Interpreter Services

For members who do not speak English or do not feel comfortable speaking it, Arkansas Total Care has a free service to help. This service is very important because you and your doctor must be able to talk about your medical or behavioral health concerns in a way you both can understand. Our interpreter services are provided at no cost to you and can help with many different languages. This includes sign language. We also have Spanish-speaking representatives available who can help you as needed. Arkansas Total Care members who are blind or visually impaired can call Member Services for an oral interpretation. Video or Telephone Relay interpretation services should call Member Services at 1-866-282-6280 (TTY: 711).

Reporting Abuse, Neglect, or Exploitation

If you know or suspect that a member is experiencing any of the following, contact Child Protective Services at 1-800-482-5964 or Adult Protective Services at 1-800-482-8049. If the member is in danger, contact the police immediately at 911.

- Abuse
- Neglect
- Exploitation
- Child maltreatment
- Adult maltreatment

Statement of Non-Discrimination

Arkansas Total Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Arkansas Total Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Arkansas Total Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
  - If you need these services, contact Member Services at 866-282-6280

If you believe that Arkansas Total Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

- **1557 Coordinator,**
- **PO Box 31384, Tampa, FL 33631,**
- **855-577-8234,**
- **TTY: 711,**
- **FAX: 866-388-1769,**
- **SM_Section1557Coord@centene.com.**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our **1557 Coordinator** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **https://www.hhs.gov/ocr/complaints/index.html**

This notice is available at **Arkansas Total Care's** website:
https://www.arkansastotalcare.com/Statement-of-Non-Discrimination.html

Table of Contents

Welcome & Resources

Welcome to Arkansas Total Care. Arkansas Total Care is committed to providing whole health solutions for people with intellectual and developmental disabilities (IDD) and behavioral health (BH) needs. Our unique, person-centered approach ensures each member receives comprehensive Care Coordination tailored specifically to them. With over 20 years of experience, the partners at Arkansas Total Care provide support services that create healthier, happier individuals — ultimately improving their overall quality of life.

The Provider-Led Arkansas Shared Savings Entity (PASSE) is a model of organized care that will address the needs of certain Medicaid beneficiaries who have complex BH and IDD service needs. Under this unique organized care model, providers of specialty and medical services enter into new partnerships with experienced organizations that perform the administrative functions of managed care. Together, these groups of providers and their managed care partners form a PASSE.

The purpose of the PASSE is to:

- Improve the health of Arkansans who need intensive levels of specialized care due to mental health, intellectual, or developmental disabilities.
- Link providers of physical healthcare with providers of behavioral healthcare and services for those with developmental disabilities.
- Coordinate care for individuals with intensive levels of specialized care needs.

Arkansas Total Care is a health plan that gives you choices — from choosing your primary care provider (PCP) to participating in special programs that help you stay healthy.

Visit our website at ArkansasTotalCare.com for more information and services.

Member Handbook

This Member Handbook is an overview of Arkansas Total Care and your plan. With this Handbook, you will be able to learn more about:

- Your rights.
- Your benefits.
- Your duties.

Please read this book carefully and keep it safe for future use. This book tells you how to access Arkansas Total Care's healthcare services. It also gives you information about benefits like:

- What is covered by Arkansas Total Care.
- What is not covered by Arkansas Total Care.
- How to get the care you need.
- How to get your prescriptions filled.
- What you will have to pay for your healthcare or prescriptions.
- What to do if you are unhappy about your health plan or coverage.
- Materials you will receive from Arkansas Total Care.

If you would like another copy of this Member Handbook, call Member Services at 1-866-282-6280 (TTY: 711). We will send you one at no charge. You can also visit our website at ArkansasTotalCare.com to view this Handbook online.

Provider Directory

Arkansas Total Care has a list of all the doctors, hospitals, and clinics we work with. We call this list the Provider Directory. The Provider Directory has the following information about our providers:

- Type or specialty (such as PCPs)
- Address and telephone number
- Office hours
- Accessibility of sites/facilities
- Languages spoken (other than English)
- If they are accepting new Medicaid clients

You can view the Provider Directory by:

1. Going to our website at ArkansasTotalCare.com.
2. Calling Member Services at 1-866-282-6280 (TTY: 711). They can help you find a provider in your area. They can also send you a free copy of our Provider Directory.

Arkansas Total Care Website

ArkansasTotalCare.com

Arkansas Total Care's website has resources and features that make it easy for you to get quality care. It also gives you information on your benefits and services, such as:

- Member Handbook
- Provider Directory
- Arkansas Total Care programs and services
- Current Arkansas Total Care news and events

Our secure Member Portal houses resources that will improve your experience with Arkansas Total Care. In the Member Portal, you can:

- Complete online form submissions.
- Change your PCP.
- View care gaps.
- View claims submitted on your behalf.
- Access and print a copy of your Member ID Card.

How to Create a Member Account

Step 1:	Visit **ArkansasTotalCare.com**. Click **For Members**.
Step 2:	Under **Login To Your Account**, click **Login Now**.
Step 3:	Click **Create New Account** to begin creating your account. Enter your email address and full name. Select your language preference.
Step 4:	Create a password. Click **Create Account**. You will get an email asking to verify your account. Log in with your email address and password to finish registering your account.
Step 5:	Enter your Member ID. Enter your date of birth. Click **Submit**.
Step 6:	Congratulations! Your secure Member Portal account has been created.

How to Get Help in the Member Portal

At the top of your screen, click on **Message** to send a message to Arkansas Total Care. You will receive a response to your message within one to two business days.

You can also call Member Services at 1-866-282-6280 (TTY: 711).

How to Change Your Address

Step 1:	Visit **ArkansasTotalCare.com**. Click **For Members**.
Step 2:	Under **Login To Your Account**, click **Login Now**. Log in to your member account.
Step 3:	Click the profile icon.
Step 4:	Click on **Change** next to the current address. Enter your new address.
Step 5:	Click **Save**. It may take up to 24 hours for your address to update.

After changing your address in the Member Portal, please contact the Arkansas Department of Human Services (DHS) at 1-800-482-8988 to update your address with them as well.

Consumer Advisory Council

The Consumer Advisory Council (CAC) is a group of members, parents, and guardians (including Arkansas Total Care staff as appropriate) that reviews and reports on a variety of issues. The purpose of the CAC is to gather member and community input about the approach and effectiveness of Arkansas Total Care's programs, policies, and services. The CAC is a collaborative effort to enhance the service delivery system in local communities.

The CAC communicates through multiple channels to make sure members can provide input and ask questions. The CAC enables Arkansas Total Care to ask questions and get feedback from members. Video conferencing may be used as needed to provide opportunities for members to attend meetings. The CAC's responsibilities may include review of topics and items like member satisfaction results, customer service and/or quality improvement efforts, and member education materials for relevance, understanding, and ease of use, among other topics.

For more information about the CAC, talk with your Care Coordinator or call Member Services at 1-866-282-6280 (TTY: 711).

Quality Improvement (QI)

Arkansas Total Care is committed to giving you quality healthcare. Our main goal is to promote your health and help you manage any illness or disability. Our program is in line with the standards set by the National Committee for Quality Assurance (NCQA) and the Institute of Medicine (IOM). To promote safe, reliable, and quality healthcare, our programs:

- Do a thorough check on providers when they become part of the Arkansas Total Care provider network.
- Make sure Arkansas Total Care members have access to all types of healthcare services.
- Provide educational items about general healthcare and specific illnesses.
- Send reminders to get annual tests, treatments, or screenings.
- Investigate any concerns you have about the healthcare you have received. If you are worried about the care you got from your doctor or any service provided by Arkansas Total Care, please call Member Services at 1-866-282-6280 (TTY: 711).

Arkansas Total Care believes that getting input from members like you will help make the services and quality of our programs better. We send out a member survey each year that asks questions about your experience with the healthcare and services you receive.

If you get one of our member surveys, please be sure to fill out the survey to help us better serve you. If you would like a copy of our Quality Assessment and Performance Improvement (QAPI) plan, please contact us and we will send you one.

How to Contact Us

Arkansas Total Care
P.O. Box 25010
Little Rock, AR 72221
Monday–Friday, 8 a.m.–5 p.m. CT

Member Services: 1-866-282-6280 (TTY: 711)

Medical Management: 1-866-282-6280 (TTY: 711)

Vision/Pharmacy Services: 1-866-282-6280 (TTY: 711)

Other Important Phone Numbers:

24-Hour Nurse Advice Line: 1-866-282-6280 (TTY: 711)

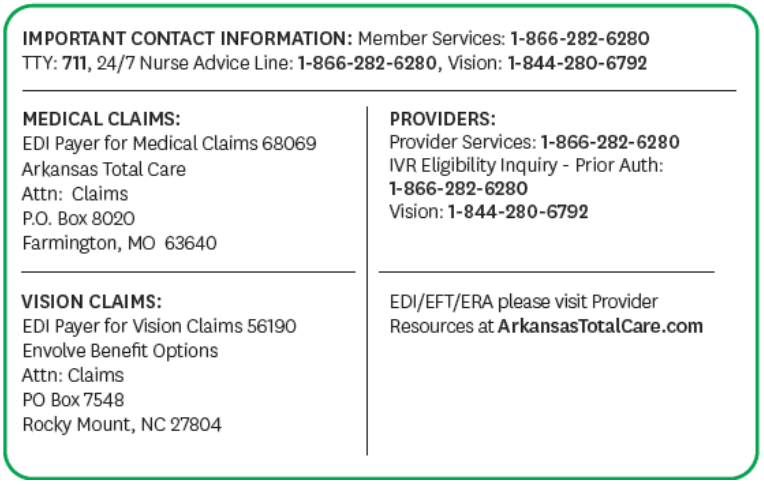
Emergency Services: 911

Your Member ID Card

We will mail your Arkansas Total Care Member ID Card within five business days of your enrollment. This card is proof that you are a member of Arkansas Total Care. You should keep it with you at all times. Please show your card every time you go for any service covered by Arkansas Total Care. If needed, you can print a replacement ID card from the Member Portal.

