower Healthcare Solutions:

- Medical Doctor (MD)
- Doctor of Osteopathic Medicine (DOM)
- Doctor of Podiatric Medicine (DPM)
- Optometrists
- Nurse practitioners (NP)
- Physician Assistants (PA)
- Certified Nurse-Midwives
- Occupational Therapists
- Speech and Language Pathologists
- Physical Therapists
- Psychologists
- Independent behavioral health professionals who contract directly with the PASSE including Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), Licensed Marriage/Family Therapist (LMFT), and Licensed Independent Substance Abuse Counselor (LISAC)
- Home and Community-Based Providers who provide services under the CES Waiver or the 1915(i) authority.
- Board Certified Behavioral Analysts (BCBAs)
- Community Support Systems Provider (CSSP)

Individual Practitioner Credentialing

Empower, and its delegates on behalf of Empower, conduct a thorough credentialing process that includes, but is not limited to, primary source verification of the following items:

- Current, unencumbered (not subject to probation, suspension, supervision and/or other monitoring requirements), and valid license to practice as an independent provider at the highest level certified or approved by the state or states in which

services are performed for the provider's/participating provider's specialty (individual practitioners)

- Current, unencumbered (not subject to probation, suspension, supervision and/or other monitoring requirements), and valid license to practice and/or operate independently at the highest level certified or approved by the state or states in which services are performed for the provider's/participating provider's facility/program status (organizations)
- Clinical privileges in good standing at the institution designated as the primary admitting facility, with no limitations placed on the ability to independently practice in his/her specialty (individual practitioners)
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline, or licensure (individual practitioners)
- Current specialty board certification, if indicated on the application (individual practitioners)
- A copy of a current Drug Enforcement Agency (DEA) certificate and/or Controlled Dangerous Substance (CDS) Certificate where applicable (individual practitioners)
- No adverse professional liability claims which result in settlements or judgments paid by or on behalf of the provider of care which disclose an instance of, or pattern of, behavior which may endanger members
- Good standing with state and federal authorities and programs (organizations)
- No exclusion or sanctions from government-sponsored health benefit programs (e.g., Medicare/Medicaid) (individual practitioners and organizations)
- Current specialized training as required for certain levels or areas of specialty care (individual practitioners)
- Malpractice and/or professional liability coverage in amounts consistent with Empower's policies and procedures (individual practitioners and organizations)
- An appropriate work history for the provider's/participating provider's specialty (individual practitioners)

Practitioners must submit a complete practitioner credentialing application with all of the required attachments. Incomplete applications cannot be processed. Providers are notified of any discrepancies found, and any criteria not met. Providers will have the opportunity to submit additional, clarifying information to correct any identified discrepancy. Discrepancies and/or unmet criteria may disqualify the practitioner for network participation.

Once the practitioner has been approved for credentialing and contracted with Empower as a solo provider, or verified as a staff member of a contracted group practice, Empower will notify the practitioner or the group practice credentialing contact of the date on which they may begin to serve members.

Organizational Credentialing

To be credentialed, facilities must be:

1. Licensed or certified by the state in which they operate, and the license must be in force and in good standing at the time of credentialing or re-credentialing.
2. If the facility reports accreditation by The Joint Commission (JCAHO), Council on Accreditation of Services for Family and Children (COA), Council on Accreditation of Rehabilitation Facilities (CARF), or DNV GL HealthCare (DNV), such accreditation must be in force and in good standing at the time of credentialing or re-credentialing of the facility.
3. The facility must also show evidence of current malpractice insurance with adequate coverage levels.
4. The credentialed facility is responsible for credentialing and overseeing its clinical staff.
5. Structured site visits are required for all unaccredited organizations.

Once the facility has been approved for credentialing and contracted with Empower, or their affiliates on behalf of Empower, to serve members all licensed or certified professionals listed on the application may treat members in the facility setting. Home and Community-Based Services (HCBS) Credentialing.

The credentialing process for HCBS providers will include an annual on-site inspection and a full review of applicable requirements to include audit requirements, complaint resolution process, performing provider requirements, and

licensure and/or certification for the services provided.

Re-credentialing

Providers must submit an updated re-credentialing application every three (3) years and continue to meet established credentialing criteria and quality-of-care standards for continued participation in Empower's provider network. Failure to comply with re-credentialing requirements, including timelines, may result in removal from the network.
It is critically important that providers keep their contact information, particularly email, mailing and credentialing address, updated, as this is the primary method for early communication of re-credentialing notification.

Re-credentialing deadlines are firm. If deadlines are not met, the provider is considered to be out-of-network. Ensuring that Empower has current contact information allows the PASSE to provide ample notice of re-credentialing requirements and deadlines and to prevent termination..

Site Visits

As part of credentialing or re-credentialing, Empower may conduct a site visit of the provider's offices or locations. Site visits are arranged in advance and include, but may not be limited to, an evaluation using the Empower site and operations standards and an evaluation of clinical recordkeeping practices against Empower's standards. The current Empower site visit tools are available for review at https://www.getempowerhealth.com/providers/ from the Providers page click "Provider Forms and Resources". As the site visit tool is subject to modification without notice, participating providers are encouraged to check the website for the most current site visit tool before scheduled site visits. While Empower, at its discretion, may require a site visit in the course of credentialing and/or re-credentialing processes based on information submitted and/or obtained in the process, site visits will be conducted for providers of care in unaccredited organizations as well as providers of care with two or more documented member complaints in a six-month time frame relating to physical accessibility, physical appearance, adequacy of waiting/examining room space, or alleged quality of care issues.

Following a site visit, Empower will provide a written report detailing the findings. This report may include required monitoring where applicable and/or requirements for the participating provider to submit an action plan.

Out of Network Providers

Reimbursement

Arkansas Medicaid mandates that all, non-exempt out-of-Network Providers, be reimbursed at the reduced rate of 90% of the Medicaid Fee Schedule, unless Provider and Empower agree to a different rate.

Single Case Agreements

Requests for a Single Case Agreement can be made by contacting Empower Utilization Management. Out-of-Network Providers must receive a Prior Authorization for services requested in a Single Case Agreement. Single Case Agreement pricing is not to exceed payment for like services to in-network Providers.

Balance Billing

No Provider can balance bill any Medicaid PASSE members for any Medicaid covered service.

Care Coordination

Care Coordination Services

Every member of Empower is part of the Care Coordination program. The goal of the Care Coordination program is to collaborate with the member, their PCP, and all his/her providers to achieve the highest possible levels of wellness, functioning, and quality of life. Empower's Care Coordinators manage member care across the total continuum of care and services, which include medical, pharmacy, behavioral health, intellectual and developmental disability, and long-term support services.

The model is designed to help members obtain needed services and assist them in the coordination of their healthcare and other needs. The Care Coordinators monitor the delivery of integrated services through regular contacts with our members and ongoing communication with other providers, establishing linkages to family service agencies, community service organizations, the court system, schools, and other appropriate resources. Care Coordination also includes

member and family education and connects the member to providers and supportive services.

Act 775 of the 2017 Arkansas Regular Session defined care coordination as including the following activities:

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

Continuity, Transitions, and Coordination of Care

Empower complies with Conflict-Free Case Management rules pursuant to 42 CFR 441.330(c)(1)(iv). Conflict-free care coordination is a critical protection for members and a matter of program integrity.

Empower Care Coordinators are responsible for assisting the member with moving between service settings, for example with the move from the residential treatment setting to community-based care, and to ensure that the member is placed in or remains at the most appropriate and least restrictive setting that meets that member's needs.

Empower Care Coordinators assist when a new member joins Empower from another PASSE to ensure that services continue without disruption.

When a member wants to change their PCP or needs access to a specialty provider, Empower Care Coordinators will work with the member to identify resources in their area and will work with the provider to ensure the appropriate appointments are made.

During transitions from or to other PASSE entities, Empower ensures 90 days of continuity of community based services and will not adjust services without the member's consent during that time frame.

Continuity and coordination of care with providers are critical to verifying members are receiving the proper care in an appropriate setting. In addition, where continuity and coordination exist, there is less chance of medication or treatment errors. Continuity and coordination of care are monitored using a combination of claims data, medical record chart reviews, and surveys of providers. The specific issues chosen for evaluation are referenced in the current year's work plan. Providers must supply copies of medical records to Empower upon request and at no charge to Empower or the member.

Person-Centered Service Plan (PCSP)

The Care Coordinator is the single point of contact for all the member's providers, ensuring the development and effective execution of the member's Person-Centered Service Plan (PCSP). The Care Coordinator works to proactively integrate service delivery based on the member's PCSP. The PCSP is a plan based on the comprehensive, multi-disciplinary assessment that captures all of the member's needs and is utilized to plan and drive care coordination contacts and actions.

In developing a member's PCSP, we incorporate clinical determinations of need, functional status, and barriers to care, such as lack of caregiver supports, impaired cognitive abilities, and transportation needs. All services are included in a member's PCSP, as it is intended to provide a holistic approach to a member's care and activities.

All enrolled members who have an existing PCSP or Master Treatment Plan (MTP) carry that care plan with them when they are enrolled in Empower. Empower will honor the existing PCSP or MTP, including any authorizations for services under the PCSP or MTP previously provided, until the new PCSP is developed.

Empower is responsible for the creation, monitoring, and updating of the PCSP for all enrolled members. The PCSP will be updated at least annually for each enrolled member. A copy of the member's PCSP and any updates will be maintained by Empower and all providers coordinating and/or providing care.

All PCSPs include the enrolled member's health information without limitation, including:

- Medical and mental health diagnoses
- Medical and social history
- PCP and primary provider of Behavioral Health and/or Developmental Disability services
- The individual who has the legal authority to make decisions on behalf of the enrolled member
- Indication of whether or not an advance directive or living will have been created for or by the enrolled member
- The enrolled member's outlined goals and objectives
- All services necessary for the enrolled member, including the amount and duration of service
- 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

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

- Living in their own home with significant conditions or treatments such as pain control, hypertension, enteral feedings, oxygen, wound care, and ventilators
- 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
- 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
- Having significant medical conditions requiring ongoing monitoring or screening

The Care Coordinator is also responsible for coordinating and scheduling PCSP development meetings. The PCSP development meeting should be attended in person by the member and his or her parent/legal guardian, the member's primary caregivers, and the Care Coordinator. Alternative meeting arrangements can be made to meet the member's needs if there are any extenuating circumstances.

The meeting should include other individuals who may attend in person, by telephone, or video conference such as Home and Community-Based Services (HCBS) providers, professionals who have conducted evaluations or assessment, and anyone else the member desires to attend, including friends and family who support the 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.

Coordination Between Health Care Providers

Empower encourages all healthcare providers to collaborate with the Care Coordinators to ensure our members receive the care he/she needs. In many cases, the providers have extensive knowledge of the member's medical condition, mental status, psychosocial functioning, and family situation. Communication of this information to Care Coordination and other healthcare providers during treatment is encouraged, with member consent when required.

Any provider that is engaged in a member's care of service should initiate communication with a member's Care Coordinator and with any specialty providers whenever there is a problem with service delivery that can affect the member's current condition and treatment. Providers can reach out to carecoordination@empowerarkansas.com if you have questions regarding a member's care coordinator.

Examples of shared information include:

- A significant change in status (i.e.: the member entered foster care)
- Identifying and recommending resources
- Changes to the PCSP
- Hospital admissions
- Emergency room visits

Empower providers should report specific clinical information to the member's Care Coordinator to preserve the continuity of the treatment process. The Care Coordinator will periodically reach out to the provider for updates; however, providers are often aware of

issues that need to be added to the PSCP in order for services to be authorized. With appropriate written consent from the member and as part of the care management team it is the provider's responsibility to keep the member's Care Coordinator abreast of the treatment status and progress by forwarding the following to the member's Care Coordinator:

- A copy of the current treatment plan
- Any updates on progress/regression
- Results of functional assessments Notification of the member's noncompliance with treatment plan (if applicable)
- Discharge Plan

Clinical Review

Provider of care cooperation in efforts to review care prospectively is an integral part of care coordination activities. Subject to the terms of the member's benefit plan and applicable state and/or federal laws and/or regulations, providers of care must notify Empower before admitting a member to any non-emergency level of care. Empower may request clinical information at various points in treatment to ensure the ongoing need for care and treatment that is appropriate and effective in improving health outcomes for members.

In all cases, providers of care are encouraged to contact Empower before initiating any non-emergency treatment to verify member eligibility and to clarify what the authorization or certification requirements are, if any, for the proposed treatment.

Before initial determinations of medical necessity, the member's eligibility status and coverage administered by Empower should be confirmed. Care Coordinators will work with members and providers in situations of emergency, regardless of eligibility status.

The Care Coordinator in coordination with the provider will provide the member with information about available community support services and programs available under the member's benefit plan.

Primary and Specialty Care Providers

Primary Care Physicians (PCP)

The primary care provider is a board-certified, board-eligible, or otherwise approved network provider who has the responsibility for managing the complete care of his or her patient, our member. Every Empower member is assigned PCP. The PCP will oversee the care of our members through direct services or by referral to specialty services. In partnership with the Care Coordinator, the PCP will ensure appropriate care for the member. The Care Coordinator is a valuable resource to assist with referrals, provision of transportation and post discharge transitions. Providers with certain specialties may participate as a primary care provider and include family practice, general practice, pediatrics, internal medicine, geriatrics, and FQHC's or RHC's. A PCP must be enrolled in Arkansas Medicaid to participate with Empower.

The PCP must provide timely and adequate access to routine and emergent appointments and are encouraged to offer after-hours in the evenings and/or weekend appointments. All providers are required to comply with the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973 in providing physical accessibility standards in their physical locations.

We ask our PCP's to offer 24-hour coverage to care through arrangements that may include:

- A telephone line access to a live voice 24-hour, 7 days a week

OR

- An answering machine that will immediately page an on-call medical professional. The medical professional should promptly return a call and provide information and instructions for treating emergency or non-emergency conditions, make appropriate referrals, and/or provide information regarding accessing other services and handling other medical problems during hours the PCP's office is closed.

Members have the right to select their PCP. If a female Enrolled Member's designated PCP is not a women's health specialist, Empower will provide the Enrolled Member with direct access to a women's health specialist within the Provider Network for covered routine and preventative women's health care services. Upon enrollment, the member may select a PCP from the directory or call Member Services at (866) 261-1286 for assistance selecting a new

provider. If a member within your practice needs assistance in selecting your practice as their PCP, call Member Services at (866) 261-1286 for assistance. Members may consider the provider's specialty, accessibility, gender, ethnic background and languages spoken in the selection process. The member handbook includes instructions on how to choose a PCP. The Empower provider network directory is updated regularly and is available to the Empower Member Services department to assist new members in selecting a PCP. Members who do not select a PCP will be assigned to one using the enrollment information provided such as geographic proximity to the provider, age, and language. Members may request a PCP change by contacting Empower Member Services at (866) 261-1286.

Specialty Care Providers

When providing care to our members, specialty care providers must coordinate care with the PCP, except for services that the member may self-refer which includes mental health and substance abuse or for obstetrical and gynecological care. Specialty Care Providers must obtain necessary prior authorization for hospital admissions or specified procedures that require prior authorization.

The specialty care provider must communicate regularly with the PCP regarding any specialty treatment. Specialists are to report the results of their services to the member's PCP just as they would for any of their patients. The specialist should copy all test results in a written report to the PCP. The PCP is to maintain specialist reports in the member's central medical record and take steps to ensure that any required follow-up care is scheduled and provided.

The responsibilities of specialists include:

- Ensuring that no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws shall be excluded from participation in, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider's obligation under its agreement with Empower or in the employment practices of the provider
- Reporting results of their services to the member's PCP to enable coordination and follow-up of member's care
- Complying with all statutory and regulatory requirements of the Medicaid program, to include enrollment in the Arkansas Medicaid program
- Verifying member's eligibility and complying with any authorization requirements of Empower
- Collaborating with Empower's Care Coordinator as needed on an on-going basis
    - The Care Coordinator may outreach to the treating specialist as needed to update the Person Centered Service Plan.

Provider Enrollment

Title XIX of the Social Security Act created a joint federal-state medical assistance program commonly referred to as Medicaid. Arkansas Code Ann § 20-77-107 authorizes the Department of Human Services to establish a Medicaid Program in Arkansas. The Medicaid Program provides necessary medical services to eligible persons who would not be able to pay for such services.

Title XIX of the Social Security Act provides federal grants to states for medical assistance programs. The stated purpose of Title XIX is to enable the states to furnish the following assistance:

- Medical assistance to families with dependent children, the aged, the blind, the permanently and totally disabled, the medically needy and children under 18 whose income and resources are insufficient to meet the costs of necessary medical services
- Rehabilitation and other services to help these families and individuals attain or retain the capability for independence or self-care

Any provider of health care services must be enrolled in the Arkansas Medicaid Program before Empower will cover any services provided to Arkansas Medicaid members. Enrollment as a Medicaid provider is contingent upon the provider satisfying all rules and requirements for provider participation as specified in the applicable provider manual, state and federal law. Persons and entities that

are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll or to remain enrolled, as Medicaid providers.

All providers must sign all applicable forms that require a signature, as well as the Arkansas Medicaid Provider Contract. The signature must be an original signature or an approved electronic signature of the individual provider. The provider's authorized representative may sign the contract for a group practice, hospital, agency or other institution.

Provider Participation

Empower shall not refuse to contract, or terminate existing contractual relationships, with providers because a provider:

- Advocates on behalf of a member
- Files a complaint with or against Empower
- Appeals a decision or determination made by Empower

Participating providers are independent contractors of Empower. This means that participating providers practice and operate independently and are not employees of Empower. Empower does not direct, control, or endorse health care or treatment rendered or to be rendered by providers or participating providers. Empower encourages participating providers to communicate with members to discuss available treatment options, including medications and available options, regardless of coverage determinations made to or to be made by Empower or a designee of Empower. Treating providers, in conjunction with the member (or the member's legal representative), make decisions regarding what services and treatment are rendered. Any preauthorization, certification, or medical necessity determinations by Empower relate solely to payment. Participating providers should direct members to Empower or their respective Empower care coordinator, or member services, for questions regarding coverage or limitations of coverage under their benefit plan before rendering non-emergency services.

Providers Voluntarily Leaving the Network & Continuity of Care Requirements

Providers must give Empower notice of voluntary termination following the terms of their participation agreement with our health plan. For a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier:

Empower Healthcare Solutions Attn: Network
17500 Chenal Pkwy., Suite 300
Little Rock, AR 72223

Providers must supply copies of medical records to the members' new physician upon request and facilitate the members' transfer of care at no charge to Empower or the member.
The PASSE must notify members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, and helps them select a new practitioner. The PASSE must notify members affected by the termination of a practitioner or practice group which provides Behavioral Health or Developmental Disability Services specialty care at least 30 calendar days prior to the effective termination date, and helps the member select a new Behavioral Health or Developmental Disability Services specialty provider.

Empower will notify affected members in writing of a provider's termination If the terminating provider is a PCP, Empower will request that the member select a new PCP. If a member does not select a PCP prior to the provider's termination date, Empower will automatically assign one to the member.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 60 calendar days or such time as Empower can arrange for appropriate healthcare for the member with a participating provider. Providers must continue to render planned services for members who are pregnant in their second or third trimester or their postpartum period.

