Manual for Empower Healthcare Solutions Providers

www.getempowerhealth.com

empower
HEALTHCARE SOLUTIONS
How to Use this Manual

Empower Healthcare Solutions (Empower) is committed to our providers and strives 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 is updated, as needed, to reflect updates and changes, and can be found on Empower’s website.

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 administer training to network providers and staff regarding updates and policies.
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Welcome To Empower

Welcome to Empower! 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) working in partnership with the Arkansas Department of Human Services/Division of Medical Services (DHS/DMS). Empower works to accomplish our goal by collaborating with providers like you to oversee and deliver health services to our members.

Overview

Welcome to Empower’s network of participating providers. This handbook is an extension of the provider agreement and includes necessary information for doing business with Empower Healthcare Solutions, Beacon Health Options, Inc. and its affiliates and subsidiaries.

Empower’s website includes an extensive amount of provider resources. The website features updates to this handbook, provider communication and events, and links to the provider portal that includes tools for authorization, claims, and eligibility. The Empower website can be accessed at 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.

Direct questions, comments, and suggestions regarding this handbook should be directed to:

Empower Healthcare Solutions
EmpowerhealthcaresolutionsPR@empowerhcs.com (855) 429-1028

About Us

Empower is a newly formed partnership between Beacon Health Options and five provider organizations. Empower holds a management services agreement with Beacon Health Options to conduct administrative services and help the organization adopt and implement managed care strategies to operate as a PASSE.

Our goal is to empower individuals to lead fuller, healthier lives at home and in their communities. Empower integrates physical health, behavioral health, developmental and intellectual disability care, and social support services in order to increase access to care while improving the quality of life for our members. We want members and providers be part of the treatment team to coordinate and improve care.

Empower’s partnership includes six organizations:

- 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.
- Beacon Health Options (Beacon): Beacon is the nation’s largest organization exclusively dedicated to assessing and addressing the clinical and social needs of individuals experiencing mental illness, addiction and developmental disabilities. Since 2010, Beacon has had contracts with the Arkansas Department of Human Services to assist in administering the behavioral health care delivery system.
- Independent Case Management (ICM): ICM is a statewide premier provider of home and community-based supports to individuals with intellectual and developmental disabilities.
The PASSE is Arkansas’ new model of care that addresses the overall health care needs of Medicaid beneficiaries who have complex behavioral health and/or intellectual and developmental disability (IDD) service needs.

**Goals of the PASSE program are to:**
- Coordinate and integrate treatment delivery across all of the individual’s providers
- Improve total health outcomes for the target population
- Increase local service capacity to help individuals with IDD access quality care and support services within their own communities
- Ensure flexibility in the individuals’ service array to address all of their health care needs
- Slow or decrease spending growth and costly acute care stays by promoting efficient and effective services

**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.

**The Arkansas Healthcare Alliance, LLC:** The Alliance is comprised of 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.

**Woodruff Health Group, LLC (ARcare):** ARcare operates as a Federally Qualified Health Center (FQHC). In addition, 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 pharmacies, and four wellness centers to serve underserved communities and provide access to quality health care.
Communicating with Empower

Key Contact Information

- Care Coordination
- Claims
- Clinical Appeals
- Complaints/Grievances: 866-261-1286 | TTY 711
  getempowerhealth.com
- Credentialing & Contracting
- Member Customer Service
- Member Benefits, Eligibility, and Authorizations

Provider Services: 855-429-1028

- Fraud, Waste, Abuse: 866-261-1286 | TTY 711
  complaintsandgrievance@empowerhcs.com

- Pharmacy Help Desk (Pharmacies Only): 800-364-6331

Regulatory Contact Information

- 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
Empower Provider Portal Functionality

Provider Portal
Empower’s provider portal allows providers instant access to too many helpful tools and resources.

Once registered, providers and their office staff can access the following features:

• Access to Empower’s Provider Directory (Portal registration is not required)
• Submit professional claims
• Check claims status and history
• Verify member eligibility
• Submit a prior authorization request
• View other important documents and forms

Please contact a Provider Relations representative for a tutorial on the secure provider site. You can reach us by email at EmpowerHealthcareSolutionsPR@Empowerhcs.com or by phone at 855-429-1028.

Website
You can visit Empower’s website www.getempowerhealth.com 24 hours a day, 7 days a week. Utilizing Empower’s website can significantly reduce the need for providers to make telephone calls providers need to make regarding the health plan, and can be done any time of the day or night.

Providers can find the following information on the website:

• Billing Resources and Guidelines
• Clinical guidelines
• Empower news
• Critical Incidents reporting guidelines
• Fraud Waste & Abuse reporting guidelines

• Member benefits
• Member communications
• Preferred Drug List (or formulary)
• Prior authorization lookup
• Provider Portal
• Provider Directory
• Provider manual and forms
• Wellness information

We are continually updating our website with the latest news and information, so save www.getempowerhealth.com to your “Favorites” list.

Verifying Eligibility
Members should present their ID card at the time of service. Providers should verify eligibility on every date of service, prior to rendering services to the member. Eligibility can be verified by logging in to the secure provider portal at www.getempowerhealth.com. You can search by date of service, plus any one of the following:

• Member last name and date of birth
• Empower ID number and date of birth

You can look up multiple members in a single request.

Provider Services
The goal of Empower is to make the provider experience positive by being your advocate.

Empower is here to furnish you and your staff with the tools and information that will enable you to partner with us as seamlessly as possible to provide the highest quality of healthcare to our members. Provider Services is available Monday through Friday from 8:00 – 5:00 CST.
Translator and Interpreter Services
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.

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.

Provider Participation

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, 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 prior to rendering non-emergency services.

Provider Enrollment
Title XIX of the Social Security Act created a joint federal-state medical assistance program commonly referred to as Medicaid. Ark 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 for 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 by the provider to Arkansas Medicaid beneficiaries. 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 and 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 Rights & Responsibilities**

Providers have the rights and responsibilities to:

1. Be treated by their members and other healthcare workers with dignity and respect.
2. Receive accurate and complete information and medical histories for members’ care.
3. Have their members act 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.
4. Expect other network providers to act as partners in members’ treatment plans.
5. Expect members to follow their directions, such as taking the right amount of medication at the right times.
6. Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
   a. Recommend new or experimental treatments.
   b. Provide information regarding the nature of treatment options.
   c. Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self-administered.
   d. Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment.
   e. Make a complaint or file an appeal against Empower and/or a member.
   f. File a grievance with Empower on behalf of a member, with the member’s consent.
g. Have access to information about Empower’s quality improvement programs, including program goals, processes, and outcomes that relate to member care and services. This includes information on safety issues.

h. 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.

i. Treat members with fairness, dignity, and respect.

j. Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency.

k. Maintain the confidentiality of members’ personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.

l. Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider’s practice/office/facility.

m. Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.

n. Allow members to request restriction on the use and disclosure of their personal health information.

o. Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.

p. 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.

q. Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.

r. 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.

s. Respect members’ advance directives and include these documents in the members’ medical record.

t. Allow members to appoint a parent, guardian, family member, or other representative if they cannot fully participate in their treatment decisions.

u. Allow members to obtain a second opinion, and answer members’ questions about how to access healthcare services appropriately.

v. Collaborate with other healthcare professionals who are involved in the care of members.

w. Obtain and report to Empower information regarding other insurance coverage.

x. Follow all state and federal laws and regulations related to patient care and patient rights.

y. Participate in Empower data collection initiatives, such as HEDIS and other contractual or regulatory programs.

z. Review clinical practice guidelines distributed by Empower.

aa. Comply with Empower’s Medical Management program as outlined in this manual.

bb. Notify Empower in writing if the provider is leaving or closing a practice.

cc. Contact Empower to verify member eligibility or coverage for services, if appropriate.

dd. Disclose overpayment or improper payments to Empower.

e. 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.
ff. Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language.

gg. Provide members, upon request, with information regarding the provider’s professional qualifications, such as specialty, education, residency, and board certification status.

hh. Only provide members with approved Empower marketing materials, including flyers and letters.

ii. 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.

jj. Object to providing relevant or medically necessary services on the basis of the provider’s moral or religious beliefs or other similar grounds.

kk. Disclose to Empower, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice, even if there is no substantial financial risk between Empower and the physician or physician group.

Credentialing

Empower conducts a rigorous credentialing process for network providers based on CMS and National Committee for Quality Assurance (NCQA) and other accreditation and regulatory guidelines. All providers must be approved for credentialing by Beacon or their affiliates to participate in the network and must comply with recredentialing standards by submitting all requested information within the specified timeframe. Some providers have credentialing requirements waved in 2019.

Private solo and group practice clinicians are individually credentialed, while facilities are credentialed as organizations. The processes for both are described below. To request credentialing information and application(s), email Empower.Network@empowerhs.com.

Empower will credential the following individual or group health care practitioners who are contracted directly with Empower Healthcare Solutions:

- Medical Doctor (MD)
- Doctor of Osteopathic Medicine (DOM)
- Doctor or 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), 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)
Individual Practitioner Credentialing

Beacon, and its affiliates 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/participating provider 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 Beacon’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 required attachments. Incomplete applications cannot be processed. Providers are notified of any discrepancies found and any criteria not met. Providers have the opportunity to submit additional, clarifying information to correct the 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 the provider may begin to serve members of specified health plans.
Organizational Credentialing

To be credentialed, facilities must be 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 recredentialing. 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 recredentialing of the facility. The facility must also show evidence of current malpractice insurance with adequate coverage levels.

The credentialed facility is responsible for credentialing and overseeing its clinical staff.

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 may treat members in the facility setting. Structured site visits are required for all unaccredited organizations.

Site Visits

In addition and as part of credentialing or recredentialing, Empower may conduct a structured site visit of provider’s/participating provider’s offices/locations. Site visits 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 tool is available for review on the website. 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 prior to scheduled site visits. While Empower, at its discretion, may require a site visit in the course of credentialing and/or recredentialing processes based on information submitted and/or obtained in the process, site visits will be conducted for providers/participating providers in the following categories:

- Unaccredited organizations
- Providers/participating providers 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

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

Home and Community Based Services (HCBS)

All HCBS providers must be enrolled in Arkansas Medicaid as a HCBS provider by January 1, 2020. The credentialing process for HCBS providers will include an annual on-site inspection and full review of applicable requirements to include audit requirements, complaint resolution process, performing provider requirements, and licensure and/or certification for the services provided.

Recredentialing

Providers must submit an updated recredentialing 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 recredentialing 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 recredentialing notification. Recredentialing deadlines are firm, the consequences of not meeting these deadlines are that the provider is considered to be out-of-network and members are transitioned to in-network providers if deadlines are not met. Assuring that Empower has current contact information allows Empower to notify providers with ample advanced notice of recredentialing requirements and deadlines and prevent termination.