If you do not get your Arkansas Total Care ID card in the mail or are not able to print a replacement card, please call Member Services at 1-866-282-6280 (TTY: 711).

Below is an example of an Arkansas Total Care Member ID Card:



How Your Plan Works

Member Services

Our Member Services team will tell you how Arkansas Total Care works. They will also help you get the care you need. Member Services can help you:

- Find a primary care provider (PCP).
- Get a new Member ID Card.
- Get information about covered and uncovered benefits.
- File grievances and appeals.
- Get interpretation services.
- Get information about your health.
- Find a doctor or specialist in our network.
- Report a potential fraud issue.
- Get a copy of member materials, including in another language or format.
- Get information about Case Management.

To talk with Member Services, call 1-866-282-6280 (TTY: 711). We are open Monday–Friday from 8 a.m. to 5 p.m. CT. Calls received while we are closed or on holidays are answered by our 24-Hour Nurse Advice Line.

24-Hour Nurse Advice Line

The 24-Hour Nurse Advice Line is a free health information phone line staffed by medical professionals who are ready to help answer your questions. The Nurse Advice Line is open 24 hours a day, every day of the year. The nurses answering the calls have spent a lot of time caring for people and are eager to help you.

If you need help with anything listed below, call 1-866-282-6280 (TTY: 711).

- Medical advice
- Health information library
- Answers to questions about your health
- Advice about a sick child
- Behavioral health emergencies

There are times you may not be sure if you need to go to the emergency room (ER). If you aren't sure, call the Nurse Advice Line. They can help you decide where to go for care. If you have an emergency, call 911 or go to the nearest ER. The Nurse Advice Line is able to communicate in English and in Spanish. They can use translation services for more than 200 other languages as well as needed.

Care Coordination

To make getting the care you need easier, we will pair you with a Care Coordinator to work with you and your providers. Your Care Coordinator is the best way to communicate with Arkansas Total Care.

Once you are an Arkansas Total Care member, the Care Coordination team will reach out to you within 15 business days to conduct a service assessment and health risk assessment. This will help them pair you with a Care Coordinator. Your Care Coordinator will then reach out and set up a time to meet with you in person to complete a Person-Centered Service Plan (PCSP).

Care Coordinators can help you:

- Find a PCP.
- Schedule an appointment with your PCP.
- Get health education and coaching.
- Complete a PCSP.

- Coordinate with other healthcare providers for diagnostics, ambulatory care, and hospital services.
- Get help with social determinants of health, such as access to healthy food and exercise.
- Do activities focused on the health of you and your community, including outreach and patient panel management.
- Coordinate community-based management of medication therapy.
- File grievances and appeals.
- Get interpretation services for meetings set up by Arkansas Total Care.
- Find a doctor or specialist.
- Report a potential fraud issue.
- Get a copy of member materials, including materials in another language or format.
- Assist with scheduling transportation services.

Contacting Your Care Coordinator

Get in touch with you Care Coordinator by calling Member Services at 1-866-282-6280 (TTY: 711). Ask to speak with your Care Coordinator.

How to Contact Us

Arkansas Total Care
P.O. Box 25010
Little Rock, AR 72221

Phone: 1-866-282-6280 (TTY: 711)
Email: Members@ArkansasTotalCare.com
Hours: Monday–Friday, 8 a.m.–5 p.m. CT

After-Hours Services

After-hours services are available when the Call Center is closed, including after normal business hours, weekends, holidays, and for unplanned telephone outages. Call Member Services at: 1-866-282-6280 (TTY: 711) after hours, and you will be routed to our Nurse Advice Line. Our Nurse Advice Line is staffed with nurses 24/7.

After-hours services include, but may not be limited to:

- Emergency assessment and referral for members in crisis.
- Help determining if you should go to the emergency room, urgent care, or if your health concern can be treated by your physician.

Your Person-Centered Service Plan (PCSP)

Your Care Coordinator will meet with you and your planning team to create a PCSP that identifies all the services you need and the providers you will work with. Your Care Coordinator will schedule the meeting based on when and where you would like it to occur, as well as who you would like to attend.

Arkansas Total Care will review all of the services you receive within our plan, help identify any gaps in care, and suggest additional or different types of services based on your needs.

We can help you get access to clinical professionals such as physicians, pharmacists, psychiatrists, nurses, and behavioral health professionals who can complete care reviews and make recommendations if you are facing a complex care need. Our staff can provide recommendations and consult with your providers.

Guardianship

Arkansas Total Care must keep documentation establishing legal guardianship. If you are the legal guardian of an Arkansas Total Care member, please provide legal guardianship documentation to the Care Coordinator as soon as possible after joining the PASSE.

How to Change Your Care Coordinator

To change your Care Coordinator, call Member Services at 1-866-282-6280 (TTY: 711).

Care Management

Our Care Management program is tailored to your health needs. Care Managers are licensed social workers or registered nurses that will work with you, in addition to your Care Coordinators, to address short-term health goals. Your Care Manager can assist you in removing barriers, provide teaching on health conditions or medications, and assist you with resources in your community.

Care Managers can help manage conditions or health-related events such as:*

- Changes in a condition.
- ER visits or hospital admissions.
- Education of disease processes.
- Falls or other injuries.
- New diagnosis or medication.
- Difficulty in living environment or work arrangement of loved ones.
- Need for additional training.
- Transition from residential facilities/intermediate care facility to the community.
- Complex discharge needs.

*This list does not include all conditions we help manage through the Care Management program.

If you would like to participate in our Care Management program, call Member Services at 1-866-282-6280 (TTY: 711). You can also call your Care Coordinator.

Membership and Eligibility Information

Eligibility

In order to be enrolled in a PASSE, you must complete an independent assessment through Optum and be determined to have Tier 2, Tier 3, or Tier 4 needs.

Enrollment

Every year, there is an Annual Enrollment Period that allows members to change their PASSE. The state of Arkansas will send you a letter telling you that Open Enrollment is occurring. They will also tell you what you can do to change your PASSE. During Open Enrollment, you can choose another health plan for any reason. For questions about changing your PASSE, please contact the PASSE Member Line at 1-833-402-0672.

Disenrollment/Reinstatement

If you are disenrolled from Arkansas Total Care, you can be reinstated for the following month with no lapse in coverage. To do so, you must reestablish your eligibility and have it entered into the Medicaid Management Information System (MMIS) by the last day of the month. To reestablish your eligibility, contact the Access Arkansas Eligibility Call Center at 1-800-482-8988. The decision to reinstate your eligibility comes from the state of Arkansas, not from Arkansas Total Care.

If a lapse in eligibility is not resolved within the above timeframe, you will not be reinstated for the following month. You will be disenrolled from Arkansas Total Care. If a continuity of care issue arises and all parties agree, you can be reinstated into Arkansas Total Care. If you have questions about your eligibility or would like to have your eligibility reinstated, call the Access Arkansas Eligibility Call Center at 1-800-482-8988.

Major Life Changes

Life changes might affect your eligibility with the state. If you have a major change in your life, please call the Access Arkansas Eligibility Call Center at 1-800-482-8988 within 10 days. It is important to report these changes. You should also call Arkansas Total Care Member Services at 1-866-282-6280 (TTY: 711) to let us know of the change.

Some examples of major life changes include:

- A change in your name.
- Moving to a different address.
- A change in your job/income.
- A change in your family size.
- A change in disability.
- Pregnancy.
- Moving to a new county or state.

Benefits & Services

Covered Services

This section describes your Arkansas Total Care covered benefits. With Arkansas Total Care, you are entitled to receive medical services and the benefits listed in this section. You are responsible for payment of any non-covered services. Covered benefits are listed in this section.

Please Note:

- Arkansas Total Care will not limit or deny services because of a condition you already have.
- For services which are medically necessary and covered by Arkansas Total Care, you will not have any copayments (copays), deductibles, or other cost sharing that requires you to pay a portion of the fee — except as noted in the Member Responsibilities section.
- If you receive healthcare services which are not medically necessary or if you receive care from doctors who are out of the Arkansas Total Care network, you may be responsible for payment. If you have questions about medical necessity or which doctors are in your network, call Member Services at 1-866-282-6280 (TTY: 711).
- You have the right to a second opinion from a provider at no cost to you.

In Lieu of Services

In Lieu of Services (ILOS) are services that are not covered by traditional Medicaid and are not usually a PASSE-covered benefit. Arkansas Total Care may provide ILOS if it's a more cost-effective substitute for a service covered under the PASSE program. DHS must approve ILOS before they can be offered to members.