Provider Rights & Responsibilities

Provider Rights

Providers have the right to:

1. Contact Empower to verify member eligibility or coverage for services
2. Collaborate with other healthcare professionals who are involved in the care of members
3. Not be excluded, penalized, or terminated from participating with Empower for having developed or accumulated a substantial number of patients in the Empower with high-cost medical conditions
4. Object to providing relevant or medically necessary services based on the provider's moral or religious beliefs or other similar grounds
5. Receive accurate and complete information and medical histories for member care
6. Expect other network providers to act as partners in members' treatment plans
7. Be treated with dignity and respect by their members and other healthcare workers
8. Expect members to follow their directions, such as taking the right amount of medication at the right times
9. Have their members behave in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly
10. Have access to information about Empower's quality improvement programs, including program goals, processes, safety issues, and outcomes that relate to member care and services
11. Contact Empower's Provider Services with any questions, comments, or problems, including suggestions for changes in the QIP's goals, processes, and outcomes related to member care and services
12. Make a complaint or file an appeal against Empower and/or a member
13. File a grievance with Empower on behalf of a member, with the member's consent

Providers must also support members, within the scope of their practice, in making decisions regarding relevant and/or medically necessary care and treatment, including the right to:

1. Recommend new or experimental treatments
2. Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self-administered
3. Provide information regarding the nature of treatment options
4. Provide information on the risks and consequences associated with each treatment option or choosing to forego treatment

Provider Responsibilities

It is the providers' responsibility to:

1. Treat members with fairness, dignity, and respect
2. Provide services in a physically and therapeutically safe environment
3. Not discriminate against members based on race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency
4. Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
5. Only provide members with approved Empower marketing materials, including flyers and letters
6. Provide members notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility
7. Provide members with an accounting of the use and disclosure of their personal health information under HIPAA
8. Allow members to request restrictions on the use and disclosure of their personal health information
9. Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records without cost to the member
10. Amend a member's medical or billing record if the member thinks the information is inaccurate or incomplete and requests a change to the record or, if the provider does not agree with the member's request for amendment, add to the record a statement of disagreement submitted by the member

11. Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process
12. Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language
13. Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status
14. Tell a member if any proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment
15. Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal
16. Respect members' advance directives and include these documents in the members' medical records
17. Allow members to appoint a parent, guardian, family member, or other representatives if they cannot fully participate in their treatment decisions
18. Allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately
19. Obtain and report information to Empower regarding other insurance coverage
20. Follow all state and federal laws and regulations related to patient care and patient rights
21. Participate in Empower Quality of Care, Grievance, and Incident investigations, as well as Quality Improvement Activities
22. Participate in Empower data collection initiatives, such as HEDIS and other contractual or regulatory programs
23. Review clinical practice guidelines distributed by Empower
24. Comply with Empower's Medical Management program as outlined in this manual
25. Notify Empower in writing if the provider is leaving or closing a practice
26. Disclose overpayment or improper payments to Empower
27. Agree to no balance billing. Providers will not charge Empower members for covered services, including those denied by Empower for lack of timely filing. Invite member participation, to the extent possible, in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed-upon treatment goals, to the extent possible
28. Ensure the health and safety of individuals who are enrolled in the Arkansas Medicaid PASSE program and report incidents that put the health and safety of members at risk

Terminating Care of a Member

Any provider type may request to terminate the care of a member if the member:

- Repeatedly fails to keep scheduled appointments
- Fails to comply with the treatment plan
- Is abusive to the provider or staff (physically or verbally)
- Impedes operations of the practice through disruptive behavior unrelated to their medical condition.

The provider may discontinue seeing the member after the following steps have been taken:

- Incidents have been properly documented in the member's chart
- A certified letter has been sent to the member, with a copy to Empower Provider Services, documenting the reason for the termination, indicating the date for the termination, informing the member that the provider will be available for urgent care for 30 days from the date of the letter, and instructing the member to call Member Services or their care coordinator for assistance in selecting a new provider
- A copy of the letter and certification information is entered into the member's medical record

The member is responsible for contacting Member Services to select another provider. The provider or member services may refer the member to their care coordinator to assist the member in finding a different provider. The provider terminating the care of a member is the member's PCP, and the member does not select a new PCP, Empower will auto-assign the member to a PCP.

Provider Confidentiality Policies and Procedures

Providers must have policies and procedures available to protect the confidentiality of member information and records. These policies must apply to all individuals that access member information. The policies and procedures specifically address:

- the health plan and any delegates use and disclosure of member protected health information (PHI) appropriately to protect member privacy
- access to confidential information on a "need to know basis" with disclosure of the minimum information needed
- the maintenance and retention of medical records (both original information and documentation used for medical management, care management, and quality assessment)
- rights for members to access their PHI, including requesting restrictions on, amendments to and accountings of disclosures of their medical information
- protecting the identity of the member, practitioner, or provider by encrypting all aggregated and individual data reported as a component of the QM process
- protecting the content of all meeting minutes and internal communications (including electronic documents) by clearly identifying these documents as confidential and by maintaining such documents securely and by shredding such documents if the disposal is indicated

All provider agreements require that contracted providers must comply with appropriate policies and procedures to preserve patient confidentiality and comply with HIPAA regulations.

Provider Medical Records

Provider Medical, Clinical, And Service Record* Standards

*Note: In this section, "medical records" includes "medical records", "clinical records", and "service records".

Providing quality care to our members is important to Empower. According to the Centers for Medicare & Medicaid Services (CMS) "General Principles of Medical Record Documentation, "The medical record chronologically documents the patient's care and is an important element contributing to high quality care." Every provider and practitioner is responsible for maintaining an electronic or paper medical record for each individual member and must keep accurate and complete medical records in compliance with Empower requirements, the provider's accreditation standards, and federal and state regulations.

Empower-specific documentation requirements for provider medical records are published on the Empower website under the Provider tab "Provider Quality Improvement Activities". For more information regarding specific requirements for medical, behavioral health, HCBS, and psychiatric residential treatment facility record standards, please refer to standards specified in the applicable Arkansas Department of Human Services Medicaid provider manuals and/or other applicable manuals.

Records that are current, accurate, detailed, complete and comprehensive, legible, and organized assist in the following:

- Documentation of Course of Treatment and Outcomes:
  - supports diagnosis
  - documents medical necessity and justification for treatment
  - assures appropriateness of level of care and services
  - establishes a record of services and treatment provided and the effectiveness of services and treatment
- Communication, Coordination, and Continuity of Care among providers
- Compliance with the Health Insurance Portability and Accountability Act (HIPAA)

- Legal Documentation and Protections:
  - serves as a legal document describing the course of the member's treatment
  - assists in protecting the legal interest of the member, provider, and direct service practitioner (i.e., legal cases, disability benefits)
- Billing Processes:
  - verifies legitimacy of billable services
  - enables accurate billing coding and insurance claims
  - reduces improper payments
- Quality Reviews and Quality Improvement Activities (internal and external)
- Data and Research, including Health Employer and Information Data Set (HEDIS) measures

Records Must Be Complete, Current, Legible, and Organized

The Provider is responsible for maintaining an electronic or paper record for each individual member. All records should have the date of each service encounter, the provider's original signature or electronic signature of the person (identified by name, credential, and title) who is responsible for providing the service and date signed.

CMS does not provide a specific time in which documentation must be completed, but practitioners are expected to complete the documentation of services during or as soon as practicable after a service is provided to maintain an accurate medical record.

All documentation in the record must be legible to someone other than the writer. Signatures documenting the identity of the service provider are to be legible with credentials and title. For paper records, include a signature sheet in the record or legibly print the writer's name under the signature. Electronic signatures should be date- and time-stamped.

Paper and electronic records must be uniformly organized and easily accessible. The documentation should be organized systematically and each section of the record should be easily recognized for retrieval of information (i.e. lab section, encounter notes, correspondence, etc.). An indexing and filing system must be maintained for all records. [Note: *A description of the filing system either shall be present in each member's record or provided to the DHS PASSE Quality Assurance unit and Empower upon request.*] For paper records, pages must be securely attached in the file.

Records Must Be Confidential and Secure

Records must be maintained in a manner that ensures ease of accessibility at the time of service provision and protects member confidentiality, including the member's Protected Health Information (PHI). All information related to members shall be treated as confidential. Standards for maintaining records throughout treatment/service provision, the release of records, and the archiving and disposal of records after discharge from treatment must be established. Members' medical records must be secure and inaccessible to unauthorized access in order to maintain member confidentiality and to prevent unauthorized disclosure of information, loss, alteration, or destruction of the record.

Empower providers are required to guard member protected health information (PHI) as confidential and in compliance with Health Insurance Portability and Accountability Act (HIPAA) privacy standards, Confidentiality of Substance Use Disorder Patient Records regulations (42 CFR Part 2), and all other applicable federal and state regulations.

These protections should include, but are not limited to, the following:

- Maintain records and information in an accurate and timely manner
- Ensure timely access by members to their records and information that pertains to them
- Protect member records from unauthorized access, including restricted access to electronic records
- Take precautions to prevent inadvertent or unnecessary disclosure of PHI
- Ensure that information is released only in accordance with applicable federal or state law in pursuant to court orders or subpoenas
- Abide by all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information
- Educate and train staff on PHI and HIPAA regulations and procedures

Access to Records

The location of paper records, and all of the information contained therein, must be controlled from a central location (See Section 142.300 of the Arkansas Medicaid Manual). While medical records are to be stored in a secure manner, they must be easily and promptly available to the service provider each time the member presents for a service. In addition, records must be available for authorized entities to conduct record reviews.

Access to member records must be limited to only those staff members who have a need to know the information contained in the records of the member and must not be accessible to unauthorized persons. The only individuals that may access a member's records are:

- The member
- The legal guardian of the member, if applicable
- Provider staff providing direct care or care coordination services to the member
- Authorized provider administrative staff
- Any other individuals authorized by the member or their legal guardian with a signed consent to release information (for HCBS providers: documentation identifying additional individuals with access to a member's service record)
- Empower staff for purposes of care coordination, utilization review, claims audits, quality of care or other quality reviews, collection of Health Employer and Information Data Set (HEDIS), and other data collection, studies, and reporting
- Representatives of Arkansas Department of Human Services and other state or federal agencies with authority over the provider and/or Empower

For paper files Access Sheets shall be located in the front of the record to maintain confidentiality according to 5 U.S.C. § 552a. If there is no signed release for unauthorized persons to review the record, they will need to sign the access sheet with date, title, the reason for reviewing, and signature whenever the record is reviewed or any material is placed in the record. Electronic Medical Records automatically track document access and changes. Providers need to know how to access this report within their respective systems.

Record Storage and Retention

Providers need to have a data recovery plan for electronic records in the event of data loss (i.e. fire, vandalism, system failure). The backup system should have the capability in the event of a system failure of restoring the data within a period of time that will permit no more than minimal disruption in the delivery of care and services to members.

A storage system for records of inactive members compliant with state and federal requirements is expected. Storage should allow retrieval within 24 hours.

Each provider must retain all records for five (5) 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 records may relate are finally concluded, whichever period is later. Federal legislation further requires that any accounting of private healthcare information or HIPAA polices or complaints must be retained for six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

The Arkansas Medical Society recommends that physicians keep records for at least 10 years from the date of last treatment, unless the patient is "deceased, is incompetent, or is a minor". Arkansas State Medical Record Laws [*016 24 Code Ark. Rules and Regs. 007 § 14(19) (2008)*] have no minimum record retention periods for physicians, but require that hospitals maintain records for 10 years after the last discharge for adult patients and, for minor patients, retain complete medical records for two (2) years after the age of majority (i.e., until patient turns 20).

Records Must Be Available to Members and to Empower

Members have the right to access or receive their individual medical record. Providers are required to provide access to or a copy of their record to the member, or their authorized representative, upon request without charge.

Empower has the right to access records of our members for the purpose of care coordination, claims payment or audits, assessing quality of care or other quality reviews, special reviews or audits requested by the State, performing utilization management functions, collection of data, and other reporting. Medical records may also be requested as part of our Quality Improvement Program, such as collection of data for reporting requirements and data

collection, such as the Healthcare Effectiveness Data and Information Set (HEDIS). Providers are required to cooperate with all Empower quality activities. HIPAA privacy regulations allow for sharing of PHI for purposes of making decisions around treatment, payment, or health plan operations.

Empower may request submission of hard copies of records via fax or secure email, remote access to electronic member records, or access to and copies of records at the provider site.

Failure to furnish medical records upon request may result in sanctions being imposed.

Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Empower members. If the member or member's guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers then this should also be noted in the medical record.

Nondiscrimination Policy Statement

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

Members who contact Empower with an allegation of discrimination are immediately informed of their right to file a grievance. This also occurs when an Empower representative working with a member identifies a potential act of discrimination. Members are advised to submit a verbal or written account of the incident and are assisted in doing so, if assistance is requested. Empower will document and monitor all alleged acts of discrimination. Grievance Coordinators can be contacted via Provider Services at 1 (855) 429-1028 or via email at complaintsandgrievances@empowerarkansas.com.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights. Downloadable PDF complaint forms can be found on the Department of Health and Human Services website: https://www.hhs.gov/sites/default/files/ocr-60-day-frn-cr-crf-complaint-forms-508r-11302022.pdf.

SUBMIT VIA MAIL:

US Department of Health and Human Services
200 Independence Avenue SW
HHH Building, Rm. 509F
Washington DC 20201.
BY PHONE: 1 (800) 368-1019, TTY/TTD: 1 (800) 537-7697
ONLINE: OCR Complaint Portal
https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Provider Issues that are Immediately Communicated to Empower

Providers will immediately notify Empower if any of the following events occur:

- Provider's business license to practice in any state is suspended, surrendered, revoked, terminated or subject to terms of probation or other restrictions
- Provider has any malpractice claim asserted against it by an Empower member, any payment made by or on behalf of Provider in settlement or compromise of such a claim or any payment made by or on behalf of provider pursuant to a judgment rendered upon such a claim
- Provider is the subject of any criminal investigation or proceeding

- Provider is convicted for crimes involving moral turpitude or felonies
- Provider is disciplined by a state board of medicine or a similar agency
- Provider is named in any civil claim that may jeopardize financial soundness
- The provider's business address, telephone number, ownership or Tax Identification Number changes
- Provider's professional or general liability insurance is reduced or canceled
- Provider becomes incapacitated such that the incapacity may interfere with member care for 24 hours
- There is any material change or addition to the information submitted as part of the provider's application for participation with Empower Healthcare Solutions
- There is any other act, event or occurrence, which materially affects the provider's ability to carry out its duties under the Provider Services Agreement or in this Manual

Communication Aids and Materials for Members

Providers must ensure that:

- All member communication materials are developed for presentation in a culturally competent manner that enhances members' understanding and meets a sixth-grade reading/comprehension level.
- All written material must be provided in a font size no smaller than 12 point.
- All written materials must be made available in both English and Spanish.
- For individuals whose primary language is not English, an interpreter must be provided free of charge in accordance with the Federal Limited English (LEP) regulations.
- Interpretation, either oral or written, of any provided information must be made available in any language spoken by the enrolled member or potential member.
- All written and oral information must be provided in alternative formats, when appropriate, and in a manner that takes into consideration a member's special needs, including are visual impairments, hearing impairment, limited reading proficiency or limited English proficiency.
- Auxiliary aids and services must be made available upon request for enrolled members and potential members with disabilities.
- A Teletypewriter Telephone/Text Telephone (TTY/TDY) number must be provided for enrolled members and potential members.
- Translation of all materials must be provided at the appropriate reading level and in the culturally appropriate equivalent to the English version.

Accommodations for Members with Disabilities

Provider locations delivering covered services to Empower members should comply with the Americans with Disabilities Act (ADA) standards. If this is not possible, provider locations must provide adequate or reasonable physical access, and other accommodations and equipment, to allow people with both physical and mental disabilities to receive care at the location.

Empower monitors and reports provider facilities' accessibility and ADA compliance status. Annually, providers are asked to complete an ADA assessment checklist to self-monitor compliance with the Americans with Disabilities Act standards.

Advance Directives

PCPs and other providers delivering care to Empower members must ensure that adult members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives, including behavioral health. Providers must document such information in the medical record.

For members who have executed advance directives, the practitioner should discuss potential medical emergencies with the member and any designated family members or significant others named in the advance directive, if available. The discussion should be stored in the medical record and documents shared with other providers caring for the member.

Appointment Standards and Timeliness of Service

In compliance with state-contract guidelines, Empower requires the following access standards for emergent, urgent and routine service requests:

Emergent, Non-Life-Threatening Appointment Requests involve an individual or family presenting or describing an immediate need that requires an expedited response and may require medically necessary, covered behavioral health services that should begin immediately, reflective of a standardized timeframe associated with the person's clinical need, including referral to appropriate crisis services. The initial response may be telephonic or face-to-face.

Urgent Appointment Requests are managed 24 hours per day, 7 days per week and involve a person or family presenting in serious need of medically necessary behavioral health services, requiring an urgent response. The action should be initiated promptly within a timeframe indicated by the person's clinical needs, and no later than twenty-four (24) hours from the initial identification of need.

Routine Appointment Requests involve a person or family's health request for a routine intake and/or appointment that is not immediate or urgent and should be provided no later than 21 business days from the request.

Waitlists for Services involves provider unavailability to needed or desired member services. Empower requires immediate notification if waitlists are initiated for any contracted services or populations. Notification should include the access challenges contributing to the waitlist and how they will be addressed, including timeframes for eliminating these barriers to meeting accessibility standards.

In addition, Empower requires that all providers ensure access to language assistance, including Braille for the visually impaired, bilingual staff and interpreter services to those with limited English proficiency, as well as access to TDD/TTY lines during all hours of operation.

Care Coordinators assist members with scheduling appointments for routine and urgent needs and ensure timely follow up with the chosen provider.

Access for Members

Empower primary care and specialty providers shall provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week, and they shall have a published after-hours telephone number. Voicemail alone after hours is not acceptable. After-hours coverage must be accessible using the medical office's published daytime telephone number. The selected method of 24-hour coverage must connect the caller to someone who can render a clinical decision or reach the practitioner or covering medical professionals for a clinical decision. If applicable, the practitioner or covering medical professional must return the call within 30 minutes of the initial contact.

Home and Community-Based Services Accessibility & Access

HCBS provider-owned/leased/rented residential settings must be fully accessible by the member, compatible with the services being provided to the member, and compatible with the needs of each member and their staff, as provided in the member's PCSP. Each HCBS provider-owned/leased/rented residential facility must comply 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."

Behavioral Health Services Accessibility & Access

A timely response is critical to individuals and families requesting behavioral health services. The response time is determined by the acuity of the individual or the family has assessed behavioral health clinical needs. It is also essential to engage with an individual or family and supporting the member's satisfaction with the services provided.

Appointment Accessibility Standards

Empower follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. Provider Services monitors compliance with these standards on an annual basis.
Providers must offer hours of operation no less than those hours offered to other insured patients in their practice. The table below outlines the type of service and the scheduling timeframes to be followed by all providers.

