2025

# Virginia Medicaid's Cardinal Care Managed Care Program and FIDE SNP Provider Manual

– Cardinal Care Managed Care

– Humana Dual Fully Integrated H2875-001 (HMO-POS D-SNP)

– Humana Dual Fully Integrated H2875-003 (HMO D-SNP)

Humana®

CardinalCare
Virginia's Medicaid Program

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# Contents

# Chapter 1: Introduction

## Welcome

Welcome and thank you for becoming a participating provider with Humana®, serving the Cardinal Care Managed Care Contract in Virginia. Humana is a community-based health plan that serves Medicaid members throughout Virginia. We strive to work with our network healthcare providers to make it as easy as possible to do business with us. Through strong partnerships with local providers, we facilitate the provision of high quality, integrated care and access to services our members need to be healthy.

Humana's 60+ years of managed care experience have allowed us to cultivate extensive expertise and resources, uniquely positioning us to form strong partnerships with Virginia providers and effectively serve our Virginia Cardinal Care membership by making healthcare delivery simpler and reducing costs while improving health outcomes. We bring a history of innovative programs and collaborations to ensure your Humana-covered patients receive the highest quality of care, including community-based partnerships and services to help them successfully navigate complex healthcare systems. With a focus on preventive care and continued wellness, our approach is simple: we want to make it easier for our members to get the healthcare they need, when they need it.

We ensure our members receive the highest quality of care and services by offering:

- Care management and care transitions programs
- Analytical tools to identify members who might benefit from special programs and services
- An ongoing focus on member service, health education and activities to promote health and wellness
- Community engagement and collaboration to ensure the comprehensive needs of members are addressed
- Access to behavioral health (BH) services including crisis intervention and a dedicated hotline
- An award-winning history in member services, training, clinical programs and member satisfaction
- The ability to scale, innovate and provide ongoing support to our extensive provider network

## About Cardinal Care Managed Care

Virginia's Medicaid managed care program is called Cardinal Care Managed Care (CCMC). Humana provides Medicaid managed care services to individuals enrolled in the CCMC program statewide. Managed care-covered populations include low-income families and children; aged, blind and disabled (ABD) individuals; medically complex Modified Adjusted Gross Income (MAGI) adults (adults ages 19–64 who are parents or caretaker adult relatives with a child younger than 19); and individuals receiving long-term services and supports (LTSS).

## About this manual

This provider manual is intended to supplement your network provider contract with Humana, serving the CCMC. Any revisions and amendments to this manual are part of your network provider contract. However, your network provider contract takes precedence over any language in this manual. This provider manual is available online at **Humana.com/HealthyVA**. Provider Relations Representatives help providers access this manual during onboarding and after, as needed.

In this manual, you can easily find information about:

- Covered services
- Member eligibility
- Prior authorizations
- Claims submission
- Provider responsibilities
- Quality and compliance
- Care management
- Grievances and appeals
- And more

For information on Humana's Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) in Virginia, please refer to the **appendix of this provider manual**.

## Manual updates and changes

This manual is revised annually—and more often as needed—to provide new information and updates. The web-based version will represent the latest update. Providers will be notified and provided with an updated link, as applicable, when a revised manual is posted to **Humana.com/HealthyVA**.

## Compliance and ethics

Humana serves a variety of audiences, including members, providers, government regulators and community partners. We serve them best by working together with honesty, respect and integrity. We are all responsible for complying with all applicable state and federal regulations, along with applicable Humana policies and procedures.

Humana is committed to conducting business legally and ethically. A compliance plan has been established by Humana that:

- Formalizes Humana's commitment to honest communication within the company and within the community, inclusive of our network providers, members and employees
- Develops and maintains a culture that promotes integrity and ethical behavior
- Facilitates compliance with all applicable local, state and federal laws and regulations
- Implements a system for early detection and noncompliance reporting with laws and regulations; fraud, waste and abuse concerns; or noncompliance with Humana's policy, professional, ethical or legal standards
- Allows Humana to resolve problems promptly and minimize negative impact on our members or business including financial losses, civil damages, penalties and sanctions

Our general compliance and ethics expectations for providers include:

- Acting according to professional ethics and business standards
- Notifying Humana of suspected violations, misconduct or fraud, waste and abuse concerns
- Cooperating fully with any investigation of alleged, suspected or detected violations of applicable state or federal laws and regulations
- Notifying Humana if you have questions or need guidance for proper protocol

For questions about provider expectations, please contact your Provider Relations representative or call Provider Services at **844-881-4482**. We appreciate your commitment to compliance with ethics standards and reporting identified or alleged violations of such matters.

## Accreditation

Humana holds a strong commitment to quality. We demonstrate our commitment through programs based on national standards, when applicable. Humana will seek accreditation from the National Committee for Quality Assurance (NCQA) for our Medicaid lines of business.

## Helpful websites

Providers can obtain plan information from **Humana.com/HealthyVA** and **Humana.com/Publications**. This information includes:

- Health and wellness programs
- Provider publications (including provider manual, newsletters and program updates)
- Pharmacy services
- Claim resources
- Quality resources
- What's new

For help or more information regarding web-based tools, please call Provider Services at **844-881-4482**.

## Provider portal

Humana has partnered with **Availity Essentials™** to give providers access to member and claim data for multiple payers using 1 platform and login. With Availity Essentials, providers can:

- Submit claims and view claim status
- Check eligibility and benefits
- Submit and view authorizations
- Submit appeals
- View remittance advice

To learn more, call Availity Essentials at **800-282-4548** Monday – Friday, 8 a.m. – 8 p.m., Eastern time, or visit **www.availity.com**.

