Health Plan Review for Home and Community Based Service Providers

June 18, 2019

Housekeeping

- Please mute your phone
- Please don't put this call on hold – we'll all hear the hold music

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- The presentation is a general summary that explains certain aspects of the program, but is not a legal document.
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    - ü https://www.arkansastotalcare.com/providers.html

For Providers

The best support is close to home. That's why Arkansas Total Care operates from your neighborhood. We partner with local services and providers. Our team brings over 20 years of healthcare experience. We look forward to continuing that dedication.

Every individual should live with respect and dignity. We will help our members to maximize their independence. We will also help and maintain members quality of life in their chosen setting.

If you are interested in joining us as a provider, please visit our Become a Provider page.

Login To Your Account

Access your secure provider information any time.

Login Now

Arkansas Total Care provides the tools and support you need to deliver the best quality of care. Please view our listing on the left that covers forms, guidelines and helpful links.

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Agenda

- Introductions
- PASSE Overview
- Person Centered Service Plan Overview
- PCSP Planning Phases
- Prior Authorization
- Important Reminders and Tips
- Contact Information

Acronym

Acronym	Description
ARTC	Arkansas Total Care
BH	Behavioral Health
CC	Care Coordinator
DHS	Department of Human Services
IDD	Intellectual Developmental Disability
MTP	Master Treatment Plan
PASSE	Provider-led Arkansas Shared Savings Entity
PCSP	Person Centered Service Plan
POC	Plan of Care

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PASSE Overview

What is A PASSE

- A PASSE is a Provider-led Arkansas Shared Savings Entity
- Created by Act 775
- DHS defines the PASSE as "A new model of Organized Care that will address the needs of certain Medicaid Beneficiaries who have complex behavioral health and intellectual and developmental disabilities service needs"
- Provider-led in that providers must own at least 51% of the new company
- To learn more about the PASSE program visit Medicaid's website at: https://humanservices.arkansas.gov/about-dhs/dms/passe

Purpose of the PASSE

- To improve the health of Arkansans who have need of intensive levels of specialized care due to mental health, intellectual or developmental disabilities
- To link providers of physical health care with providers of behavioral health care and services for individuals with developmental disabilities
- To coordinate care for all community-based services for individuals with intensive levels of specialized care needs
- To reduce excess cost of care due to under-utilization and over-utilization of services
- To allow flexibility in the array of services offered to the population served
- To reduce costs by organizing care, not just by managing finances
- To increase the number of service providers available in the community to the population covered

About Arkansas Total Care

Arkansas Total Care is a newly formed partnership between Arkansas Health & Wellness, Mercy Health, and Lifeshare, Inc.

Mercy Health- Mercy operates 7 acute care, specialty care, and critical access hospitals in Arkansas, with additional facilities in Kansas, Missouri, and Oklahoma. Mercy provides primary and physical health services as well as behavioral and pharmacy services.

LifeShare- A licensed IDD and community-based provider in Arkansas, supporting people with Intellectual and Developmental Disabilities and other complex needs. For more than 20 years, LifeShare has created person-centered empowering programs and now works with other providers in manage care settings to collaboratively build programs that empower the lives of the people we collectively support.

Arkansas Health & Wellness- Arkansas Health & Wellness currently offers both Ambetter (a health insurance marketplace plan) and Allwell (a Medicare Advantage plan) in Arkansas. Arkansas Health & Wellness has a history of providing products and services for under/uninsured populations, employers, and self-employed groups. Through its corporate parent, Centene, Arkansas Health & Wellness also has over 30 years of experience supporting the community and those covered by Medicaid, including members with IDD and Behavioral Health needs.

Person Centered Service Plan (PCSP) Overview

What is a PCSP?

- The PCSP is a comprehensive plan of care developed to help individuals who receive intellectual developmental disabilities (IDD) and behavioral health (BH) services
- This process guides the delivery of services and support towards achieving outcomes in areas of the individual’s life that are most important to the member, such as:
    - Health
    - Relationships
    - Work
    - Home
- The PCSP is a “living plan” that is flexible and adapts as the member’s needs and desires change

What is Included in the PCSP?