If Arkansas Total Care offers an ILOS to you as a substitute for a covered service or setting under the State plan, you are not required to use it. You still retain all rights and protections described in this handbook and the right to receive the service or setting covered under the State plan on the same terms you would if the ILOS was not offered. Arkansas Total Care will not use ILOS to reduce, discourage, or jeopardize your access to services and settings covered under the State plan. Additionally, Arkansas Total Care will not deny access to a service or setting covered under the State plan on the basis that you:

- Have been offered an ILOS as an optional substitute.
- Are currently receiving an ILOS as a substitute for a service or setting covered under the State plan.
- Have utilized an ILOS in the past.

Notice Regarding Medicare: As a member, if you are also covered by Medicare, you have the right to continue to see your Medicare primary care provider (PCP). After Medicare pays your claim, Arkansas Total Care will pay your Medicare deductibles and coinsurance amounts. For us to do this, the provider must also be registered with the Arkansas Medicaid program.

Benefits

For specific information regarding your benefits, visit the Member Services section of our website at ArkansasTotalCare.com/members.html.

For information about any benefits that are available to you through Arkansas Medicaid, and not covered by Arkansas Total Care, call the Access Arkansas Eligibility Call Center at 1-800-482-8988. You can also visit the Arkansas Medicaid website at portal.mmis.arkansas.gov/armedicaid/member/Home/tabid/55/Default.aspx.

The PASSE must make sure that a member has access to all needed services covered under the Medicaid State Plan, the 1915(i) State Plan Amendment, and the Community and Employment Supports (CES) Waiver. This includes therapy services and services through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program for children.

State Plan Services:

- Personal Care
- Primary Care
- Durable Medical Equipment
- Occupational Therapy
- Speech Therapy
- Physician Specialists
- Pharmacy
- Hospital Services
- Physical Therapy
- Nursing Services
- Family Planning
- Inpatient Psychiatric
- Outpatient Behavioral Health Counseling

CES Waiver Services:

- Respite
- Supported Employment
- Supported Living
- Community Transition Services
- Supplemental Support
- Specialized Medical Supplies
- Adaptive Equipment
- Environmental Modifications
- Consultation

1915 (i) Behavioral Health Services:

- Supportive Employment
- Respite
- Behavioral Assistance
- Peer Support
- Family Support Partners
- Adult Rehabilitation Day Treatment
- Child and Youth Support
- Individual Life Skills Development
- Crisis Stabilization Intervention
- Therapeutic Host Home
- Therapeutic Communities
- Supportive Housing
- Partial Hospitalization
- Community Reintegration Program
- Supportive Life Skills
- Group Life Skills Development
- Aftercare Recovery Support (Substance Abuse)

Services that are not covered by the PASSE, but are covered by Medicaid:

- Nonemergency Medical Transportation (NET)
- Transportation to and from Early Intervention Day Treatment (EIDT) and Adult Development Day Treatment (ADDT)
- Dental benefits
- School-based services provided by school employees
- Skilled Nursing Facility (SNF) services. Limited Rehabilitation Stays are not an excluded SNF service.
- Assisted Living Facility (ALF) services

- Human Development Center (HDC) services. 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, the Arkansas Independent Choices (IC) program, or a successor waiver for the elderly and adults with physical disabilities

- Transplants

- Abortions, except as allowed by state or federal law

Member Payment Responsibility

When You Have to Pay and When You Don't

Arkansas Total Care will cover most of your medical bills, but there are times when services are not covered or are limited. You should not get a bill if the medical service you received is a covered Arkansas Total Care benefit. You will be responsible for all non-covered services. Information about covered and non-covered services is in this Handbook and on the Arkansas Total Care website.

Members should follow the guidelines below:

- Always ask if the service is covered before you receive it.

- If you want to know if a specific procedure code or pharmacy item is covered, call Member Services at 1-866-282-6280 (TTY: 711).

- If you receive a non-covered service, your provider may ask you to sign a statement saying that you will pay for the service.

- You must use a provider who accepts your Arkansas Total Care Member ID. If you are an Arkansas Total Care member, you must use a provider in the Arkansas Total Care network. If you do not, you may have to pay the bill.

- Show your Arkansas Total Care Member ID at the time you get the service or item. If you do not, you may have to pay the bill.

- If your provider suggests you get a service that is not covered, you must pay for that service if you choose to get it.

- If you request a service that is not covered, you must pay for that service.

How to Obtain Healthcare

What Is a PCP?

When you enroll in Arkansas Total Care, you must choose a primary care provider (PCP). Your PCP is a doctor you see on a regular basis to take care of your medical needs. Arkansas Total Care recommends that you see your PCP within the first 90 days of becoming a member, even if you are not sick. You should get all of your basic medical care from your PCP. You can call your PCP when you are sick and do not know what to do. Seeing your doctor for regular check-ups helps you find health problems early. This can help prevent going to the ER.

If you have never seen your PCP, we suggest that you call your PCP as soon as you join Arkansas Total Care. You can introduce yourself as a new member and make an appointment in the first 90 days for a preventive visit. It is best not to wait until you are sick to meet your doctor for the first time.

Three easy steps to establish a PCP relationship:

1. Choose a doctor. You will be able to switch to a different doctor during our new member welcome call. You can also call Member Services at 1-866-282-6280 (TTY: 711). Or you can let your Care Coordinator know that you would like to change doctors.

2. Make an appointment with your doctor after you become an Arkansas Total Care member.

3. Talk to your doctor about any health problems you are having.

PCP Responsibilities

Your PCP will:

- Make sure that you get all medically necessary services in a timely manner.
- Follow up on the care you get from other medical providers.
- Provide any ongoing care you need.
- Update your medical record. This includes keeping track of all the care you get from your PCP and specialists.
- Provide services in the same way for all patients.
- Give you regular physical exams.

- Provide preventive care.
- Give you regular immunizations.
- Make sure you can contact them or another doctor at all times.
- Talk about what Advance Directives are and file them in your medical record.

Choosing Your PCP

Arkansas Total Care has a list of all providers in our network on our website. Using our Find a Provider tool, you will see a list of doctors and hospitals. You will also see their contact information and specialties. Our Provider Directory will show the addresses, phone numbers, and any languages the provider speaks. When picking a PCP, look for one of the following:

- Family Practitioner
- General Practitioner
- Internal Medicine
- Nurse Practitioner
- Obstetrician/Gynecologist (OB/GYN)*
- Advanced Practice Registered Nurse

Specialists can be your PCP for special needs, upon request. Arkansas Total Care works to have the best provider network for all our members. New doctors are added daily, so check our website at ArkansasTotalCare.com to see if new providers have been added. If you would like a free copy of our Provider Directory or want to know more about a PCP before you choose, please call Member Services at 1-866-282-6280 (TTY: 711). Female patients may have direct access to women's health specialists in addition to their PCP if their PCP is not a women's health specialist.

*Though you can opt to have a specialist as a PCP, the specialist must elect to be a PCP. For OBGYN, they have to elect to be a PCP option. If they do not elect to be a PCP, they cannot be selected.

Changing Your PCP

You may change your PCP at any time. If you want a new PCP, contact your Care Coordinator or Member Services at 1-866-282-6280 (TTY: 711). You can also change your PCP in the Member Portal. Please call Member Services or your Care Coordinator at 1-866-282-6280 (TTY: 711) to let us know if you have changed your PCP.

Making an Appointment With Your PCP

Once you have selected a PCP, make an appointment to meet them within 90 days. This will give you and your PCP a chance to get to know each other. They can give you medical care, advice, and information about your health.

Call your PCP's office to make an appointment. Remember to take your Arkansas Total Care Member ID Card with you every time you go to the doctor's office.

If you have difficulty getting an appointment to see your doctor, please call your Care Coordinator or Member Services at 1-866-282-6280 (TTY: 711).

After-Hours Appointments With Your PCP

You can call your PCP's office for information on getting care in your area. If you have a medical problem or question and cannot reach your PCP during normal office hours, you can call the 24-Hour Nurse Advice Line. If you have an emergency, call 911 or go to the nearest ER.

IMPORTANT: If you cannot keep an appointment, please call the doctor's office to cancel at least 24 hours in advance. If you need to change an appointment, call the doctor's office as soon as possible. They can make a new appointment for you. If you need help getting an appointment, call your Care Coordinator at 1-866-282-6280 (TTY: 711).

What to Do if Your Provider Leaves the Arkansas Total Care Network

If your PCP is planning to leave the Arkansas Total Care provider network, we will send you a notice before the date this occurs, or as soon as we are notified. Your Care Coordinator will work with you to find a new PCP so you always have access to the care you need. If you want a different PCP, please call Member Services at 1-866-282-6280 (TTY: 711). You can change your PCP at any time.

Arkansas Total Care may approve visits with your doctor for up to 90 days after they leave the network. We can do this if you are in active treatment with your doctor. Members in the second or third trimester of pregnancy can keep the same doctor until after the first post-partum visit. During this time, we will help you find a new doctor. You will get the same covered services. The doctor must agree to:

- Treat you for your healthcare needs.
- Accept the same payment rate from Arkansas Total Care.

- Follow Arkansas Total Care's quality assurance standards.
- Follow Arkansas Total Care's policies about Prior Authorization and using a treatment plan.
- Provide necessary medical information to you about your care.

Continued coverage is available only if your PCP or specialist was not terminated by Arkansas Total Care due to quality of care.