Appointment Type	Access Standard
E mergency 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
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

Providers are required to:

- Prioritize appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair, interpretive linguistic needs, non-compliant individuals, cognitive impairments, etc.)
- Be capable of scheduling a series of appointments as needed by the member
- Identify and attempt to reschedule missed appointments
- Answer member telephone inquiries the same day for non-symptomatic concerns
- Provide after-hours telephone care for non-emergent, symptomatic issues within 30 minutes of a member's call
- After-hours calls must be documented in a written format and later transferred to the member's medical record
- Provide after-hour care with emergency appointment slots
- Schedule continuous availability of professional, allied, and support personnel to provide covered services within normal working hours
- Provide in-network coverage in the event of a provider's absence

Cultural Competency

Empower is committed to network providers' full recognition and care for the culturally diverse needs of its member population. Culture is a collection of beliefs, values, customs, ways of thinking, communicating and behaving specific to a group, including group habits and competencies. Every health care encounter is impacted by culture, which affects provider-patient interaction, treatment modalities and adherence to medication and treatment. Culture influences concepts of health and wellness, disease perception, help-seeking behaviors, member comfort level, verbal and nonverbal communication styles and member treatment expectations.

Empower's Cultural Competency Plan (CCP) guides and monitors efforts to ensure cultural competency by assessing and improving healthcare quality and equity, reducing health care disparity and delivering culturally and linguistically appropriate health care services to its member population. Culturally and linguistically appropriate services (CLAS) are healthcare services that are respectful of, and responsive to, the patient's cultural and linguistic needs.

The Americans with Disabilities Act (ADA) provides a framework for unlawfulness in the discrimination against persons with disabilities, physical or mental impairments substantially limiting one or more major life activities, and discrimination against a person based on that person's association with a person with a disability. Accommodations for people with disabilities include:

- Physical accessibility
- Effective communication
- Policy modification
- Accessible medical equipment

Providers should capture information about accommodations that may be required in the member's medical record, and when making referrals to other providers, communicate with the receiving provider regarding any necessary accommodations that may be required for that member.

Empower strives to assist members and providers with any inquiries and grievances. Assessment and resolution of any issues regarding cultural competence are conducted in a timely manner, according to Department of Human Services' required timelines and expediency of member and/or provider need.

Practitioner Network Cultural Responsiveness:

a. Empower contracted providers are expected to provide interpreter and other language access services for Limited English Proficiency (LEP) members in compliance with all applicable federal and state requirements.
b. Empower contracted provider network includes multicultural and multilingual practitioners in threshold languages and cultures of the membership. When a member calls Empower for provider referrals and if the member's electronic file is flagged with a language or cultural requirement, the Member Services Representative advises the member of the availability of bilingual providers and providers meeting their cultural needs.
c. A provider search is conducted to identify providers, who meet the cultural and linguistic requirements. If an appropriate provider is not available to meet the access timeliness standards, Empower arranges Single Case Agreements (SCA) with non-contracted providers, if available, who meets the specific language/culture requirement. For linguistic needs, the SCA requires the provider to attest to proficiency in the specific language.

d. For language needs if a bilingual provider cannot be identified, Empower will arrange for face-to-face interpreter service.
e. Annually a summary of Empower's CCP is to be distributed to participating providers with information on how to access a full copy on the website and how to obtain a hard copy at no charge to the provider.

Monitoring Network Adequacy for Cultural Competency

Reports such as the annual Cultural Competency Plan Evaluation and Population and Cultural and Linguistic Analysis are produced to assess the current practitioner and provider networks and their ability to meet the cultural and linguistic needs of Empower members. Based on the analysis, achievements are noted, opportunities for improvement identified, and interventions implemented to improve the quality of care and service to our diverse member populations

Cultural Competency Credentialing Requirements

During the contracting, credentialing and re-credentialing processes, Empower network providers will be required to provide practitioner and provider cultural/ethnic, linguistic and racial information, as well as accommodations made for members with disabilities (e.g. materials in braille, large font materials, handicap access, etc.). Empower will confirm languages used by providers, including American Sign Language, and physical access to provider office locations during the contracting and/or credentialing/re-credentialing processes, Provider Orientations and site visits.

Cultural Competency Training for Providers

Empowers' network providers, vendors and their staff have an obligation to deliver culturally competent health care by possessing attitudes, skills and policies that enable effective work in cross-cultural settings.

Training is available to support providers in meeting the following goals:

- Being educated about the linguistic needs and cultural differences of members
- Understanding the population served
- Being responsive and sensitive to member needs
- Communicate effectively with members

Provider Cultural Competency training materials are available to network providers on Empower's website and additional training resources can be found at the following websites:

- U.S. Department of Health and Human Services Office of Minority Health – www.ThinkCulturalHealth.hhs.gov
- Centers for Medicare and Medicaid Services- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining

Cultural Competency Monitoring & Reporting

Empower performs an annual evaluation of Cultural Competency practices, which includes the monitoring of member needs and provider cultural and linguistic services.

In order to achieve progress towards cultural competence, Empower collects and maintains data on the following indicators:

Cultural and Linguistic Quality Metrics	Goal
Utilization tracking	
Number and percent of calls to Empower that used one or more language interpreter services	NA
Percent of Empower members who requested translation services	NA
Percent of Empower staff that are bilingual	NA

Turnaround Time	
Percent of time that the TTY/TTD services and foreign language interpretation were available when needed by members who called the Empower's customer service phone line (CMS measure)	95%
Percent of time the member materials were made available to members in the language they requested within 21 calendar days of request.	95%

Adult and Child CAHPS® Survey (to assess cultural/ethnic and special needs sensitivity)	
Child CAHPS® Survey Q 31. In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for your child to understand?	85%
Adult CAHPS® Survey Q 12. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?	85%

BH Member Satisfaction Survey (to assess cultural/ethnic and special needs sensitivity)	
Percent of members that responded positively to question: *In the last 12 months, how often did counseling or treatment needs meet your language religious or cultural needs?*	85%
Percent of members that responded positively to question: *How often did Empower staff member(s) explain things in a way you could understand?*	85%

National Core Indicator (NCI) Adult In-Person Survey™. (to determine if thresholds are met and warrant special intervention)	
BI-15 What is this person's preferred means of communication?	10% Threshold
BI-10 Is this person diagnosed with an intellectual disability (ID)?	10% Threshold
BI-11 If yes, what level of ID?	10% Threshold

Empower Member Personal Service Care Plan Assessment Questions (to determine if threshold are met and warrant special intervention)	
Race	10% Threshold
Primary Language Spoken in the Home	10% Threshold
Preferred modes of Communication	10% Threshold

Grievances	
Number of grievances per 1000 members that are about cultural and linguistic issues	<1/1000 members

On an annual basis, Empower works with research vendors to administer member condition specific surveys, health and service needs assessments and overall member satisfaction surveys. Results from these various assessment tools are used to identify opportunities to assure Empower is providing culturally and linguistically appropriate services to the populations it serves. 10% Threshold is based upon the Threshold language policy implemented by California and other states within the US. This policy mandates language assistance services for Medicaid enrollees, whose primary language or means of communication, is other than English. If a 10% threshold of the member population's primary language is other than English; this is considered significant and requires interpretive services.

Additionally, Empower strives to assist members and providers with timely resolution of any inquiries and grievances. Grievances that are about cultural and linguistic issues are tracked and monitored to assure members receive culturally and linguistically appropriate services.

Home and Community-Based Services (HCBS)

Ensuring the health and safety of individuals who are enrolled in the Arkansas Medicaid PASSE program and who are served through the Arkansas Community Employment Supports (CES) 1915(c) waiver and Arkansas Community Independence Services "i" State Plan amendment authority under 1915(i) is a shared responsibility among the Arkansas Department of Human Services (DHS), each Provider-led Arkansas Shared Savings Entity (PASSE), and each provider of home and community-based services ("HCBS provider"). Empower will adhere and apply all DHS policies and requirements pertaining to HCBS services and enrolled providers. Oversight of HCBS Services by Empower will include Incident Reporting, Grievances and Grievance Appeals from Access to Care, Grievances and Grievance Appeals from Quality of Care, PCSP reviews, member survey data from the National Core Indicator Survey, and any Department of Human Services Quality of Care Special Investigations.

HCBS Organizational Requirements

Provider Governing Documents Available for Inspection

All governing documents, policies, procedures, or other equivalent operating documents of an Empower HCBS provider shall at all times be readily available for Empower and DHS inspection and review upon request.

Legal Existence and Good Standing

An Empower 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. If there is a change in provider status, the provider is responsibly for notifying Empower.

HCBS Management Requirements

Appointment of an Executive Director

Each Empower HCBS provider must appoint an Executive Director, or other titled officer position, that is vested with the authority and responsibility of overseeing all day-to-day operations.

Management Point of Contact

An Empower HCBS provider must appoint a single member of management as the point of contact for all Quality Assurance matters. The DHS PASSE unit, in conjunction with Empower, will oversee compliance with the below minimum standards.

HCBS Mandated Reporters of Neglect or Abuse

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

Member Financial Safeguards

This Section applies if the HCBS provider serves, as a representative payee of a member, is involved in managing the funds of the member, receives benefits on behalf of the member, or temporarily safeguards funds or personal property for the member. HCBS providers who serve as representative payees must comply with all requirements and best practices set forth by the Social Security Administration as an Organizational Payee.

The HCBS provider is responsible for ensuring that each member's funds are used solely for the benefit of the member and must ensure that the member can receive the benefit of those items or services for which they are paying.

Policy and Procedures

The HCBS provider must demonstrate that there is a system in place to protect the financial interests of all members.

The PASSE HCBS provider must implement policies that define:

- How members will provide informed consent for the expenditure of their funds.
- How members will access their financial records.
- How member accounts/funds will be segregated and maintained for accounting purposes.
- The safeguards and procedures in place to ensure that member funds are used only for designated and appropriate purposes.
- How interest will be credited to the accounts of the members, if applicable.
- A mechanism that provides evidence that member funds were expended in the manner authorized.

HCBS provider personnel involved with member funds and the member or their legal guardian must receive a copy of the HCBS provider's Financial Safeguards Policies and Procedures. Appropriate documentation that member has been notified of this Policy and Procedures must be available to Empower upon request.

Access to Financial Records

Members and their legal guardians must have access to financial records concerning the member's account/funds at all times.

Consent Requirements

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

- Limiting funds a member may expend or invest in a specific instance.
- Designating how much a member may expend or invest for a specific purpose.
- Establishing time frames where a member is required, or prohibited from expending or investing their funds.
- Delegating responsibility for expending or investing a member's funds.

Hiring Procedures and Required Personnel Records

Prior to employment, the HCBS Provider must obtain and verify each of the following from an applicant:

- A completed job application that includes all the applicant's required current and up-to-date credentials.
- A signed criminal conviction statement.
- 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.
    - Empower and DHS require criminal background checks for the applicant, if a member is to be permitted to stay overnight in an applicant's residence.
    - A signed attestation declaring the truth of the application.
- Completed reference checks.
- A successfully passed drug screen.
- 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.

Within thirty (30) days of employment, the HCBS provider shall obtain and verify:

- A completed Adult Maltreatment Central Registry check (see A.C.A. § 12-12-1716, or any successor statutes), or a second submission request if a response has not been received.
    i. An Adult Maltreatment Central Registry check must be completed for the employee, where a member is approved and permitted to stay overnight.
- A completed Child Maltreatment Central Registry check (A.C.A. § 12-18-901 et. seq., or any successor statutes), or a second submission request if a response has not been received.
    i. A Child Maltreatment Central Registry check must be completed for the employee, where a member is approved and permitted to stay overnight.
- A successfully passed criminal background checks for the employee, their spouse, and any children or other adults over the age of eighteen (18) residing in a residence where a member is approved and permitted to stay overnight.

Training Requirements

First Aid Training

Within thirty (30) days of hire, all staff that may be required to provide emergency direct care services to a member (such as on-call emergency staff or management), shall be required to 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. Training Certification must be maintained and kept up to date throughout the time any staff is providing services. The course must provide a certificate of completion that can be maintained in the staff's personnel file.

Any services provided by a staff person before 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.

Member Specific Training

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

- General training on member's PCSP
- behavior management techniques/programming
- medication administration and management
- emergency and evacuation procedures
- appropriate and productive community integration activities
- training specific to certain medical needs

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

Other Required Training

Staff must receive appropriate training on the following topics at least once every two (2) calendar years:

- HIPAA policies and procedures
- procedures for incident reporting
- emergency and evacuation procedures
- introduction to behavior management
- Arkansas guardianship statutes
- Arkansas abuse of adult statutes
- Arkansas Child Maltreatment Act
- Nurse Practice Act
- member financial safeguards
- community integration training
- appeals procedure for individuals served by the program
- preventing and reporting maltreatment of children and adults
- Any other topics where circumstances dictate staff should receive training to ensure the health, safety, and welfare of the member.

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

HCBS Member Rights

Each HCBS provider, at a minimum, must ensure its' members the right to be free from:

- physical or psychological abuse or neglect
- retaliation
- coercion
- humiliation
- financial exploitation

The application of corporal punishment to HCBS members is **strictly prohibited**. "Corporal punishment" refers to the application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior.

Providers must also ensure that members have:

- The freedom to control their financial resources.
- The freedom to receive, purchase, possess and use individual personal property. Any restriction on this right must be supported by an assessed need and justified in the member's PCSP.
- The freedom to actively and meaningfully make decisions affecting their life and access pertinent information in a timely manner to facilitate such decision making.
- The right to privacy. Any restriction on this right must be supported by an assessed need and justified in the PCSP.
- The right to choice of a roommate when sharing a bedroom.
- The freedom to associate and communicate publicly or privately with any person or group of people of the member's choice at any time. Any restriction on this right must be supported by an assessed need and justified in the PCSP.
- The freedom to have visitors of their choosing at any time.
- The freedom of religion.
- The right to be free from the inappropriate use of physical or chemical restraint, medication, or isolation as punishment.
- The opportunity to seek employment and work in competitive, integrated settings.
- Freedom from being required to work without compensation.
- The right to be treated with dignity and respect.
- The right to receive due process.
  - HCBS providers must ensure
  - members 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.).
  - HCBS provider rules may not contain provisions that result in the unfair, arbitrary, or unreasonable treatment of a member.
- The right to contest and appeal HCBS provider decisions affecting the member.
- The right to request and receive an investigation in connection with an alleged infringement of a member's rights.

- The freedom to access their records, including information regarding how their funds are accessed and utilized and what services were billed for on the member's behalf. Additionally, all members and legal guardians must be informed of how to access the member's service records and the HCBS provider must ensure that appropriate equipment is available for them to obtain such access.
  - Members may not be prohibited from having access to their service records unless a specific state law indicates otherwise.
- The right to live in a manner that optimizes, but does not regiment, member initiative, autonomy, and independence in making life choices, including but not limited to:
  - Choice of HCBS providers
  - Service delivery
  - Release of information
  - Composition of the service delivery team
  - Involvement in research projects, if applicable
  - Daily activities
  - Physical environment
  - With whom to interact
- Other legal and constitutional rights.

Member/Guardian Rights Policy

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

HCBS Member Safety, Comfort, and Accessibility

Safety Equipment

HCBS providers must maintain the following safety equipment in each setting in which members reside:

- Functioning smoke detectors, heat sensors, carbon monoxide detectors and/or sprinklers
- Functioning fire extinguishers
- Functioning flashlight
- Functioning water heater
- Emergency contact numbers (i.e. law enforcement, poison control etc.)
- First-Aid kit

Emergency and Evacuation Procedures

The HCBS provider must also establish emergency procedures which include detailed actions to be taken in the event of an emergency. 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. The HCBS provider shall maintain an emergency alarm system for each type of drill (fire and tornado). Members, as appropriate, must be educated and trained about emergency and evacuation procedures. 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).

Members who live in a private/independent home defined as a home that is owned or leased by the member, or a member of the member's family for their personal private use are presumed compliant with the HCBS Settings Requirement.

There shall be written emergency procedures for:

- Fires
- Natural disasters
- Utility failures
- Medical emergencies
- Safety during violent or other threatening situations

Evacuation procedures must address:

- When evacuation is appropriate
- Complete evacuation from the physical facility
- The safety of evacuees
- Accounting for all persons involved
- Temporary shelter, when applicable
- Identification of essential services
- Continuation of essential services
- Emergency phone numbers
- Notification of the appropriate emergency authorities

Member Comfort

The HCBS provider must ensure that each HCBS provider-owned/leased/rented residential settings provide a safe and comfortable environment tailored towards the needs of the member, as provided for in their PCSP. This shall include, but not be limited to:

- All HCBS provider-owned/leased/rented residential settings must meet all local and state building codes, regulations and laws.
- The temperature must be maintained within a normal comfort range for the climate.
- The interior and exterior of the residential setting must be maintained in a sanitary and repaired condition.
- The residential setting must be free of offensive odors.
- The residential setting must be maintained free of infestations of insects and rodents.
- All materials, equipment, and supplies must be stored and maintained in a safe condition. Cleaning fluids and detergents must be stored in original containers with labels describing contents.

Member Accessibility

HCBS provider-owned/leased/rented residential settings must be fully accessible by the member, compatible with the services being provided to the member, and compatible with the needs of each member and their staff, as provided in the member's PCSP. Each HCBS provider-owned/leased/rented residential facility must comply 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."

Required Independence and Integration

Members 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 member.

HCBS providers must take reasonable steps to ensure that members are safe and secure in their homes and communities, taking into account the member's informed and expressed choices. Participant risk and safety considerations shall be identified and potential interventions considered that promote independence and safety with the informed involvement of the member.

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

Settings must be able to provide members access to community resources and be located in a safe and accessible location. Members must have access to the community in which they are being served. The site shall assure adequate/normal interaction with the community as a group AND as an individual. (This can be achieved through transportation or local community resources.)

- The living and dining areas must be provided with normalized furnishings for the usual functions of daily living and social activities.
- The kitchen shall have the equipment, utensils, and supplies to properly store, prepare, and serve three (3) meals a day.
    - Members must have access to food at any time.
        - Any modification to this requirement must be based on an assessed need and documented in the member's PCSP.

Bedroom areas are required to meet the following:

- Shall be arranged so that privacy is assured for members. 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.
- Members must have a choice of a roommate when shared by one or more individuals. The PASSE HCBS provider must actively address the need to designate space for privacy and individual member interests.
- Physical arrangements shall be compatible with the physical needs of the individuals.
- Each member shall have an individual bed. Each bed must have a clean, adequate, comfortable mattress.
- Beds are of suitable dimensions to accommodate the member who is using it. Mattresses must be waterproof as necessary.
- Each member must have a suitable pillow, pillowcase, sheets, blanket, and spread.
- Bedding must be appropriate to the season and member's personal preferences. Bed linens must be replaced with clean linens at least weekly.
- Bedroom furnishings for members shall include shelf space, individual chest or dresser space, and a mirror. An enclosed closet space adequate for the belongings of each member must be provided.
- Eighty (80) square feet per member in multi-sleeping rooms; one hundred (100) square feet in single bedrooms.
- Members have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Members who live in a private/independent home defined as a home that is owned or leased by the member, or a member of the member's family for their personal private use are presumed compliant with the HCBS Settings Requirement.