**Medical Records**

Providers must keep accurate and complete medical records. Such records will help enable providers to render the highest-quality healthcare service to members. To ensure the member’s privacy, medical records should be kept in a secure location.

Medical record is defined as the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member’s participating primary care physician or other provider, that documents all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- Member’s name, and/or medical record number are on all chart pages
- Personal or biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.)
- Notation of any spoken language translation or communication assistance is prominent.
- All entries are legible and maintained in detail
- All entries are dated and signed or dictated by the provider rendering the care
- Significant illnesses and or medical conditions and all past and current diagnoses are documented on the problem list
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record. If no known allergies, NKA or NKDA are documented
- An up-to-date immunization record is established for pediatric members or an appropriate history is made in chart for adults
- Evidence that preventive screening and services are offered in accordance with Empower’s practice guidelines
- Appropriate subjective and objective information pertinent to the member’s presenting complaints is documented in the history and physical
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger), medical history relating to prenatal care, birth, surgeries and or childhood illnesses
- Working diagnosis is consistent with findings
- Treatment plan is appropriate for diagnosis
• Confidentiality of member information and records protected
• Evidence that an advance directive has been offered to adults 18 years of age and older

**Primary Care Physicians (PCP)**

Every Empower member will be assigned to a PCP. The role of the PCP is to manage the total care of the member. The PCP will oversee much of the care of our member through direct services or referral to specialty services. In coordination with the Care Coordinator, the PCP will help ensure appropriate care for the member. The PCP can be a physician or an advanced practice registered nurse (APRN). 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. The PCP must be enrolled in Arkansas Medicaid in order 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,
Specialty Care Providers

Specialty care providers provide care to members referred to him/her by the enrollee’s PCP. The specialty care provider must coordinate care through the PCP, with the exception of services that the member may self-refer to include mental health and substance abuse providers or for obstetrical and gynecological care, and must obtain necessary prior authorization for hospital admissions or specified procedures that require prior authorization.

The specialist must coordinate services with the PCP. It is important that the specialty care provider 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 member’s PCP and coordinate care and follow-up with PCP

• Complying with all statutory and regulatory requirements of the Medicaid program, to include enrollment in the Arkansas Medicaid program

• 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 condition, make appropriate referrals, and/or provide information regarding accessing other services and handling other medical problems during hours the PCP’s office is closed.

Empower PCP’s will have online access to view assigned members. A provider may verify eligibility online at www.getempowerhealth.com or by calling Provider services at (855) 429-1028.

Members have the right to select their PCP. Upon enrollment, the member may select a PCP from the directory or call Member Services at (866) 261-1286 for help to select a new provider. The member may consider the provider’s specialty, accessibility, gender, ethnic background and languages spoken in the selection process. The member handbook includes a description of how to choose a PCP. The Empower provider network will be submitted to the 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 (e.g., geographic proximity to the provider, age and language).

Empower encourages members to maintain a patient relationship with their PCP in order to appropriately support care continuity. However, a member may request a PCP change by contacting Member Services at (866) 261-1286.
• Verifying member’s eligibility and complying with any authorization requirements of Empower
• Collaborate with Empower’s Care Coordinator as needed on an on-going basis

Behavioral Health Services Accessibility & Access
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’s assessed behavioral health clinical needs. It is also essential to engage the individual or family and to support the member’s satisfaction with the services provided.

Appointment Standards and Timeliness of Service
Empower, in compliance with state-contract expectations, requires the following access standards for emergent, urgent and routine service requests:

• Emergent, Non-Life-Threatening Appointment Requests an individual or family presenting or describing an immediate need requires an expedited response to the individual or family who may be in need of medically necessary covered behavioral health services response should begin without delay, 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 (24 hours per day, 7 days per week): A person or family presenting in serious need of medically necessary behavioral health services requires an urgent response. The action should be initiated in a prompt manner, 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 A person or family’s behavioral health requests for a routine intake that is not immediate or urgent should be provided no later than 21 business days from the request.

• Waitlists for 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 access 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.

24-Hour 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 professional for a clinical decision.

• If applicable, the practitioner or covering medical professional must return the call within 30 minutes of the initial contact.
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
- After-hour care with emergency appointment slots
- Schedule continuous availability of professional, allied, and supportive personnel to provide covered services within normal working hours
- Provide in-network coverage in the event of a provider’s absence

**Accommodations for Members with Disabilities**

Provider locations where Empower members receive covered services should comply with the Americans with Disabilities Act 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 there.

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

**Advance Directives**

PCPs and other providers delivering care to Empower members must ensure adult members 19 years of age and older receive information on advance directives and are informed of their right to execute advance directives, including for 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 designated family member or significant other, if named in the advance directive and, if available. The discussion should be stored in the medical record and documents shared with other providers caring for the member.

**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); or
- 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.

**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. In addition, 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 in their postpartum period.

**Cultural Competency**

Empower is committed to having all Empower network providers fully recognize and care for the culturally diverse needs of the members they serve. To accomplish this aim, Empower has established a Cultural Competency Plan to help guide and monitor efforts to ensure cultural competency, building on Empower partner experience and established relationships in the communities served.

Culturally and linguistically appropriate services (CLAS) are healthcare services that are respectful of, and responsive to, the patient’s cultural and linguistic needs. Care is designed to be effective, understandable and respectful.

- Effective Care is care that successfully restores the client to the desired health status and takes steps to protect future health by incorporating health promotion, disease prevention, and wellness interventions. In order for health services to be effective, the clinician must accurately diagnose the illness, discern the correct treatment for individual, and negotiate the treatment plan successfully with the member.

- Understandable Care focuses on the need for patients to fully comprehend questions, instructions, and explanations from clinical, administrative, and other staff. To be understandable, the concepts must “make sense” in the cultural framework of the individual.

- Respectful Care includes taking into consideration the values, preferences, and expressed needs of the member and to helping create an environment whereby patients from diverse backgrounds feel comfortable discussing their specific needs with any staff member.

It is equally important for providers to maintain “Disability Awareness.” The Americans with Disabilities Act (ADA) defines a person with a disability as a person who has a physical or mental impairment that substantially limits one or more major life activities, and includes people who have a record of impairment, even if they do not currently have a disability, and individuals who do not have a disability, but are regarded as having a disability.

It is unlawful to discriminate against persons with disabilities or to discriminate 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
To successfully meet the demands for ‘disability awareness,’ providers should capture information about accommodations that may be required in the patient’s medical record, and when making referrals to other providers, communicate with the receiving provider regarding any necessary accommodations that may be required.

**Cultural Competency Training Goals & Requirements**

Empower network providers, vendors and their staff have an obligation to deliver culturally competent health care and services by possessing attitudes, skills, and policies that enable effective work in cross-cultural settings. Training is available to support providers meet goals that include but are not limited to:

- Being educated about the linguistic needs and cultural differences of members
- Having an understanding of the population that we serve
- Being responsive and sensitive to the member’s needs
- Having the ability to communicate effectively with members

Empower confirms the languages used by providers, including American Sign Language, and physical access to provider office locations during Provider Orientations and site visits.

Additionally, Empower will facilitate annual cultural-sensitivity training to all Empower staff and to provider offices.

Provider offices should have their own cultural sensitivity and competency training. Provider Service Representatives will introduce these topics during Provider Orientation to ensure required topics are covered.

**Cultural Competency Monitoring & Reporting**

Empower performs an annual evaluation of Cultural Competency practices, which will includes monitoring of member needs and provider cultural and linguistic services. Empower will maintain data of the following indicators towards achieving cultural competence:

**Language**

- Percent of members who speak Spanish or other prevalent language(s)
- Percent of Empower staff who speak Spanish or other prevalent language(s)
- Percent of provider offices with self-designated prevalent-languages-speaking staff

**Gender**

- Availability of female and male primary care and obstetrician/gynecological providers throughout the geographic area (100% within set standards)

**Training**

- Percent of provider offices who have participated in annual Cultural Competency training
- Percent of Empower staff who have participated in annual Cultural Competency training

**Education**

- In-service sessions for Empower staff from a local organization to increase effectiveness of culturally competent service delivery

**Complaints around Cultural or Language Services**

- Assessment and resolution of complaints regarding cultural competence in a timely manner
**Nondiscrimination Policy**

Empower complies with Section 1557, nondiscrimination law in the Affordable Care Act (ACA). Empower does not engage in, aid or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color or national origin in providing aid, benefits or services to beneficiaries. Empower does not utilize or administer criteria having the effect of discriminatory practices on the basis of 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 them to discrimination on the basis of gender or gender identity. In addition, in compliance with the Age Act, Empower may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Empower provides health coverage to members on a nondiscriminatory 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.

If you or your patient believes that Empower has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with the grievance coordinator via Provider Services at (855) 429-1028.

**Provider Notification**

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, or 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.
- The provider is disciplined by a state board of medicine or a similar agency.
- Provider is named in any civil claim that may jeopardize Provider’s financial soundness.
- There is a change in provider’s business address, telephone number, ownership, or Tax Identification Number.
- 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.
- Any material change or addition to the information submitted as part of provider’s application for participation with Empower Healthcare Solutions.
- Any other act, event or occurrence which materially affects provider’s ability to carry out its duties under the Provider Services Agreement or in this Manual.
Communication Materials to Members

Providers must ensure:

• All member communication materials developed for presentation in a layout and manner that enhances members’ understanding in a culturally competent manner 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 member 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 at the appropriate reading level and found to be culturally appropriate equivalent to the English version.

Member Enrollment

Enrollment in Empower

The State of Arkansas enrolled members in a PASSE based on responses on the Arkansas Independent Assessment, or ARIA. These answers helped the State assign a level – or tier – of meet the members’ need. Empower cannot discriminate against the member on the basis of their health.

• Seven days after notification of enrollment in Empower, a member may use our services.

• If a member has questions about how they were enrolled in Empower, they can contact DHS at (833) 402-0672.

Changing Your PASSE

• Members may switch to another PASSE. In fact, it is their right. However, this can only be done when members are initially enrolled or during open enrollment, unless the member can show cause.

• To request a transition to another PASSE, the member should contact the Arkansas Department of Human Services, Beneficiary Support Center, Phone Number: (833) 402-0672.
When You Can Make Changes

You can change your PASSE at the following times:

• Within the first 90 days of enrollment. After 90 days, however, you cannot make a change for another 12 months unless there is cause. Once you change a PASSE, you cannot make another change for 12 months or until the following enrollment period.

• Special open enrollment in spring 2019. In 2019, DHS will hold two open enrollment periods. The spring open enrollment will be May 1st – 31st, 2019. Any changes during this open enrollment will take place within 7 days of the change being processed.