Medical Services

Medically Necessary Services

Covered services that you receive must be medically necessary. This means getting the right care, at the right place, at the right time. Arkansas Total Care uses standard guidelines to check medical necessity. Arkansas Total Care does not reward its network providers or their staff for denying care.

Prior Authorization

When you need care, always start with a call to your primary care provider (PCP). Some covered services may require Prior Authorization or review by Arkansas Total Care before services are provided. This includes services or visits to an out-of-network provider and some specialists. Home health services and some surgeries also need to be reviewed. Your doctor can tell you if a service needs to be reviewed. The list can be found on our website at ArkansasTotalCare.com. You can also call Member Services at 1-866-282-6280 (TTY: 711) to see if something needs to be reviewed by us. Prior Authorizations are not required for emergency medical services.

Your doctor will give us information and documentation about why you need the service. Arkansas Total Care will look to see if the service is covered and that it is appropriate. Arkansas Total Care will make the decision as soon as possible, based on your medical condition. Your provider should request a non-urgent Prior Authorization at least five calendar days before the service is needed.

Prior Authorization decisions for non-urgent services will be made within two business days of Arkansas Total Care getting all the information we need to complete our review of the service. Your doctor will get a letter if the service is approved or denied. For urgent services, a decision will be made within one business day after Arkansas Total Care gets all information needed to complete the medical necessity review.

For urgent requests, Arkansas Total Care will make a reasonable attempt to call your provider with the decision. If you or your doctor is not happy with the decision, you can ask for a second review. This is called an appeal. See the Member Satisfaction section of this Handbook for more information about appeals.

If there are any major changes to the Prior Authorization process, we will let you and your doctors know right away.

Referrals to Specialty Care

Your PCP can take care of many of your most common needs. From time to time, you may need to see a doctor for specific medical problems, conditions, injuries, and/or diseases. If this is the case, you have the option to see a specialist.

A specialist is a doctor who works in one healthcare area. Some examples of specialists are doctors who only work with the heart, skin, or bones.

You can visit a specialist at any time. Arkansas Total Care does not have a referral requirement. Referrals are not necessary, but they can be helpful.

Your PCP can help you find a specialist, or you can go straight to the specialist. If the specialist you want to see is not in the Arkansas Total Care network, you may need to get Prior Authorization before seeing the specialist. See the Prior Authorization section of this Handbook for more details.

Please be aware that some specialists will not see you without a referral. For questions about getting a referral, call Member Services at 1-866-282-6280 (TTY: 711). If you are having an emergency, call 911.

Emergency Services

Urgent Care

Urgent care is not the same as emergency care. Urgent care is needed when you have an injury or illness that must be treated within 48 hours. It is usually not life threatening, but you cannot wait for a visit to your PCP.

Please call your Care Coordinator after you have visited an Urgent Care Center or ER.

Emergency Room

Emergency rooms are for anything that could endanger your life (or your unborn child's life if you are pregnant). Anything that could endanger your life without immediate medical attention is an emergency situation. ERs treat accidental injuries or the onset of what appear to be a medical condition.

Go to the ER if your doctor tells you to go or you have a life-threatening emergency. If your doctor does not tell you to go to the ER, or if your condition is not life-threatening, follow these steps:

- Call your PCP. Your PCP may give you care and directions over the phone.
- If it is after hours and you cannot reach your PCP, call the 24-Hour Nurse Advice Line at 1-866-282-6280 (TTY: 711). You will be connected to a nurse.

Go to the ER if you experience:

- Severe chest pain or heart attack.
- Drug overdose.
- Poisoning.
- Bad burns.
- Shock. You may sweat, feel thirsty or dizzy, or have pale skin.
- Convulsions or seizures.
- Trouble breathing.
- Sudden inability to see, move, or speak.
- Severe dental pain or swelling.
- If you are pregnant, in labor, and/or bleeding.
- If you feel like you are going to harm yourself or others.
- Gun or knife wounds.

Go to an Urgent Care Center or call your PCP if you have/need:

- Flu, colds, sore throats, and earaches.
- A sprain or strain.
- A cut or scrape that does not need stitches.
- To get more medicine or have a prescription filled.

You can use this list to help you decide where you need to go for care. Note that it does not include all the reasons you may need to visit your PCP, an Urgent Care Center, or the ER.

Pharmacy

Pharmacy Program

Arkansas Total Care members can use their prescription drug benefits by going to a pharmacy that is in the Arkansas Total Care network. Members should always bring their Arkansas Total Care Member ID when they fill a prescription.

Arkansas Total Care does not cover all medicines. If you have questions about what medicines are covered by Arkansas Total Care, call Member Services at 1-866-282-6280 (TTY: 711) for help.

Preferred Drug List (PDL)

The Preferred Drug List (PDL) is a list that shows which drugs are preferred under the pharmacy benefit. Arkansas Medicaid updates this list. They may change the list throughout the year. You can access this list by visiting ArkansasTotalCare.com/members/pharmacy.html. The PDL does not list all covered drugs or all coverage limits.

Arkansas Total Care does not cover all medicines, and some medicines have limits. These limits may include, among others:

- Age limits.
- Quantity limits.
- Prior Authorization requirements.

Your doctor can request an authorization for coverage outside of these limits. Instructions on how to obtain a Prior Authorization can be found on our website at ArkansasTotalCare.com/providers/pharmacy.html. If you have questions about which medicines are covered by Arkansas Total Care, or any limitations a medicine may have, call Member Services at 1-866-282-6280 (TTY: 711).

General Requirements

All prescriptions are subject to certain limits. These include:

- Drugs may be filled up to a maximum 31-day supply.
- Arkansas Total Care may require that up to 90% of your medicine has been used before a refill is available to you. Certain exceptions to this may apply. See the Lost, Stolen, or Damaged Medications section of this Handbook for more details.
- For a drug to be covered, it has to be prescribed by a provider that is registered with the Arkansas Medicaid program.
- Prescriptions must be filled at a pharmacy in the Arkansas Total Care network in order to be covered.
- Show your Arkansas Total Care Member ID to the pharmacist when your prescription is filled. If you do not, you may have to pay the bill.
- Different companies may make the same drugs. For your prescription to be covered, the company that makes the drug must be registered with the Medicaid Drug Rebate Program (MDRP).

See below for information about other limits and coverage for certain types of prescriptions.

Over-the-Counter Drugs (OTCs)

Arkansas Total Care covers certain over-the-counter drugs (OTCs). All covered OTCs appear in the PDL or the Arkansas Medicaid Covered OTC Drug List. For an OTC drug to be covered by Arkansas Total Care, it must be written on a valid prescription by a licensed provider and meet the other limits in this Handbook. OTC drugs that do not meet these limits are not covered by Arkansas Total Care.

Compounds

Arkansas Total Care may cover compounded prescription claims made from two or more ingredients. Compound prescriptions must have at least one ingredient that can be covered in order for the drug as a whole to be covered. If one or more of the ingredients is not covered by Arkansas Total Care, Arkansas Total Care will not pay for those ingredients.

If the pharmacist chooses to provide a compounded drug even though some of the ingredients are not covered, you are not responsible for the cost of those ingredients.

Dual Eligibility

Arkansas Total Care does not cover any drug that is covered by Medicare Part D for members who receive Medicare benefits under Part A or Part B.

Arkansas Total Care will cover a limited list of drugs that are excluded from all Part D plans. A list of products that can be covered for dual-eligible members can be found on the Arkansas Medicaid website at AR.PrimeTherapeutics.com/documents/268611/269354/Medicare+Part+D+Excluded%E2%80%94Allowed+by+Arkansas+Medicaid.pdf/1a3cbfbb-250e-eb2a-3585-2c5cbd8cb0fb (PDF).

Transition Fill

Some drug limits are waived for the first 90 days of membership. Arkansas Total Care waives certain drug limits to allow for a transition of care. The limitations lifted may include, among others:

- Prior Authorization requirements.
- Drugs that are not preferred.
- Certain quantity limits.
- Age limits.

The maximum amount of medicine Arkansas Total Care will allow to be filled during this period is a 93-day supply. The only way to extend your supply is to get a Prior Authorization from Arkansas Total Care.

Emergency Supply

Certain drugs may require Prior Authorization from Arkansas Total Care or be subject to other limits. A pharmacy may dispense a 72-hour (three-day) supply of medicine to any member who is waiting on a Prior Authorization review. The purpose of granting you this emergency drug supply is to avoid an interruption of current therapy or delay the start of therapy.

All pharmacies in the Arkansas Total Care network are authorized to fill a 72-hour supply of medicine. The pharmacy will be paid for the 72-hour supply of medicine whether or not the Prior Authorization request is approved. An emergency supply override can be obtained by having the pharmacy call the Pharmacy Services Help Desk at 1-833-587-2011.

Lost, Stolen, or Damaged Medications

If your prescription is lost, spilled, or stolen, you will be allowed one override per year. Additional overrides may be available in the event of a natural disaster.

If your prescription was stolen, a police report must be filed for your prescription to be filled. If your medicine has been stolen and you need an override, take the police report to your pharmacy. Your pharmacist will need to call the Pharmacy Services Help Desk at 1-833-587-2011. The Help Desk will guide your pharmacist through how to fax the police report to them. An override cannot be given unless a police report is sent by your pharmacist and received by Pharmacy Services.