Bathroom areas are required to meet the following criteria:

- Sole access may not be through another member's bedroom. Commodes, tubs, and showers used by members must provide for individual privacy.
- A minimum of one commode and sink is provided for every four (4) members. Lavatories and commode fixtures are designed and installed in an accessible manner so that they are usable by the members living in the residential setting.
- A minimum of one tub or shower is provided for every eight (8) members.
- Must be well ventilated by natural or mechanical methods.

Members who live in a private/independent home defined as a home that is owned or leased by the member, or a member of the member's family for their personal private use are presumed compliant with the HCBS Settings Requirement.

Home and Community-Based Services (HCBS) Settings Requirements

All 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:

- Be chosen by the member from among setting options including non-disability specific settings (as well as an independent setting), and an option for a private unit in a residential setting.
  - Choice must be identified/included in the member's PCSP.
  - The choice must be based on the member's needs, preferences and, for residential settings, resources available for room and board.
- Ensure a member's rights of privacy, dignity and respect and freedom from coercion and restraint.
- Must optimize, but not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- Facilitate member choice regarding services and supports and who provides them.
- The setting must be integrated into and support full access to the greater community by the member, 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 members not receiving CES Waiver services.
- The unit or dwelling must be a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the member receiving services, and the member has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.
- Each member has privacy in their sleeping or living unit, which must include the following:
  - Units have entrance doors lockable by the member, with only appropriate staff having keys to doors.
  - Members sharing units have a choice of roommates in that setting.
  - Members have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- Members have the freedom and support to control their schedules and activities and have access to food at any time.
- Members can have visitors of their choosing at any time.
- The setting is physically accessible to the member.
- Any modification of the additional conditions specified in items 6 through 10 above must be justified in the member's PCSP. The following requirements must be documented in the member's PCSP:
  - Identify a specific and individualized assessed need.
  - Document the positive interventions and supports used before any modifications to the PCSP.
  - Document less intrusive methods of meeting the need that has been tried but did not work.
  - Include a clear description of the condition that is directly proportionate to the specific assessed need.
  - Include regular collection and review of data to measure the ongoing effectiveness of the modification.
  - Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
  - Include the informed consent of the member.
  - Include an assurance that interventions and supports will cause no harm to the member.

Members who live in a private/independent home defined as a home that is owned or leased by the member, or a member of the member's family for their personal private use are presumed compliant with the HCBS Settings Requirement.

HCBS Provider Restraint and Intervention Identification

HCBS providers are required to advise all staff, families, and members on how to recognize and report the unauthorized use of a restraint or restrictive intervention.

Restraints & Restrictive Intervention

Required Restraint and/or Intervention PCSP Information

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

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

Reporting each Incident where Restraint or Intervention was Used

An incident report must be completed and submitted to DHS PASSE Quality Assurance unit and Empower, 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 (3) times in any thirty (30) day period, permitted use of restraints and interventions must be discussed by the PCSP development team, addressed in the PCSP, and implemented under an appropriate behavior management plan.

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

- The behavior initiating the use of restraint or intervention.
- The length of time the restraint or intervention was administered.
- The name of the person that authorized the use of the restraint or intervention.
- The names of all individuals involved and outcomes of the use of the restraint or intervention.

Personal and Emergency Restraint Acceptable Use

Providers are prohibited from using any restraints or restrictive interventions on a member unless the member has a behavior management plan in place 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.

Permitted restraints and interventions may be used only when a challenging behavior exhibited by the member threatens the health or safety of the member or others. The use of restraints or interventions must be supported by a specific assessed need as justified in the member's PCSP, and only performed as provided in the member's behavior management plan. There is a limited exception to this requirement when the use of an emergency restraint is necessary.

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

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

Direct Observation
A member must be continuously under direct visual and auditory observation by staff members during any use of restraints or interventions.

Required Prior Counseling
Before absence from a specific social activity or a temporary loss of personal possession is implemented, the member must first be counseled about the consequences of the behavior and the choices they can make.

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.

Definitions of Restraints and Interventions
Physical Intervention - The use of a manual technique intended to interrupt or stop a behavior from occurring.

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 member's body. This does not include briefly holding, without undue force, a member to calm them, or holding a member's hand to escort them safely from one area to another.

Restrictive Intervention - Procedures that restrict or limit a member'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 is temporarily, for a specified time, removed from positive reinforcement or denied opportunity to obtain positive reinforcement to provide the member with the opportunity to regain self-control. **Under no circumstances may a member be physically prevented from leaving.**

Mechanical Restraint - (**Not Permitted)** Any physical apparatus or equipment used to limit or control challenging behavior. This would include any apparatus or equipment that cannot be easily removed by the member, restricts the member's free movement or normal functioning, or restricts normal access to a portion or portions of the member's body. **Under no circumstances are mechanical restraints permitted to be used on a member.**

Chemical Restraint - (**Not Permitted**) 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 member.**

Seclusion – (**Not Permitted**) The involuntary confinement of a member alone in a room or an area from which the member is physically prevented from having contact with others or leaving. **Under no circumstances is seclusion permitted to be used on a member.**

Covered and Excluded Health Services

Empower members are eligible for all of the PASSE covered services under the Arkansas Division of Medical Services. All services must be medically necessary. The Arkansas Division of Medical Services defines medical necessity as a service that 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 member requesting the service. Access to the Arkansas Medicaid Manuals by provider type can be found at https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/manuals/

Covered Services

- Advanced nursing & RN provider services
- Pacemakers and internal surgical prostheses
- Augmentative communication devices
- Extended rehabilitative hospital services
- Psychiatric residential treatment services for members under age 21
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for members under age 21
- Outpatient behavioral health services
- Chiropractic services
- Durable Medical Equipment
- Factor VIII injections
- Hospice care
- Occupational therapy
- Orthotic and prosthetic appliances
- Personal care
- Prescription drugs
- Respiratory care services
- Speech therapy
- Physical Therapy
- Pediatric or family nurse providers' services
- Home and Community-Based Services
- Developmental day treatment services (Adult Developmental Day treatment and Early Intervention Day Treatment)
- Federally qualified health center services
- Medical equipment, supplies, and appliances for home use
- Ambulatory surgical center services
- Intellectual disability services in an intermediate care facility (other than an institution for mental diseases)
- Nurse midwife services
- Nurse anesthetist services
- Private duty nursing
- Critical access hospital
- Emergency services
- Family planning services
- Inpatient hospital services
- Optical lab services
- Outpatient hospital services
- Physician services
- Psychologist Services
- Rural health clinic services
- Tobacco cessation counseling
- OBGYN and gynecological nurse provider services
- Maternity care and clinical services before and after birth
- End-stage renal disease facility services
- Hearing aids, accessories, and repairs for members under age 21
- Psychiatric inpatient services
- Intensive Outpatient Substance Abuse Treatment for members age 16+
- Chemotherapy
- Vision Care
- X-ray services
- Burn therapy
- Physical therapy services provided by a home health agency
- Dialysis
- Eye prostheses
- Home Health services
- Laboratory services
- Optometrist services
- Outpatient surgical procedures
- Podiatrist services
- Radiation therapy
- Specialized wheelchair

Preventive Health

Empower realizes the importance of prevention, wellness, and improvements in lifestyle risks and works with network physicians and health plan members to encourage the use of preventive services and programs to assist with changing lifestyle risks, such as smoking. To monitor adherence to recommended preventive services, adult preventive guidelines are adopted and distributed to both members and providers annually. Adherence to the preventive health guidelines is measured and evaluated at least quarterly and quality improvement strategies are initiated where opportunities are identified through HEDIS measurements and gaps in care reporting. Health plan services or initiatives are in place to assist members such as the availability of health risk appraisals, innovations in member services, and reminders encouraging wellness and prevention.

Through member outreach and support, including health advocacy and health management programs, the health plan promotes member wellness and prevention of illness. Members eligible for activities are identified using multiple data sources such as claims data, pharmacy data, health assessment results and data collected through the case management and utilization management processes. Targeted follow-up with members provides specific activities to support member wellness and achieve optimal health status.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT is a federally mandated Medicaid program developed to ensure that the Medicaid population younger than the age of 21 is monitored for preventable and treatable conditions, which, if undetected, could result in serious medical conditions and/or costly medical care. Empower will track the progress of all members younger than the age of 21 and perform outreach as needed to encourage members to obtain EPSDT health screens according to the American Academy of Pediatrics Guidelines for screening intervals. Once a condition is detected, treatment may be considered under EPSDT Special/Expanded Services if it is not a currently covered benefit under Medicaid, if medical necessity is proven. EPSDT preventive health screens that result in any treatment recommendations must be monitored to ensure follow up has occurred.

For members under age 21, all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services rendered by an EPSDT-certified provider are covered and recorded per the EPSDT periodicity schedule. Providers rendering EPSDT services receive training on these services through the state's program. Services include:

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

Inter-periodic well-child services and health care services necessary to prevent, treat or ameliorate the physical, behavioral or developmental problems or conditions with services in the sufficient amount, duration and scope to treat the identified condition, and are subject to limitation only based on medical necessity, including:

- Chiropractic services
- Nutrition counseling
- Audio-logical screening when performed by a PCP
- Private-duty nursing
- Durable medical equipment including assistive devices

Family Planning

Comprehensive family planning services are covered including:

- Office visits for family planning services
- Laboratory tests, including Pap smears
- Contraceptive devices such as Mirena, Paraguard, and Implanon (Precertification is not required.)
- Voluntary sterilization (including Essure Micro-Insert if done in an obstetrician's office)

Members may see any provider they choose in Network with Empower, without a referral, for family planning services, including out of network providers, for ages 21 and above.

Vision Care

Routine and medically necessary vision care services are covered. Empower is responsible, at a minimum, for providing the following routine eye exams. Coverage includes one eye examination every 12 months.

Vision Hardware

Coverage includes standard spectacle lenses with a retail allowance for glasses every 12 months and contact lenses if medically necessary and prior authorized. All members who receive contact lenses are allowed a pair of glasses. Tinted lenses, plastic lenses, and contact lenses for cosmetic purposes are not allowed. For members under 21, replacement frames and lenses are covered annually if they are lost, stolen or broken. For members 21 and over, replacement lenses are covered for post-operative cataract members if prior authorized. Also, adult members diagnosed with diabetes are eligible to receive a second pair of eyeglasses within the 12 months if their prescription changes more than one diopter. Adult members are additionally allowed one visual prosthetic device every 24 months from the last day of service.

Other Testing/Training

- Prior authorized Orthoptic and/or plenoptic training for members ages twenty (20) and under and for CHIP eligible members ages eighteen (18) and under.
- Prior authorized Sensorimotor examinations (1 per 12 months) for members twenty (20) and under and for CHIP eligible children ages eighteen (18) and under who have received a covered diagnosis based on specific observed and documented symptoms.
- Prior authorized developmental testing (1 per 12 months) for members twenty (20) and under and for CHIP eligible children ages eighteen (18) and under who have received a covered diagnosis based on specific observed and documented symptoms.

Excluded Services

- Nonemergency medical transportation (NET) under the Medicaid carved out program
- Dental benefits under the capitated Medicaid carved out program
- School-based services provided by school employees
- Skilled nursing facility services (Limited Rehabilitation Services are not considered an excluded skilled nursing facility service)
- Assisted living facility services
- Human Development Center (HDC) services (including full admission to an HDC); Respite stays and conditional admission at HDCs are not excluded services
- Transplant Services (Pharmacy services related to transplants are not excluded)

Providers must supply copies of medical records to Empower upon request and at no charge to Empower or the member.

Services for Behavioral Health and Developmental Disabilities

In addition to covering traditional Arkansas Medicaid State Plan services, Empower includes an array of **home and community-based waiver services** for members with developmental disabilities and/or behavioral health needs. All CES and HCBS waiver services must be delivered in accordance with waiver requirements and consistent with the Provider-Led Arkansas Shared Savings Entity (PASSE) Program, and/or other applicable manuals or instructions.

1915(c) CES Waiver Services
- Supportive Living
- Respite
- Supported Employment
- Adaptive Equipment
- Environmental Modification
- Specialized Medical Supplies
- Supplemental Support
- Consultation Services
- Crisis Intervention Services
- Community Transition Services

1915(i) HCBS Services
- Adult Rehabilitation Day Services
- Behavior Assistance
- Peer Supports
- Family Support Partners
- Supportive Life Skills Development
- Child and Youth Support Services
- Supportive Employment
- Partial Hospitalization
- Mobile Crisis Intervention
- Therapeutic Communities
- Therapeutic Host Homes
- Residential Community Reintegration
- Planned and Emergency Respite Services
- Supportive Housing

Services Requiring Prior Authorization and Notification

Prior authorization is the prospective process in which medical necessity criteria are reviewed against the intensity of the services requested against the severity of the illness to determine medical necessity and appropriateness of the service(s) request. Some covered services require precertification prior to services being rendered, while other covered services require notification before being rendered.

A notification is a communication from the provider informing Empower of their intent to

render covered medical services to Empower members. Emergent and urgent services require notification within 24 hours, or the next business day, following admission. Elective and routine inpatient services also require authorization prior to services rendered. These requests may be submitted via the portal, phone or fax.

Services requiring prior authorization can be found on the website at
https://www.getempowerhealth.com/providers/ and then click "Provider Forms and Resources".

They include, but are not limited to:

Medical Services

Please note the following: Unlisted procedure codes that are manually priced require prior authorization.

Advanced Imaging
- CT/CTA
- MRI/MRA
- PET/SPECT
- Nuclear medicine studies
- Gastrointestinal tract imaging with endoscopy capsule

Exclusions

Imaging rendered in the **emergency department**, an **inpatient setting** or in an **observation unit** does not require prior authorization.

Admissions

- All elective admissions, procedures and/or surgeries
- Inpatient Acute Hospital Admissions
  - Medical – Notification is also required within 24 hours of an emergency room visit or the direct admission from a clinic or provider office, or next business day
  - Surgical – Clinical updates are also required accompanying continued stays
- Admission into any long-term acute care, rehabilitative hospital, or skilled nursing facility
- Observation stays extending beyond 48 hours
- Radiology procedures requiring inpatient stays or observation
- All bariatric procedures
- Intermediate care facilities

Allergy Testing

Prior authorization is required for allergy testing on children under the age of five.

Cosmetic Procedures

All cosmetic procedures except for reduction mammoplasty, otoplasty and rhinoplasty require prior authorization.

Dental

Dental services which fall under the medical benefit category such as orthognathic surgery and outpatient anesthesia for patients over 6 years of age require prior authorization.

Drugs & Immunizations

Any drug or immunization which costs more than $1,000, chemotherapy and immunosuppressive drugs, allergy injections, and other types of injections that are covered for a specific diagnosis or condition require prior authorization.

Durable Medical Equipment (DME), External Prosthetic Appliances (EPA), and Supplies

- DME costing more than $1,000 (includes accumulated costs)
- Any DME, orthotics, or prosthetics with a billing code ending in 99
- Orthotics or prosthetics costing more than $750 for patients who are 21 years of age or older
- Ostomy supplies exceeding the benefit limits as established by the Arkansas Medicaid State Plan
- Enteral supplies for children up to age four
- DME Enteral Nutrition Infusion Pump and Enteral Feeding Pump Supply Kit for Beneficiaries Under Age 21

Experimental & Investigational

Any and all experimental and or investigational treatments and therapies require prior authorization.

Home Infusion Intravenous Therapy

All home infusion therapy services require prior authorization.

Hyperalimentation Therapy

All hyperalimentation services require prior authorization.

Injections, Radiopharmaceuticals and Therapeutic Agents

Inpatient injections, radiopharmaceuticals and therapeutic agents require prior authorization.

Intensive Cardiac and Pulmonary Rehabilitation Services

Both inpatient and outpatient intensive cardiac and pulmonary rehabilitation services require prior authorization.

Molecular Diagnostics Testing

All molecular diagnostics testing services require prior authorization.

Non-Emergency Ambulance Services

Reimbursement for non-emergency ambulance transfers requires a prior authorization. Prior authorization requests for non-emergency ambulance transfers must be submitted for utilization review within **21 days** from the date the services were rendered.

Obstetrics & Gynecology

- Induction of labor prior to 39 weeks' gestation
- More than 2 OB ultrasounds per pregnancy
- Termination of pregnancy
- Genetic testing
- Certified Nurse-Midwife (for IP services based on Medical Necessity)
- Hospital stays exceeding 2 days for vaginal delivery or 4 days for cesarean
- Hysterectomies

Out of Network & Non-Participating Provider Services

All out-of-network physicians and hospital and ancillary service requests, both inpatient and outpatient, will require prior authorization with the exception of emergency room services. (Reimbursement for emergency services is allowed only for providers who have active licensure through the Arkansas Division of Medical Services at the time that services are rendered.)

Outpatient Bariatric Procedures

All outpatient bariatric procedures require prior authorization.

Outpatient Pain Management

Specific outpatient pain management services; exceptions can be found here.

Pharmacy & High Dollar Medications

All medications with costs exceeding $1,000 with the exception of medications administered in an inpatient setting require prior authorization.

Private Duty Nursing

Private duty nursing services require prior authorization. Clinical updates are required and must be continuously reviewed. Review requirements must be incorporated during the review process

Personal Care

All Personal Care services require a prior authorization. Prior authorizations must be submitted to Empower's Utilization Management Department via the provider portal or fax. All providers must submit claims through the Electronic Visit Verification (EVV) system. See section 14 for information regarding EVV.

Retisert Implantation

Fluocinolone Acetonide Intravitreal implants require prior authorization.

Sleep Studies

Facility based sleep studies require prior authorization.

Behavioral Health Services & Developmental Disability Services

- Autism treatment under EPDST (ABA) – Under 21
- Inpatient psychiatric treatment
- Intermediate Care Facility
- Partial hospitalization
- Planned respite – Under 21
- Psychiatric residential treatment – Under 21
- Residential community reintegration – Under 21
- Substance abuse detox (IP or OP-Obs only) – 18 & older
- Intensive Outpatient Services-Substance Abuse
- Therapeutic communities - 18 & older
- All 1915(c) CES Waiver Services

Services Which Do Not Require Prior Authorization

- Primary care visits
- Specialist office visits (Note: Referrals to in-network specialists are not required for payment; however, Empower highly recommends PCPs supply the member with instructions for follow-up care)
- Routine laboratory tests (excluding genetic testing) performed in the PCP's office or contracted laboratory
- Routine X-rays, EKGs, EEGs or mammograms at a network specialist office at a freestanding radiology facility or a network hospital
- Routine outpatient individual behavioral health therapy services at a network specialist office

***If a service or regulation is not listed in this provider manual, you must reference the appropriate Arkansas Medicaid Provider Manual,**
https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/manuals/

Empowers Pharmacy Program

Member Pharmacy Access

Empower has partnered with CVS Caremark to maintain a comprehensive network of pharmacies to ensure that pharmacy services are available and accessible to all Members 24 hours a day.

The Pharmacy Locator tool at Caremark.com lets you quickly and easily find the best network pharmacy for your needs. To access the tool, click on "Pharmacy Locator" in the "Plan & Benefits" drop-down menu at Caremark.com, or open the Caremark mobile app and tap "Pharmacy Locator."