• During the annual open enrollment. Open enrollment is a 30-day period during which you can switch PASSEs. Typically, open enrollments occur once a year in the fall. Any changes made during open enrollment take effect January 1 of the following year.

• When there is cause. You 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 can occur for other reasons as well. If you have questions, concerns, or think there is cause, please call Member Services at (866) 261-1286.

Disenrollment

Only DHS can disenroll a member from Empower. This happens if DHS determines the member is no longer eligible for a PASSE for the following reasons:

• Member is no longer eligible for Medicaid.
• Member lives in a facility like a nursing home.
• Member needs services that are not provided by Empower.
• If the member has been disenrolled.
• You are reassessed and determined to not meet the level of need for the PASSE program.

The PASSE may not request that a member be disenrolled, except in circumstances which involve fraud or other gross misuse of coverage. All requests for disenrollment must be submitted to DHS Beneficiary Support.

Reinstatement

If the member loses Medicaid eligibility, the member may not lose coverage if they are reinstated within the month.

To do so the member must:

• Show DHS proof of eligibility.
• Have their information entered into the DHS system by the last day of the month.
• If a member re-enrolls within 180 days, the member will be re-assigned to Empower. If the member re-enrolls after 180 days, the member must complete a new ARIA, and will be automatically assigned to a new PASSE if they qualify. This PASSE may be Empower or a different PASSE depending on DHS rules.
**Member Rights**

*Members have the right to ...*

- Receive information about Empower, including services, benefits, practitioners, providers, member rights and responsibilities and clinical guidelines

**Respect**

*Members have the right to ...*

- Be part of decisions about care plans, including right to refuse treatment
- Execute advance directives without fear of being treated unfairly
- Receive a copy of member rights and responsibilities
- Tell Empower what you think rights and responsibilities as a member should be
- Be treated with respect, dignity, and privacy no matter what
- Have anyone members choose to speak on his/her behalf
- Decide who will make medical decisions for a member if they cannot make them
- Understand his/her Person-Centered Service Plan (PCSP) and receive the services listed in it
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Live in an integrated and supported setting in the community and have control over aspects of his/her life
- Be protected in the community
- Exercise his/her rights without having the quality of your care affected

**Communication**

*Members have the right to ...*

- Get information about services, benefits, or providers, care guidelines, and member rights and responsibilities
- Receive written notice of changes regarding your care coordination provider within seven days
- Receive a member handbook and provider directory soon after enrollment
- Talk with providers about your treatment options without cost or coverage being factors
- Know about covered services, benefits, and decisions about health care payment with his/her plan, and how to find these services
- Obtain information regarding a member’s treatment record with signed consent in a timely manner
- Provide input to Empower
- Request and receive a copy of medical records and request that they be amended or corrected
- Receive information on available treatment options and alternatives, and have this information given in understandable and appropriate way
- Oral interpretation services free of charge for any Empower materials in any language

**Complaints**

*Members have the right to ...*

- Make complaints (verbally or in writing) about staff, services, or the care given by providers
- Appeal if a member disagrees with a decision about care. Empower administers appeal rights as stipulated under a benefit plan
Confidentiality

Members have the right to ...

• Keep communication about health information private

Access to Care, Services, & Benefits

Members have the right to ...

• 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 and Billing

Members have the right to ...

• Know the facts about any charge or bill you receive

Member Responsibilities

• Members have the responsibility to provide information, to the best of his/her ability, which Empower, or a provider may need to plan treatment.
• Members have the responsibility to learn about his/her condition and work with providers to develop a plan for care. Members have the responsibility to follow the plans and instructions for care agreed to with providers.
• Members are responsible for understanding his/her benefits, what is covered and what is not covered. Members are responsible for understanding that will be responsible for payment of services they receive that are not included in the Covered Services List for their coverage type.

• Members have the responsibility to notify Empower and providers of changes such as address changes, phone number change, or change in insurance.
• If required by their benefits, members are responsible for choosing a primary care provider and site for the coordination of all his/her medical care.
• Members are responsible for contacting Behavioral Health Provider, if one exists, if they experience a mental health or substance use emergency.
Covered 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 beneficiary requesting the service.

Medically Necessary Covered Services Include:

- Adult developmental day treatment services
- Advanced nurse providers and registered nurse provider services
- Ambulatory surgical center services
- Audiologist services
- Burn therapy
- Chemotherapy
- Chiropractor services
- Critical access hospital
- Dialysis
- Early and periodic screening and diagnosis of individuals under 21 years of age and treatment of conditions found
- End-stage renal disease facility services
- Emergency services
- Eye prostheses
- Factor 8 injections
- Family Planning Services
- Federally qualified health center services
- Home and Community Based Services
- Hearing aid dealer services
- Hearing aids, accessories, and repairs
- Home Health services
- Medical supplies, equipment, and appliances suitable for use in the home
- Durable medical equipment (DME)
- Augmentative communication devices
- Specialized wheelchairs
- Diapers/under pads
- Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency
- Hospice care
- Inpatient hospital services
- Intellectual disability services in an intermediate care facility (other than in an Institution for Mental Diseases)
- Laboratory services
- Maternity clinic services (limited to services before and after childbirth)
- Mentally retarded care in intermediate care facilities
- Nurse anesthetist services
- Nurse-midwife services
- Obstetric-gynecologic and gynecological nurse provider services
- Occupational therapy
- Optical lab services
- Optometrist services
- Orthotic appliances
- Outpatient behavioral health services
- Outpatient hospital services
- Outpatient surgical procedures
- Pacemakers and internal surgical prostheses
- Pediatric or family nurse providers’ services
- Personal care
- Pregnancy care, extended services
- Prescription drugs
- Private duty nursing
- Psychiatric inpatient services for individuals under age 21
- Psychologist services
- Podiatrist services
- Physical therapy and related services
- Physician services
- Radiation therapy
- Rehabilitative hospital services - Extended
- Respiratory care services
- Rural health clinic services
- Speech therapy
- Tobacco cessation counseling
- Transplant candidates are evaluated for coverage requirements and are referred to the appropriate agencies and transplant centers
- X-ray services
Excluded Services
The following services are excluded from payment by Empower:

- Nonemergency medical transportation
- Dental benefits in a capitated program
- School-based services provided by school employees
- Skilled nursing facility services (Limited Rehabilitation Stay is not considered an excluded skilled nursing facility service)
- Assisted living facility services;
- Human Development Center (HDC) services (including full admission to a HDC); Respite stays and conditional admission at HDCs are not excluded services
- Waiver services provided to the elderly and adults with physical disabilities through the ARChoices in Homecare program or the Arkansas Independent Choices program, or a successor waiver for the elderly and adults with physical disabilities
- Abortions, unless the pregnancy is the result of incest or rape; or the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition that manifests during pregnancy, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed

Behavioral Health and DD/HCBS Services
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 waiever services must be delivered in accordance with the waiver requirements and consistent with the Division of Disability Services CES Wavier Provider Manual.

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

In addition to the 1915(c) Waiver Services, Empower will also cover 1915(i) HCBS Services. All 1915(i) HCBS services must be delivered in accordance with the waiver requirements and consistent with the Division of Behavioral Health Outpatient Behavioral Health Provider Manual.

The 1915(i) HCBS services include:
- 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
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 current 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 in accordance with 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 PEMS) 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 test and assessments.

• Health education/anticipatory guidance, including a dental referral at 12 months old.

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

• Chiropractic services

• Nutrition counseling

• Audiological 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, without referral, for family planning services, including out of network providers, for ages 21 and above.
Home and Community Based Services (HCBS)
Ensuring the health and safety of individuals who are enrolled in the Arkansas Medicaid PASSE program and are served through the Arkansas Community Employment Supports (CES) 1915(c) waiver and 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 as outlined below:

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.

Management Requirements
• 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.

• 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.

Hiring Procedures and Required Personnel Records
Prior to Employment
• The HCBS Provider must obtain and verify each of the following from an applicant prior to employment:
  - 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, their spouse, and any children or other adult over the age of eighteen (18) if a beneficiary is to be permitted to stay overnight in an applicant’s residence.
  - A signed declaration of truth of statement.
  - 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.

Post-Employment
• The HCBS provider shall obtain and verify within thirty (30) days of an applicant’s employment
  - 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. An Adult Maltreatment Central Registry check must be completed for the employee, their spouse, and any children or other adult over the age of
eighteen (18) that resides in a residence where a beneficiary 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. A Child Maltreatment Central Registry check must be completed for the employee, their spouse, and any children or other adult over the age of eighteen (18) that resides in a residence where a beneficiary is approved and permitted to stay overnight.

- A successfully passed criminal background check for the employee, their spouse, and any children or other adult over the age of eighteen (18) residing in a residence where a beneficiary is approved and permitted to stay overnight.

Incident Reporting
HCBS providers must submit an incident report to the DHS PASSE Quality Assurance unit and Empower using the automated form DHS 1910 via secure e-mail upon the occurrence of any one of the following events:

• Death of beneficiary.
• The use of any restrictive intervention, including seclusion, or physical, chemical, or mechanical restraint on a beneficiary.
• Suspected maltreatment or abuse of a beneficiary.
• Any injury to a beneficiary that:
  - Requires the attention of an Emergency Medical Technician, a paramedic, or physician
  - May cause death
  - May result in a substantial permanent impairment
  - Requires Hospitalization
• Threatened or attempted suicide by a beneficiary.
• The arrest of a beneficiary, or commission of any crime by a beneficiary.
• Any situation in which the whereabouts of a beneficiary is unknown for more than two (2) hours (i.e. elopement and/or wandering), or where services are interrupted for more than two (2) hours.
• Any event where a staff member threatens a beneficiary.
• Unexpected occurrences involving actual or risk of death or serious physical or psychological injury to a beneficiary.
• Medication errors made by staff that cause or have the potential to cause serious injury or illness to a beneficiary, including, but not limited to, loss of medication, unavailability of medication, falsification of medication logs, theft of medication, a missed dose, wrong dose, a dose being administered at the wrong time, by the wrong route, and the administration of the wrong medication.
• Any violation of a beneficiary’s rights that jeopardizes the health, safety, or quality of life of the beneficiary.
• Any incident involving property destruction by a beneficiary.
• Vehicular accidents involving a beneficiary.
• Biohazard incidents involving a beneficiary.
• An arrest or conviction of a staff member providing direct care services.
• Any use or possession of a non-prescribed medication or an illicit substance by a beneficiary.
• Any other event that might have resulted in harm to a beneficiary or could have reasonably endangered the health, safety, or welfare of the beneficiary.