# Chapter 2: Contact Information

## Provider Relations representatives

Humana has knowledgeable Provider Relations representatives assigned for each Virginia Medicaid region with extensive knowledge about Humana's policies and processes. They are happy to assist you with answering questions, triaging issues, onboarding, learning about Humana and providing ongoing practice support. Please visit **Humana.com/HealthyVA** to find the Provider Relations representative in your area.

## Phone numbers for contacting Humana and our vendors

| Contact | Phone number |
|---|---|
| **Provider Services**<br>Provider Services associates can help with questions, concerns, inquiries and complaints regarding the managed care program, covered services, member enrollment, Utilization Management, referral requirements, care coordination, provider network contracting and credentialing, claims payments and authorization requests. | **844-881-4482**<br>Monday – Friday,<br>7 a.m. – 7 p.m., Eastern time |
| **Member Services**<br>Humana maintains a toll-free Member Call Center to assist members with various concerns, health crises, complaints and questions. Capabilities of Member Call Center advocates include, but are not limited to, explaining covered services, identifying providers in the network and explaining what to do in an emergency or urgent medical situation. | **844-881-4482**<br>8 a.m. – 8 p.m.,<br>Eastern time, 7 days a week |
| **Interpreter Services** | **877-320-2233**<br>24 hours a day, 7 days a week |
| **Clinical Intake Team (CIT)** | **844-881-4482**<br>Monday – Friday, 8 a.m. – 8 p.m.,<br>Eastern time. |

| Contact | Phone number |
|---|---|
| **NICU Admissions** | **855-391-8655**<br>Monday – Friday, 8:30 a.m. – 5 p.m., Eastern time |
| **Clinical Triage Line (Behavioral Health Crisis, Addiction and Recovery Treatment Services ARTS, Nurse and Care Coordination Line)** | **888-445-8714**<br>24 hours a day, 7 days a week |
| **Availity Essentials Customer Service/Tech Support** | **800-282-4548**<br>Monday – Friday, 8 a.m. – 8 p.m., Eastern time |
| **Fraud, Waste and Abuse Special Investigations Unit (SIU) Hotline** | **800-614-4126**<br>24 hours a day, 7 days a week |
| **Ethics Help Line** | **877-5-THE-KEY (877-584-3539)**<br>24 hours a day, 7 days a week |
| **Humana transportation** | **877- 718-4215** |

## Phone numbers for contacting the state

| Contact | Phone number |
|---|---|
| **Department of Medical Assistance Services (DMAS) Fraud and Abuse Referral Hotline** | **866-486-1971**<br>24 hours a day, 7 days a week |
| **DMAS - Cover Virginia Call Center** | **855-242-8282**<br>Monday – Friday, 8 a.m. – 7 p.m. and Saturday, 9 a.m. – noon, Eastern time |

## Mailing addresses for Humana

| Contact | Phone number |
|---|---|
| **Provider Correspondence** | **Humana**<br>Correspondence<br>P.O. Box 14359<br>Lexington, KY 40512-4359 |
| **Provider Reconsideration** | **Humana**<br>Provider Reconsideration<br>P.O. Box 14359<br>Lexington, KY 40512-4359 |

| Contact | Phone number |
|---|---|
| **Member Grievances and Appeals** | **Humana**<br>Member Grievances and Appeals<br>P.O. Box 14163<br>Louisville, KY 40512- 4163 |
| **Humana Claims Office** | **Humana**<br>Claims Office<br>P.O. Box 14359<br>Lexington, KY 40512-4359 |
| **Fraud, Waste and Abuse** | **Humana**<br>Special Investigations Unit<br>1100 Employers Blvd.<br>Green Bay, WI 54344 |

# Chapter 3: Member Eligibility and Enrollment

## Member eligibility

DMAS determines Medicaid eligibility and provides eligibility information to Humana via an 834 file for members assigned to Humana. Individuals determined eligible as of the 18th of the month have an effective date of the first of the following month (for example, an individual is identified as being eligible May 7 will have an effective date of June 1). Individuals found to be eligible after the 18th are enrolled with an effective date of the first of the second month (for example, an individual is identified as being eligible May 19 will have an effective date of July 1).

The eligibility categories included in the Virginia Cardinal Care Program include:

- **Family Access to Medical Insurance Security (FAMIS) Plan Children –** Comprehensive health coverage for uninsured children ages 0-18 not eligible for Medicaid, with family income at or below 200% of the federal poverty level (FPL) (plus a 5% disregard)
  - FAMIS is the Commonwealth's Children's Health Insurance Program (CHIP) program, also referred to as Title XXI, administered by DMAS and jointly funded by the state and federal governments.
- **FAMIS MOMS –** FAMIS MOMS are uninsured, pregnant and postpartum members of any age, ineligible for Medicaid, with family income at or below 200% of the federal poverty level (plus a 5% disregard).
  - FAMIS MOMS is part of Virginia's CHIP program and authorized under a Section 1115 CHIP waiver. The benefit package is aligned with that of Medicaid pregnant individuals.
- **MAGI Adults (also known as the Medicaid expansion group) –** This population includes adults who are aged 19–64 years old, with incomes up to 138% of the federal poverty level (133% plus a 5% income disregard), who do not have Medicare and who are not otherwise eligible for a Medicaid mandatory coverage group.
  - Low-income families, qualified pregnant women and children, individuals eligible under the aged, blind and disabled groups are examples of mandatory eligibility groups, as described in 12 VAC 30-30-10.
- **Former Foster Care –** Eligibility ranges from age 18 to 26
  - These individuals were formerly covered under a foster care designation.
- **Aged, Blind and Disabled Population (ABD) –** ABD individuals

## Verifying member eligibility

Before providing any services—except emergency services—you must verify member eligibility. You should ask members to present an ID card each time you render services. If you are not familiar with the patient seeking care and cannot verify the person as a Humana member, you should ask to see photo identification. Eligibility can be verified by signing in to Availity Essentials, navigating to Patient Registration, then selecting Eligibility and Benefits Inquiry.