The Pharmacy Locator lets you:

- Enter your zip code or city and state to find the closest network pharmacies
- Add filters to find pharmacies with the amenities you need
- Narrow your search results by specific pharmacies
- Designate or change your primary pharmacy with one click

For areas where there are no pharmacies open 24 hours a day, Members may call Empower member services for information on how to access pharmacy services. Contact information is also located on the Empower website www.getempowerhealth.com

Specialty Pharmacy Solutions

Empower has partnered with the **CVS Specialty Pharmacy Solutions** to offer specialty pharmacy services to Members who are taking medications to treat long-term, life-threatening or rare conditions. As one of the leading and most experienced providers of specialty pharmacy services, CVS Specialty understands the complex nature of injectable, infused and select oral medications. That expertise allows them to provide Members the medication needed, along with personalized, clinical support. While CVS Specialty is not a neighborhood pharmacy you can walk into, they can have Member medications available for pickup at any CVS Pharmacy. Members can also get their medications delivered to their home, work, or doctor's office.

Pharmaceutical Management Tools

Empower's pharmaceutical management procedures are a vital part of the pharmacy program. Together they ensure and promote the utilization of clinically appropriate drug(s), which leads to the improvement of the health and well-being of our Members.

The most commonly utilized management tools in the pharmacy program include:

- Preferred Drug List (PDL)
- Quantity Limit (QL)
- Age Limit (AL)
- Over-The-Counter (OTC) Medications
- Mandatory Generic
- Step Therapy (ST)
- Specialty Drug Program
- Pharmacy Lock-In Program
- Coverage Determination or Prior Authorization (PA) Process

Several of these drug management tools are described in additional detail below.

To help patients get the most out of their pharmacy benefit please refer to the following guidelines when prescribing:
National standard of care guidelines for management and treatment of conditions (e.g., American Thoracic Society Clinical Practice Guidelines on the Definition, Evaluation, and Treatment of Severe Asthma, Joint National Committee (JNC) Hypertension guidelines) Empower Clinical Guidelines can be found at

https://www.getempowerhealth.com/providers/ and click "Clinical Practice Guidelines"

- Prescribed drugs listed on Empower's Preferred Drug List (PDL) https://arkansas.magellanrx.com/provider/docs/rxinfo/PDL.pdf
- Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class

Preferred Drug List (PDL)

Empower Health is required to use the DHS Medicaid PDL and provide coverage for all drugs and dosage forms listed therein. The Arkansas Medicaid Preferred Drug List is subject to revision following consideration and recommendations by the DHS's Pharmaceutical and Therapeutics (P&T) Committee. Always refer to the Preferred Drug List document for the most current list of preferred drugs located at www.getempowerhealth.com

The PDL is arranged in order by therapeutic classification. To locate a specific drug or therapeutic class, use the search feature available in Adobe Acrobat Reader. The PDL identifies age limits and clinical prior authorization (PA) requirements.

Quantity Limits

To ensure members are getting the most cost-effective dose of medication, a quantity limit or dose duration may be placed on certain drugs. These limits are based on FDA guidelines, clinical literature, and manufacturer's instructions. Quantity limits promote the appropriate therapeutic use of the drug, prevent waste, and help control costs. Quantity limits are also used to help prevent billing errors. Please refer to the PDL to view drugs with quantity limits.

Age Limits

Some drugs have an age limit associated with them. Empower utilizes age limits to help ensure proper medication utilization and dosage, when necessary. Medications with age limits are identified on the PDL.

Over-the-Counter (OTC) Medications

OTC items listed on the PDL require a valid prescription. Examples of OTC items listed on the PDL include (coverage is subject to change):

- Multivitamins & multivitamins with iron
- Iron
- Antihistamines
- Enteric-coated aspirin
- Insulin
- Topical antifungals
- Ibuprofen
- Permethrin
- Meclizine
- H-2 receptor antagonists

Generic Medications

The use of generic medications is a key pharmaceutical management tool. Generic drugs are as effective as and generally cost less than their brand name counterparts. Their use can contribute to cost-effective therapy.

Generic drugs must be used when listed on the PDL. A Prior Authorization Form should be completed and submitted to Empower Health's pharmacy department along with clinical justification when requesting a non-PDL medication that requires prior authorization and/or a brand name medication when the generic is available on the PDL. Pharmacy Prior Authorization forms can be found at https://www.getempowerhealth.com/pharmacy/pharmacy-forms-resources/.

Step Therapy

Step therapy is targeted towards therapeutic classes that have multiple medication options. While clinical effectiveness may be similar among medication options in a therapeutic class, pricing and factors promoting optimal drug use can vary. Step therapy may require a trial and failure or contraindication to clinically appropriate preferred alternative(s) before allowing coverage for the non-preferred medications.

Pharmacy Lock-In Program

The Empower Pharmacy Lock-In Program is designed to ensure medical and pharmacy benefits are received at an appropriate frequency and are medically necessary. The program utilizes claims data to evaluate overutilization in targeted therapeutic categories, duplication of therapy from multiple providers, and ensure proper utilization of plan benefits. Enrollees who meet the criteria to be enrolled in the Pharmacy Lock-In Program will receive written notice of the lock-in status along with details surrounding the program. The designated provider(s) will also receive written notification of the enrollee's enrollment into the program. The Empower Lock-In Program has different criteria then the DHS program.

The Lock-In Program is not intended to penalize or punish the member. The program is intended to:

- Connect members with case managers who can identify reasons for overuse of medical services and provide education on their health care needs
- Reduce inappropriate use of health care services
- Facilitate effective utilization of health care services
- Enhance the quality of care by developing a stable patient-physician and patient-pharmacist relationship

Emergency Supply

For medically necessary drugs as defined by DHS, pharmacies may dispense a 72-hour emergency supply of medication if they are unable to contact the prescriber for prior authorization. This does not apply to drugs excluded from coverage by state and federal regulations.

Coverage Limitations

Empower covers all drug categories currently available on the DHS Medicaid PDL. The following is a list of non-covered (i.e., excluded from the Medicaid benefit) drugs and/or categories:

- Select Agents when used for anorexia, weight loss, or weight gain.
- Agents when used to promote fertility.
- Agents when used for cosmetic purposes or hair growth.
- Medicaid Pharmacy Program covers prenatal vitamins for females of childbearing age and fluoride preparations for children however; other vitamins/mineral products are not covered.
- Agents, when used for the treatment of sexual or erectile dysfunction, are not covered unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.
- Empower will not reimburse prescriptions for early refills, duplicate therapy or excessively high dosages for Members.

Prescription Medications and Prior Authorization

When is a Prior Authorization (PA) Required?

PA is necessary for some medications to establish medical necessity and to ensure eligibility for coverage per State and/or Federal regulations. This may be due to specific Food and Drug Administration (FDA) indications, the potential for misuse or overuse, safety limitations, or cost-benefit justifications.

PA is required for medications that are:

- Outside the recommended age, dose or gender limits
- Certain drugs not listed on the PDL
- Drugs listed on the PDL which still require Prior Authorization
- Brand name drugs when a generic exists
- Duplication in therapy (i.e. another drug currently used within the same class)
- New to the market and not yet reviewed by DHS's P&T Committee
- Prescribed for off-label use or outside of certain diseases or specialties; or
- Most self-injectable and infusion medications (including chemotherapy)

How does a provider request an exception?

Providers may request an exception to Empower's Preferred Drug List either verbally or in writing.
For written requests, providers should complete an Arkansas Medicaid Prescription Drug Program Statement of Medical Necessity Prior Authorization Request, supplying pertinent Member medical history and information.

A request form may be accessed on Empower's website at https://www.getempowerhealth.com/pharmacy/ and click "Pharmacy Forms and Resources".To submit a request over the phone, Providers may call (855) 429-1028 or 1-800-364-6331 to our automated phone systems in order to speak with a pharmacy specialist.

If Authorization cannot be obtained, and the drug is Medically Necessary as defined by DHS, up to a 72-hour emergency supply of the non-preferred drug can be supplied to the Member.

What Happens During the Pharmacy PA Review Process?

A Pharmacy Coordinator compares all of the request information to Empower's clinical authorization criteria. If the request does not meet Empower's clinical authorization criteria, it is forwarded to a registered Pharmacist. Additional information may be requested via fax or telephone from the prescribing provider.

If the pharmacist cannot approve the request, the request is forwarded electronically to an Empower Medical Director for a decision.

How Providers Are Notified of Pharmacy PA Decisions

A fax will be sent to the requesting provider's submitted fax number with one of the following PA decisions.

Approved: The PA request has been approved for pharmacy reimbursement. Based on the medication and if requested by the prescriber, approvals may be granted for up to twelve (12) months.

Partial Denial: Reimbursement has been approved for a therapeutic alternative or for a different dose than requested.
Deferral: The final PA action was not decided due to the need for additional information. Providers must fax the requested information back to the plan to obtain a final PA decision.

Denial: The PA request was denied. All PA denials are issued by a licensed physician. These decisions may be appealed.

Denial rationale: Included on every PA denial fax, and whenever possible, with a recommendation for an alternate preferred medication. However, denials for medications not indicated for clinical use may not include medication alternatives.

Pharmacy Denial and Appeal Process

An authorization request for outpatient pharmacy services may be denied for lack of medical necessity, or it may be denied for failure to follow administrative procedures outlined in the Provider Contract or this Provider Manual. Denial letters are generated by Empower to the member and the prescriber. The plan faxes a denial notification to the prescriber if fax numbers are available.

Utilization Management

UM Process and Criteria

The Utilization Management (UM) process encompasses after hours' service, prior authorization, concurrent review, ambulatory review, retrospective (post-service) review, and discharge planning. The clinical decision process begins when a request for authorization of service or clinical information is received. Request types may include authorization of specialty services, skilled/rehabilitative services, outpatient services, ancillary services, scheduled inpatient services, and/or notification of emergent/urgent inpatient services. All approved services must be medically necessary. The process is complete when the requesting provider and member have been notified of the determination and any required letters have been processed and received.

The UM staff support activities across the continuum of care to affect optimal outcomes, achieve continuity of care, support appropriate services, and manage the care of member benefits.

The primary function of the UM staff is to facilitate efficient resource utilization, and review and verify medical appropriateness and necessity for members whose needs are represented in the following categories:

- pre-certification /prior authorization of services
- out-of-network services
- transition of care
- admission and concurrent review
- retrospective review
- discharge planning

Staff reviews clinical information against utilization review criteria developed by McKesson InterQual® products to determine the medical necessity and appropriateness for requested medical services. This includes medical coverage guidelines, internal medical policies and community standards for each case. The member's specific benefit package is also taken into consideration. Services are also reviewed in accordance with the Arkansas Medicaid Fairness Act.

- Medical necessity criteria are selected or developed and approved by the Empower Utilization Management (UM) Workgroup Sub-committee and presented to Empower Medical Quality Management Committee (MQMC) with input from participating physicians and providers. When developing criteria approval from the appropriate regulatory body, input from participating specialists, and support by published scientific evidence are all taken into consideration. Criteria and medical policies are reviewed annually against current industry standards and any applicable revisions are made and approved by the UM and MQMC Committees.

Home and Community-Based services and supports are considered non-medical in nature that address the needs of individuals with functional limitations who need assistance with everyday activities. Services for members are generally rendered as an alternative to institutionalization. Services rendered must be supported by a specific assessed need and justified in the PCSP. Regulations for these services are established in the Federal Code of Regulation rule 42 CFR § 441.301(c) (4)-(5).

When applying criteria to a request for services the following information is taken into consideration: age, comorbidities, complications, the progress of treatment, psychosocial situation, home environment, as well as the availability and ability of the local health care system to provide for the member's medical needs. Information is obtained from the member's medical record, treating providers, and/or the member or member representative. If the documentation supplied is insufficient or requires clarification, the review staff may contact the treating provider for additional clinical information.

Utilization reports are prepared regularly to communicate, to internal management and participating providers, the information needed to monitor for over and under utilization of services and effect better utilization of health care services.

Definition of Medical Necessity

Utilization Management is the evaluation of the medical necessity, quality, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health plan benefits.

All services must be medically necessary. The Arkansas Division of Medical Services defines medical necessity as:

All Medicaid benefits are based upon medical necessity. A service is "medically necessary" if meets the following:

- 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
- 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 mere 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 under the preceding criteria or is generally regarded by the medical profession as experimental inappropriate or ineffective using unless objective clinical evidence demonstrates circumstances making the service necessary.

UM decision-making is based only on appropriateness of care and service, the existence of coverage, and available criteria. Empower does not reward providers or other individuals conducting utilization review for issuing denials of coverage or services, and Empower does not encourage decisions that result in under-utilization.

All providers are required to obtain prior authorization from the Plan's UM department for inpatient services and specified outpatient services. Failure to submit a request for authorization within timeframe may result in an adverse determination. For a complete list of services that require prior authorization, please visit the Plan's website www.getempowerhealth.com.

Review Criteria

Empower has adopted utilization review criteria developed by McKesson InterQual® products to determine the medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Interqual Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for provider judgment. Criteria for services that are not available within InterQual subsets are subject to physician review. Interqual Criteria can be found on the Empower Provider Portal.

Appropriate Utilization

Poor quality of care can be the result of either under or over-utilization of services and is appropriately addressed jointly by the Quality Improvement and Medical Management departments. Monitoring of under-utilization is integral to the health management programs and specifically relative to services that assess the current state of the member's clinical condition such as medication refills and routine testing. Over-utilization is assessed in the ambulatory setting through a review and analysis of diagnostic, laboratory, and pharmacy services, and in the inpatient setting through review of compliance with guidelines for admission and appropriateness of discharge planning. Occurrences of sentinel events and hospital-acquired conditions are monitored and managed as a potential quality of care case.

Treatment and Service Planning

Providers of care must develop individualized treatment and/or service plans that utilize assessment data, address the member's current problems related to the behavioral health diagnosis or developmental disability condition, and identify specific goals and objectives as it relates to the member's treatment or service needs. The member/guardian, and/or significant others, as appropriate, must be involved in the treatment planning process. A Master treatment plan (MTP) is done annually in conjunction with the Care Coordination Person-Centered Service Plan (PCSP) and should be done prior to or during the PCSP conference. Initial treatment plans must be developed within 14 calendar days of the member entering treatment. Periodic review of the MTP is required every 180 days.

Providers of care are expected to document progress toward meeting goals and objectives in the member's record and to review and revise plans as appropriate. Treatment plans must be signed by the physician overseeing the member's care, the treating professional, and the member or guardian if the member is under 18 years old.

Discharge Planning

Discharge planning is an integral part of treatment and begins with the initial review. As a member is transitioned from inpatient and/or higher levels of care, Care Coordination staff will review/discuss with the provider the discharge plan for the member.

Notification of Discharge

Hospitals and other facilities must notify Empower at least twenty-four (24) hours in advance of any discharge from inpatient hospital stays, including psychiatric hospital stays.

The following information may be requested and must be documented:

- Discharge date
- Aftercare date
- Date of first post-discharge appointment (must occur within seven days of discharge)
- With whom (name, credentials)
- Where (level of care, program/facility name)
- Other treatment resources to be utilized
- Medications
- Patient/family education regarding the purpose and possible side effects
- Medication plan including responsible parties
- Support systems
- Familial, occupational and social support systems available to the patient
    - If key supports are absent or problematic, how is this being addressed?
- Community resources/self-help groups recommended (note purpose)
- Medical aftercare (if indicated, note plan, including responsible parties)
- Family/work community preparation
- Family illness education, work or school coordination, or other preparation done to support successful community reintegration. (Note specific plan, including responsible parties and their understanding of the plan)

Adverse Clinical Determination/Peer Review

If a case does not appear to meet medical necessity criteria at the requested level of care, the Utilization Management Care Manager (UM CM) attempts to discuss the member's needs with the provider of care and to work collaboratively with the provider of care to find an appropriate alternative level of care. If no alternative is agreed upon, the UM CM cannot deny a request for services. Requests that do not appear to meet medical necessity criteria or present quality of care issues are referred to a peer reviewer for second-level review. It is important to note that only a doctoral-level peer reviewer can clinically deny a request for services.

All written or electronic adverse determination notices include:

- The specific reason(s) for the determination not to certify
- A statement that the clinical rationale, criteria, (or copy of the relevant medical necessity criteria), guidelines, or protocols used to make the decision will be provided, in writing, upon request by contacting the UM Department at (855) 429-1028
- Rights to and instructions for initiating an appeal, including the opportunity to request an expedited appeal if applicable for first-level appeals, and information about the appeal process
- The right to request an appeal verbally, in writing, or via fax transmission
- The timeframe for requesting an appeal
- The opportunity for the member, provider of care to submit, for consideration as part of the appeals process, written comments, documents, records, and other information relating to the case
- Information regarding the appeals process for urgent care including that expedited external review may occur concurrently
- The member's right to bring a civil action under the Employer Retirement Income Security Act of 1974 (ERISA), when applicable

Requesting Prior Authorization

The Utilization Management (UM) department is committed to assuring prompt, efficient delivery of healthcare services and to monitor the quality of care provided to Empower members. All providers are required to obtain prior authorization from the Plan's UM department for services outlined above. Failure to submit a request for authorization may result in a denial. Authorization can be obtained by submitting requests electronically via the Provider Portal or by calling Provider Services at (855) 429-1028.

When an authorization request is received, the information will be reviewed, and the member's eligibility verified. However, since a member's eligibility may change prior to the anticipated date of service, eligibility must be verified on or prior to the date of service.

Prior authorization requests for a planned or elective medical or behavioral health admission, service, or procedure may be submitted up to 30 calendar days, no later than 5 business days, prior to the beginning date of service. Services that require a prior authorization cannot be backdated. Exceptions can be made to backdate authorizations up to one (1) business day in urgent cases. The authorized service must be rendered within 90 days of the authorization.

Please note the following:

- Authorization requests for urgent and elective inpatient continued stay requests are required to be submitted within 24 hours, or within 1 business day, of the last covered date of service. Requests for elective Psychiatric Residential Treatment Facility (PRTF) requests can be submitted up to 7 calendar days prior to the last covered date of service.
- Initial requests for Intermediate Care Facilities (ICF) for newly attributed PASSE members can be backdated for up to 1 business day. ICF continued stay requests may be submitted up to 30 calendar days in advance.
- Admission to elective inpatient programs including, but not limited to, Psychiatric Residential Treatment Facilities, Intermediate Care Facilities, and the UAMS Child Diagnostic Unit must occur within 10 calendar days from the date of the authorization.
    - Failure to notify Empower Healthcare Solutions of the member's admission within that timeframe will result in the request being voided and will necessitate a new authorization request from the provider.
- Failure to submit requests timely could result in gaps in coverage dates. Dates of service requested outside of the submission timeframe may not be reviewed and are subject to an adverse determination. Empower does not conduct retroactive reviews for prior authorized services due to failure to request services timely.

***Retroactive requests** for services that require a prior authorization are allowed only if the member's eligibility lapses during or prior to an episode of care. Retroactive authorization requests must be submitted within 30 days of the redetermination date.

Extension of Benefit

An extension of benefit may be requested for services that have an allowed annual benefit threshold within 365 days of the date that services were rendered and should be submitted in accordance with the timely filing requirements for claim submissions.

UM Time Frames

Standard Authorization: Within two (2) business days of Empower's receipt of all clinical information necessary to make the authorization or adverse determination.

Urgent Authorization: Within one (1) business days of Empower's receipt of all clinical information necessary to make the authorization or adverse determination or as expeditiously as the enrolled member's health condition requires.