Mandatory Generic

For most drugs, the pharmacist must give you a generic drug when there is one available. If there is a generic drug that is preferred, the brand-name drug will not be covered without Prior Authorization from Arkansas Total Care. If you and your provider feel that a brand-name drug is medically necessary, your provider can ask for Prior Authorization to cover the brand-name drug.

Pharmacy Lock-In Program

Arkansas Total Care reviews member profiles to promote patient safety and proper use of pharmacy benefits. We may decide that it will be helpful for you to have prescriptions filled at only one pharmacy. This is called a Pharmacy Lock-In Program. Arkansas Total Care uses several factors to decide if a member would benefit from a Pharmacy Lock-In Program.

The factors we use to determine this include, but are not limited to:

- If the member has used multiple pharmacies or prescribers within a 30-day period.

- If the member is using a combination of drugs that are not recommended by current clinical and FDA guidance (such as opioids and benzodiazepines in combination).

- If the member uses medicines at higher daily doses than current clinical sources recommend.

If you are placed in the Pharmacy Lock-In Program, Arkansas Total Care will choose an initial pharmacy based on where you usually have prescriptions filled. We will mail a letter to you telling you when your lock-in starts, and where your prescriptions can be filled. All prescriptions will need to be filled at the pharmacy selected by Arkansas Total Care. Arkansas Total Care will not cover any prescriptions filled outside of this pharmacy.

The lock-in will continue for at least one calendar year. In some cases, Arkansas Total Care may decide that it would be helpful for the lock-in to continue.

If you would like to appeal the decision to place you in a Pharmacy Lock-In Program, you will have 30 days to do so. Please submit requests in writing to:

Arkansas Total Care
Attn: Appeals Department
P.O. Box 2010
Little Rock, AR 72221

If the pharmacy we select is not convenient for you, an initial request for pharmacy change will be granted. You can request this change by calling Member Services at 1-866-282-6280 (TTY: 711). Any additional requests to change pharmacies will require a proof of residence change. Examples of proof of residence include a state driver's license, state ID, utility bill in your name, leasing contract in your name, etc.

If the pharmacy you are locked into does not have your medicine, you may use a different one for a 72-hour supply. The other pharmacy must be in the Arkansas Total C are network. In order to fill a 72-hour supply, the pharmacy should call the Pharmacy Services Help Desk at 1-833-587-2011.

Health Management

Health Risk Screening

Arkansas Total Care wants to know how we can better serve you. One way we do this is by asking you to fill out the Health Risk Screening Form found on the Member Portal. This form gives us information to determine your needs. The Member Portal can be accessed at Member.ArkansasTotalCare.com. If you have questions about the form, please call Member Services at 1-866-282-6280 (TTY: 711).

Behavioral Health Services

Arkansas Total Care will cover your behavioral health needs. You may go to any behavioral health provider in our network. Be sure to look at the Arkansas Total Care provider list located on our website. You can also call Member Services at 1-866-282-6280 (TTY: 711).

Behavioral healthcare includes care for individuals who abuse drugs or alcohol or need other mental health services. Call us to get behavioral health specialists to help you or your Arkansas Total Care family member. You do not need a referral from a doctor for these services. We will help you find the right provider. Call1-866-282-6280 (TTY: 711) to get help right away. Our 24-Hour Nurse Advice Line means that we are here for you 24 hours a day, seven days a week.

How Can Arkansas Total Care Help?

We have Care Coordinators and a Member Services team that can assist you with:

- Locating providers.
- Scheduling appointments.
- Interpretation services.

What to Do in a Behavioral Health Emergency

You should call 911 if you or your family member are having a life-threatening behavioral health emergency. If you or your family member are not having a behavioral health emergency but need behavioral health services, you do not have to wait for an emergency to get help. Call our 24-Hour Nurse Advice Line at 1-866-282-6280 (TTY: 711). We can help you or your family member with depression, behavioral illness, substance abuse, or emotional questions. You can call 24 hours a day, seven days a week. In addition, you can call or text 988 which is a Suicide and Crisis Lifeline.

Provider-Led Arkansas Shared Savings Entity Ombudsman

Arkansas Total Care is a Provider-Led Arkansas Shared Savings Entity (PASSE). As a participant of the PASSE program, you have the right to access the Office of the PASSE Ombudsman. The Ombudsman will encourage you to discuss your concerns with Arkansas Total Care first. Please see the Grievances section.

The Ombudsman's role is to ensure PASSEs resolve issues or complaints.

A PASSE Ombudsman is someone who will help:

- If you are having issues with PASSE Care Coordination Services.
- If you are having trouble contacting your PASSE.
- If you have questions about your Independent Assessment determination results.
- If you have questions about appeals.
- If you are dissatisfied with the services received from the PASSE.
- If you are a provider and have questions about enrollment in the PASSE.
- If you have a concern or issue and don't know who else to call.

The Arkansas Department of Human Services (DHS) employs the Office of the PASSE Ombudsman. The actions of the Office are wholly theirs, independent of Arkansas Total Care. Complaints about non-compliance with Advance Directive laws and regulations can be filed with the PASSE Ombudsman hotline. Complaints related to PASSE services can also be filed with the hotline.

There are four ways to contact the Office of the PASSE Ombudsman:

By phone:
1-844-843-7351. Those who have a hearing or speech impairment can call toll free by dialing 1-888-987-1200 and selecting option 2.

By email:
Submit issues or complaints by emailing
PASSEombudsmanOffice@dhs.arkansas.gov.

By mail:
Office of Substance Abuse and Mental Health Services
Office of Ombudsman
P.O. Box 1437 Slot-S 0171
Little Rock, AR 72203-1437

By fax:
501-404-4625

Person-Centered Service Planning

What Is a Person-Centered Service Plan (PCSP)?

Person-centered service planning is an ongoing process that helps you make a plan for your future. In person-centered planning, your team will focus on you and your health goals for the year.

Through this process, we get to know who you are so that we can better support your needs. You and the people you choose direct this process. It helps identify your strengths, preferences, and needs. This team will work together to develop a PCSP.

A PCSP is a comprehensive plan of care developed to help those who receive intellectual and developmental disability (IDD) and behavioral health (BH) services. The PCSP process guides the delivery of services and support to achieve outcomes in areas of your life that are most important to you.

You direct the planning. Your Care Coordinator and PCSP team will work with you to identify strengths, preferences, and needs.

A PCSP Can:

- Support you in a different way, where the focus is on what is important to you.
- Recognize your strengths, interests, and goals. A PCSP helps you reach your goals in a team environment.
- Surround you with a circle of support, where your team of providers will work together to develop a plan with you and make it happen.

How Does a PCSP Work?

- You choose who you want to be on your PCSP team. Family members, friends, your doctors, and others who know about your life are all good choices.
- Once you put your team together, we will schedule your PCSP development meeting. The meeting will be set at a time and place that works best for you.
- You will have as much control as you want, and you can get help from the people you trust. A Care Coordinator will be there to help guide you through the process.

Your PCSP Will Contain:

- Information about your lifestyle choices, any risks or challenges, and a plan to overcome those challenges.
- Your chosen goals and who will help you work toward those goals.
- A list of services that you and your team have identified as being helpful to you.

Family Planning Services

Arkansas Total Care covers family planning services. You can get these services and supplies from providers even if they are not in our network. You do not need a referral. These services are free for our members. These services are voluntary and confidential, even if you are younger than 18 years old. Some examples of family planning services are:

- Education and advice from trained personnel to help you make choices.
- Information about birth control.
- Physical exams.

Pregnancy Program — Start Smart for Your Baby®

If you are pregnant, please fill out the member Notification of Pregnancy through your Member Portal or notify your Care Coordinator.

Start Smart for Your Baby (Start Smart) is our program for members who are pregnant. Arkansas Total Care wants to help you take care of yourself and your baby throughout your pregnancy. Information about how to be healthy during pregnancy can be sent to you by mail or over the phone. You can also find resources on our website. Our Start Smart staff can answer questions you have and provide support.

If you are pregnant and smoke cigarettes, Arkansas Total Care can help you stop smoking. We have a no-cost program to help pregnant members stop smoking. Healthcare staff work with you and give education, counseling, and the support needed to help you quit. Working as a team over the phone, you and your health coach can develop a plan to make changes in your behavior and lifestyle. If you would like to participate in our Start Smart for Baby program, call Member Services at 1-866-282-6280 (TTY: 711). You can also call your Care Coordinator.

Member Satisfaction

Grievance Process

Arkansas Total Care wants to take care of any problems or concerns. A grievance is any complaint or dispute, other than an organization determination, that tells us about your unhappiness with how Arkansas Total Care provides health services. You can file a grievance if you have a problem with things such as:

- Quality of care.
- Being able to reach someone by phone.
- Ease of getting information.

Arkansas Total Care will not treat you differently if you file a grievance. Filing a grievance will not affect your healthcare services. For Arkansas Total Care to review your concern, you must provide the following information:

- Your first and last name
- Your Arkansas Total Care Member ID Number
- Your phone number
- Details about what you are unhappy with
- What you would like to happen when contacting us to file a grievance

You or your authorized representative can file a grievance orally or in writing. We will help you fill out any forms to file a grievance. This includes providing interpreter services and telephone assistance.

We will let you know that we have received a grievance from you within five business days. If you file a grievance orally, we will send a letter that confirms we got your grievance. This letter will include a written summary of the grievance.