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- Information about the member's lifestyle choices, any risks or challenges, and a plan to overcome those challenges
- The PCSP outlines the members' goals and who will help them work toward achieving those goals
- The member's IDD Plan of Care (POC) and BH Master Treatment Plans (MTP) address the following:
  - Physical health
  - Behavioral health
  - Social and long-term support needs
- The incorporated POC/MTP identifies specific services and the services providers used to meet stated goals, as well as their frequency, amount, and duration

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Who Creates the PCSP?

- The member and/or member's representative choose who will be part of developing the plan which could include the following:

Family Members → Doctors → Informal Supports → Friends → Guardians → Others who are Integral and Knowledgeable about the Member's life

- The PCSP is completed by the member's assigned Care Coordinator (CC)
- The CC is responsible for ensuring the POC/MTP is incorporated into the PCSP and services are authorized in accordance with the POC/MTP

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Person-Centered Service Planning Phases

PCSP Development Process

- ARTC has three phases within the PCSP development process and they are:

Phase 1
PCSP
Preparation &
Coordination

Phase 2
PCSP
Development

Phase 3
PCSP
Completion &
Implementation

Phase 1: PCSP Preparation & Coordination

- Member and/or guardian works with the CC to schedule a PCSP planning meeting and facilitate completion of service planning:
  - PCSP planning meeting occurs annually (at a minimum) – Once every 365 calendar days or less
  - Conducted face-to-face
  - CC must provide the member and/or guardian with necessary information and support to direct the planning process to the maximum extent possible, enabling the member and/or guardian to make informed choices
  - Must be held no more than 45 days prior to the effective plan date

Items the CC Will Assist the Member With

- Arrange location, date and time of planning meeting date
- Review services currently being received and the providers of those services
- Discuss the member's needs and desires (broad or long range goals)
- Make the member aware of their choice and ability to add, end or change any services or providers, including alternative settings and services that are available
- Identify whom they would like to attend their planning meeting
- Review reportable events and safety plan (if applicable)
- Inform the chosen paid and unpaid providers, family, or friends of the services the member would like to receive from them and notify them of the planning meeting date

Attempts to Contact

- CC must attempt to contact the member/guardian to schedule the in-person PCSP meeting
- Attempts to contact the member include the following:
  - Telephonic contact during which the CC attempted to speak to the member/guardian
    - ü This must be attempted 3 different times on 3 different days
  - Outreach to the member's primary provider of service to assist with reaching the member
  - A certified letter sent to the member's mailing address on file
- All attempts to contact the member will be documented in the ARTC member's record

Phase 2: Development of the PCSP

- This phase includes development of a complete description of services the member needs and identification of the member's goals
- Each agency/service provider chosen by the member and/or guardian to provider nee or continued services must participate in service planning with the member and guardian (if applicable)
- Agency/Service Provider Service Documentation information must include:
  - Identification of the type of DD waiver/BH services to be provided
  - Name of the provider delivering the service
  - Total amount by service (if applicable)
  - Total plan amount authorized (if applicable)
  - Beginning and ending date for each service
  - Supported Living Array worksheet:
    - ü Listing units and total cost by service and level of support (if applicable)

Phase 2: Development of the PCSP (con't)

- Adaptive Equipment, Environmental Modifications, Specialized Medical Supplies, Supplemental Support, and Community Transition worksheets:
    - Listing units and total cost by service (if applicable)
- Provider Information sheet showing case management provider, case manager, supportive living provider, and direct care supervisor (if applicable)
- Narrative justification for the revision to the initial plan of care must, at a minimum, justify the need for requested services
- Narrative justification for annual continued-stay reviews must address utilization of services used or unused within the past year, justify new services requested and address risk assessment

CC, Agency Service Provider, and Guardian will assist the Member

Talk about the member's desired/needed care from the provider

Review previous Service and Goal Descriptions specific to the service

Share with the Agency Service provider what their goals are for the upcoming year for this service area, including broad or long term goals, and identify their needs and desires

Review Reportable Events and Safety Plan, if applicable

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CC, Agency Service Provider, and Guardian will assist the Member (con't)

- Establish the member's choice for how to sign and receive the PCSP documents (paper or electronic)
- Review all of the IDD, HCBS, and ARTC Rights & Responsibilities
- Review the Appeals & Grievances Process
- Create a plan for assessing the member's satisfaction with their plan and services
- Learn how to report potential abuse, neglect, and exploitation.