Note: Failure to follow authorization, certification, and/or notification requirements, as applicable, may result in administrative denial/non-certification and require that the member be held harmless from any financial responsibility for the provider's/participating provider's charges.

Provider Administrative Reconsiderations

A provider has the right to request an administrative reconsideration in accordance with the requirements set forth in §160.000 and §190.000 of the Medicaid Provider Manual, and with all applicable federal and state laws, rules, and regulations, including 42 CFR Part 431, subpart E (Fair Hearings for Applicants and Members) and 42 CFR Part 438, Subpart F (Grievance and Appeal System), the Medicaid Fairness Act, and the Arkansas Administrative Procedures Act (Ark. Code Ann. § 25-15-201 et seq.). Although they have this right, a provider is not required to request an administrative reconsideration prior to filing an appeal under the Medicaid Fairness Act.

An administrative reconsideration may be requested within thirty (30) calendar days of the date on the notice of adverse determination. The request may be submitted by emailing to AR_Appeals@EmpowerArkansas.com, by faxing to (501) 325-0336, or by mailing to:

Empower Healthcare Solutions, LLC
ATTN: Appeals
PO Box 211446
Eagan, MN 55121

Empower will acknowledge all reconsideration requests within five (5) business days. A second MD will review the original adverse determination in addition to any additional information that is submitted. Resolutions will be sent no later than thirty (30) calendar days from the date of the receipt of the administrative reconsideration request.

Any adverse resolution of a reconsideration request can be appealed by the Provider within (30) calendar days to the Arkansas Department of Health, Office of Medicaid Provider Appeals. The appeal must be submitted in writing to:

Office of Medicaid Provider Appeals
4815 West Markham Street, Slot 31
Little Rock, AR 72205

The request for reconsideration must include:

- A statement regarding the reason for the appeal
- A copy of the notice of the adverse decision or action to be reconsidered, and
- Any additional documentation to support medical necessity.

Administrative appeals at the Department of Health will be conducted by an independent administrative law judge employed by the Arkansas Department of Health.

Electronic Visit Verification (EVV) for Personal Care Services

Empower has partnered with HHAeXchange (HHAX) to facilitate all Electronic Visit Verification (EVV) for Personal Care Services. In compliance with the 21st Century Cures Act Mandate, Personal Care visits must be electronically verified for:

- Type of Service
- Date of Service
- Location of Service
- Patient
- Caregiver performing service
- Start/end time of service

Claim submissions, visit scheduling, and service verifications are completed in the HHAX Portal.

Claims

Claim Submission Guidelines

Empower is required by state and federal regulations to capture specific data regarding services rendered to its enrollees. The provider must adhere to all billing requirements to ensure the timely processing of claims. When required data elements are missing or invalid, claims will be rejected by Empower for correction and resubmission. The provider who performed the service to the Empower enrollee must submit the claim for a billable service.

Claims filed with Empower are subject to the following procedures:

- Verification that all required fields are completed on the CMS-1500 or UB-04 forms
- Verification that all diagnosis and procedure codes are valid for the date of service
- Verification of enrollee eligibility for services under Empower during the period in which services were provided
- Verification that the services were provided by a participating provider or that the "out-of-network" Medicaid Provider has received authorization to provide services to the eligible enrollee
- Verification of whether there is Medicare coverage or any other third-party resources and, if so, verification that Empower is the "payer of last resort" on all claims submitted to Empower
- Verification that an authorization has been given for services that require prior authorization by Empower
- Verification that the provider is enrolled with Arkansas Medicaid during the claim date of service and that the claim includes the appropriate NPI code and taxonomy code on file with Arkansas Medicaid **Note: (atypical providers, as defined by the state of Arkansas, are not required to submit an NPI. These providers should instead provide the Medicaid ID on loop 2010BB-REF02 segment).**

In addition, Empower uses claim edit applications following NCCI, AMA, and CMS guidelines:

- **Procedure unbundling** - billing two (2) or more CPT codes when one (1) CPT code exists for same procedure
- **Incidental procedures** - procedures performed at the same time as a more complex procedure but requires little to no additional physician resources or is clinically integral to the performance of the procedure
- **Mutually-exclusive procedures** - two (2) or more procedures that should not be performed or billed for the same enrollee on the same date of service
- **Multiple surgical procedures** - surgical procedures are ranked according to the clinical intensity and are paid following percentage guidelines
- **Multiple Procedure Payment Reduction (MPPR)** - for selected therapies applies to multiple procedures and multiple units
- **Duplicate procedures** - procedures billed more than once on the same date of service
- **Assistant surgeon utilization -** reimbursement and coverage determination

Claims for ER services may be subject to review for medical necessity and whether treatment was required for an emergency medical condition.

As part of the agreement between Empower and the provider, the provider agrees to cooperate with Empower in its efforts to comply with all applicable Federal and State laws.

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

Claims Questions

If you have questions regarding a claim you may contact Empower Provider Services at 855-429-1028 between 8:00 am and 5:00 pm CT to address the issue or question. Always record your reference number or ticket #'s and the representative's name. If a resolution cannot be reached, complete the Claim Inquiry Form on our website (www.getempowerhealth.com/providers) and reach out to your provider relations manager for assistance at empowerhealthcaresoltionspr@empowerarkansas.com. Include all relevant documentation related to the claim inquiry to ensure expedited response.

Timely Filing Requirements

The original clean claim must be submitted within 365 days from the date of service and must include all necessary information as outlined in this Provider Manual. In addition, all codes used in billing must be supported by appropriate medical record documentation. A clean claim is defined as a claim for reimbursement submitted to Empower by a health care practitioner, pharmacy or pharmacist, hospital or person entitled to reimbursement that contains the required data elements and any attachments requested by Empower.

Resubmission of previously processed claims with corrections and/or requests for adjustments must be submitted within one hundred and eighty (180) days of notification of payment/denial.

Claims originally rejected for missing or invalid data elements must be corrected and resubmitted within 365 days. Rejected claims are not registered as received in the claims processing system.

Claim Requirements

The CMS-1500 claim form must be completed for all professional medical services, and the UB-04/CMS 1450 claim form must be completed for all facility claims. All claims must be submitted within 365 days.
Empower has aligned its NPI and taxonomy code requirements with the state's Master Provider Registry (HIPAA-compliant where applicable):

- Member's name
- Member's Empower ID number
- Member's date of birth
- Provider name according to contract
- Provider tax ID number and state Medicaid ID number
- NPI of billing provider and rendering provider when applicable
- Medicaid ID of billing provider and rendering provider when an atypical provider
- Date of service
- Place of service
- ICD-10 diagnosis code/revenue codes
- Procedures, services or supplies rendered, CPT-4 codes/HCPCS codes/Revenue Codes
- Days or units
- Modifiers as applicable
- Coordination of benefits (COB) and/or other insurance information
- Any other state-required data
- Present on Admission (POA) Indicator
- Applicable Value Code

NPI Number Requirements

To report your NPI, log on the HealthCare Provider Portal by entering your user ID and password. Proceed by following the steps to report your NPI. If you have already reported your NPI number to Arkansas Medicaid, your NPI information has been successfully linked to your Arkansas Medicaid Provider number. If you have any questions or problems regarding your NPI, contact DHS Provider Enrollment at (501) 376-2211 (for local or out-of-state calls) or (800) 457-4454 (toll-free).

Additional Documentation Required for Developmental Disability and Behavioral Health Services

Additional documentation may be required for services delivered through the CES waiver, intermediate care facilities, and various behavioral health services. Providers are required to comply with all data collection and reporting requirements promulgated by the Office of Long-Term Care, the Division of Developmental Disabilities and the Division of Behavioral Health found in the menu located at https://humanservices.arkansas.gov/about-dhs/dpsqa/office-of-long-term-care/consumer-long-term-care-information/types-of-facilities#2.

Provider Preventable Conditions

Empower requires all providers to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made via the POA indicator. Empower cannot make payments for any provider-preventable conditions in accordance with 42 CFR § 438.3(g). Empower must track this data and submit a report quarterly that identifies all provider-preventable conditions.
The report must include, at a minimum:

- Improper 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
- Procedures performed which result in negative consequence(s) for the enrolled member

There is an indicator on the claim called the POA indicator; the Provider will complete this box if the above applies.

Submitting Member Encounters

Empower is required to submit encounter data to the Arkansas Department of Human Services (DHS). Provider assistance is an essential component of this requirement.

DHS requires complete, accurate, and timely encounter data to effectively assess the availability and costs of services rendered to Medicaid enrollees. The data we provide affects DHS funding of the Medicaid Program, including Empower.

Data regarding encounters is also used to fulfill the CMS required reporting in support of the Federal funding of State Medicaid plans. According to Empower policy, providers must report all member services by claims submission either electronically or by mail to Empower.

Submitting a Claim

Portal Submission

CMS -1500 claims can be submitted via the Empower Portal from the Empower website, www.getempowerhealth.com.

Paper Submission

Paper claims should be submitted to Empower on standard CMS forms (CMS 1500/UB-04). Please submit to the following address:

Empower Healthcare Solutions
Attn: Claims
PO BOX 211446
Eagan, MN 55121

Electronic Submission

Empower Electronic Payer ID: 12956

Empower maintains claims processing procedures designed to comply with the requirements of client plans, government-sponsored health benefit programs, and applicable state and/or laws, rules, and/or regulations. Electronic Data Interchange (EDI) allows for faster, more efficient, and cost-effective claims submission for providers. EDI, performed in accordance with nationally recognized standards, supports industry efforts to reduce administrative costs.

The following sections describe the procedures for electronic claim submission, including descriptions of claims and report process flows, information on unique electronic billing requirements, and various electronic submission exclusions.

Hardware/Software Requirements

Change Healthcare (formerly Emdeon) can accept electronic data from numerous providers in several standardized EDI formats. Providers may submit claims electronically as long as their software can send EDI claims through either direct submission to Change Healthcare or through another clearinghouse/vendor. Upon receipt, the clearinghouse forwards the accepted information to Empower in an agreed- upon format.

For those interested in electronic claim filing, contact your EDI software vendor or the Change Healthcare Provider Support Line at (800) 845- 6592 to arrange transmission.

Empower encourages all providers to submit claims electronically.

Claims Status Review

Providers may view claims status using any of the following methods:

- **Online** – Check eligibility/claims status by accessing the Empower Provider Portal at https://bharportal.valence.care/
- **Telephone** – You may also check eligibility and/or claims status by calling Empower at (855) 429-1028.
- **Real-Time** – Depending on your clearinghouse or practice management system, real-time claims status information is available to participating providers via their clearinghouse.

Coordination of Benefits Process

Coordination of Benefits (COB) refers to the activities involved in determining Medicaid benefits when an Empower member has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.

Empower adheres to state-specific guidelines and federal regulations when coordination of benefits is available with other health insurance (OHI), other third-party liability (TPL), medical subrogation, or worker's compensation.

For COB determination, Empower pays the difference between the amount paid by the third-party insurance and Empower's Medicaid maximum allowable amount. The third-party payment is inclusive of direct patient liability such as copayment, deductible, and coinsurance. Empower will not make any payment if the amount received from the third-party insurance is equal to or greater than Empower's Medicaid allowable amount.

Empower is a payer of last resort when any commercial or Medicare plan covers the member. Providers should submit claims for members covered by Medicare directly to Medicare. Should Empower be liable for any remainder of the claim, Medicare will submit that directly to Empower. The Medicare ERA or EOP will denote that it has been sent to Empower with a remark code "MA18" or "N89". Providers may refer to Chapter 26 of the Medicare Claims Processing Manual for additional guidance. Empower is obligated to process claims involving auto insurance or casualty services as the primary payer if bills do not include a notation or payment by any insurance that is not a commercial or Medicare plan. There may be other instances in which Empower is obligated as the primary payer to include:

- Prenatal care for pregnant women, including services that are part of a global OB package.
- Preventive pediatric services, including Early and Periodic Screening Diagnosis and Treatment (EPSDT) and administration of vaccines to children under the Vaccines for Children (VFC) program.
- Services covered by third-party liability that is derived

from an absent parent whose obligation to pay support is being enforced by Child Support Enforcement.

Participating providers should obtain information from members as to whether the member has health benefits coverage from more than one source, and if so provide this information to Empower when submitting claims.

Coordination of benefits amongst different sources of coverage is governed by the terms outlined in the member's benefit plan as well as applicable state and/or federal laws, rules and/or regulations. Participating providers agree that payment from primary and secondary payers for covered services rendered to members will not exceed the rate specified in the provider agreement, to the extent not otherwise required by applicable laws or regulations.

Participating providers must submit a copy of the primary insurer's Explanation of Payment (EOP), except for when Medicare is primary, that includes the primary payer's determination when submitting claims to Empower. The services included in the claim submitted to Empower should match the services included in the primary payer EOP. In addition, the provider will need to complete the necessary COB fields on the claim and include payment information from the primary payer's Electronic Remittance Advice (ERA) or by converting the EOP into standard coding use in an ERA.

Some exceptions to this can be found in Empower's updated Third Party Liability Policy.

Authorization, certification or notification requirements under the member's benefit plan still apply in the coordination of benefits situations.

It is the responsibility of the member to report the name and policy number of any other payment source to the provider of medical services at the time services are provided. The member must also authorize the insurance payment to be made directly to the provider.

It is the provider's responsibility to be alert to the possibility of third-party sources and to make every effort to obtain third-party insurance information. The provider should also inquire about liability coverage in accident cases and pursue this or notify Medicaid. It is the responsibility of the provider to file a claim with the third-party source and to report the third-party payment to the Medicaid Program.

All paid services that are limited by the Medicaid Program count toward the patient's benefit limits even when the amount of Medicaid payment is reduced to zero by the amount of third party liability, except for Medicare crossover claims with no secondary payer other than Medicaid.

Scenario	Documentation Policy
Commercial provided primary coverage- Empower to cover as secondary	Submit claim with Primary EOB attached. Primary EOB must match claim billed to Empower (units, DOS, billed charge, CPT, modifiers etc.)
Commercial Carrier excluded services	Annual verification required based on benefit year; accepted documents: EOB denial, Exclusion list from Carrier, Carrier attestation of excluded service

Scenario	Documentation Policy
Commercial pays primary for IP or OP services	Empower will cover up to the Medicaid allowed based on provider contract. If service not covered by Medicaid, no payment issued
Commercial pays $0 due to benefit exhausted/non covered service	Empower will cover service as Primary payer. Provider will follow Empower PA requirements as defined.

Medicare/Medicaid Crossover Claims

If medical services are provided to a patient who is entitled to and is enrolled with, coverage within the original Medicare and Medicaid benefits, it is necessary to file a claim only with the original Medicare plan. The claim must be filed according to Medicare's instructions and sent to the Medicare intermediary. The claim should automatically cross to Empower if the provider is properly enrolled with Arkansas Medicaid and indicates the member's dual eligibility on the Medicare claim form.

When the original Medicare plan intermediary completes the processing of the claim, the payment information is automatically crossed to Medicare's Coordination of Benefits Agreement (COBA) process and from there crossed to Empower and the claim is processed in the next weekend cycle for Medicaid payment. Exceptions to the above:

- Claims for Medicare members entitled under the Railroad Retirement Act do not cross to Medicaid. The provider of services must request payment of co-insurance and deductible amounts through Medicaid according to the instructions below after Railroad Retirement Act Medicare pays the claim.
- Medicare Advantage/Medi-gap Plans (like HMOs and PPOs) are health plan options that are available to members, approved by Medicare but run by private companies. Since these claims are not through the original Medicare plan directly, these claims do not automatically cross to Medicaid; and the provider must request payment of Medicare-covered services co-insurance and deductible amounts through Medicaid.

Federal regulations dictate that providers must file the Medicaid portion of claims for dually eligible members within 365 days of the beginning date of service. The Medicare claim will establish timely filing for Medicaid if the provider files with Medicare during the 365-day Medicaid filing deadline. Medicaid may then consider payment of a Medicare deductible and/or coinsurance, even if the Medicare intermediary or carrier crosses the claim to Medicaid after more than a year has passed since the date of service. Medicaid may also consider such a claim for payment if Medicare notifies only the provider and does not electronically forward the claim to Medicaid. Federal regulations permit Medicaid to pay its portion of the claim within six (6) months after the Medicaid "agency or the provider receives notice of the disposition of the Medicare claim."

Providers may not electronically transmit any claims for dates of service over 365 days in the past to the Arkansas Medicaid fiscal agent.

Empower has established a list of known codes that Medicare does not cover. The Medicare bypass list are codes approved by Arkansas Medicaid to be sent to Empower as a primary payer. The Medicare bypass list can be found here.

Scenerio	Documentation Policy
Medicare provided primary coverage- Empower to cover as secondary	Submit claim to Medicare for adjudication and Medicare will transmit claim data via COBA process
Medicare Carrier excluded service (Bypass list)	No EOB/documentation required- submit claim directly to Empower

Scenario	Documentation Policy
Medicare pays primary for Outpatient Service	Empower will pay the patient liability of Deductible and/or Co-insurance only
Medicare pays primary for Inpatient service	Empower will pay up to the Medicaid Allowed based on the provider contract. If service not covered by Medicaid, no payment issued from Empower.
Medicare pays $0 due to benefit exhausted/non covered service	Empower will cover service as Primary payer. Provider will follow Empower PA requirements as defined.

Balance Billing or Remaining Cost for Covered Services

Participating providers may not balance bill members for covered services rendered. This means that the participating provider may not bill, charge or seek reimbursement or a deposit, from the member for covered services except for applicable member expenses, and non-covered services. Participating providers are required to comply with provisions of Empower's code of conduct where applicable, including, without limitation, cooperation with claims and billing procedures and participation in training and education. Balance billing education is provided by Empower as included in quarterly Fraud, Waste, and Abuse provider training. Empower discourages billing members for missed appointments.

Providers must supply copies of medical records to Empower upon request and at no charge to Empower or the member.

The following information needs to match the primary claim when submitting secondary claims to empower.

Date of Service
Service Code
Charged Amount

Rejected and Denied Claims

Rejected claims are defined as claims with invalid or missing data elements (such as the provider tax identification number) that are returned to the provider or EDI source without registration in the claims processing system. In addition, claims from providers who do not have an active Arkansas Medicaid Provider ID or an NPI (unless the provider is an atypical provider as defined by the state of Arkansas) listed in the state's system of record will be rejected. Providers should make sure their information is up to date with the state to avoid rejection.

Since rejected claims are not registered in the claims processing system, the provider must re-submit corrected claims within 365 calendar days from the date of service. This requirement applies to claims submitted on paper or electronically. Denied claims are different than rejected claims and are registered in the claims processing system, but they do not meet requirements for payment under Empower guidelines.

Notification of Denial via Remittance Advice

Any CPT/HCPCS level 1 or 2 codes that have been denied due to claims editing will be associated with the appropriate disposition code on the remittance advice.