## Member enrollment

A member's enrollment with Humana may be the result of their selection of Humana as their managed care organization (MCO) or assignment by DMAS. Humana accepts enrollment assignments for any eligible member as determined by DMAS. Humana keeps you informed of the enrollment status of each member by reporting enrollment status in Availity Essentials, as outlined in the **Verifying member eligibility section of this manual**.

## Enrollment broker

The enrollment broker plays a critical role in the CCMC program by assisting members in understanding their health plan options, educating members on each MCO's benefits and services, helping members complete paperwork necessary for enrolling in a plan or changing plans and providing unbiased choice counseling to ensure members make an informed decision on their healthcare.

Members can contact the enrollment broker by:

- Downloading the free Virginia Managed Care App on their Android or iPhone. They can compare health plans, find a provider, change their health plan and more.
- Going to the Verify/Login page. After they log in, they can select "Choose a Plan."
- Calling the Managed Care Helpline at **800-643-2273 (TTY: 800-817-6608)**, Monday – Friday, 8:30 a.m. – 6 p.m. Interpreter services are free.

## Newborn Medicaid enrollment

FAMIS eligibility rules ensure continuous eligibility for newborns up to 12 months following birth. However, to receive ongoing coverage, the newborn's parent or guardian should call the Cover Virginia Call Center at **855-242-8282**, Monday – Friday, 8 a.m. – 7 p.m. and Saturday 9 a.m. – 12 p.m., or their local Department of Social Services (DSS) office to quickly enroll their newborn.

To help Humana ensure newborns are enrolled in Medicaid or FAMIS as quickly as possible, we encourage contracted hospitals to submit enrollment information for eligible newborns via the streamlined online enrollment process through the Medicaid provider web portal.

For newborns of Humana-enrolled members, Humana provides coverage effective with the newborn's date of birth. The timeliness of the newborn's enrollment with Humana in the Medicaid system is

dependent on how quickly the parent reports the child's birth to the Cover Virginia Call Center at **855-242-8282** or their local DSS office to have the child enrolled in the Medicaid system. Humana provides coverage for these infants during the entire birth month, plus 2 additional consecutive months, as follows:

- Whether or not the newborn receives a Medicaid or FAMIS ID number; **and**
- Whether or not the birth member remains enrolled with Humana

To notify Humana of the newborn, please complete the Newborn Notification of Delivery Form on **Humana.com/HealthyVA** within 24 hours of the birth.

## New member kits

Each new member household receives a new member kit, a welcome/introduction letter and an ID card for each person in the family who has joined Humana. New member kits are mailed separately from the ID card. The new member kit contains:

- Quick Start Guide booklet
- Release of information forms
- Continuity of care form
- A postage-paid business return envelope to use when returning forms
- A postcard the member can use to order printed materials such as a member handbook or provider directory

## Member identification card

All new Humana members receive a Humana member ID card. A new card is issued only if the information on the card changes, if a member loses a card or if a member requests an additional card.

The Humana member ID card does not guarantee eligibility or benefits coverage. Members may lose Medicaid eligibility at any time. Therefore, it is important that member eligibility is verified prior to every service. Eligibility can be verified by going to Availity Essentials as outlined in the **Verifying member eligibility section of this manual**.

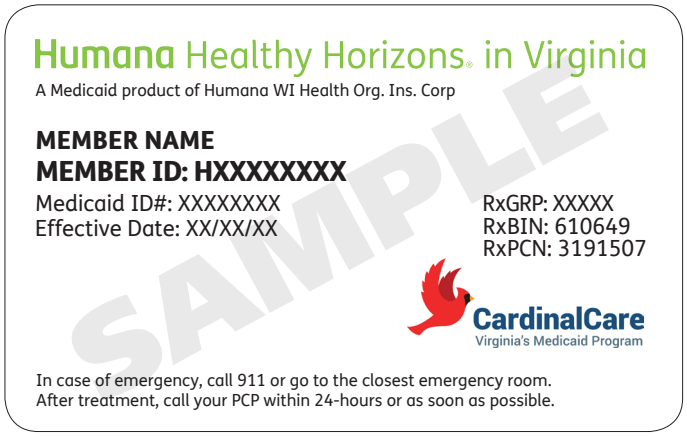
Humana' member ID card includes:

- Cardinal Care Managed Care logo
- Name of the member
- Member's Medicaid identification number
- Member's Humana identification number
- Name and address of Humana
- Member's copayment obligations (if applicable)
- Telephone number for the Clinical Triage Line (Behavioral Health/ARTS crisis and nurse line)

- Instructions on what to do in an emergency
- Other information needed to process claims
- Telephone number for the dental program
- Telephone number for transportation services
- Telephone number for Humana' Member Services department