Grievance Timeline

Each grievance is different and will be given the time it deserves. Most grievances should be resolved within 30 calendar days of the day we received the initial oral or written grievance. We will acknowledge that we got your grievance within writing within five business days of receiving it.

Up to 14 more days may be added to this timeframe if:

- The person who filed the grievance requested additional time.
- Arkansas Total Care needs more information to resolve the grievance.
- It is in the member's best interest to extend the timeframe.

Arkansas Total Care will notify you of the grievance resolution in writing within two business days of the resolution. We will still do so within the 30-day resolution timeframe. The notice of resolution will include:

- The results of the resolution process.
- The date it was completed.
- Further appeal rights, if any.

To file a grievance, please contact us at:

Arkansas Total Care
Attn: Quality Department
P.O. Box 25010
Little Rock, AR 72221

Phone: 1-866-282-6280 (TTY: 711)

Appeal Process

An appeal is a request for Arkansas Total Care to review the action of concern, its existing or additional documentation, and make an appeal decision. You can request this review by phone or in writing.

If Arkansas Total Care refuses to pay for a service, you will get a letter telling you so. If you disagree with the decision, you can appeal the decision.

Your request for appeal must go to our Appeals Office. It is helpful if you also send a copy of the letter you received from us telling you of our decision. The letter we sent telling you of our decision will have a date on it. You will have 60 calendar days from that date to request an appeal. Your request for an appeal will be denied if the Appeals Office does not get your appeal request within 60 calendar days.

If we are going to reduce or stop a service we had approved in the past, you have the right to request to keep getting the service until we make our decision if:

- The request for the appeal is timely.
- 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.
- You or your parent/legal guardian files for a continuation of benefits promptly.

To keep getting the service, you must ask to keep getting the service and file an appeal within 10 days of receiving the notice or the effective date of the action. If you appeal the action and keep getting the service, you may have to pay for the service if we deny your appeal.

Send your request for an appeal to the address in your denial letter or to the address below:

Arkansas Total Care
Attn: Grievance & Appeals Office
P.O. Box 25010
Little Rock, AR 72221

Phone: 1-866-282-6280 (TTY: 711)
Fax: 866-811-3255

State Fair Hearing

You will receive a letter if Arkansas Total Care upholds our denial of a service. If our denial is upheld, you will have the right to a State Fair Hearing before a DHS hearing officer.

If you are a member who would like a State Fair Hearing, send your request to the DHS Office of Appeals and Hearings. Providers who would like a State Fair Hearing should send their request to the Arkansas Department of Health Office of Medicaid Provider Appeals.

It is helpful if you also send a copy of the letter you got from Arkansas Total Care telling you that payment for a service was denied to the Office of Appeals and Hearings (or the ADH Office of Medicaid Provider Appeals).

You have 90 days from the date on your Arkansas Total Care appeal decision letter to request a State Fair Hearing. Your request for a State Fair Hearing may be denied if the Office of Appeals and Hearings or ADH Office of Medicaid Provider Appeals does not get your request within that timeframe.

You should ask for a State Fair Hearing if you believe:

- It was wrong to deny your request for service.
- You did not receive enough help.
- You asked for a service and did not get it.
- Someone forced you to accept a service you did not want.
- Someone discriminated against you.

To ask for a State Fair Hearing, send a letter to:

DHS Office of Appeals and Hearings
P.O. Box 1437, Slot N401
Little Rock, AR 72203-1437

Phone: 501-682-8622
Fax: 501-404-4628

Important Member Information

What to Do if You Get a Bill

There are some services that are built into your plan and some that are not. Services that are included are called covered services. If you follow the plan rules, you will not be billed for any covered services. Call your doctor right away if you ever get a bill for a service that is covered by Arkansas Total Care.

You should talk with your doctor about what is covered and what is not under your Arkansas Total Care plan. Make sure they have all your insurance information and know to bill Arkansas Total Care.

If you still get bills from the doctor after you give your insurance information, call Member Services at 1-866-282-6280 (TTY: 711). We are here to help. Do not pay the bill yourself if the service is covered by Arkansas Total Care.

If you ask for a non-covered service, you will have to sign a statement with your doctor. This statement says that you will pay for the service. You will have to pay the bill for a non-covered service, not Arkansas Total Care. If you have any questions about a bill, call Member Services at 1-866-282-6280 (TTY: 711).

Other Insurance

You need to tell us if you have any other insurance coverage. We will work with the other insurance plan to coordinate your benefits. You also need to tell Medicaid about the other insurance.

Do You Have Insurance With Arkansas Total Care and Medicare?

If you have insurance with Arkansas Total Care and Medicare, it is okay for you to go to a doctor who accepts Medicare. Make sure you tell your doctor that you have insurance with both Medicare and Arkansas Total Care.

Medicare will pay the claim. If the provider is registered with the Arkansas Medicaid program, Arkansas Total Care will pay your Medicare deductibles and coinsurance amounts.

Fraud, Waste, and Abuse (FWA) Program

Arkansas Total Care is committed to preventing, identifying, and reporting all instances of fraud, waste, and abuse. To report these things, call our FWA Hotline at 1-866-685-8664. You do not need to give your name.

Fraud, waste, and abuse means that a member, a provider, or another person is misusing the Medicaid program or Arkansas Total Care resources. This could include things like:

- Loaning, selling, or giving your Arkansas Total Care Member ID Card to someone else.
- Misusing Arkansas Total Care or Medicaid benefits.
- Billing Arkansas Total Care for services that are supposed to be free.
- Wrongfully billing to Arkansas Total Care.
- Billing Arkansas Total Care for services that were not provided.
- Any action to defraud Arkansas Total Care or the Medicaid program.

Your healthcare benefits are given to you based on your eligibility for the Medicaid program. You must not share your Arkansas Total Care Member ID Card with anyone. Arkansas Total Care's network providers must report any misuse of benefits to Arkansas Total Care. Arkansas Total Care must report any misuse or wrongful use of benefits to Medicaid. If you misuse your benefits, you could lose them. Medicaid may take legal action against you if you misuse your benefits.

If you think a doctor, a hospital, another Arkansas Total Care member, or another person is misusing Medicaid or Arkansas Total Care benefits, tell us right away. We will take action against anyone who is misusing the Medicaid program. Your call will be taken seriously.

Notify us of fraud, waste, and abuse by mail at:

Arkansas Total Care
Attn: Compliance Department
P.O. Box 25010
Little Rock, AR 72221

You can also call our FWA Hotline at 1-866-685-8664. You do not need to give your name.

Report any misuse to the Arkansas Medicaid Fraud and Abuse Division:

Arkansas Attorney General's Office
Attn: Medicaid Fraud and Abuse Division
323 Center Street, Suite 200
Little Rock, AR 72201

Phone: 501-682-2007 or 800-482-8982

Member Rights & Responsibilities

This Member Handbook informs you of your rights and responsibilities as an Arkansas Total Care member. Arkansas Total Care network providers are expected to respect and honor your rights. You may ask for a copy of Arkansas Total Care's policies regarding your rights and find it on the website.

As an Arkansas Total Care member, you have the right to:

- Receive information in accordance with 42 CFR § 438.10. This includes, but is not limited to:
    - An oral interpretation in all languages, and written translation in each prevalent non-English language. This includes written materials with taglines in the top non-English languages in the state.
    - Large print materials explaining written translations or oral interpretation to understand the information provided. Large print means printed in a font size no smaller than 18-point.
    - Written materials that are critical to getting services. This includes this Member Handbook, appeal and grievance notices, and denial and termination notices. These materials must be made available in the top non-English languages in Arkansas.
    - Upon request, written materials in alternative formats at no cost.
    - Upon request, auxiliary aids and services at no cost.
    - Written materials, including taglines, in the prevalent non-English languages in the state. Oral interpretation. Large print availability of written translations.
    - Interpretation services at no cost, including oral interpretation and the use of auxiliary aids such as TTY and American Sign Language.

- Choose a participating provider for any service you are eligible and authorized to receive under your PCSP. This includes a primary care provider (PCP).
- Execute an Advance Directive without discrimination in the provision of care or otherwise.
- Live in an integrated and supported setting in the community and have control over aspects of your life.
- Understand your PCSP and receive the authorized services contained within it.
- Be protected in the community.
- Be treated with respect and due consideration for your dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a manner fitting your condition and ability to understand.
- Participate in decisions regarding your healthcare, including the right to refuse treatment.
- Get needed, available, and accessible healthcare services covered under the PASSE.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of your medical records, and to request that they be amended or corrected.
- Exercise your rights without Arkansas Total Care treating you adversely.
- File a grievance with Arkansas Total Care as it relates to Arkansas Total Care and any representatives of Arkansas Total Care. This includes participating providers.
- Be given written notice of a change in your Care Coordination provider within seven business days.
- Receive a Member Handbook and network directory within five business days of attribution.
- Ask for information about Arkansas Total Care at no cost.
- Retain all rights and protections if offered In Lieu of Services as described in the Benefits & Services section of this handbook.