When a claim is denied because of missing or invalid mandatory information, the claim should be corrected and resubmitted within One hundred and eighty (180) days of notification of payment/denial either electronically or via paper to the general claim address:

Empower Healthcare Solutions
Attn: Claims
PO BOX 211446
Eagan, MN 55121

Corrected Claims

Follow the instructions on the Provider Billing FAQ for detailed directions regarding how to submit a corrected claim to Empower.
Corrected claims can be sent:

Submit Corrected Claims		
Clearinghouse	Provider Portal	Paper
Original Claim Number	Original Claim Number	Original Claim Number
Update EDI Batch Claim segment details	Modify Claim Feature	Marked as Corrected or Replacement Claim

When an overpayment is identified, the claim will be adjusted, the money will be recovered, and the transaction will be reported on the Remittance Advice. There is no need to submit a refund check.

When an underpayment is identified, the claim will be adjusted, the additional funds will be sent, and the transaction will be reported on the Remittance Advice.

Overpayment

Providers must return any overpayment to Empower at the address outlined in this handbook utilizing the Empower Voluntary Self Disclosure of Overpayment Form. (42 CFR 438.608 (d)(2)).

If Empower recognizes an overpayment and the need for a refund, a letter outlining the details will be sent sixty (60) days prior to the recovery occurring. These adjustments will be reported on the Remittance Advice.
Information about the process for appeals of claims is set out in the appeals section of this handbook.

Rate Changes

Empower is committed to following Arkansas Medicaid rates and fee schedules. Should DHS update their fee schedule or notify Empower of a rate increase or decrease, claims will be systemically recalculated without provider intervention needed.
How Should Providers Bill a Rate Increase?

- DHS notifies provider of rate change and effective date
- Providers submit claims to Empower with the new rate with dates of service on or after the effective date
- No other action needed from the provider

*Note: If providers submit claims to Empower with the old rate after the effective date, providers will need to submit corrected claims to receive the updated rate.

The Process for Paying Claims When There is an Approved Rate Increase is as Follows:

- Empower is notified of an Arkansas Medicaid rate change by DHS
- Programing of the new rate in the Empower claims system is started
- Empower pays providers at the old rate until programing is completed
- Once programing is complete a recalculation project will begin and providers will be retroactively paid the difference between old rate and new rate

Claim Inquiry and Appeals

Providers who believe there was an error made during claims processing or if there is a discrepancy in the payment amount may begin the claim inquiry process.

Provider claim inquiry process

The claim inquiry process consists of two internal steps and a third external step.

Claim reconsideration: The claim reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim reconsideration step. We accept reconsideration requests in writing or verbally. Reconsiderations filed more than 180 business days from the *EOP* will be considered untimely and denied unless good cause can be established.
When submitting reconsiderations, please complete the claim inquiry form on www.getempowerhealth.com and include as much information as possible to support why the claim was not paid as expected. If a reconsideration requires clinical expertise, the appropriate clinical professionals will review. If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

Provider Reconsideration Request:
Providers who disagree with the outcome of the reconsideration and/or have received a denial of payment, have the option of filing a provider reconsideration or they may file a request for a fair hearing directly with Arkansas Dept. of Health. The provider reconsideration must be submitted in writing, received within thirty (30) calendar days from the date on the notice of the adverse decision/action, and must include:

- A copy of the notice of adverse decision or action to be considered, and
- Any additional documentation to support medical necessity.

The Provider may submit a provider reconsideration to the following address:

Empower Healthcare Solutions
Attn: Provider Reconsideration
PO BOX 211446
Eagan, MN 55121

The provider will receive written notification of the outcome of the provider reconsideration whether it is upheld or overturned.

All upheld determinations will be sent to the provider in a letter with the reason the plan upheld the adverse decision/action. Any provider reconsiderations overturned or modified by the plan will be reprocessed, and the provider will receive an explanation of payment (EOP) as a notification and an overturned or modified determination letter.

Any adverse resolution of a provider reconsideration request can be appealed by the provider within thirty (30) calendar days to the Department of Health, Office of Medicaid Provider Appeals.

State fair hearing: Providers have the right to request a Medicaid fair hearing from the state. When a Provider asks for a fair hearing, a hearing officer who works for the state reviews the adverse decision made by the plan.

How to Ask for a Fair Hearing: The Provider may ask for a fair hearing up to 30 days after they receive the plan's decision.

The Provider may ask for a fair hearing in writing to:

ADH Office of Medicaid Provider Appeals
4815 West Markham Street, Slot 31
Little Rock, AR 7220
Phone 501-683-6626
Fax: 501-661-2357

The written request for a Medicaid fair hearing must include the following information:

- Member name
- Member Medicaid ID number
- Member information and phone number where member can be reached
- A statement regarding reason for appeal
- Any notice of action received by provider from which provider is seeking an appeal

The Provider may also include the following information if the information is known:

- Why you think we should change the decision
- Any medical information to support request
- Who you would like to help with your fair hearing

After getting your fair hearing request, DHS will notify you in writing of receipt of your fair hearing request.

Quality Improvement Program

The mission of the Empower Quality Improvement Program, in collaboration with the Clinical and Medical Affairs functional areas, is to help people live their lives to the fullest potential by transforming the lives of those we serve through promotion, support and facilitation of high quality, cost-effective, evidence-based care and service known to improve health outcomes.

Our local presence and broad expertise create opportunities for collaborative programs that reward Providers and Facilities for clinical quality and excellence. Providers and Facilities are expected to cooperate with Quality Improvement activities. Our commitment to health improvement and care management provides added value to Members and health care professionals – helping improve both health and health care costs. Empower takes a leadership role to improve the health of our communities and is helping to address some of health care's most pressing issues. The Quality Improvement ("QI") Program Description defines the quality infrastructure that supports Empower's QI strategies.

- The QI Program Description establishes QI Program governance, scope, goals, objectives, structure, and responsibilities encompassing the quality of medical, behavioral health care, and services provided to Members.
- The QI Work Plan is developed to track and monitor ongoing progress made on QI activities during the year. The QI Work Plan includes Empower's approach to patient safety for Members and improving medical, behavioral health, and supportive care: quality of care and services, safety, quality of service and Members' experience.
- The QI Evaluation assesses outcomes of Empower's medical, behavioral health and supportive care programs, processes activities and performance in the quality and safety of clinical care and other service. The QI Evaluation also evaluates how the QI Program goals and objectives were met.

Empower Quality Goals and Objectives

The following QI Program goals and objectives support Empower's vision and values; promote continuous improvement in quality care, patient safety for members, and quality of service to our members, providers and facilities:

- To develop and maintain a well-integrated system, continuously identifying, measuring, assessing and improving clinical and service quality outcomes through standardized and collaborative activities.
- To respond to the needs and expectations of internal and external customers by evaluating performance and taking action relative to meeting those needs and expectations, including compliance with the Arkansas PASSE Agreement, state and federal regulatory requirements, accreditation requirements and Empower policies and procedures.
- To promote processes that help reduce medical errors and improve patient safety for members by implementing member-focused, provider and safety initiatives.
- To identify and promote educational opportunities for members, medical and behavioral healthcare providers and other health care professionals.
- To conduct operations in a manner, protecting the confidentiality, safety and dignity of all members and assuring meeting culturally diverse needs.
- To maintain a health plan model that empowers the provider to make decisions and enables proactively managing health care.

Patient Safety

Reportable Conditions

Empower providers are contractually required to follow Empower's QI programs including, but not limited to, reporting certain diseases, infections or conditions in accordance with (Ark. Code Ann. § 20-7-101 et seq.).

Empower requires all providers to report provider preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made.

Payments will not be made for any provider preventable conditions in accordance with 42 CFR § 438.3(g). Provider preventable conditions data will be tracked, and a quarterly report identifying this data will be submitted.

The report will include, at a minimum:

- Incorrect surgical or other invasive procedures performed on an enrolled member; surgical or other invasive procedures performed on the wrong body part; surgical or other invasive procedures performed on the incorrect patient
- Results with negative consequences for the enrolled member
- CMS Medical Preventable Conditions

Incident Reporting

Empower has a system for identifying, reporting, investigating, and monitoring reportable events, as defined by federal, state, and health plan requirements. Providers have the responsibility to ensure the health and safety of members, to report incidents that put the health and safety of members at risk, and to take immediate steps, when there is an incident, to protect members from further harm, and respond to any emergency needs of members.

A reportable event, or Incident, is an occurrence that must be reported by providers of member services to Empower and to the Arkansas Department of Human Services Division of Quality Assurance. Reporting is necessary in order to eliminate or diminish potential safety issues for members, to meet federal and state regulations, and to monitor and ensure quality of care.

Empower Providers are required to notify Empower and the DHS PASSE Quality Assurance Unit within required timeframes upon the occurrence—or becoming aware—of a reportable event. If the Incident Report is submitted within the required timeframes, the Incident Report serves as the notification and no other notification is required. The contacts for both Empower and the DHS PASSE Quality Assurance Unit are identified on the DHS QA Incident Report Form.

The Incident Report must be submitted (or notification made) within **one hour** upon the occurrence—or becoming aware—of the following events:

- Death of a member
- Injury to a member that may result in a substantial permanent impairment
- Unexpected occurrences involving actual or risk of death or serious physical or psychological injury to a member
- Incidents, regardless of category, that a service provider should reasonably know might be of interest to the public and/or media and could potentially involve publicity. [Note: The DHS Communications Director must also be notified.]

The Incident Report must be submitted (or notification made) within **24 hours** (no later than two days for HCBS services) following the occurrence—or becoming aware—of the following events:

- Any situation in which the whereabouts of a member is unknown (elopement/missing/ wandering) for more than 30 minutes (two hours for HCBS services) or where services are interrupted for more than two (2) hours
- Arrests, commission of crimes, and/or convictions of a member
- Biohazard incident involving a member
- Disturbance:
  - Any incident involving property destruction by a member
  - Any incident involving threatening or disruptive behavior of such a nature that it causes fear of imminent injury or results in injury

- Injury of a member requiring the attention of an Emergency Medical Technician (EMT) / Paramedic / Physician or requiring Emergency Room Care or Hospitalization
- Medication Errors that cause serious injury to a member or that are made by staff that cause or have the potential to cause serious injury or illness to a member
  - Note: Includes, but not limited to: loss, unavailability, or theft of medication; falsification of medication logs; errors in dosage (missed or wrong dose); errors in administration (wrong medication, wrong route of administration, wrong time)
- Provider Staff threatens, abuses, or neglects a member
- Provider Staff who provide direct care services is arrested or convicted
- Rape of a member
- Suicide threatened or attempted by a member
- Suspected Maltreatment, Abuse (Physical/Verbal/Sexual), Neglect, or Exploitation of a member
  - Exploitation of a member includes, but is not limited to, fraudulent or otherwise illegal or unauthorized use of member's resources, such as funds, assets, or property; misappropriation of member's belongings or money without consent; misuse of member's power of attorney or guardianship.
    Note: The Arkansas Child Maltreatment Act and the Arkansas Adult Maltreatment Act deem all staff of service providers to be mandated reporters of any suspected adult or child abuse, neglect, exploitation, and maltreatment and must make reports immediately to the Arkansas Adult Abuse Hotline or the DHS Child Abuse Hotline at 800-482-5964.
- Use of Restrictive Interventions (Chemical and Mechanical Restraints and Seclusion) with a member:
  - Chemical Restraint is 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; any drug that (1) is administered for the sole purpose of preventing, modifying, or controlling challenging behavior; (2) has the temporary effect of restricting the member's freedom of movement; and (3) is not a standard treatment for the member's medical or psychiatric condition.
  - Mechanical Restraint is any physical apparatus or equipment used to limit or control challenging behavior. This would include any apparatus or equipment that cannot be easily removed by the member, restricts the member's free movement or normal functioning, or restricts normal access to a portion or portions of the member's body.
  - Seclusion is the involuntary confinement of a member alone in a room or an area from which the member is physically prevented from having contact with others or leaving; preventing a member from leaving a time out area is considered seclusion.
  - Note: The Arkansas DHS DDS Community and Employment Supports (CES) Waiver Minimum Certification Standards and Agreement Outlining Minimum Standards for PASSE HCBS Providers prohibit the use of Chemical Restraints, Mechanical Restraints, and Seclusion. The Arkansas Minimum Licensing Standard for Child Welfare Agencies for Residential Agencies prohibits the use of Chemical Restraints and Mechanical Restraints, *although Chemical Restraints may be utilized in a PRTF if ordered by a physician.*
- Use of Restrictive Interventions (Physical/Personal Restraint) with a member:
  - Physical/Personal Restraint is the application of physical force without the use of any device, for the purpose of restraining the free movement of a member's body; does not include briefly holding without undue force for the purpose of calming or comforting, or holding member's hand to safely escort from one area to another)

- Use or Possession of a non-prescribed medication or an illicit substance by a member during service provision or at the site of service provision
- Vehicular accident involving a member during service provision
- Violation of member rights that jeopardizes the health, safety, or quality of life of a member or any other event that might have resulted in harm to a member or could have reasonably endangered the healthy, safety, or welfare of the member

Incident Reporting Form

The current DHS QA Incident Report Form (currently, the Revised 08/29/2019 version) for PASSEs is completed when a reportable incident occurs. This form can be found on the DHS website https://humanservices.arkansas.gov/divisions-shared-services/developmental-disabilities-services/forms-documents/

Providers may utilize their own Incident Reporting form; however, the provider's form must provide all of the information required on the DHS QA Incident Report Form.

Completing the Incident Report

Provide all of the information requested on the Initial Incident Report form. Documentation should include "who, what, where, when, and how" regarding the event/incident when this information is available. Be as specific and complete as possible regarding events, frequency, time periods, etc. If all of the information is not provided, a follow up with the provider submitting the report will be required in order to complete the form.

If all of the required information is not available at the time of the Initial Incident Report filing, additional information should be submitted as soon as it becomes available in a Follow-up or Final Incident Report. To submit a Follow-up or Final Report, re-submit the Initial Incident Report with the applicable "Follow-up" or "Final" report type checked and the date and additional information added to the Report. In order to differentiate new information added in the narrative sections of the report from information that was originally submitted, precede the new information in the narrative with the date it was added.

Submitting the Incident Reporting Form

Incident Reports are submitted via fax or secure/encrypted email to the member's PASSE and to the DHS Quality Assurance Unit. When submitting the report via email, providers are asked to please include both Empower and DHS in the same email. This is requested to reduce duplication of reports sent to DHS, as Empower must submit the Report if there is no evidence that it was sent to DHS.

When an incident involves provider staff, such as an incident of staff threatening, neglecting or abusing a member, and the provider is in network with multiple PASSEs, the Incident Report must be submitted to all of the PASSEs. The completed Report, which includes all of the member's information, is submitted only to Empower. Any identifying information regarding the member must be redacted, however, from the Incident Report being sent to the other PASSEs of which the individual is not a member.

The DHS QA Incident Report Form includes the email addresses and 24-hour telephone numbers for making notification by phone and for submitting Reports by email for all of the PASSEs. The DHS Quality Assurance email address is also identified at the bottom of both pages 1 and 2 of the Form. Contact information for making notification and submitting Incident Reports:

Empower Healthcare Solutions:
incident.reporting@empowerarkansas.com
Emergency Number/Report Line (866) 261-1286
Fax (501) 325-0701

DHS PASSE Quality Assurance Unit:
DHS.DDS.Central@arkansas.gov
Emergency Number/Report Line (501) 371-1329
Fax (501) 682-8656

Potential Quality of Care Concerns and Reviews

A Potential Quality of Care (PQOC) Concern is a concern that the care provided to a member did not meet a professionally recognized standard of health care. It is a deviation from a reasonably expected standard of care on the part of the provider based on established medically necessary criteria and/or safety standards essential to maintain safety and promote improved health and functioning.

For purposes of identifying PQOC concerns, a standard of care is defined as: a medical or psychological treatment guideline which specifies appropriate diagnosis and treatment for a certain type of patient, illness, or clinical circumstance based on scientific evidence and collaboration between medical and/or psychological professionals involved in the treatment of a given condition. It is the level of competence in performing medical tasks accepted as reasonable and reflective of a skilled and diligent health care provider; i.e., at which an ordinary, prudent professional having the same training and experience in good standing in a same or similar community would practice under the same or similar circumstances.

The Empower Quality Management Department tracks and trends all potential QOC issues reported to Empower by members, providers, and other stakeholders and investigates potential QOC issues based upon a pattern or prevalence of issues, severity and circumstances of the issue, member safety prioritization, and recognition of potential liability issues. A Quality of Care Review is a review focused on determining whether the quality of the service(s) provided to a member was consistent with professionally recognized standards of health care.

Criteria are used in identifying PQOC issues during the performance of utilization review activities, review of member and provider grievances and incident reports, review of medical necessity appeals, and physician monitoring activities. Criteria include, but are not limited to, member deaths or abuse, serious injuries, medication errors, suicide attempts, member privacy grievances, and provider patterns of issues relative to substandard care. Referral to the Potential Quality of Care process may be the resolution to a member's grievance. When the referral is the resolution of a member's grievance, the member is informed of the PQOC referral and that the details and results of the Quality of Care Review will not be disclosed to the member.

PQOC issues are categorized as:

- Access to Care (i.e., delay in care, refusal to refer member to specialist)
- Patient Safety/Environment (i.e., serious fall while in healthcare facility, homicide or suicide in healthcare facility)
- Practitioner Behavior/Competence (i.e., provider/staff abuse of member, member commits suicide within 72 hours of being discharged from hospital)
- Treatment (i.e., inappropriate/ineffective treatment, missed diagnosis)

Once a PQOC issue is identified, Empower will request member and provider records and any supporting documentation or other information relevant to the case for review. Providers are required to actively cooperate with the investigation. We will make every effort to facilitate the prompt and easy gathering of information from the provider. Methods used to secure relevant records and information from the provider may include utilizing encrypted email, facsimile (fax), overnight mail, overnight delivery, or hand delivery of communications or may involve sending Empower staff to the provider's office or facility.
After reviewing all available information, the Empower Medical Director will make a determination as to the presence of a significant quality issue. A severity index rating is assigned, according to the following criteria:

- Level 0 – Not a Quality of Care Issue
  - Did not meet Criteria as a QOC issue
- Level 1 – No Quality Issue Substantiated
  - Care rendered is within the national and community standard of care and behavior for that condition or situation
  - Care raises mild concern about quality of care
  - Level would be higher rating if a pattern of similar episodes developed
  - Given the information received, there was no clear cause or effect; the quality issue is indeterminate

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- Level 2 – Quality Issue – Does not impact the Care Outcome
  - Met Criteria as a QOC issue, but did not impact the care of the member
- Level 3 – Clear and Significant Quality Issue – Does Impact the Care Outcome
  - Clinical practice clearly falls below national and local standards and expectations (Example: Failure to pursue a diagnosis for a mass found on mammogram)
  - Amount and types of care were inadequate
  - Care was not provided in a timely manner
  - Care was not provided in a medically-appropriate setting
- Level 4 - Complex and Significant Quality Issue
  - Issues might be repeated, complex, unclear, ambiguous, or especially serious.
  - Situations or cases present complex or ambiguous issues or data (Example: Multiple inter-related diagnosis, multiple providers, or a prolonged episode of care)
  - Situation or case involves an apparent serious, but not emergent and/or repeated pattern of substandard care that is likely to result in future dangers to the members or to the health plan
- Level 5 - Emergency Quality Issue – Issue Raised is Egregious
  - Alleged action by the provider represents a clear and serious breach of accepted ethical behavior (Example: A convincing allegation of sexual molestation)
  - Alleged, action represents a clear and serious breach of accepted standards of care, such that continued care of patients by the provider could endanger their safety or health (Example: A surgical event or situation that indicates loss of judgement or skill)

Based upon severity, Quality of Care concerns may be reviewed by Empower's Peer Review Committee(PRC). The Medical Director and the PRC may make recommendations for remedial actions in response to the Quality of Care issue. Any actions taken will depend upon the area and type of problem identified and on whether the issue was an isolated event or part of a clear pattern or trend and the provider's response. Remedial actions may include, but are not limited to, telephone discussion or written correspondence with the provider, increased intensity of utilization management activity, requirement for consultation with Empower on best practices, or requirement of a Corrective Action Plan (CAP) from the provider.