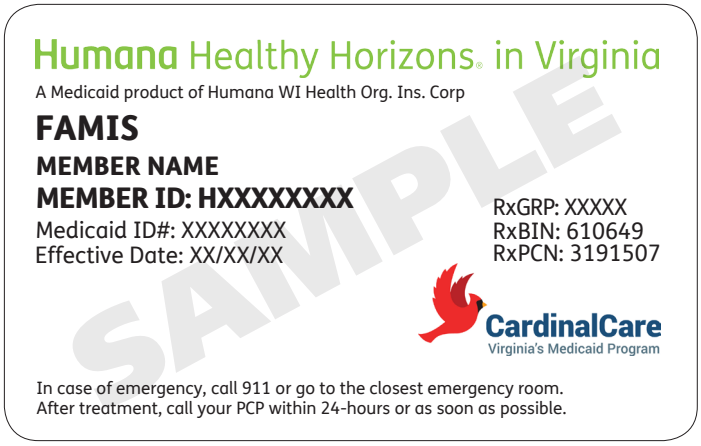
Humana mails all member ID cards no later than 5 business days from the member's effective date.

### Sample Humana member ID card front and back:





### Sample Virginia Medicaid FAMIS member ID card front and back:




## Role of the primary care provider

A primary care provider (PCP) delivers preventive and primary medical care for eligible members and certifies service authorizations and referrals for all medically necessary specialty services. PCPs serve as the member's initial and most important point of interaction with Humana's provider network. PCPs accept primary responsibility for the management of a member's healthcare. PCPs are the member's point of access for preventive care or an illness and can treat the member directly, refer the member to a specialist (secondary/tertiary care) or admit the member to a hospital. PCPs help facilitate a "medical home" for members. This means PCPs help coordinate healthcare for the member and provide additional health options to the member for self-care or care from community partners.

Healthcare providers who may qualify as PCPs include:

- Family medicine providers
- General practice providers
- Geriatric medicine (internal medicine) providers
- Internal medicine providers
- Obstetrics and gynecology providers
- Pediatrics providers
- Pediatric adolescent medicine providers
- Adolescent medicine (internal medicine) providers
- Adolescent medicine (family medicine) providers
- Primary care nurse practitioners
- Primary care physician assistants
- Geriatric medicine (family medicine) providers
- Women's health nurse practitioners
- Adult medicine providers

## PCP choice and assignment

Humana offers each member the opportunity to choose a Humana-affiliated PCP to the extent open panel slots are available. Members can select a PCP from our provider directory at **Humana.com/FindADoctor**. With the exception of dual-eligible members, Humana ensures each Cardinal Care member has an assigned Medicaid-participating PCP at the date of enrollment. If eligible members do not request an available PCP, then Humana assigns the new member to a PCP within our network at the time of enrollment, taking into consideration such known factors as:

- Current provider relationships
- Language needs
- Age and sex
- Enrollment of family members (e.g., siblings)
- Area of residence

Humana notifies the member in writing, on or before the effective date of enrollment with Humana, of their PCP's name, location and office telephone number.

Children and Youth with Special Healthcare Needs (CYSHCN) can request their PCP be a specialist.

## PCP changes

Humana members can select a new PCP or be assigned one by request when Humana has terminated a PCP or when a PCP change is ordered as a part of the resolution to a formal grievance proceeding. When a member changes PCPs, Humana facilitates the process to make the member's medical records or copies available to the new PCP within 10 business days from receipt of the request.

## Member disenrollment

Upon disenrollment from Humana's Cardinal Care Managed Care Plan, Humana notifies each member in writing of their disenrollment and the effective date of disenrollment. With respect to the disenrollment of newborns, Humana informs the mother/parent/guardian of the newborn that to continue the newborn's eligibility, the mother/parent/guardian must notify DSS to obtain a Medicaid ID number for the newborn. All disenrollments are effective 11:59 p.m., Eastern time, on the last day of enrollment. If the disenrollment is the result of a plan change, it is effective the last day of the month. If the disenrollment is the result of any exclusion, it can be effective at any time.

## Referrals for release due to ethical reasons

Humana network providers are not required to perform any treatment or procedure that is contrary to the provider's conscience, religious beliefs or ethical principles, in accordance with 45 C.F.R. 88.

The provider must refer the member to another provider who is licensed, certified or accredited to provide care for the individual service appropriate to the patient's medical condition. The referred-to provider must be actively enrolled with DMAS to provide Medicaid services to beneficiaries and be in Humana's Medicaid provider network. Providers can reach out to case management to help with a provider referral at **VAMCDCareManagement@humana.com**.

When a provider believes their conscience, religious beliefs or ethical principles require involuntary dismissal of the member as their patient, the provider's office must notify the member of the dismissal by certified letter. The letter should include:

- The reasoning behind the dismissal request
- Referral to another provider who is licensed, certified or accredited to provide care for the service appropriate to the patient's medical condition. The provider must be actively enrolled with DMAS to provide Medicaid services to beneficiaries and must be in Humana's network
- Instructions to call Humana Member Services at **844-881-4482 (TTY: 711)** for assistance in finding a preferred in-network provider.

A copy of the letter must be mailed or faxed to Humana at:

**Humana Provider Relations**
Grievances and Appeals Department
P.O. Box 14163
Lexington, KY 40512-4163

Fax: **800-949-2961**

Please call Provider Services at **844-881-4482** if you have questions about the member release reasons or procedures.