As an Arkansas Total Care member, you have the responsibility to:

- Be familiar with Arkansas Total Care procedures to the best of your abilities.
- Contact Arkansas Total Care to get information and have questions answered.
- Give providers accurate and complete medical information.
- Follow care prescribed by your provider or let the provider know why treatment cannot be followed, as soon as possible.
- Keep appointments and follow-up appointments.
- Access preventive care services.
- Live a healthy lifestyle and avoid behaviors known to be harmful.
- Understand your health problems and take part in developing mutually agreed-upon treatment goals.
- Give accurate and complete information needed for care to Arkansas Total Care and all of your healthcare and support providers.
- Make your PCP aware of all other providers who are treating you. This is to ensure communication and coordination in care. This also includes behavioral health providers.
- Ask questions of providers to learn the risks, benefits, and costs of treatment options. Make care decisions after carefully weighing all factors.
- Follow Arkansas Total Care's grievance process as outlined in this Member Handbook if there is a disagreement with a provider.
- Choose a PCP.
- Treat providers and staff with dignity and respect.

Changing Your PASSE

The Arkansas Department of Human Services (DHS) is responsible for PASSE assignments. DHS assigned you to Arkansas Total Care. You may switch to another PASSE without cause for up to 90 days after you were enrolled or re-enrolled. You can also change to another PASSE without cause during the annual Open Enrollment Period, which is in October. After the first 90-day period and outside of the Open Enrollment Period, you can switch to a different PASSE only for a valid cause as determined by DHS in accordance with 42 CFR 438.56.

If would like to request to switch to a new PASSE, call the DHS Beneficiary Support Center at the number provided below. DHS is responsible for receiving and processing your request. Arkansas Total Care is not involved in the decision-making process for PASSE changes. DHS will let you know if they require you to submit an appeal or grievance to Arkansas Total Care first. If Arkansas Total Care does not resolve your appeal or grievance timely, your request will be automatically approved by DHS. You have the right to appeal if you do not agree with the decision DHS makes.

If approved, the effective date of your new PASSE assignment will be the first day of the second month following DHS's receipt of your request. For example, if DHS received your request on January 15, your effective date with your new PASSE would be March 1.

To request a transition to another PASSE, call the DHS Beneficiary Support Center at 1-833-402-0672.

Advance Directives

There might be times when you are not able to make healthcare choices for yourself. If you are unable to speak, your doctors may not know what kind of care you would prefer. An Advance Directive is a legal document. It tells your doctor what kind of care you agree to in case of a situation where you are unable to communicate. With this document, your doctors will know what kind of medical treatment you would choose or not choose.

All adult Arkansas Total Care members have the right to make Advance Directives. Arkansas Total Care will give you information on Advance Directives and include applicable state laws. You can call Member Services at 1-866-282-6280 (TTY: 711) for help finding the form. You can also talk to your PCP about Advance Directives. Ask your PCP to put the form in your file when you are done.

Work with your PCP to make decisions that will set your mind at ease. An Advance Directive can help your doctors and others to understand your wishes about your health. Advance Directives will not take away your right to make your own decisions. They will work only when you are unable to speak for yourself. You will not be discriminated against for not having an Advance Directive.

Examples of Advance Directives include:

- Living wills.
- Healthcare powers of attorney.
- Do Not Resuscitate (DNR) orders.

As a member of Arkansas Total Care, you have the right to:

- Accept or refuse treatment.
- Make Advance Directives.
- Get a copy of Arkansas Total Care's policies about respecting your rights and the state law. This includes a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.
- File your complaints about non-compliance with Advance Directive laws and regulations with the state's compliance hotline.
- File a complaint against the PASSE or any of its representatives. Representatives include in-network providers. See the Member Satisfaction section of this Handbook for more details.
- Be free from the requirement to get a referral for a specific family planning provider, whether or not that provider is in the Arkansas Total Care network.

Healthcare Declarations in Arkansas

Overview

Under Arkansas Law,* if you are a competent adult age 18 or older, you have the right to participate in making your own treatment decisions, including the right to accept or refuse specific forms of healthcare. As one means of exercising this right, the law allows you to complete written declarations containing instructions as to the kinds of healthcare decisions you wish to have made on your behalf if you become terminally ill or permanently unconscious and unable to make such decisions on your own. These declarations serve the same purpose under Arkansas law as living wills serve in other states.

Suggested Forms of Declaration

Arkansas law specifies two standard forms of declaration. The first deals with the possibility of terminal illness. The second deals with the possibility of permanent unconsciousness. If you wish to make a declaration, you are free to use either or both of these suggested forms. You are also free to use different wording. You can get the standard forms or information on where to obtain them from your doctor or other healthcare provider. You can also get them from your attorney.

You should be aware that the standard forms do not necessarily address all the choices you may have the legal right to make. For example, you may wish to add more detailed instructions concerning your care, such as whether you wish to have water and food given to you through artificial means if you become terminally ill or permanently unconscious. If you have questions that your doctor or other healthcare provider is unable to answer, or if you wish to amend the standard forms by adding special instructions, you may wish to consult with a lawyer or other qualified professional.

Choices Contained in the Standard Forms of Declaration

Each of the standard forms of declaration allows you to choose one of the following approaches:

1. To instruct your physician to withhold or withdraw life-sustaining treatments that are no longer necessary for your comfort, care, or the alleviation of pain. **OR**

2. To appoint someone else to act as your healthcare proxy in making health decisions. This includes the decision to withhold or withdraw life-sustaining treatment if you become terminally ill or permanently unconscious.

Steps for Completing a Declaration

To be effective, your declaration(s) must be signed by you or by someone else acting at your direction. They also must be witnessed by two individuals. A declaration becomes effective when both of the following have occurred:

1. The declaration is communicated to your attending physician (the physician primarily responsible for your care). **AND**

2. Your attending physician and another consulting physician determine that you are in a terminal condition and no longer able to make decisions about administration of life-sustaining treatment.

If You Wish to Revoke Your Declaration(s)

If you have completed a healthcare declaration and later wish to revoke it, you may do so at any time and in any manner, without regard to your mental or physical condition at the time you wish to revoke. A revocation becomes effective when it is communicated to the attending physician or other healthcare provider by the person who is revoking, or by someone who is a witness to the revocation. Methods of revocation can include a clear written or oral expression of your wish to revoke, or physical destruction of the original and any copies of the declaration.

Completing a Healthcare Declaration for Another Person

In the case of minors and adults who are no longer able to make healthcare decisions, a declaration may be executed by another person acting on their behalf. Arkansas law enforces the below order of priority and provides that a declaration may be executed by the first of the following individuals, or category of individuals, who exists and is reasonably available for consultation:

1. A legal guardian of the patient, if one has been appointed

2. The parents of the patient, in the case of an unmarried patient under age 18

3. The patient’s spouse

4. The patient’s adult child or, if there is more than one, the majority of the patient’s adult children participating in the decision

5. The parents of a patient over the age of 18

6. The patient’s adult sibling or, if there is more than one, the majority of them participating in the decision

7. Persons standing in loco parentis (in place of the parents) to the patient

8. A majority of the patient’s adult heirs at law who participate in the decision

Safeguards

In addition, Arkansas law affords the following protections:

1. A patient, even one who has been determined to be terminally ill, may continue to make decisions regarding life-sustaining treatment so long as they are able to do so.

2. The declaration of a terminally ill patient will not be given effect in the case of a patient known to be pregnant, as long as it is possible that the fetus could develop to the point of live birth with continued application of life-sustaining treatment.

3. Any physician or other healthcare provider who is unwilling to carry out the instructions of a patient or proxy under the law has an obligation to take all reasonable steps necessary to transfer the care of such patient to another physician or provider who will do so.

4. In Arkansas, it is improper for a healthcare provider or insurer to prohibit or require the execution of a declaration as a condition of receiving health insurance coverage or the delivery of healthcare services.

5. A declaration executed in another state in compliance with the law of that state is also valid for the purposes of Arkansas law.

*A.C.A. 20-17-201, et seq. Other rights of minors are covered in A.C.A. 20-17-214.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective December 14, 2022

For help to translate or understand this, please call Member Services at 1-866-282-6280 (TTY: 711).

Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-866-282-6280 (TTY: 711).

Covered Entity's Duties:

Arkansas Total Care is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Arkansas Total Care is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in effect, and notify you in the event of a breach of your unsecured PHI.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend, and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

Arkansas Total Care reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have, as well as any of your PHI we receive in the future. Arkansas Total Care will promptly revise and distribute this Notice whenever there is a material change to the following:

- Uses or disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the Notice

We will make any revised Notices available on our website or through a separate mailing.

Internal Protections of Oral, Written, and Electronic PHI:

Arkansas Total Care protects your PHI. We have privacy and security processes to help. These are some of the ways we protect your PHI:

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how we may use or disclose your PHI without your permission or authorization:

- **Treatment.** We may use or disclose your PHI to a physician or other healthcare provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making Prior Authorization decisions related to your benefits.
- **Payment.** We may use and disclose your PHI to make benefit payments for the healthcare services provided to you. We may disclose your PHI to another health plan, to a healthcare provider, or to another entity subject to federal Privacy Rules for their payment purposes. Payment activities may include:
    - Processing claims.
    - Determining eligibility or coverage for claims.
    - Issuing premium billings.
    - Reviewing services for medical necessity.
    - Performing utilization review of claims.

- **Healthcare Operations.** We may use and disclose your PHI to perform our healthcare operations. These activities may include:
    - Providing customer services.
    - Responding to complaints and appeals.
    - Providing Care Management and Care Coordination.
    - Conducting medical review of claims and other quality assessments.
    - Improvement activities.