Sensitive Information

- Sensitive information could include aspects of the member's life, which are, or should be, personal and private
- When sensitive issues are identified, the CC will assist the member in considering options for addressing them
- Some sensitive issues may be addressed as part of routine health care and may be documented in the medical record

Phase 3: PCSP Completion & Implementation

- PCSP must be approved by the member or the guardian (if there is one) before the plan is considered complete
- The approval signatures of the member (and/or the guardian), the CC, and all others who are responsible for implementing the plan are required
    - If the member or guardian disapproves of all or part of a plan, the planning team must address these concerns in a new or amended plan
- CC will supply the member or member's designated legal representative with a final PCSP, once all parties have signed the agreement (via paper or electronically)
- Final PCSP will be provided to the member according to the method selected in the member's completed plan, within the established timeframe of the PCSP meeting
- The CC will document member confirmation of receipt of a finalized plan with date, time and method of confirmation
- Once all parties have signed the agreement, ARTC will supply each of the member's applicable service providers with a copy of the PCSP through the ARTC provider portal

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- For participating providers, all new requests for services (for new or existing members) should be checked using our Pre-Auth Check tool on the ARTC website to quickly determine if a service requires prior authorization
- **IDD members:**
    - All existing services in the PCSP are subject to review by ARTC for annual approval/renewal
    - Upon review, a letter will be drafted to inform the member and provider of the approved services, including the count and duration of the approved authorization
- **BH members:**
    - All existing services in the PCSP will be reviewed by ARTC quarterly (4 x per year) for renewal
    - All existing services up for renewal should be submitted to ARTC prior to the service expiration date to prevent a break in services.
    - All new requests for services should be submitted on an as needed basis
    - Upon review, a letter will be drafted to inform the member and provider of the approved services, including count and duration of the approved authorization

Additional PCSP Meetings

- Additional PCSP meetings may be necessary due to changes in condition or circumstance that require updates to the member's plan, which would impact the scope, amount or duration of services included in the PCSP
- Examples of changes in condition or circumstance, include, but are not limited to:
  - Change in functional ability to perform two or more Activities of Daily Living (ADLs) or three or more Instrumental Activities of Daily Living (IADLs) compared to the most recently assessed functional ability
  - Change in behaviors that may lead to loss of foster placement or removal from the home
  - Significant change in informal support availability, including death or long-term absence of a primary caregiver, and/or any participant identified changes in informal caregiver availability that results in persistent unmet needs that are not addressed in the most recently developed PCSP
  - Post-transition from any alternate setting of care (i.e.: state hospital, nursing home, etc.), when the member was not residing in a community-based setting for thirty days or greater
  - Any health and/or safety concern

When a PCSP Meeting Should Be Held

- PCSP meeting shall be held:
    - Subject to the convenience of the member
    - Within an appropriate timeframe of ARTC's notification or awareness of necessitating circumstances
- CC must follow up with monthly telephone calls and face-to-face visits quarterly (4 x per year):
    - Face-to-face is the preferred method of contact for this visit

Prior Authorization

Do You Need a Prior Authorization?

Inpatient Services

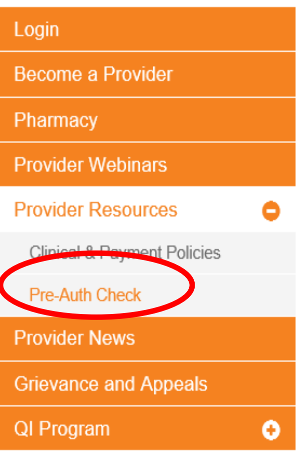
Service	PA
Acute Facility	**YES - PA Needed**
Residential Treatment Facility	**YES - PA Needed**
Intermediate Care Facility	**YES - PA Needed**