# Chapter 4: Member Rights and Responsibilities

## Member rights

Humana requires our staff and affiliated providers to comply with any applicable federal and state laws that pertain to member rights. Humana complies with Title VI of the Civil Rights Act of 1964 as implemented at 45 CFR Part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR Part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; Section 1557 of the Patient Protection and Affordable Care Act; and all federal and state laws and regulations regarding privacy and confidentiality.

Members have the right to:

- Be free from discrimination based on race, color, ethnic or national origin, age, sex, sexual orientation, gender identity and expression, religion, political beliefs, marital status, pregnancy or childbirth, health status or disability
- Be treated with respect and consideration for their privacy and dignity
- Get information about their health plan, provider, coverage and benefits
- Understand the healthcare information they receive
  - Interpretation, written translation and auxiliary aids are available at no cost.
- Access healthcare and services in a timely, coordinated and culturally competent way
- Receive information from their provider and health plan about treatment choices and have a candid discussion of appropriate or medically necessary treatment options, regardless of cost or benefit coverage
- Participate in all decisions about their healthcare, including the right to say “no” to any treatment offered
- Ask their health plan for help if their provider does not offer a service because of moral or religious reasons
- Get a copy of their medical records and ask they be changed or corrected in accordance with state and federal law

- Have their medical records and treatment be confidential and private
  - Humana will only release their information if it is allowed under federal or state law or if it is required to monitor quality of care or protect against fraud, waste and abuse.
- Live safely in the setting of their choice
  - If a member or someone they know is being abused, neglected or financially taken advantage of, they should call their local DSS or Virginia DSS at **888-832-3858**.
- Receive information on their rights and responsibilities and exercise their rights without being treated poorly by their providers, Humana or DMAS
- Make recommendations regarding the member rights and responsibilities policy
- Be free from any restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- File appeals and complaints and ask for a state fair hearing
- Exercise any other rights guaranteed by federal or state laws (the Americans with Disabilities Act, for example)

## Member responsibilities

Members have the responsibility to:

- Follow their member handbook, understand their rights and ask questions when they do not understand or want to learn more
- Treat their providers, Humana staff and other members with respect and dignity
- Choose their PCP and, if needed, change their PCP
- Be on time for appointments and call their provider's office as soon as possible if they need to cancel or if they are going to be late
- Show their Humana member ID card whenever they get care and services
- Provide (to the best of their ability) complete and accurate information about their medical history and their symptoms
- Understand their health problems and talk to their providers about treatment goals, when possible
- Work with their care manager and care team to create and follow a care plan that is best for them
- Invite people to their care team who will be helpful and supportive to be included in their treatment
- Tell Humana when they need to change their care plan
- Get covered services from the Humana network when possible
- Get approval from Humana for services that require a service authorization
- Use the emergency room for emergencies only
- Pay for services they get that are not covered by Humana or DMAS
- Report suspected fraud, waste and abuse

- Call Humana Member Services at **844-881-4482** to let them know if:
  - Their name, address, phone number or email have changed
  - Their health insurance changes (from their employer or workers' compensation, for example) or they have liability claims, like from a car accident
  - Their member ID card is damaged, lost or stolen

## Distribution of member rights and responsibilities

Humana distributes member rights and responsibility statements to the following groups after their enrollment and annually thereafter:

- New members
- Existing members
- New providers
- Existing providers

# Chapter 5: Provider Rights and Responsibilities

## Provider rights and responsibilities

Your rights and responsibilities as providers contracted with Humana are outlined in this chapter, throughout this provider manual and in your network contract with Humana. Additionally, it is your responsibility to comply with all applicable state and federal laws and regulations. If you have any questions about your rights and responsibilities, please contact your Provider Relations Representative or Provider Services at **844-881-4482**.

## Provider responsibilities

- The Provider agrees to ensure confidentiality of family planning services in accordance with Medicaid Contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act.
- As applicable, providers must agree to abide by the terms of the Medicaid contract for the timely provision of emergency and urgent care. Emergency services shall be available 24 hours a day and 7 days a week; urgent care appointments and symptomatic office visits shall be available as soon as the symptom demands but in no event more than 24 hours of the member's request. Where applicable, providers must agree to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency department Memorandums of Understanding signed by Humana in accordance with the Medicaid Contract.
- Providers must agree not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of medically necessary and covered Medicaid services.
- Except in the case of death or illness, providers must agree to notify Humana at least 30 days in advance of disenrollment and agree to continue care for their panel members for up to 30 days after such notification, until another provider is chosen or assigned.
- Providers must meet Humana' standards for licensure, certification and credentialing.
- In accordance with requirements set forth in 1932(d)(6) and 1173(b) of the Social Security Act, each provider rendering covered services must have a unique National Provider Identifier (NPI) in accordance with the system set up under Section 1173(b) of the Social Security Act. This rule applies to all provider types and specialties.