  In our healthcare operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to federal Privacy Rules. The entity must also have a relationship with you for its healthcare operations. This includes:
    - Quality assessment and improvement activities.
    - Reviewing the competence or qualifications of healthcare professionals.
    - Case Management and Care Coordination.
    - Detecting or preventing healthcare fraud and abuse.
- **Group Health Plan/Plan Sponsor Disclosures.** We may disclose your PHI to a sponsor of the group health plan, such as an employer or other entity that is providing a healthcare program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the PHI. This includes agreeing not to use the PHI for employment-related actions or decisions.

Other Permitted or Required Disclosures of Your PHI:

- **Fundraising Activities.** We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt out or stop receiving such communications in the future.
- **Underwriting Purposes.** We may use or disclose your PHI for underwriting purposes, such as to make a decision about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing any PHI that is genetic information in the underwriting process.

- **Appointment Reminders/Treatment Alternatives.** We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us. We may use and disclose your PHI to provide you with information about treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.

- **As Required by Law.** If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.

- **Public Health Activities.** We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclose your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety, or effectiveness of products or services under the jurisdiction of the FDA.

- **Victims of Abuse and Neglect.** We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law to receive such reports if we have a reasonable belief of abuse, neglect, or domestic violence.

- **Judicial and Administrative Proceedings.** We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to a/an:

    - Court order.
    - Administrative tribunal.
    - Subpoena.
    - Summons.
    - Warrant.
    - Discovery request.
    - Similar legal request.

- **Law Enforcement.** We may disclose your relevant PHI to law enforcement when required to do so. For example, we may disclose PHI in response to a:

    - Court order.
    - Court-ordered warrant.
    - Subpoena.
    - Summons issued by a judicial officer.
    - Grand jury subpoena.

    We may also disclose your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.

- **Coroners, Medical Examiners, and Funeral Directors.** We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.

- **Organ, Eye, and Tissue Donation.** We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking, or transplantation of:

    - Cadaveric organs.

    - Eyes.

    - Tissues.

- **Threats to Health and Safety.** We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

- **Specialized Government Functions.** If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:

    - To authorized federal officials for national security.

    - To intelligence activities.

    - To the Department of State for medical suitability determinations.

    - For protective services of the President or other authorized persons.

- **Workers' Compensation.** We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

- **Emergency Situations.** We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interest. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with healthcare; to protect your health or safety, or the health or safety of others; or for the safety and security of the correctional institution.

- **Research.** In certain cases, we may disclose your PHI to researchers when their clinical research study has been approved, and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization:

We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:

- **Sale of PHI.** We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are getting compensation for disclosing the PHI in this manner.

- **Marketing.** We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

- **Psychotherapy Notes.** We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment, or healthcare operation functions.

Individuals Rights:

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

- **Right to Request Restrictions.** You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment, or healthcare operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or healthcare operations to a health plan when you have paid for the service or item out of pocket in full.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right applies only if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where you PHI should be delivered.

- **Right to Access and Receive a Copy of Your PHI.** You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot feasibly do so. You must make a request in writing to obtain access to your PHI. If we deny your request, we will give you a written explanation and tell you if the reasons for the denial can be reviewed. We will also tell you how to ask for such a review or if the denial cannot be reviewed.

- **Right to Amend your PHI.** You have the right to ask that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be changed. We may deny your request for certain reasons. For example, we may deny your request if we did not create the information you want amended and the creator of the PHI is able to perform the change. If we deny your request, we will give you a written explanation. You may respond with a statement that you disagree with our decision. We will attach your statement to the PHI you request that we change. If we accept your request to change the information, we will make reasonable efforts to inform others, including people you name, of the change and to include the changes in any future disclosures of that information.

- **Right to Receive an Accounting of Disclosures.** You have the right to get a list of instances within the last six-year period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, healthcare operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will give you more information on our fees at the time of your request.

- **Right to File a Complaint.** If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

  You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, S.W.
  Room 509F HHH Bldg.
  Washington, D.C. 20201

  Phone: 1-800-368-1019 (TTY: 1-800-537-7697)
  Email: OCRComplaint@HHS.gov
  Website: HHS.gov/hipaa/filing-a-complaint/complaint-process/index.html

  We will not take any action against you for filing a complaint.

- **Right to Receive a Copy of this Notice.** You may request a copy of our Notice at any time by using the contact information listed at the end of the Notice. If you receive this Notice on our website or by email, you are also entitled to request a paper copy of the Notice.

Contact Information:

If you have any questions about this Notice, our privacy practices related to your PHI, or how to exercise your rights, you can contact us in writing or by phone using the contact information listed below.

Arkansas Total Care
Attn: Privacy Official
P.O. Box 205010
Little Rock, AR 72221

Phone: 1-866-282-6280 (TTY: 711)

Glossary of Terms

Advance Directive. What you tell people about what you want for your healthcare if you are not able to tell them for yourself. A living will is the most common form of an Advance Directive.

Appeal. A request for Arkansas Total Care staff to review a Notice of Action (NOA). An NOA is what we send you when Arkansas Total Care denies the care that you want, limits the amount of care, denies care that had been approved by us in the past, or denies payment for care. When you appeal a decision, it starts a formal procedure that challenges an adverse decision or action that was taken by the PASSE.

Authorization. A decision to approve special care or other medically necessary care. An authorization is also called a referral.

Behavioral Health (BH) Services. Mental Health and Substance Use Disorder (SUD) services.

Continuity and Coordination of Care. Healthcare that is provided on an ongoing basis. It starts with the member's first contact with a PCP and follows the member through all instances of care. It is care that is uninterrupted.

Eligible(s). A person who has been determined eligible to receive services as provided for in the State Medicaid Plan.

Emergency Care. Care you get when you have an injury or illness that must be treated immediately or that is life-threatening.

Grievance. A formal complaint about any matter other than a benefit determination. Grievances may include quality of care, quality of services provided, and aspects of interpersonal relationships like rudeness of a provider or employee, or failure to respect a member's rights regardless of whether remedial action is requested. Grievances include an enrollee's right to dispute an extension of time proposed by the PASSE to make an authorization decision.

Home Healthcare. All the medical and other health-related services that are delivered in the home of a medically homebound patient by a healthcare professional.

Immunizations. Necessary shots to protect you or your family member from life-threatening diseases.

Inpatient. Services that you get when you are checked into a hospital.

Medicaid. The medical assistance program authorized by Title XIX of the Social Security Act.

Member ID Card. A card that states that you are a member of Arkansas Total Care. See an example of this card in the Your Member ID Card section of this Handbook.

Medical Necessity. A health intervention or treatment that is an otherwise covered category of service and is not specifically excluded from coverage. It must be medically necessary, given these five things:

a. Authority. The treatment is recommended by the doctor or other health professional treating you and they believe that it is necessary for you.

b. Purpose. The treatment is intended to treat a medical condition that you have.

c. Scope. The treatment gives you the amount of medication or service you need to improve without giving you more than you need to help your condition.

d. Evidence. The treatment is known to be effective in improving health outcomes. For new treatments that have not been tested as much, effectiveness is determined by medical evidence provided by the doctor asking that you get the treatment.

e. Value. The treatment is cost-effective for this condition compared to other treatments. This includes no intervention. “Cost-effective” does not have to mean lowest price. A treatment may be medically indicated but not be a covered benefit. An intervention may also not meet this definition of medical necessity.

Treatments that do not meet this definition of medical necessity may still be covered.

A treatment may be considered cost-effective if the benefits and harms compared to the costs is an efficient use of resources for those with the condition. When we evaluate treatments to see if they meet the above requirements, we base our decision on the individual member, including their medical history.

“Effective” means that the treatment can be expected to improve the condition (within reason), and to have benefits that outweigh any potential harmful effects.

Member. A person who gets services from Arkansas Total Care as defined by the state of Arkansas.

Notice of Action (NOA). A document that is mailed to you when we make a decision about your care. It includes:

a. The action that is planned.

b. The reason for the planned action.

c. The regulation or statute that supports the action.

The NOA will also explain your rights to expedited or standard appeals. It tells how to ask for a State Fair Hearing and how to ask that you keep getting services during an appeal or State Fair Hearing.

Outpatient. A treatment or procedure that can be done without being checked into a hospital.

Prescription Drugs. Any medicine that cannot be purchased over the counter or without a written request from your doctor.

Protected Health Information (PHI). Health information that identifies an individual.

Provider. A physician, hospital, or any other person licensed or authorized to provide healthcare services.

Provider Directory. A list of all providers who participate in the Arkansas Total Care network.

Primary Care Provider (PCP). The provider who is the entry point into the healthcare system for a member. A PCP provides primary care. They also keep track of referrals to specialist care and authorized hospital services. The PCP maintains continuity of care.

Referral. A request by a PCP on a member's behalf that directs the member to get medically necessary, covered services from another healthcare professional.

Specialist. A doctor who has specific, detailed training in a particular medical field.

Termination. A member's loss of eligibility for the Arkansas Medicaid program. When this happens, the member is automatically disenrolled from Arkansas Total Care.

Treatment. Care you may receive from doctors and facilities.

Urgent care. When you have an injury or illness that must be treated within 48 hours. It is not life-threatening.