In addition to submitting incident reports for the reportable incidents described above to the DHS PASSE Quality Assurance unit using the automated form DHS 1910
Required Incident Report Contents
• Initial Incident Report: Each initial incident report filed by a PASSE HCBS provider must contain the following information:
  - Date of the incident
  - Detailed description of the accident/injury
  - Time of the incident
  - Location of incident
  - Persons involved in the incident
  - Other agencies contacted regarding incident, and the name of the individual in the agency that was contacted
  - Whether the guardian was notified of the incident and time of notification,
  - Whether the police were involved, and if so, a detailed description of their involvement
  - Any action taken by Provider or staff of Provider, both at the time of the incident and subsequent to the incident
  - Any expected follow-up
  - Name of person that prepared the report

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

Reporting Timeframes
Immediate Reporting
Providers must report the following incidents to the on call emergency number for the Empower within one hour of occurrence, regardless of hour:
• Suicide
• Death from adult abuse
• Death from child maltreatment
• Serious injury
DHS PASSE Quality Assurance Unit must be notified within 1 working day of any such occurrence as listed above.

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

All Other Incident Reports
Except as otherwise provided above in subsection A and B, all reportable incidents must be reported to the DHS PASSE Quality Assurance unit, and Empower, using the automated form DHS 1910 via secure e-mail no later than two (2) days following the incident. Any incident that occurs on a Friday is still considered timely if reported by the Monday immediately following.
The HCBS provider must ensure that the application of corporal punishment to beneficiaries is prohibited. “Corporal punishment” refers to the application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior.

- The freedom to control their own 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 beneficiary’s person centered service plan (“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 roommate when sharing a bedroom.
- The freedom to associate and communicate publicly or privately with any person or group of people of the beneficiary’s choice at any time. Any restriction on this right must be supported by an assessed need and justified in the PCSP.
- 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 a 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.

- A new form DHS-1910 should be submitted for follow-up and final reports only when there is insufficient space on the original form. Whenever a new form is submitted, the date of the original written report must be included for cross-referencing.

**Mandated Reporters**

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

**Beneficiary/Guardian Rights Policy**

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

**Beneficiary Rights**

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

**The right to be free from:**
- physical or psychological abuse or neglect
- retaliation
- coercion
- humiliation
- financial exploitation
• The right to be treated with dignity and respect.

• The right to receive due process.
  - HCBS providers must ensure beneficiaries have access to legal entities for appropriate and adequate representation, advocacy support services, and must adhere to research and ethics guidelines (45 CFR § 46.101 et. seq.).
  - HCBS provider rules may not contain provisions that result in the unfair, arbitrary, or unreasonable treatment of a beneficiary.

• The right to contest and appeal HCBS provider decisions affecting the beneficiary.

• The right to request and receive an investigation in connection with an alleged infringement of a beneficiary’s rights.

• The freedom to access their own records, including information regarding how their funds are accessed and utilized and what services were billed for on the beneficiary’s behalf. Additionally, all beneficiaries and legal guardians must be informed of how to access the beneficiary’s service records and the HCBS provider must ensure that appropriate equipment is available for them to obtain such access.
  - Beneficiaries may not be prohibited from having access to their own service records, unless a specific state law indicates otherwise.

• The right to live in a manner that optimizes, but does not regiment, beneficiary initiative, autonomy, and independence in making life choices, including but not limited to:
  - Choice of HCBS providers
  - Service delivery
  - Release of information
  - Composition of the service delivery team
  - Involvement in research projects, if applicable

• Other legal and constitutional rights.

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

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

• The HCBS provider is responsible for ensuring that each beneficiary’s funds are used solely for the benefit of the beneficiary.

• The HCBS provider must ensure that the beneficiary is able to receive the benefit of those items/services for which they are paying. By way of illustration, if a beneficiary is paying for internet, the beneficiary should have a device with which to access the internet; if the beneficiary pays for a cell phone plan, then the beneficiary should have a functioning cell phone.
Access to Financial Records
Beneficiaries and their legal guardians must have access to financial records concerning the beneficiary’s account/funds at all times.

- Financial Safeguards Policy and Procedures

The PASSE HCBS provider must implement policies that define:

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

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

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

Restraints & Restrictive Intervention
Behavior Management Plan Required
A Provider is prohibited from using any restraints or restrictive interventions on a beneficiary unless the beneficiary has a developed and implemented behavior management plan which incorporates alternative strategies to avoid the use of restraints and restrictive interventions, and includes the use of positive behavior support strategies as an integral part of the behavior management plan. There is a limited exception to this requirement when the use of an emergency restraint is necessary.

Definitions of Restraints and Interventions
- “Physical restraint” or “personal restraint”: the application of physical force without the use of any device (manually holding all or part of the body), for the purpose of restraining the free movement of a beneficiary’s body. This does not include briefly holding, without undue force, a beneficiary in order to calm them, or holding a beneficiary’s hand to escort them safely from one area to another.
- “Physical Intervention”: the use of a manual technique intended to interrupt or stop a behavior from occurring.
- “Restrictive intervention”: procedures that restrict or limit a beneficiary’s freedom of movement, restricts access to their property, prevents them from doing something they want to do, requires them to do something they do not want to do, or removes something they own or have earned. The definition would include the use of “time-out,” in which a beneficiary is temporarily, for a specified period of time, removed from positive reinforcement or denied opportunity to obtain positive reinforcement for the purpose of providing the beneficiary with
the opportunity to regain self-control. Under no circumstances may a beneficiary be physically prevented from leaving.

- **“Mechanical restraint”:** any physical apparatus or equipment used to limit or control a challenging behavior. This would include any apparatus or equipment that cannot be easily removed by the beneficiary, restricts the beneficiary's free movement or normal functioning, or restricts normal access to a portion or portions of the beneficiary's body.
  - Under no circumstances are mechanical restraints permitted to be used on a beneficiary.

- **“Chemical restraint”:** the use of medication for the sole purpose of preventing, modifying, or controlling challenging behavior that is not associated with a diagnosed co-occurring psychiatric condition.
  - Under no circumstances are chemical restraints permitted to be used on a beneficiary.

- **“Seclusion”:** the involuntary confinement of a beneficiary alone in a room or an area from which the beneficiary is physically prevented from having contact with others or leaving.
  - Under no circumstances is seclusion permitted to be used on a beneficiary.

### 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 prior to any modifications to the PCSP that permits 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 beneficiary or legal guardian.
• Include an assurance that the use of the restraint or intervention will cause no harm to the beneficiary.

Emergency Restraint
Personal restraints (use of staff member’s body to prevent injury to the beneficiary or another person) are allowed in cases of emergency, even if a behavior management plan incorporating the use of restraints has not been developed and implemented. An “emergency” exists in the following situations:
• The beneficiary has not responded to de-escalation or other positive behavior support strategies and the behavior continues to escalate.
• The beneficiary is a danger to themselves or others.
• The safety of the beneficiary and those nearby cannot be assured through positive behavior support strategies.

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 pursuant to an appropriate behavior management plan.

Any use of restraint or intervention, whether permitted or prohibited, also must be documented in the beneficiary’s daily service log, maintained in 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 personnel 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.

Medication Logs
Prescription Medications: HCBS Providers delivering direct care services must maintain medications logs detailing the administration of prescribed medications to the beneficiary. The prescribed medication logs must be readily available review, and document the following for each administration of a prescribed medication:
• Name and dosage of the medication administered.
• Route the medication was administered.
• Date and time the medication was administered (recorded at the time of medication administration).
• Initials of the staff administering or assisting with the administration of the medication.
• Any side effects or adverse reactions to the medication.
• Any errors in administering the medication.
PRN and Over-the-Counter Medications: HCBS providers delivering direct care services must also maintain logs concerning the administration of PRN and over-the-counter medications. The logs for the administration of prescription PRN and over-the-counter medications must document the following:

- How often the medication is used.
- Date and time each medication was administered (recorded at the time of medication administration).
- The circumstances in which the medication is used.
- The symptom for which the medication was used.
- The effectiveness of the medication.

Medication Administration Error Reporting/Charting: Any medication administration errors occurring or discovered must be recorded in the medication log and immediately reported to a supervisor. “Medication administration errors” include, but are not limited to, the loss of medication, unavailability of medication, falsification of medication logs, theft of medication, a missed dose, wrong dose, a dose being administered at the wrong time or by the wrong route, the administration of the wrong medication, and the discovery of an unlocked medication lock box that is supposed to be locked at all times.

- An incident report must be filed with DHS PASSE Quality Assurance unit and Empower, for any medication administration error that caused or had the potential to cause serious injury or illness to a beneficiary.

Required Oversight Documentation: Each HCBS provider delivering direct care services must ensure that supervisory level staff review on at least a monthly basis all beneficiary medication logs to determine if:

- All medications were administered accurately as prescribed.
- The medication is effectively addressing the reason for which it was prescribed.
- Any side effects are noted, reported, and being managed appropriately.

**Daily Service Activity Logs**

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

- The name and sign-in/sign-out times for each direct care staff member.
- The specific services furnished.
- The date and actual beginning and ending time of day the services were performed.
- Name(s) of the staff/person(s) providing the service(s).
- The relationship of the services to the goals and objectives described in the beneficiary’s individualized PCSP.

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

Required Service Record Documentation

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

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

Beneficiary Records Maintenance & Storage Retention Requirements

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

- The beneficiary
- The legal guardian of the beneficiary, if applicable
- Professional staff providing direct care or care coordination services to the beneficiary

- Authorized Provider administrative staff
- Any other individual authorized by the beneficiary or their legal guardian

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

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

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

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

- Direct Care Staff Access: The HCBS provider shall ensure all direct care and care coordination staff has adequate access to the beneficiary’s file/service record including, current PCSP and other pertinent information necessary to
Training Requirements

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

- 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 prior to receiving the above described First Aid Training can only be performed in a training role, under the supervision of another staff person that has already had the required First Aid Training.
- Training Certification must be maintained and kept up to date throughout the time any staff is providing services.

Beneficiary Specific Training: Prior to beginning service delivery, staff must receive the amount of individualized, beneficiary-specific training that is necessary to be able to effectively and safely provide the supportive living services required pursuant to the beneficiary’s PCSP, including, but not limited to:
- general training on beneficiary’s PCSP
- behavior management techniques/programming;
- medication administration and management;
- setting-specific emergency and evacuation procedures
- appropriate and productive community integration activities; and
- training specific to certain medical needs.

Documentation evidencing that the necessary types and amount of beneficiary-specific training were completed must be maintained in the personnel file of the supportive living staff member at all times. This type of individualized, beneficiary-specific training shall be required each time a beneficiary’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
  - Appeals Procedure for Individuals Served by the Program
  - Beneficiary Financial Safeguards
  - Community Integration Training
  - Procedures for Preventing and Reporting Maltreatment of Children and Adults
  - Other topics where circumstances dictate staff should receive training to ensure the health, safety, and welfare of the beneficiary.

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

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

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

• All PASSE 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.