  - Providers must use these identifiers when submitting data to Humana. The NPI is provided by **the Centers for Medicare & Medicaid Services (CMS)**, which assigns the unique identifier through its National Plan and Provider Enumeration System (NPPES).
- At the time of application to become part of Humana' network, credentialing and/or recredentialing and/or upon request from Humana, providers must disclose required information for disclosure of ownership interests, business transactions and information on persons convicted of crimes related to any federal healthcare programs.
- Providers must screen their directors, officers, employees and contractors initially and on a monthly basis against the Exclusion Lists to determine whether any of its employees/contractors have been excluded from participating in Medicare, Medicaid, State Children Health Insurance Program (SCHIP) or any federal healthcare programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. Providers must immediately report to Humana any exclusion information upon discovery. Providers must accept and acknowledge civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to members.
- Providers must be screened, enrolled (including signing a DMAS Medicaid provider participation agreement) and periodically revalidated in DMAS' Medicaid Enterprise System (MES) Provider Services Solution (PRSS). This does not require Humana's network providers to render services to fee-for-service (FFS) beneficiaries.
  - If a provider is only providing Medicare services to dual eligible Cardinal Care members enrolled in the Humana Cardinal Care Medicaid plan, the provider is not required to enroll in MES PRSS.
  - Humana out-of-network providers are not required to submit an application and enroll as a provider in PRSS. However, Humana registers all providers outside our network using the PRSS non-par participation registration (NPPR) file.
- Providers must maintain records for 10 years from the date the provider contract terminates.
- Providers must provide copies of member records and access to their premises to representatives of Humana, as well as duly authorized agents or representatives of DMAS, the U.S. **Department of Health & Human Services** and the State Medicaid Fraud Unit. Providers must agree otherwise to preserve the full confidentiality of medical records in accordance with applicable state and federal laws.
- Providers must maintain and provide a copy of the member's medical records, in accordance with 42 CFR §438.208(b)(5), to members and their authorized representatives as required by Humana and within no more than 10 business days of the member's request.
- Providers must forward medical records to Humana within 10 business days of Humana's request.
- Providers must submit utilization data for members enrolled with Humana in the format specified by Humana, consistent with Humana's obligations to DMAS, as related to quality improvement and other assurance programs as required.

- Providers must agree to participate in and contribute required data to Humana's quality improvement and other assurance programs.
- As applicable, providers must agree to act as a PCP for a predetermined number of members, not to exceed the panel size limits set forth in the Medicaid Contract, to be stated in the network provider agreement.
- Providers must promptly provide or arrange for the provision of all services required under the provider agreement. This provision must continue to be in effect for subcontract periods for which payment has been made even if the provider becomes insolvent until such time as the members are withdrawn from assignment to the provider.
- Providers must comply with corrective action plans initiated by Humana.
- Except for patient pay liability amounts for LTSS services as established by the local Department of Social Services, providers shall accept Humana's payment as payment in full and shall not bill or balance bill a Medicaid member for Medicaid Covered Services provided during the member's period of Humana enrollment. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a member for any Medicaid Covered Service provided is expressly prohibited. This includes those circumstances where the provider fails to obtain necessary referrals, service authorization or fails to perform other required administrative functions.
- Should an audit by Humana or an authorized state or federal official result in disallowance of amounts previously paid to a provider, the provider must reimburse Humana upon demand. Providers shall not bill the member in these instances.
- Providers must agree not to bill a member for medically necessary services covered under the Medicaid Contract and provided during the member's period of Humana enrollment. This provision shall continue to be in effect even if Humana becomes insolvent. However, if a member agrees in advance of receiving the service and in writing to pay for a non-Medicaid covered service, then Humana, providers or Humana's subcontractor can bill.
- Providers must comply with federal contracting requirements described in 42 CFR Part 438.3, including identification of/nonpayment of provider preventable conditions, conflict of interest safeguards, inspection and audit of records requirements, physician incentive plans, recordkeeping requirements, etc.
- Providers must cooperate with Humana's quality improvement activities for member services and experience.
- Providers must report fraud, waste and abuse.
- Providers are required to report Critical incidents.
- Providers must understand and agree performance data can be used by Humana.
- Providers who bill for personal care and respite care services must commit to use an Electronic Visit Verification (EVV) system.
- Providers must treat Humana members with the same dignity and respect afforded to all patients, including the same high standards of care and operating hours

- Providers must complete annual trainings which include:
  - General Compliance (**Ethics Every Day** and Compliance policy)
  - Fraud, waste and abuse
  - Medicaid provider orientation training
  - Cultural competency
  - Health, safety and welfare (abuse, neglect and exploitation)

## PCP responsibilities

In addition to the responsibilities of all providers in Humana' Cardinal Care Medicaid Network, PCPs are also responsible, at a minimum, for:

- Managing and coordinating the medical and behavioral healthcare needs of members to ensure all medically necessary services are made available in a timely manner
- Referring patients to subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available
  - Communicating with all other levels of medical care to coordinate and follow up the care of individual patients
- Maintaining a medical record of all services rendered by the PCP and a record of referrals to other providers and any documentation provided by the rendering provider to the PCP for follow-up and/or coordination of care
- Developing a plan of care to address a patient's risks and medical needs and other responsibilities as defined in this section
- Providing phone coverage for handling patient calls 24 hours a day, 7 days a week
- Working with Humana's care managers to develop plans of care for members receiving care management services
- Conducting screens to determine whether the member needs BH services for common behavioral issues, including, but not limited to:
  - Depression
  - Anxiety
  - Trauma/adverse childhood experiences (ACEs)
  - Substance use
  - Early detection
  - Identification of developmental disorders/delays
  - Social-emotional health and health-related social needs (HRSN)

# Health Insurance Portability and Accountability Act compliance

Title II of the Health Insurance Portability and Accountability Act (HIPAA) requires standardization of electronic patient health, administrative and financial data; unique health identifiers for individuals, employers, health plans and healthcare providers; and security standards protecting the confidentiality and integrity of individually identifiable health information past, present or future.

## Personally identifiable information and protected health information

In the day-to-day business of patient treatment, payment and healthcare operations, Humana and its providers routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, there are various standards and industry best practices that guide how PII is appropriately protected when stored, processed and transferred in the course of conducting normal business. Providers should take measures to secure their patients' data.