Outpatient & Prescription Services

Service	PA
IDD Waiver services with existing authorizations from AR Medicaid (end dates are extended to 12/31/2019)	**NO - PA Not Needed**
All other outpatient services & prescriptions with existing authorizations from AR Medicaid (end dates are extended to 8/31/2019)	**NO - PA Not Needed**
All new services & prescriptions that are not included in an existing authorizations from AR Medicaid	**YES - PA Needed**
Non-waiver authorized services that member will exhaust prior to 9/1/2019	**YES - PA Needed**

Pre-Auth Check Tool

- Pre-Auth Needed Tool- Check to see if a service needs a Prior Authorization
- You will need to answer 6 questions with the radio buttons before the box to enter your code will appear
- Once your code is entered, you will see a green N for no auth required, a red Y for auth required, or a blue C for conditional.



Pre-Auth Check

Use our tool to see if a pre-authorization is needed. It's quick and easy. If an authorization is needed, you can access our login to submit online. For the best experience, please use the Pre-Auth tool in Chrome, Firefox, or Internet Explorer 10 and above.

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response

Vision Services need to be verified by Envolve Vision.
Dental Services are provided through Delta Dental or MCNA. Please verify.
Complex imaging, MRA, MRI, PET, and CT scans need to be verified by NIA

Non-participating providers must submit Prior Authorization for all services.
For non-participating providers, Join Our Network.

Would this be Emergency or Urgent Care, Dialysis or are these family planning services billed with a contraceptive management diagnosis?

☐ Yes ☐ No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	○	○
Are anesthesia services being rendered for pain management?	○	○
Are oral surgeon services being rendered in the office?	○	○
Are chiropractic services being rendered?	○	○
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	○	○
Are hospice services being provided?	○	○

Enter the code of the service you would like to check:

99213 [Check]

C Conditional — **99213** - OFFICE/OUTPATIENT VISIT EST
Pre-authorization required for non-participating providers only.

To submit a prior authorization Login Here.

Prior Authorization Turnaround Timeframes

Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices.

All out-of-network providers will be required to request a prior authorization for services performed starting 9/1/2019.

TURNAROUND TIME* FOR AUTHORIZATIONS	
Urgent review	1 Business Day
Non-urgent review	2 Business Days
Prescription	24 Hours

*Turnaround time is based on receipt of all necessary information

Prior Authorizations

All new requests for services (for new or existing members) should be checked using our **Pre-Auth Check Tool** on the website to quickly determine if a service requires prior authorization.

Please visit ArkansasTotalCare.com

under For Provider, Provider Resources tab, Pre-Auth Check

Submit Prior Authorization

After you determine if a service requires authorization, submit via one of the following ways:

PHONE

1-866-282-6280 (TDD/TTY: 711)

After normal business hours and on holidays, calls are directed to the plan's 24-hour nurse advice line. Notification of authorization will be returned phone, fax, or web.

FAX

1-833-249-2342

ARTC19-H-109

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Arkansas Total Care updated Clinical and Payment policies as of May 1, 2019. You can find the policies under Provider Resources tab.

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FOR PROVIDERS

- Login
- Become a Provider
- Pharmacy
- Provider Webinars
- Provider Resources
  - Clinical & Payment Policies
  - Pre-Auth Check
- Provider News
- Grievance and Appeals
- QI Program

Clinical & Payment Policies

WHAT ARE CLINICAL POLICIES?

WHAT ARE PAYMENT POLICIES?

Arkansas Total Care Policies

ARTC CLINICAL POLICIES

ARTC PAYMENT POLICIES

ARTC PHARMACY POLICIES

Important Tips and Reminders

Revision Request to Supportive Living Waiver Plan

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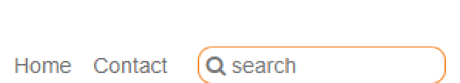
- Provider requesting for change in Waiver Services prior to Arkansas Total Care Personal Care Service Plan (PCSP) development must adhere to the following:
  - Provider must submit the following:
    - CES 703 Waiver PCSP Form:
      - https://humanservices.arkansas.gov/images/uploads/ddds/CES-703_Waiver_PCSP_Forms.docx
    - CES 110 Pro-Rated Staff Worksheets:
      - https://humanservices.arkansas.gov/images/uploads/ddds/CES-110_Pro-Rated_Staff_Worksheets.xlsx
    - Copy of narrative/revision summary
    - Change amount and include a justification:
      - This should include change requested and the reason for the change in order to support the request
- Submit all forms and documentation via fax at: 1-833-249-2342