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

There shall be written emergency procedures for:
• Fires
• Natural disasters
• Utility failures
• Medical emergencies
• Safety during violent or other threatening situations
Additionally, the emergency procedures must satisfy the requirements of applicable authorities, and contain practices appropriate for the locale (example: nuclear evacuations for those living near a nuclear plant).

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

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

• 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

**Safety Equipment**
HCBS providers must maintain the following items in each setting in which beneficiaries reside:

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

• Functioning fire extinguishers

• Functioning flash light

• Functioning hot water heater

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

• First-Aid kit

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

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

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

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

• Settings must be able to provide beneficiaries access to community resources and be located in a safe and accessible location. Beneficiaries must have access to the community in which they are being served. The site shall assure adequate/normal interaction with the community as a group AND as an individual. (This can be achieved through transportation or through 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 equipment, utensils, and supplies to properly store, prepare, and serve three (3) meals a day. Beneficiaries must have access to food at any time. Any modification to this requirement must be based on an assessed need and documented in the beneficiary’s PCSP.

Bedroom areas are required to meet the following:
• Shall be arranged so that privacy is assured for beneficiaries. Sole access to these rooms cannot be through a bathroom or other bedrooms. Bedrooms must be equipped with a functioning lock with only appropriate staff having keys.
• Beneficiaries must have a choice of roommate when shared by one or more individuals. The PASSE HCBS provider must actively address the need to designate space for privacy and individual beneficiary interests.
• Physical arrangements shall be compatible with the physical needs of the individuals.
• Each beneficiary shall have an individual bed. Each bed must have a clean, adequate, comfortable mattress.
  - Beds are of suitable dimensions to accommodate the beneficiary who is using it. Mattresses must be waterproof as necessary.
  - Each beneficiary must have a suitable pillow, pillowcase, sheets, blanket, and spread.
  - Bedding must be appropriate to the season and beneficiary’s personal preferences. Bed linens must be replaced with clean linens at least weekly.
• Bedroom furnishings for beneficiaries shall include shelf space, individual chest or dresser space, and a mirror. An enclosed closet space adequate for the belongings of each beneficiary must be provided.

• Eighty (80) square feet per beneficiary in multi-sleeping rooms; one hundred (100) square feet in single bedrooms. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Bathroom areas are required to meet the following criteria:
• Sole access may not be through another beneficiary’s bedroom. Commodes, tubs, and showers used by beneficiaries must provide for individual privacy.
• A minimum of one commode and sink is provided for every four (4) beneficiaries. Lavatories and commode fixtures are designed and installed in an accessible manner so that they are usable by the beneficiaries living in the residential setting.
• A minimum of one tub or shower is provided for every eight (8) beneficiaries.
• Must be well ventilated by natural or mechanical methods.

Home and Community Based Services (HCBS) Settings Requirements
All PASSE HCBS providers must meet the Home and Community-Based Services (HCBS) Settings regulations as established by CMS. The federal regulation for the rule is 42 CFR 441.301(c) (4)-(5). All PASSE HCBS provider owned/leased/rented residential settings must have the following characteristics:
1. Be chosen by the beneficiary from among setting options including non-disability specific settings (as well as an independent setting), and an option for a private unit in a residential setting.
  - Choice must be identified/included in the beneficiary’s PCSP.
  - Choice must be based on the beneficiary’s needs, preferences and, for residential settings, resources available for room and board.
2. Ensure a beneficiary’s rights of privacy, dignity and respect and freedom from coercion and restraint.

3. Must optimize, but not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

4. Facilitate beneficiary choice regarding services and supports and who provides them.

5. The setting must be integrated in and support full access to the greater community by the beneficiary, including the opportunity to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving CES Waiver services.

6. The unit or dwelling must be a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the beneficiary receiving services, and the beneficiary has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.

7. Each beneficiary has privacy in their sleeping or living unit, which must include the following:
   - Units have entrance doors lockable by the beneficiary, with only appropriate staff having keys to doors.
   - Beneficiaries sharing units have a choice of roommates in that setting.
   - Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

8. Beneficiaries have the freedom and support to control their own schedules and activities and have access to food at any time.

9. Beneficiaries are able to have visitors of their choosing at any time.

10. The setting is physically accessible to the beneficiary.

Any modification of the additional conditions specified in items 6 through 10 above must be justified in the beneficiary’s PCSP. The following requirements must be documented in the beneficiary’s PCSP:
   - Identify a specific and individualized assessed need.
   - Document the positive interventions and supports used prior to any modifications to the PCSP.
   - Document less intrusive methods of meeting the need that have 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 beneficiary.
   - Include an assurance that interventions and supports will cause no harm to the beneficiary.
   - Beneficiaries who live in a private/independent home defined as a home that is owned or leased by the beneficiary, or a member of the beneficiary’s family for their personal private use are presumed compliant with the HCBS Settings Requirement.
**Vision Care**
Routine and medically necessary vision care services are covered. Empower is responsible, at a minimum, for providing the following:

**Routine Eye Exams**
- For members under age 21, coverage includes one eye examination every 12 months.
- For members under age 21, coverage includes more frequent eye exams as needed in accordance with EPSDT guidelines.

**Vision Hardware**
Coverage includes standard spectacle lenses with a retail allowance for frames every 24 months. EPSDT guidelines allow one pair of lenses and frames once per year and contact lenses if medically necessary. Replacement frames and lenses are covered if they are lost, stolen or broken or if enrollee’s prescription has changed more than one-half (0.5) diopters.

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

These drug management tools are described in additional detail below. Also, to help your patient 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)
- Prescribed drugs listed on Empower’s Preferred Drug List (PDL)
- Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class

**Preferred Drug List (PDL)**
Empower Health will adopt 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 (keyboard shortcut: CTRL+F). The PDL will also tell you if there are any certain age limits or clinical prior authorization (PA) requirements.
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 child-bearing age and fluoride preparations for children; other vitamin/mineral products are not covered.
- Agents when used for the treatment of sexual or erectile dysfunction, 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.

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.

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 appropriate 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.
**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 but still require Prior Authorization (including non-preferred PDL drugs and preferred PDL drugs with criteria)
- 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 PDL verbally or in writing. For written requests, providers should complete a Prior Authorization Request Form, supplying pertinent Member medical history and information. A Prior Authorization Request form may be accessed on Empower’s website at www.getempowerhealth.com.

To submit a request, orally, call (855) 429-1028 to speak with a pharmacy specialist.

If Authorization cannot be approved or denied, 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 information on the request 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.

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved</td>
<td>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.</td>
</tr>
<tr>
<td>Partial Denial</td>
<td>Reimbursement has been approved for a therapeutic alternative or for a different dose than requested.</td>
</tr>
<tr>
<td>Deferral</td>
<td>The final PA action was not decided due to the need for additional information. Providers must fax the requested information back to the plan in order to obtain a final PA decision.</td>
</tr>
<tr>
<td>Denial</td>
<td>The PA request was denied. All PA denials are issued by a licensed physician. These decisions may be appealed.</td>
</tr>
</tbody>
</table>

Denial rationale
Is 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.

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 in to 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 over use 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; and

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.
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 you.

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 team 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 get Members the medication needed, along with personalized, clinical support.

While CVS Specialty isn’t 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.
Claims Processing

Submitting a Claim

Empower encourages all providers to submit claims electronically. For those interested in electronic claim filing, contact your EDI software vendor or the Change Healthcare (formerly Emdeon) Provider Support Line at (800) 845-6592 to arrange transmission.

Empower Electronic Payer ID: 12956

If you choose to utilize paper claims, these should be on standard CMS forms (CMS 1500/UB-04). Please submit to Empower at the following address:

Empower Healthcare Solutions
PO BOX 211446
Eagan, MN 55121

Electronic Submission

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 the health care industry’s efforts to reduce administrative costs.

The benefits of billing electronically include:

• Reduction of overhead and administrative costs. EDI eliminates the need for paper claims submission. It has also been proven to reduce claim rework (adjustments).
• Receipt of reports as proof-of-claim receipt. This makes it easier to track the status of claims.
• Faster transaction time for claims submitted electronically. An EDI claim averages about twenty-four (24) to forty-eight (48) hours from the time it is sent to the time it is received. This enables providers to easily track their claims.

• Validation of data elements on the claim form. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.

Requirements for Electronic Claim Filing

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

Hardware/Software Requirements

Providers may use different products to bill electronically. Providers may submit claims electronically as long as their software has the capability to send EDI claims to Change Healthcare (formerly Emdeon) through either direct submission or through another clearinghouse/vendor.

Change Healthcare has the capability to accept electronic data from numerous providers in several standardized EDI formats. Change Healthcare forwards the accepted information to carriers in an agreed upon format.

Contracting with Change Healthcare and Other Electronic Vendors

Providers without Change Healthcare EDI capabilities who are interested in electronic claims submission may contact the Change Healthcare Sales Department at (877) 469-3263, option 6. Providers may also choose to contract with another EDI clearinghouse or vendor who already has EDI capabilities.
After the registration process is completed and providers have received all certification material, providers must:

- Read over the instructions carefully, with special attention to the information on exclusions, limitations, and especially, the rejection notification reports.
- Contact their system vendor and/or Change Healthcare to initiate electronic submissions to Empower. (Empower electronic payer identification number is 12956)
- More information on electronic billing can be found in the Provider section of our website www.getempowerhealth.com

**Paper Claim Requirements**

Certain claims are excluded from electronic billing. At this time, the following claims must be submitted on a paper claim:

- Letters of Agreement (LOA) or Single Case Agreements;
- Sterilization claims accompanied by appropriate consent forms; and
- Providers billing on a UB-04/CMS-1450 form that are contracted with vendors that are not transmitting through Change Healthcare.

**Claims Status Review**

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

- Online – Check eligibility/claims status by logging into Empower Provider Portal at www.getempowerhealth.com
- 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.

**Contact your clearinghouse to access:**

- Change Healthcare Products for claims status transactions; or
- All other clearinghouses: Ask your clearinghouse to access transactions through Change Healthcare.

**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 in order to ensure 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 the referral for specialist or non-primary care physician claims
- Verification of enrollee eligibility for services under Empower during the time period in which services were provided
- Verification that the services were provided by a participating provider or that the “out-of-network” provider has received authorization to provide services to the eligible enrollee (excluding “self-referral” types of care)
- 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
• 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 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 same date of service)
• Assistant surgeon utilization (reimbursement and coverage determination)

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)

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

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.
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.