HIPAA also mandates that providers secure all protected health information (PHI) related to their patients. There are many administrative, physical and technical controls providers should have in place to protect all PII and PHI. Here are some important places to start:

- Use a secure message tool or service to protect data sent by email
- Have policies and procedures in place to address the protection of paper documents containing patient information, including secure storage, handling and destruction of documents
- Encrypt all laptops, desktops and portable media such as CD-ROMs and USB flash drives that may potentially contain PHI or PII

## Member privacy

The HIPAA Privacy Rule requires health plans and covered healthcare practitioners to develop and distribute a notice that provides a clear, user-friendly explanation of individuals' rights with respect to their personal health information, as well as the privacy practices of health insurance plans and healthcare practitioners.

Providers must follow HIPAA regulations and make only reasonable and appropriate uses and disclosures of protected health information for treatment, payment and healthcare operations.

## Member consent to share health information

Consent is the member's written permission to share their information. Not all disclosures require the member's permission. The following consent requirements pertain to sensitive health information (SHI) and substance use disorder (SUD) treatment:

- SHI is defined by the state (e.g., Human Immunodeficiency Virus [HIV]/Acquired Immune Deficiency Syndrome [AIDS], mental health, sexually transmitted diseases).
- SUD 42 CFR Part 2 (Part 2), at **www.ECFR.gov**, pertains to federal requirements that apply to all states.

While all member data is protected under the HIPAA Privacy Rule, Part 2 provides more stringent federal protections for individuals with SUDs who could be subject to discrimination and legal consequences in the event their information is inappropriately used or disclosed.

When consent is on record, Humana displays all member information in Availity Essentials and other health information exchanges. Providers should explain to patients that if they do not consent to let Humana share this information, other providers involved in their care may not be able to coordinate their care effectively. When a member does not consent to share this information, a message displays on the provider portal to indicate all the member's health information may not be available to all providers.

## Provider right to advise or advocate on behalf of members

Humana does not prohibit or restrict providers acting within the lawful scope of practice from advising or advocating on behalf of a member who is their patient, regardless of whether benefits for such are provided under the contract between Humana and DMAS, regarding:

- The member's health status, medical care or treatment options, including any alternative treatment that can be self-administered;
- Any information the member needs to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or nontreatment; **and**
- The member's right to participate in decisions regarding their healthcare, including the right to refuse treatment and to express preferences about future treatment decisions.

## Access to care requirements

Humana monitors our network providers for compliance with the following appointment timeliness standards on an ongoing basis, including monitoring appeals data for indications that problems may exist with access to specific providers or provider types. If members miss an appointment, they cannot be billed.

| Service type | Appointment timeliness standards |
|---|---|
| **Emergency services including crisis services** | Emergency appointments and services, including crisis services, must be made available immediately upon the member's request.<br>Follow-up to crisis services must be made within 24 hours of Humana being notified of the crisis services utilization. |
| **Routine primary care services** | Routine, primary care service appointments must be made within 30 calendar days of the member's request.<br>This standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days, or for routine specialty services (e.g., dermatology, allergy care). |

| Service type | Appointment timeliness standards |
|---|---|
| **Maternity care** | Prenatal care appointments must be made available to pregnant members as follows:<br>1. **First trimester:** Within 7 calendar days of request<br>2. **Second trimester:** Within 7 calendar days of request<br>3. **Third trimester:** Within 3 business days of request<br>4. **High-risk pregnancy:** Within 3 business days of identification of high-risk to Humana or maternity provider or immediately if an emergency exists |
| **BH services** | BH appointments must be made available as expeditiously as the member's condition requires and within no more than 5 business days from Humana' determination that coverage criteria are met. |
| **LTSS** | LTSS must be made available as expeditiously as the member's condition requires and within no more than 5 business days from Humana' determination that coverage criteria are met. |

All other services not specified in the table above shall meet the usual and customary standards for the community as determined by DMAS.

## Americans with Disabilities Act compliance

As a Humana-contracted healthcare provider, you must comply with the Americans with Disability Act (ADA), 28 CFR §35.130 and Section 504 of the Rehabilitation Act of 1973 (29 USC § 794), as well as all applicable state and/or federal laws, rules and regulations. Humana ensures programs and services are as accessible to an individual with disabilities as they are to an individual without disabilities. You must provide physical access, reasonable accommodations and accessible equipment for members with physical or mental disabilities. More details are available in your Humana provider agreement under "Compliance with Regulatory Requirements."

## Nondiscrimination policy and regulations

You must comply with all applicable federal and state laws and regulations, including, but not limited to:

- Title VI of the Civil Rights Act of 1964 as implemented at 45 CFR Part 80
- Title IX of the Education Amendments of 1972 (regarding education programs and activities)
- The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR Part 91
- The Rehabilitation Act of 1973
- The ADA of 1990 as amended
- Titles II and III of the Americans with Disabilities Act
- Section 1557 of the Patient Protection and Affordable Care Act (including but not limited to, reporting overpayments pursuant to state or federal law)

- The Deficit Reduction Act of 2005 (DRA) requiring emergency services be paid in accordance with the DRA provisions (Pub. L. No. 109-171, Section 6085) and as explained in CMS SMD #06-010
- All federal and State laws and regulations regarding privacy and confidentiality

Additionally, you must comply with all nondiscrimination requirements in the Medicaid Contract and the following nondiscrimination requirements:

- You shall not discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, sexual orientation, gender identity, physical condition, developmental disability or national origin.
- You shall provide contract services to members in the same manner as you provide those services to all non-Medicaid and non-FAMIS members, including those with limited English proficiency or physical or mental disabilities.
  - Additionally, in accordance with 42 CFR § 438.206(c)(1)(ii), you must offer hours of operation that are no less than the hours of operation offered to commercial members if you serve only Medicaid and/or FAMIS members.
- You shall post in conspicuous places, available for employees and applicants for employment, notices setting forth the provisions of the nondiscrimination clause.