The provider will be informed of the outcome of the Quality of Care review. The results of the Quality of Care investigation and any follow-up actions by the provider are considered when making decisions about participation in Empower's provider network. Ultimately, the Quality of Care process identifies opportunities for improvement in the clinical care and service to Empower members.

Performance Data

Overview of HEDIS

HEDIS *(Healthcare Effectiveness Data and Information Set)* is a set of standardized performance measures used to compare the performance of managed care plans and physicians based on value rather than cost. HEDIS is coordinated and administered by NCQA and is one of the most widely used sets of health care performance measures in the United States.

Like the quality measures utilized by CMS, Joint Commission and other external stakeholders, HEDIS measures have specific, standardized rules for calculation and reporting. HEDIS measures allow consumers, purchasers of health care and other stakeholders to compare performance across different health plans.

While the HEDIS measures are population-based measures of our health plan performance and major contributors to health plan accreditation status, Empower strives to ensure that behavioral health measure performance reflects best practice.

In an ongoing effort to improve the delivery of care and effectiveness of health services provided to members Empower monitors and evaluates HEDIS measure performance and because Empower members require more intensive levels of care for behavioral health and developmental disability needs the following Behavioral Health HEDIS measures have been prioritized for Quality monitoring:

HEDIS Measure	National Medicaid Health Plan Average http://www.ncqa.org/hedis-quality-measurement/reports
(FUH) Follow-Up After Hospitalization for Mental Illness Percentage of members with hospitalization for mental illness with a follow-up visit to behavioral health provider within 7 days of discharge **6-20 yr. old*	2019 – 48.1%
(FUH) Follow-Up After Hospitalization for Mental Illness Percentage of members with hospitalizations for mental illness with a follow-up visit to behavioral health provider within 30 days of discharge **6-20 yr. old*	2019 – 67.7%
(FUH) Follow-Up After Hospitalization for Mental Illness Percentage of members with hospitalizations for mental illness with a follow-up visit to behavioral health provider within 7 days of discharge **21+ yr. old*	2019 – 34.8%
(FUH) Follow-Up After Hospitalization for Mental Illness Percentage of members with hospitalizations for mental illness with a follow-up visit to behavioral health provider within 30 days of discharge **21+ yr. old*	2019 – 53.3%
(ADD) Follow-Up Care for Children Prescribed ADHD Medication Percentage of members with newly prescribed ADHD medication with 1 follow-up visit during the 30-day initiation phase **6-12 yr. old*	2019 – 47.5%
(ADD) Follow-Up Care for Children Prescribed ADHD Medication Percentage of members with newly prescribed ADHD medication with at least 2 follow-up visits during the 10-month continuation and maintenance phase **6-12 yr. old*	2019 – 57.6%
APC Children and Adolescents on 2 or more Antipsychotics Percentage of members on two or more concurrent antipsychotic medications (Lower rates are better) **1-17 yr. old*	2019 – 2.5%
(AMM) Antidepressant Medication Management **Effective Acute Phase Treatment**: Percentage of members diagnosed with major depression who were treated with and remained on antidepressant medication for 12 weeks **18+ yr. old*	2019- 51.2%
(AMM) Antidepressant Medication Management **Effective Continuation Phase Treatment:** Percentage of members diagnosed with major depression who were treated with and remained on antidepressant medication for 6 months **18+ yr. old*	2019- 34.4%

HEDIS Measure	National Medicaid Health Plan Average
(SAA) Adherence to Antipsychotic Medications for Individuals With Schizophrenia Percentage of members with Schizophrenia who were dispensed and remained on antipsychotic medication for at least 80 percent of their treatment period. **18+ yr. old*	2019 –61.1%
(SSD) Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications Percentage of members with Schizophrenia or Bipolar Disorder who were dispensed an antipsychotic medication and had a Diabetes screening test **18+ yr. old*	2019 –79.9%

To View the Empower HEDIS measures click here.

Improving HEDIS Scores

There are several ways providers can improve HEDIS scores. This starts with an accurate understanding of the specifications established for each HEDIS measure. All providers must bill for services delivered, according to their contract status. Claims and encounter data are the cleanest and most efficient way to report for HEDIS. If services are not billed or are not billed accurately, they cannot be included in the calculation. Accurate and timely submission of claims/encounter data can reduce the number of medical record reviews required for HEDIS rate calculation. Additionally, providers should ensure that chart documentation reflects all services provided, and providers should bill CPT codes related to HEDIS measures, such as diabetes, eye examinations and blood pressure.

Please contact the Quality Management Department with any questions, comments or concerns related to the annual HEDIS project or the medical record reviews.

Practice Pattern Analysis

A comprehensive provider program includes a complete report, listing chronic care metrics such as HEDIS, readmission rates, generic medication utilization, monitoring of certain medications and extent of use of electronic medical records. Analysis of provider information and data are utilized as a tool for initiating performance improvement and for reducing practice variation. A detailed member gap in care list accompanies the analysis. Reports are generated periodically and shared with some providers educate about best practices and to address gaps in performance.

Clinical Practice Guidelines

To assist providers in providing high-quality care, clinical practice guidelines are established or adopted in areas identified as relevant and critical to achieving positive care outcomes or when practice variation and differences in care outcomes are identified. Adopted guidelines adhere to 42 CFR § 438.236 and are disseminated to affected providers. All decisions for utilization management, member education, coverage of services and other areas to which the practice guidelines apply are consistent with the guidelines. Measurement of adherence to established practice guidelines is conducted methodically and consistently with specific action taken where non-adherence is identified. All practice guidelines are reviewed on a biennial basis and updated as needed to reflect changes in recent scientific evidence or technology. All clinical practice guidelines can be found on the Empower website under the "Clinical Practice Guildelines" tab on the provider page. A written request can be requested by calling Empower at (enter # here).

Provider Quality Improvement (QI) Initiatives

All providers are expected to participate in ongoing quality improvement initiatives implemented by Empower. These initiatives may take place at the individual provider level or a network-wide level as a provider incentive or value-based contracting initiative. As stated by the Provider Services Agreement, providers are required to deliver services, establish internal structures to monitor performance and report on any quality improvement initiatives, as requested. Quality improvement initiatives include medical record requests for Empower's annual HEDIS survey, state-required annual Medical Record Documentation Audit, investigation of reported quality of care issues reported to Empower and state incident reports.

Provider and Member Satisfaction Surveys

Provider Satisfaction Survey

Empower annually contracts with a research vendor to administer a Provider Satisfaction Survey to assess provider satisfaction with Empower's health plan services including finance, utilization management, coordination of care, pharmacy, provider relations and overall health plan satisfaction and loyalty. Network Management and the Medical Quality Management Committee review and analyze results of the survey for improvement opportunities and evaluate the efficacy of interventions implemented as a follow-up to the previous year's survey. Results may be shared through provider communications.

Member Experience with Care Coordination

Empower's Care Coordination team administers a quarterly Member Experience with Care Coordination survey to assess member satisfaction with Empower's Care Coordination services. This survey assesses member satisfaction with three aspects of care coordination:

1. Overall Satisfaction with Care Coordination services
2. Helpfulness of Care Coordination materials
3. How likely members are to recommend Empower's Care Coordination program to others

The results of this survey are reviewed quarterly by Empower's Medical Quality Management Committee (MQMC) for opportunities to improve care coordination for Empower members.

Adult and Child CAPHS Survey

Empower annually contracts with a research vendor to administer an adult and child member Consumer Assessment of Healthcare Providers and Systems (CAHPS)® survey. The CAHPS® survey is a national member satisfaction survey that asks members about the care they received from their health plan during the past year. CAHPS® data will allow Empower to create new programs for member care, gauge member satisfaction with providers and help guide changes to Empower's provider directory for easier access, care and treatment. Empower's Medical Quality Management Committee will review results of the survey for opportunities and barriers and may share results through provider communications.

Behavioral Health Member Experience Survey

Empower annually contracts with a researched vendor to administer a Behavioral Health Member Experience Survey. This survey measures key indicators of quality care and services, which will allow Empower access to insightful metrics for comparison to other health plans using the same behavioral health services. Member satisfaction with behavioral health (BH) provider referrals, BH treatment, access to BH care, coordination of care between member's primary care provider and BH provider and overall satisfaction with B H care and services. Results are analyzed by Empower and may be shared through provider communications.

Provider Access Survey

A Provider Access Survey is administered annually to assess network providers and/or provider practices adhering to appointment availability timeframe standards and after-hour protocols required by Empower. A variety of physicians/specialties are surveyed, including Primary Care Physicians (PCP), obstetricians/gynecologists, pediatricians and prescribing and non-prescribing behavioral health providers. This survey assesses emergency, urgent and routine care timeframes, prenatal care and access to after-hours care standards. Results are analyzed by Empower and may be shared through provider communications.

Medical Record Documentation Audits

Medical Record Documentation Audits are an integral part of Empower's Quality Improvement process which seeks to improve member care and treatment outcomes. The audits are conducted with the intent of improving the quality of providers' medical recordkeeping and assuring that providers are in compliance with state and federal regulations and other established standards.

Audit Process

Medical record audits are conducted utilizing a standard record review checklist. The checklist is published on the Empower Healthcare Solutions website and is available to Empower providers for review. Empower will alert providers through the provider newsletter and provider alerts prior to initiating the process of record audits.

Quality Management staff will request randomly chosen records from an established percentage of providers who have been randomly chosen to participate in the review. Written notification of the audit and request for records will be sent to the provider. Records may be submitted via encrypted email or fax or via permitted access to the provider's EMR.

Audit Results

Feedback will be given to providers whose records have been reviewed. If needed, individual providers may be asked for corrective actions to improve their record-keeping practices. Results from individual provider audits will not be published.

Empower aggregates the results of all record audits and reviews the data analysis of aggregate findings in order to identify key processes for quality improvement.

Complaints and Reconsiderations

Any provider may submit a complaint regarding issues other than those related to the terms of the provider agreement and/or performance under the provider agreement. A complaint is an expression of dissatisfaction with any aspect of Empower or Empower's service unrelated to an adverse decision/adverse determination (e.g., service complaints, complaints about Empower's policies and procedures or the policies and procedures applicable to a specific client benefit plan or government-sponsored health benefit program). Provider reconsiderations for adverse decisions/adverse determinations are handled in a separate process with the Utilization Management Department. Assistance with filing complaints and reconsiderations is available.

Empower Healthcare Solutions, LLC
Attn: Grievances and Appeals
PO BOX 211446
Eagan, MN 55121
Phone: (866) 261-1286
Email: (Providers)
complaintsandgreivances@empowerarkansas.com

Provider Complaints

Empower will acknowledge receipt of provider complaints verbally or in writing by close of business on the business day following receipt and will investigate and attempt to reach a satisfactory resolution of the complaint within 30 calendar days of receipt of the complaint. Empower will notify the provider verbally or in writing of the proposed resolution to the complaint and will also provide the procedure for filing a provider reconsideration, should the participating provider be unsatisfied with the proposed resolution. Although the provider has the option to submit an administrative reconsideration, they are not required to do so. They may go directly to the Arkansas Dept. of Health and request a fair hearing.

Provider Reconsiderations

Providers have the right to appeal this decision in accordance with the requirements set forth in §160.000 and §190.000 of the Medicaid Provider Manual, and with all applicable federal and state laws, rules, and regulations, including 42 CFR Part 431, Subpart E (Fair Hearings for Applicants and Members) and 42 CFR Part 438, Subpart F (Grievance and Appeal System), the Medicaid Fairness Act, and the Arkansas Administrative Procedures Act (Ark. Code Ann. § 25-15-201 et seq.).

If the provider is not satisfied with the proposed resolution of the complaint, the participating provider may request a provider reconsideration within 30 calendar days of receipt of the Empower proposed resolution to the complaint. Empower and/or an Empower committee not involved in review of the initial complaint will review participating provider consideration requests. Notice of the provider reconsideration decision will be issued within 30 calendar days of receipt of the reconsideration request from the participating provider.

State Fair Hearings

If the provider is not satisfied with the consideration resolution, the provider may request a fair hearing from the Arkansas Department of Health. If both the provider and member are requesting a hearing, these will also go to the Arkansas Department of Health.

Provider or Provider/Member

The Arkansas Department of Health must receive a written hearing request within thirty (30) calendar days of the date on the appeal resolution letter. Send the request to:

Arkansas Department of Health
Attn: Medicaid Provider Appeals Office
4815 West Markham Street, Slot 31
Little Rock, AR 72205

Fraud, Waste and Abuse

Empower's policy is to thoroughly investigate suspected member misrepresentation of insurance status and/or provider misrepresentation of services provided. Fraud, waste, and abuse are defined as follows:

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Waste is the thoughtless or careless expenditure, consumption, mismanagement, use, or squandering of health care resources, including incurring costs because of inefficient or ineffective practices, systems, or controls.

Abuse involves provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the 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 member practices that result in unnecessary cost to the program.

Examples of provider fraud, waste, and abuse include altered medical records, patterns for billing that include billing for services not provided, up-coding, or bundling and unbundling, or medically unnecessary care. This list is not inclusive of all examples of potential provider fraud.

Examples of member fraud, waste, and abuse include under/unreported income, household membership (spouse/absent parent), out-of-state residence, third party liability, or narcotic use/sales/distribution. This list is not inclusive of all examples of potential member fraud.

Empower continuously monitors potential fraud, waste, and abuse by providers, members, and member representatives. Empower investigates suspected fraud, waste, and abuse and will then report any suspected fraud, waste, or abuse in writing to the correct authorities, including the Office of Medicaid Inspector General.

Providers should report fraud, waste, and abuse, or suspicious activity thereof, such as inappropriate billing practices (e.g., billing for services not rendered or use of CPT codes not documented in the treatment record). Reports and questions may be made in writing to Empower at the address below or by calling the Empower Hotline at 844-478-0329.

Empower Healthcare Solutions, LLC
Attn: SIU
PO BOX 211446
Eagan, MN 55121
Empower.ethix360.com
Toll Free: 844-478-0329

Federal Deficit Reduction Act of 2005

Arkansas regulation, 2008 AR Regulation Text 5335, requires compliance with Section 6032 of the Deficit Reduction Act of 2005, which requires any network provider receiving annual Medicaid payments of at least $5 million (cumulative, from all sources) to:

- Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
- Include as part of such written policies detailed provisions regarding the network provider's policies and procedures for detecting and preventing fraud, waste, and abuse.
- Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the provider's policies and procedures for detecting and preventing fraud, waste, and abuse.

Empower requires providers to comply with the Deficit Reduction Act of 2005 in the on-going training and education to employed staff, agents, and contractors regarding the Federal False Claims Act, which establishes liability to individuals who knowingly submit false or fraudulent claims for payment by the government.

The federal government may impose penalties of not less than $10,957 and not more than $21,916 plus three times the amount of damages sustained by the government if there is a finding of a violation of the False Claims Act. The government may reduce the damages if there is a finding that the person committing the violation reports it within 30 days of discovering the violation and if the person cooperates fully with the federal government's investigation and there are no criminal prosecutions, civil, or administrative actions commenced at the time of the report and the person reporting does not have any knowledge of any such investigations. The federal government via the OIG may also use administrative remedies for the submission of false statements and/or claims that include administrative penalties of not more than $5,000 per false claim as well as determine whether suspension or exclusion from the health care program is warranted.

Contact Information

Key Empower Contacts	
Website:	www.getempowerhealth.com
Mailing Address:	Empower Healthcare Solutions P.O. Box 211446 Eagan, MN 55121
Member Services: Benefits, Eligibility, Authorizations, Provider Services, Credentialing, Contracting, Care Coordination, Claims, Clinical Appeals	(866) 261-1286 | TTY 711
Member Grievances	complaintsandgrievances@empowerarkansas.com
Provider Services: Claims questions, Business Unit ID, Prior Authorization, Eligibility	(855) 429-1028
Provider Complaints: Service complaints, Complaints about Empower's policies and procedures, Complaints about the policies and procedures applicable to a specific client benefit plan or government-sponsored health benefit program	providercomplaints@empowerarkansas.com
Pharmacy Help Desk (pharmacies only)	(800) 364-6331
Fraud, Waste & Abuse: Billing for services not rendered, up-coding, bundling or unbundling of services, medically unnecessary care, double-billing, using false credentials, or inappropriate documentation	**Phone:** (844) 478-0329 **Email:** SIU@empowerarkansas.com **Website:** www.getempowerhealth.com
Incident Reporting: Notification of incidents must be made to both Empower and to DHS. Notification to Empower may be made by phone or email. Required Incident Reports serve as notification if submitted within time frames and may be submitted via secure email or fax.	**Email:** incident.reporting@empowerarkansas.com **Fax:** (501) 325-0701 **Phone:** (866) 261-1286 TTY: 711

Key Empower Contacts	
Potential Quality of Care (PQOC) Concerns: Provider reports of PQOC concerns or submission of records relative to PQOC investigations	**Email:** empowerhealthcaresolutionsPR@empowerarkansas.com **Fax:** (888) 614-5168
Care Coordination:	carecoordination@empowerarkansas.com
Utilization Management:	utilizationmanagement@empowerarkansas.com
Provider Relations:	empowerhealthcaresolutionsPR@empowerarkansas.com
Contracting/Roster Updates	empower.network@empowerarkansas.com
Provider Reconsiderations: Claims or Utilization Management	ar_appeals@empowerarkansas.com
Credentialing:	empower.network@empowerarkansas.com

Regulatory Contacts	
DHS PASSE Quality Assurance Unit: Notification of incidents must be made to both Empower and to DHS. Notification to DHS may be made by phone, fax, or email. Required Incident Reports serve as notification if submitted within time frames and may be submitted via email or fax.	**Email:** DHS.DDS.Central@arkansas.gov **Fax:** (501) 682-8656 **Phone:** (501) 371-1329
DHS Office of Communications and Community Engagement: Incidents that a service provider should reasonably know might be of interest to the public and/or media and could potentially involve publicity must be reported to DHS Office of Communications.	**Communications Director:** (501) 682-7540 **Chief Communications Officer:** (501) 682-8946
Arkansas Department of Human Services	(501) 682-1001
AFMC PASSE Member Line	(833) 402-0672
Arkansas Office of the Medicaid Inspector General	(501) 682-8349 or (855) 527-6644
Division of Medical Services Office of the PASSE Ombudsman: Individuals with a hearing or speech impairment may contact the Ombudsman office by dialing:(888) 987-1200, option 2.	**Phone**: (844) 843-7351, **Fax**: (501) 404-4625 PASSEOmbudsmanOffice@dhs.arkansas.gov P.O. Box 1437 Slot S-418 Little Rock, AR 72203-1437