- Evaluations and management
- Anesthesia
- Surgery
- Radiology (nuclear medicine and diagnostic imaging)
- Pathology and laboratory
- Medicine
- Category II codes: supplemental tracking codes that can be used for performance measurement
- Category III codes: temporary codes for emerging technology, services or procedures

**Claim Form 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 the timeframe referenced in the provider agreement.

CMS-1500 (08-05) and UB-04 CMS-1450 claim forms must include the following information prior to the state becoming compliant with the NPI federal rule. Empower has aligned its NPI and taxonomy code requirements with the state’s (HIPAA-compliant where applicable):

- Member’s name
- Member’s Medicaid 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 when applicable
- 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
- The precertification number or copy of the precertification
- Name of referring provider
- NPI of referring provider when applicable
- Any other state-required data
- POA Indicator

**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.

- 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:
  - wrong surgical or other invasive procedure performed on an enrolled member; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
  - Has a negative consequence for the enrolled member.
There is an indicator on the claim called the POA indicator, the Provider will check this box if the above applies.

Additional Documentation Required for DD 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.

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 the following sections. 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 ninety (90) days of notification of payment/denial.

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

Third Party Liability

Empower adheres to state-specific guidelines and all federal regulations when coordination of benefits is available with other health insurance (OHI), other third party liability (TPL), medical subrogation or worker’s compensation. Empower uses covered medical and hospital services whenever available or other public or private sources of payment for services rendered to members.

Empower is a payer of last resort when any commercial or Medicare plan covers the member. Providers should submit claims for members who have Medicare 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 can refer to the 10/01/2014 Medicaid Memo, “Medicare Crossover Billing Instructions on Paper CMS 1500” 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 which 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 are 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 the claim.

Coordination of benefits amongst different sources of coverage (payers) is governed by the terms of the member’s benefit plan and applicable state and/or federal laws, rules and/or regulations. To the extent not otherwise required by applicable laws or regulations, participating providers agree that in no event will payment from primary and secondary payers for covered services rendered to members exceed the rate specified in the provider agreement.

Participating providers must submit a copy of the primary insurer’s EOB, with the exception of 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 EOB. In addition, the provider will need to complete the necessary COB fields on the claim and include payment information from the primary payer’s ERA or by converting the EOB into standard coding use in an ERA.

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

It is the responsibility of the beneficiary 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 beneficiary 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.

**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 Medicaid if the provider is properly enrolled with Arkansas Medicaid and indicates the beneficiary’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 Arkansas Medicaid and the claim is processed in the next weekend cycle for Medicaid payment. Exceptions to the above:

- Claims for Medicare beneficiaries 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/Medigap Plans (like HMOs and PPOs) are health plan options that are available to beneficiaries, 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 beneficiaries 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.”

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.

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 at (800) 457-4454 (toll free).

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
When a claim is denied because of missing or invalid mandatory information, the claim should be corrected, marked as a second submission or a corrected claim, and resubmitted within ninety (90) days of notification of payment/denial either electronically or to the general claim address:

Empower Healthcare Solutions
PO BOX 211446
Eagan, MN 55121

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

If you believe there was an error made during claims processing or if there is a discrepancy in the payment amount, please call provider services. Empower representatives can help you resolve the issue or advise whether a corrected claim or a written appeal needs to be submitted. Please submit Claims Issue Forms to the P.O. Box above.

Providers must return any overpayment to Empower at the address set forth in this handbook within sixty (60) days after the date on which the overpayment was identified, as well as notify Empower in writing of the reason for the overpayment. (42 CFR 438.608 (d)(2)).

Claims Appeals

Providers have the right to appeal the outcome of a claim. The appeal must be submitted in writing and received within one (1) year of the last process date and include supporting documentation.

The provider will receive written notification of the outcome of the appeal 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 appeal. Any appeals overturned by the plan will be reprocessed, and the provider will receive an explanation of payment (EOP) as notification.

Resubmitted claims should be resubmitted on paper. Corrected claims can be sent electronically. All corrected claims should have the corrected claim indicator (a 7) on the claim and the original claim number that you are correcting.

The Empower complaint, grievance, and appeal processes provide an effective method and dependable problem resolution procedure for the informal resolution of participating provider complaints, issues, concerns, or disputes that may arise related to the credentialing/recredentialing process, medical necessity adverse determinations, administrative denials, claims processing, and payment or denial of claims, and otherwise related to the provider agreement.

Information about the process for appeals related to credentialing and/or recredentialing decisions is set out in the appeals section of this handbook.

Information about the process for appeals of adverse determinations is set out in the appeals section of this handbook.

Corrected Claims and Requests for Appeals and/or Refunds

If you would like to discuss claims payments, you may call Provider Services at (855) 429-1028.

Providers have the right to appeal the outcome of a claim. The appeal must be submitted in writing and received within one (1) year of the last process date and include supporting documentation. Empower will respond to the appeal within thirty (30) days from the receipt date with a determination or status of the review.

The provider will receive written notification of the outcome of the appeal whether it is upheld or overturned. All upheld determinations will be sent to the provider (EOP) with the reason Empower upheld the appeal. Any appeals overturned by Empower will be reprocessed.

Resubmitted claims should be resubmitted on paper. Corrected claims can be sent electronically. All corrected claims should have the corrected claim indicator (a 7) on the claim and the original claim number that you are correcting:

- Claims originally denied for missing/invalid information for inappropriate coding should be submitted as corrected claims.
  In addition to writing “corrected” on the claim, the corrected information should be circled so that it can be identified.
Submitting Member Encounters

Empower is required to submit encounter data to Arkansas Department of Human Services (DHS). Provider assistance is an essential component of this requirement. DHS requires complete, accurate, and timely encounter data in order 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 enrollee encounters by claims submission either electronically or by mail to Empower.

Balance Billing

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.

E-Commerce Initiative

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. Providers in the Empower network are strongly recommended to electronically submit all claims.

Corrected/resubmitted paper claims should be sent to:

Empower Healthcare Solutions
PO BOX 211446
Eagan, MN 55121

Following these instructions will reduce the probability of erroneous or duplicate claims and timely filing denials on second submissions.

When the need for a refund is identified, the provider should call provider services to report the over-payment. Claim details will need to be provided, such as reason for refund, claim number, enrollee number, dates of service, etc. 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.

If Empower recognizes the need for a refund, a letter outlining the details will be sent thirty (30) days prior to the recovery occurring. These adjustments will also be reported on the Remittance Advice.

Claims Questions

If you have questions on claims you may contact Empower Provider Services at any time. You may also reach out to your provider relations representative for assistance at EmpowerHealthcareSolutionsPR@Empowerhcs.com.
Clinical Management

Utilization Management
The utilization management (UM) process encompasses the following program components: after hours service, prior authorization, concurrent review, ambulatory review, retrospective (post-service) review, and discharge planning. All approved services must be medically necessary. 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. 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 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 established criteria (InterQual) to determine medical necessity and appropriateness for requested medical services. These would include medical coverage guidelines, internal medical policies and community standards to each case. The member’s specific benefit package is also taken into consideration. All services are also reviewed in accordance with the Arkansas Medicaid Fairness Act.

Medical necessity criteria are selected or developed and approved by the Empower Quality Management, Utilization Management, and Care Management (QMUMCM) Committee and presented to Empower Medical Quality Management Committee with input from participating physicians. When developing criteria, the following are taken into consideration: approval from an appropriate regulatory body, input from participating specialists, and support by published scientific evidence. Criteria and medical policies are reviewed annually against current industry standards and any applicable revisions are made and approved by the QMUMCM Committee.

When applying criteria to a request for services the following information is taken into consideration: age, comorbidities, complications, 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 on a regular basis to communicate, to internal management and participating providers, the information needed to effect better utilization of health care services.

**Utilization Management (UM) Time Frames**

**Determination Time Frames**

<table>
<thead>
<tr>
<th>Request Type</th>
<th>Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Authorization</td>
<td>Within 5 calendar days of Empower’s receipt of the request of service, with possible extension of 14 days</td>
</tr>
<tr>
<td>Expedited Authorization</td>
<td>Within 72 hours of receipt of the request for service, or as expeditiously as the enrolled member’s health condition requires</td>
</tr>
</tbody>
</table>

*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.*

**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 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 has this been 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)

**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 it is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap or cause physical deformity or malfunction and if there is no other equally effective (although more conservative or
illness to determine medical necessity and appropriateness of the service(s) request. A notification is a communication from the provider informing Empower the intent to render covered medical services to Empower members. Emergent and urgent services require a notification within 24 hours, or the next business day, following admission and may be submitted via phone or fax.

**Services requiring prior authorization include but are not limited to:**

- Elective Inpatient Admissions related to elective procedures/surgery, LTAC, Rehabilitation, SNF, observation stays extending beyond 48 hours, all bariatric procedures, and all transplants (excluding cornea)
- OB Services: Induction of labor - if prior to 39 weeks gestation, OB ultrasound over 2 per pregnancy, stays over 2 days for vaginal delivery, stays over 4 days for cesarean delivery, termination of pregnancy
- Outpatient Bariatric Surgery
- Allergy Testing for children under the age of 5
- Home Health Services after initial evaluation
- Private Duty Nursing
- Intensive Cardiac and Pulmonary Rehabilitation Services – Inpatient and Outpatient
- Home Infusion/IVT
- Outpatient Therapy – ST/PT/OT after initial evaluation
- Chiropractic Services
- High-tech radiology
- Durable medical equipment that exceed $750
- Medications/Injectables that exceed $1,000

**Prior Authorization and Notification Requirements**

Some covered services require precertification prior to services being rendered, while other covered services require notification prior to being rendered.

A prior authorization is the prospective process in which medical necessity criteria is reviewed against the intensity of the services requested against the severity of 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 in accordance with 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, 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 may result in a denial. For a complete list of services that require prior authorization, please visit the Plan’s website www.getempowerhealth.com.

**Prior Authorization and Notification Requirements**

Some covered services require precertification prior to services being rendered, while other covered services require notification prior to being rendered.

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Requesting Prior Authorization

The UM department is committed to assuring prompt, efficient delivery of healthcare services and to monitor 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 at www.getempowerhealth.com or by calling Empower’s UM department 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 the date of service.

Review Criteria

Empower has adopted utilization review criteria developed by McKesson InterQual® products to determine 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. 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.

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 Planning**

Providers/participating providers must develop individualized treatment plans that utilize assessment data, address the member’s current problems related to the behavioral health diagnosis, and actively include the member and significant others, as appropriate, in the treatment planning process. Empower will review the treatment plans with the providers/participating providers to ensure that they include all elements required by the provider agreement, applicable government program, and at a minimum:

- Specific measurable goals and objectives
- Reflect the use of relevant therapies
- Show appropriate involvement of pertinent community agencies
- Demonstrate discharge planning from the time of admission
- Reflect active involvement of the member and significant others as appropriate

Providers/participating providers are expected to document progress toward meeting goals and objectives in the treatment record and to review and revise treatment plans as appropriate.

**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, staff will review/discuss with the provider the discharge plan for the member.