Provider Webinars

Home Contact



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- Grievance and Appeals
- PASSE Town Hall Webinar

Provider Webinars

This Provider Webinar Series offers the providers and their office staff the opportunity to learn from subject matter experts. Participants can ask questions about current topics and best practices. Registration is free and each webinar will be approximately one hour in length.

2019 Q1 Provider Webinar

When: March 6th, 2019 at 10 AM and 3 PM (CST)
Where: Online session
Summary: This webinar covers a general overview of ARTC, the PASSE model, billing, our provider portal, and contact information.

Web Wizard For Home And Community Based Service Providers

When: March 8th, 2019 at 3:00 PM-4:00 PM (CST)
Where: Online session
Summary: This webinar covers a general overview of Web Wizard.

*Webinars **

Web Wizard for HCBS Providers - March 8th - 3PM (CST)

Please choose which webinar(s) you would like to attend. Registration ends one hour before the scheduled class time.

*First Name ** *Last Name **

Provider Resources

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Provider Resources

Arkansas Total Care provides the tools and support you need to deliver the best quality of care.

Reference Materials

- Provider Newsletter - Q1 2019 (PDF)
- 2019 Provider Manual (PDF)
- Quick Reference Guide (PDF)
- Payspan (PDF)
- Secure Portal (PDF)
- Provider Education Member ID Card (PDF)
- Prior Authorization Guide (PDF)
- Incident Report (PDF)

Medical Management

- Pre-Auth Needed?
- Inpatient Prior Authorization Fax Form (PDF)
- Outpatient Prior Authorization Fax Form (PDF)

Quick Reference Guide

Quick Reference Guide

Simplify Office Administrative Tasks

Keep our Quick Reference Guide nearby to make pre-visit planning and post-visit tasks quick and easy.

Website: ArkansasTotalCare.com

- Patient care forms
- Pre-Auth Needed tool
- Arkansas Total Care News
- Provider Manual
- Preferred Drug List
- Member resources

Secure Provider Portal: Provider.ArkansasTotalCare.com

- Verify member eligibility
- Access patient health records
- View patient gaps
- Manage prior authorizations
- Submit and manage claims
- And more!

Provider Contracting

To join our network select 'Become A Provider' from the 'For Providers' tab on our website. You must currently be a participating Arkansas Medicaid provider.

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FOR PROVIDERS

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Become A Provider

Thank you for your interest in participating with Arkansas Total Care. We are excited for the chance to work with you to provide high-quality care.

If you are interested in joining our network call toll free 1-844-631-6830 or fill out the form below.

As a Arkansas Total Care provider, you can rely on:

- A comprehensive approach to care for your patients through disease management programs, healthy behavior incentives and 24-hour toll-free access to bi-lingual registered nurses
- Initial and ongoing provider education through orientations, office visits, training and updates
- A dedicated claims team to ensure prompt payment
- Minimal referral requirements and limited prior authorizations
- A dedicated provider relations team to keep you informed and maintain support in person, by email or by phone
- The ability to check member eligibility, authorization and claims status online
  Healthcare collateral for your patients (e.g., information about our benefits and services) and educational displays for your office

*Legal Practice Name or DBA **

*Specialty **

*Practice Address **

Contact Information

Arkansas Total Care

Provider Services

Phone: 1-866-282-6280
Website: arkansastotalcare.com

Email inquiries to:

Providers@ArkansasTotalCare.com

Education Requests

Would you like training for you and your staff?

You can submit your requests to

Providers@ArkansasTotalCare.com

Contracting Department

Phone Number: 1-844-631-6830
Hours of Operation: 8am-4:30pm

Provider Contracting Email Address:
ArkansasContracting@centene.com
Regular contracting inquiries and contract requests

Questions

Please use the Q & A feature to enter your questions

Thank you for joining!