**Adverse Clinical Determination/Peer Review**

If a case does not appear to meet medical necessity criteria at the requested level of care, the Care Coordination Manager (CCM) attempts to discuss the member’s needs with the provider/participating provider and to work collaboratively with the provider/participating provider to find an appropriate alternative level of care. If no alternative is agreed upon, the CCM 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
- 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
In all cases, providers/participating providers are encouraged to contact Empower prior to 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.

Coverage and payment for services proposed for and/or provided to members for the identification or treatment of a member’s condition or illness is conditioned upon member eligibility, the benefits covered under the member’s benefit plan at the time of service, and on the determination of medical necessity of such services and/or treatment.

Prior to initial determinations of medical necessity, the member’s eligibility status and coverage under a benefit plan administered by Empower should be confirmed. If eligibility information is not available in nonemergency situations, a CCM may complete a screening assessment and pend the authorization/certification awaiting eligibility verification. CCMs will work with members and providers/participating providers in situations of emergency, regardless of eligibility status.

If a member’s benefits have been exhausted or the member’s benefit plan does not include coverage for behavioral health services, the CCM, in coordination with the provider/participating provider as appropriate, will provide the member with information about available community support services and programs, such as local or state-funded agencies or facilities, that might provide sliding scale discounts for continuation in outpatient therapy, or where available under the member’s benefit plan, explore benefit exchanges with the client plan.

Clinical Review Process
Provider/participating provider 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/participating providers must notify Empower prior to admitting a member to any non-emergency level of care. The Mental Health Parity & Addiction Equity Act of 2008 requires that mental health and substance use disorder benefits, provided by group health plans with more than 50 employees, must be available on an equivalent or better basis to any medical or surgical benefits. Some benefit plans, but not all, may fall under this guideline and do not require notification or authorization for standard outpatient services. Others may allow for a designated number of outpatient sessions without prior-authorization, certification, or notification. 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.
Care Coordination

Under the innovative PASSE program, Empower’s Care Coordinators manage member care across all of the individual’s providers, including medical, pharmacy, behavioral health, intellectual and developmental disability, and long-term support services. 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 document that captures all needs of a member to ensure that all providers are coordinating care.

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 services organizations, the court system, schools, and other appropriate resources.

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. The model is designed to help members obtain needed services and assist them in coordination of their healthcare and other needs.

Care Coordination takes a systematic approach, by assessing each member’s needs and developing and implementing a PCSP for each member. Care Coordination also includes member and family education and connects the member to providers and supportive services. 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 will be included in a member’s PCSP, as it is intended to provide a holistic approach to a member’s needs.

Every member of Empower is part of the Care Coordination program.

Any provider, including PCPs, specialists, HCBS providers, discharge planners and UM professionals, can contact Empower to speak to a member’s assigned Care Coordinator.

Continuity, Transitions and Coordination of Care

Empower provides care coordination to each of its assigned members. The PASSE must have care coordinators who will work with the member’s providers to ensure continuity of care across all 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 patient and their community, including without limitation outreach, quality improvement, and patient panel management
- Coordination of Community-based management of medication therapy
chosen for evaluation are referenced in the current year’s work plan.

Care coordination services are available to Empower PASSE members 24 hours a day by contacting 866-261-1286.

**Patient Centered Service Plan (PCSP)**

All enrolled members who have an existing PCSP or Master Treatment Plan (MTP) will carry that care plan with them when they are enrolled into 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 will include the enrolled member’s health information without limitation, including:

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

Empower’s Care coordination will ensure that all services are coordinated and appropriately delivered by providers:

- 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 will 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 between PASSE entities, Empower ensures 90 days of continuity of 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 is monitored using a combination of claims data, medical record chart reviews and survey of providers. The specific issues
• 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 will give 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; or
• Having significant medical conditions requiring ongoing monitoring or screening.

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

• The member and his or her parent/legal guardian;
• The member’s primary caregivers; and
• The Care Coordinator

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

• HCBS service providers;
• Professionals who have conducted evaluations or assessment;
• Anyone else the member desires to attend, including friends and family who support member.

If the member objects to anyone’s participation in the PCSP development meeting, the Care Coordinator must ensure that they are not allowed to participate.

Coordination and Communication between All 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 the course of treatment is encouraged, with member consent when required.

Behavioral health and Intellectual/Developmental Disability providers should initiate communication with and coordinate with a member’s Care Coordinator and with any specialty providers whenever there is a problem that can affect the member’s condition or the treatment being provided. Examples of some of the information to be shared include:

• A Significant change in status that would necessitate an update to the PSCP
• To request assistance in identifying resources or to recommend resources
• Hospital admissions
• Emergency room visits
Empower encourages providers to report specific clinical information to the member’s Care Coordinator in order to preserve the continuity of the treatment process. With appropriate written consent from the member, it is the provider’s responsibility to keep the member’s Care Coordinator abreast of the treatment status and progress in a consistent and reliable manner. The following information should be included in the report to the 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)

Quality Improvement

Quality Improvement Program

The mission of the Empower Quality 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.

Empower is committed to ensuring that continuous quality/performance improvement occurs within the company and our sub-delegates. That improvement goes beyond checking the box that a service was provided to measuring that the service was of a high quality to impact outcomes. There is consistent and ongoing monitoring for applicability so Empower can achieve efficiency and effectiveness with improved outcomes for our members.

Quality Management Committee

Empower integrates an ongoing Comprehensive Quality Assessment and Performance Improvement (QAPI) Strategic Plan for the services it furnishes to its enrolled members.

The Quality Management Committee includes clinicians that specialize in providing behavioral health, HCBS, LTSS services, and includes at least one consumer advisory council member. The committee is designed to ensure quality exists at the forefront of our business to demonstrated improvements in care and service to Empower members and oversees the QAPI Strategic Plan.

The quality management committee’s responsibilities are to:

- Establish strategic direction and monitor and support implementation of the Quality Management program
- Establish processes and structure that ensure NCQA compliance
- Review planning, implementation, measurement and outcomes of clinical/service quality improvement studies
- Coordinate communication of quality management activities throughout the health plans
- Review HEDIS® data and action plans for improvement
- Review and approve the annual quality management program description
- Review and approve the annual work plans for each service delivery area
- Provide oversight and review of delegated services
- Provide oversight and review of subordinate committees
- Receive and review reports of Utilization Review decisions and take action when appropriate
• Analyze member and provider satisfaction survey responses
• Monitors utilization of service (overutilization and underutilization), member grievances, and recommendations from the Consumer Advisory council

Empower Quality Goals
• Provide high quality, accessible, and affordable health care and service to the membership through a qualified network of providers and providers who are systematically selected and retained through the credentialing and performance appraisal process
• Maintain a health plan model that empowers the provider to make decisions, and enables the provider to proactively manage health care
• Coordinate preventive care, wellness efforts and chronic care management, ensuring efforts are member-centric
• Conduct operations in a manner that protects the confidentiality, safety, and dignity of all members

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 at a network wide level. 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.

Critical Incident Reporting and Management
Empower has a critical incident/quality of care reporting and management system for incidents and quality of care concerns that occur where a member is receiving services. As a participating Empower provider, you will be required to participate in critical incident and quality of care reporting. Immediate action will be taken to ensure the member is protected from further harm. Critical incidents and quality of care concerns will be tracked and presented to our quality improvement committee for review.

Providers should notify Empower and must submit incident reports upon the occurrence of any of the following events:
• Death of a member; *Requires Immediate Reporting within one hour of the PASSE becoming aware of the occurrence
• The use of restrictive interventions;
• Suspected maltreatment or abuse of member;
• Injury to a member that requires emergency room care, or a paramedic;
• Injury to a member that results in a substantial permanent impairment; *Requires Immediate reporting within one hour of the PASSE becoming aware of the occurrence
• Injury to a member that requires hospitalization;
• Threatening or attempting suicide;
• Arrest;
• Any situation where the member eloped from a service and cannot be located within 30 minutes;
• Any event where a PASSE HCBS provider staff threatens, abuses, or neglects a member; and
• Medication errors that cause serious injury to the member.
The critical incident must be reported within 24 hours, unless otherwise noted as above, by the provider to Empower. Suspected abuse, neglect and exploitation of members who are adults must be immediately reported to the Arkansas Adult Abuse Hotline at (800) 482-8049. Suspected brutality, abuse or neglect of members who are children must also be immediately reported. Reports of suspected child abuse and dependent abuse must be made by calling the Department of Human Services’ Child Abuse Hotline at (800) 482-5964. Providers must immediately to take steps to prevent further harm to any and all members and respond to any emergency needs of members. Providers must cooperate with any investigation conducted by Empower or outside agencies.

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

HEDIS Measures
Empower ensures the following aspects of clinical care and service with a strong emphasis on transformation of the lives of the people we serve through coordination and integration of care, health outcomes (Care Coordination and HEDIS rates) and coordination of quality operations.

There are a number of ways to monitor the treatment of individuals with mental health and/or substance use conditions receive. Many of you who provide treatment to these individuals measure your performance based on quality indicators such as those to meet CMS reporting program requirements; specific state or insurance commission requirements; managed care contracts; and/or internal metrics. In most cases there are specific benchmarks that demonstrate the quality that you strive to meet or exceed.

Empower utilizes a number of tools to monitor population-based performance in quality across regions, states, lines of business and diagnostic categories. One such tool is the Healthcare Effectiveness Data and Information Set (HEDIS) behavioral health best practice measures as published by the National Committee for Quality Assurance (NCQA) as one of our tools. Like the quality measures utilized by CMS, Joint Commission, and other external stakeholders, these measures have specific, standardized rules for calculation and reporting. The 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, we strive to ensure our behavioral health measure performance reflects best practice. Our providers are the key to guiding their patient to keep an appointment after
leaving an inpatient psychiatric facility; taking their antidepressant medication or antipsychotic medication as ordered; ensuring a child has follow up visits after being prescribed an ADHD medication; and ensuring an individual with schizophrenia or bipolar disorder has annual screening for diabetes and coronary heart disease.

There are six domains of care and service within the HEDIS library of measures:

1. Effectiveness of Care
2. Access and Availability
3. Utilization and Relative Resource Use
5. Experience of Care
6. Health Plan Descriptive Information

A brief description of these measures:

1. Effectiveness of Care: Measures that are known to improve how effective care is delivered. One very important measure in this domain is Follow-up after Mental Health Hospitalization (Aftercare). In effect, this means how long someone waits to get mental health care after they are discharged from an inpatient mental health hospital. To prevent readmission and help people get back into the community successfully, best practice is from seven to thirty days after discharge.

2. Access/Availability: Measures how quickly and frequently members receive care and service within a specific time. For example, the Initiation and Engagement of Drug and Alcohol Abuse Treatment measure relies on frequency and timeliness of treatment to measure treatment initiation and treatment engagement. Studies show that an individual who engages in the treatment process have better outcome and success in recovery and sobriety.

3. Utilization and Relative Resource Use: This domain includes evidence related to the management of health plan resources and identifies the percentage of members using a service. For example, Empower measures Mental Health Utilization and Plan All Cause Readmissions.

4. Measures Collected Using Electronic Clinical Data Systems (ECDS): This is the newest domain, and it requires calculation of outcomes by accessing data through the electronic submission of a member’s electronic health record (EHR). An example of an ECDS measure is the Utilization of the PHQ-9. This demonstrates whether a PHQ-9 was administered to a patient with depression four months after initiation of treatment to measure response to treatment.

5. Experience of Care: We measure and monitor member and provider satisfaction with the overall Empower experience.

6. Health Plan Descriptive Information: We monitor and track Board Certification of physicians and psychologists; all other information is specific to the health plan.

In an ongoing effort to improve the delivery of care, Empower monitors and evaluates the effectiveness of health services provided to members.
Quality monitoring activities include but are not limited to the following HEDIS metrics:

<table>
<thead>
<tr>
<th>HEDIS Measure</th>
<th>National Medicaid Health Plan Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of hospitalization for mental illness with a follow-up visit to</td>
<td>2016 - 45.5%</td>
</tr>
<tr>
<td>behavioral health provider within 7 days of discharge *6-20 yr. old</td>
<td></td>
</tr>
<tr>
<td>Percentage of hospitalizations for mental illness with a follow-up visit to</td>
<td>2016 – 63.8%</td>
</tr>
<tr>
<td>behavioral health provider within 30 days of discharge *6-20 yr. old</td>
<td></td>
</tr>
<tr>
<td>Percentage of hospitalizations for mental illness with a follow-up visit to</td>
<td>2016 - 45.5%</td>
</tr>
<tr>
<td>behavioral health provider within 7 days of discharge *21+ yr. old</td>
<td></td>
</tr>
<tr>
<td>Percentage of hospitalizations for mental illness with a follow-up visit to</td>
<td>2016 – 63.8%</td>
</tr>
<tr>
<td>behavioral health provider within 30 days of discharge *21+ yr. old</td>
<td></td>
</tr>
<tr>
<td>Percentage of newly prescribed ADHD medication with 1 follow-up visit during</td>
<td>2016 – 44.5%</td>
</tr>
<tr>
<td>the 30-day initiation phase *6-12 yr. old</td>
<td></td>
</tr>
<tr>
<td>Percentage newly prescribed ADHD medication with at least 2 follow-up visits</td>
<td>2016 – 54.5%</td>
</tr>
<tr>
<td>during the 10-month continuation and maintenance phase *6-12 yr. old</td>
<td></td>
</tr>
<tr>
<td>Percentage of members on two or more concurrent antipsychotic medications</td>
<td>2016 – 2.4%</td>
</tr>
<tr>
<td>(Lower rates are better) *1-17 yr. old</td>
<td></td>
</tr>
<tr>
<td>Percentage diagnosed with major depression who were treated with and</td>
<td>New Measure</td>
</tr>
<tr>
<td>remained on antidepressant medication for 12 weeks *18+ yr. old</td>
<td></td>
</tr>
<tr>
<td>Percentage diagnosed with major depression who were treated with and</td>
<td>New Measure</td>
</tr>
<tr>
<td>remained on antidepressant medication for 6 months *18+ yr. old</td>
<td></td>
</tr>
<tr>
<td>Percentage of Schizophrenia who were dispensed and remained on antipsychotic</td>
<td>2016 – 59.2%</td>
</tr>
<tr>
<td>medication for at least 80 percent of their treatment period. *18+ yr. old</td>
<td></td>
</tr>
<tr>
<td>Percentage with Schizophrenia or Bipolar Disorder who were dispensed an</td>
<td>2016 – 80.7%</td>
</tr>
<tr>
<td>antipsychotic medication and had a Diabetes screening test *18+ yr. old</td>
<td></td>
</tr>
</tbody>
</table>
What Providers Can Do To Improve HEDIS Scores

- Understand the specifications established for each HEDIS measure
- Submit claims or encounter data for each and every service rendered. All providers must bill, or report by encounter submission, 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 claim/encounter data can reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided
- Bill CPT codes related to HEDIS measures such as diabetes, eye exam and blood pressure

Please contact Provider Relations at (855) 429-1028 with any questions, comments or concerns related to the annual HEDIS project or the medical record reviews.

Complaints, Grievances, and Appeals

Any member or 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 (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). Assistance with filing grievances and appeals is available. For complaints or grievances contact:

Empower Healthcare Solutions, LLC
Compliance Officer
PO BOX 211446
Eagan, MN 55121
Email: complaintsandgrievance@empowerhcs.com
Phone: (855) 429-1028

Empower will acknowledge receipt of participating provider complaints verbally or in writing, and thereafter will investigate and attempt to reach a satisfactory resolution of the complaint within 30 calendar days of receipt of the complaint. A one-time extension of 14 calendar days can be taken by Empower when a resolution cannot be reached within the above noted 30-calendar day timeframe and the extension is solely for the benefit of a member. Empower will notify the provider verbally or in writing of the proposed resolution to the complaint, along with the procedure for filing a grievance should the participating provider not be satisfied with the proposed resolution.

If the provider is not satisfied with the proposed resolution of the complaint, the participating provider may request a formal grievance, either verbally or in writing, 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 grievance requests.

Notice of the grievance decision will be issued within 30 calendar days of receipt of the grievance request from the participating provider. A one-time extension of 15 calendar days can be taken by Empower when a resolution cannot be reached within the above noted 30-calendar day timeframe and the extension is solely for the benefit of a member.
Appeals

Both the member and the provider 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 Beneficiaries) 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 either party is not satisfied with the decision on the case, the member may request a fair hearing from the Office of Appeals and Hearings or the provider may request a fair hearing from the Arkansas Department of Health. If both the provider and beneficiary are requesting a hearing, these will also go to the Arkansas Department of Health. You may use the enclosed Notice of Appeal Form to request an appeal. Please enclose a copy this Notice of Action with your appeal.

How and When to Appeal

The following individuals may file an appeal:

• The enrolled member;
• The enrolled member’s parent or legal guardian;
• An attorney authorized to represent the enrolled member;
• Another authorized representative of the enrolled member, including the representative of the enrolled member’s estate if that member is deceased;
• A direct service provider that is the subject of the adverse action/adverse decision, or the direct service provider’s legal representative or attorney.

A level 1 appeal may be requested of Empower Healthcare Solutions within 60 calendar days of the date on the notice. A second MD will review the original adverse determination in addition to any additional information that is submitted. Level 1 appeals may be submitted via fax to (855) 429-1028 or to the address listed below:

Empower Healthcare Solutions, LLC
Compliance Officer
PO BOX 211446
Eagan, MN 55121

Level 1 appeal requests can also be made orally via phone at 1-866-261-1286 or in person at 1401 W Capitol Suite 330, Little Rock, AR 72201. If filed orally a written appeal request must be received within 10 calendar days.

Empower will acknowledge all appeal requests within 5 business days. Level 1 appeal resolutions will be sent no later than 30 calendar days from the date of the appeal receipt.

Upon request by the member or his or her parent/legal guardian, the PASSE must continue the member’s benefits during the appeal, if all of the following requirements are met:

• The request for appeal is timely in accordance with 42 CFR Part 438.420.
• The appeal involves the termination, suspension or reduction of previously authorized course of treatment;
• The services were ordered by an authorized provider;
• The period covered by the original authorization has not expired; and
• The member or his or her parent/legal guardian timely files for continuation of benefits in accordance with Empower’s policy.

An expedited Level 1 appeal may also be filed when there is an urgent need for resolution not to exceed 72 hours.
If the member is unsatisfied with the outcome of the Level 1 appeal, a request for fair hearing can be sent to the following:

For Members
The Office of Appeals and Hearings must receive a written hearing request within 60 (sixty) calendar days of the date on this letter. Send your request to Office of Appeals and Hearings, PO Box 1437, Slot N401, Little Rock, AR 72203-1437.

Provider or Provider/Beneficiary
The Arkansas Department of Health must receive a written hearing request within sixty (60) calendar days of the date on this letter. Send your request to Arkansas Department of Health, Attn: Medicaid Provider Appeals Office, 4815 West Markham Street, Slot 31, Little Rock, AR 72205.

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 and, upon request, to members and potential members. 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 are conducted methodically and consistently with specific action being taken where non-adherence is identified. All practice guidelines are reviewed on at least a biennial basis and updated as needed to reflect changes in recent scientific evidence or technology.

Practice Profiles
A comprehensive provider program includes a comprehensive report listing chronic care metrics such as HEDIS, readmission rates, generic medication utilization, monitoring of certain medications, and extent of use electronic medical records. “Practice profiles” are utilized as a tool for initiating performance improvement and for reducing practice variation. Individual practice results are provided. A detailed member gap in care list accompanies the practice profile. Reports are generated on a periodic basis and shared with providers to inform the implementation of best practices to address gaps in performance.

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. In order 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.

**Member Satisfaction**
Empower currently conducts quarterly member satisfaction surveys.

**Provider Satisfaction Surveys**
Empower measures provider satisfaction through an annual survey. Results of the survey are reviewed and analyzed by Network Management and the Quality Committee for improvement opportunities and to evaluate effectiveness of interventions implemented as follow-up to the previous year’s survey. Results may be shared through provider communications.

**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 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 866-261-1286.

**Empower Healthcare Solutions, LLC**
PO BOX 211446
Eagan, MN 55121
Toll Free: 866-261-1286
TTY: 888-479-6532
Fax: 888-614-5168
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 ongoing 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.

Quality of Care Concerns
Potential quality of care concerns initiated by a member, provider or health plan staff, are tracked and investigated. The process involves receipt and logging the potential quality of care case, acknowledgement letter sent to complainant within required timeframes, request for medical records, clinical review by a physician, including a like-specialty physician (when warranted) and sent for peer review when appropriate. All quality of care cases are closed within 30 days from complaint receipt per CMS requirements. All quality of care issues, whether confirmed or negated, are filed in the individual provider’s quality file and are queried upon re-credentialing. When poor quality of care is detected, follow-up actions are agreed upon and monitored. Monitoring of sentinel events and hospital serious adverse events are considered potential quality of care events.
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.

Medical Records Audits
Empower will conduct random medical record audits as part of its Quality Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services also might be assessed during a medical record audit. Empower will provide verbal or written notice prior to conducting a medical record review. Provider must records upon request at no charge.

Confidentiality Policy
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 in order 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 disposal is indicated

In addition, all provider agreements require that contracted providers must comply with appropriate policies and procedures to preserve patient confidentiality and are in compliance with HIPAA regulations.

Appendix
Notice of Appeal Form