## Notification of demographic changes

As a contracted provider, you must notify Humana of legal and demographic changes. This ensures provider directory and claim processing accuracy. Examples of changes that require notification include:

- Change to Tax Identification Number (TIN)
- New providers added to group
- Providers leaving group
- Service address changes (e.g., new location, phone or fax numbers)
- Access to public transportation
- Standard and after-hours hours of operation
- Billing address updates
- Credentialing updates
- Panel status
- Gender
- Languages spoken in office

Send notifications of changes to the email address appropriate for your practice:

- Medical: **VirginiaProviderUpdates@humana.com**
- LTSS: **LTSSContracting@humana.com**
- BH: **VA_BH_Medicaid@Humana.com**

You are strongly encouraged to provide your race and ethnicity for Humana to reference when a member calls to request a practitioner with the same race, ethnicity and language as themselves.

## Advanced directives

PCPs have the responsibility to discuss advance medical directives with adult members 18 or older who are of sound mind at the first medical appointment. The discussion should subsequently be charted in the permanent medical record of the member. A copy of the advance directive should be included in the member's medical record inclusive of other mental health directives. The PCP should discuss potential medical emergencies with the member and document that discussion in the member's medical record.

Nothing in this manual should be interpreted to require a member to execute an advanced directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services under the Medicaid program. Humana does not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.

## Identifying and reporting member abuse, neglect and exploitation

Suspected cases of abuse, neglect and/or exploitation must be reported immediately upon discovery in accordance with § 63.2-1606 of the Code of Virginia to the appropriate agency for reporting, based on the person's age.

- **Abuse –** the suspected or known physical or mental mistreatment of a person.
- **Neglect –** repeated conduct or a single incident of carelessness that results, or could reasonably be expected to result, in serious physical or psychological/emotional injury or substantial risk of death (this includes self-neglect and passive neglect).
- **Exploitation –** illegal use of assets or resources of an adult with disabilities, including, but not limited to, misappropriation of assets or resources of the alleged victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion or in any manner contrary to law.

You must report abuse, neglect and/or exploitation **of children** to at least 1 of the following entities:

- The local Department of Social Services in the county or city where the child resides or where the abuse or neglect is believed to have occurred
- The Virginia Department of Social Services' toll-free child abuse and neglect hotline:
  - In Virginia: **800-552-7096**
  - Out-of-state: **804-786-8536**
  - TTY: **800-828-1120**

You must report abuse, neglect and/or exploitation **of adults** to at least one of the following entities:

- The local adult protective services office
- The Virginia Department of Social Services' hotline at **888-832-3858**

You should also report member abuse, neglect or exploitation of **children or adults** to Humana by:

- Fax: **877-313-7257**; **or**
- Email: **VACriticalIncidents@humana.com**

Additional information on this topic is included in Humana' required health, safety and welfare education annual compliance training. Please refer to the Provider Training subsection of this manual for more detailed information and directions for accessing this required training.

## Member billing

You must not bill a Medicaid member for medically necessary covered services provided during the member's period of Humana enrollment. However, if a member agrees in advance of receiving the service and in writing to pay for a non-Medicaid covered service, you can bill the member for that service.

## Missed appointments

In compliance with federal and state requirements, Humana members cannot be billed for missed appointments. Humana encourages members to keep scheduled appointments and to call to cancel or reschedule, if needed.

## Provider-based marketing activities

Marketing and promotional activities, including provider promotional activities, must comply with all relevant federal and state laws, including, when applicable, the antikickback statute, which is a civil monetary penalty prohibiting inducements to members.

## Provider training

You are expected to adhere to all training programs identified as compliance-based by Humana. This includes agreement and assurance that all affiliated participating providers and staff members receive training regarding the identified compliance material.

You must complete annual compliance training on the following topics as required by section 6032 of the Federal Deficit Reduction Act of 2005:

- General Compliance (**Ethics Every Day** and Compliance policy)
- Fraud, waste and abuse
- Medicaid provider orientation training
- Cultural competency
- Health, safety and welfare (abuse, neglect and exploitation)

The training on the topics outlined above is designed to ensure:

- Sufficient knowledge of how to perform the contracted function(s) effectively to support the membership of Humana
- The presence of specific controls to prevent, detect and/or correct potential, suspected or identified noncompliance and/or fraud, waste or abuse
- An attestation at the organization level must be submitted annually to Humana to certify your organization has a plan in place to comply with and conduct training on Medicaid required topics.

You have access to online training modules for the topics listed above, 24 hours a day, 7 days a week, as well as an organization-level attestation form at **Humana.com/ProviderCompliance** or through Availity Essentials. An attestation at the organization level must be submitted annually to Humana to certify your organization has a plan in place to comply with and conduct training on Medicaid required topics.

For additional provider training, visit **Humana.com/HealthyVA**. All new providers also receive Humana' Medicaid provider orientation. Provider orientations are offered via webinar and/or with Provider Relations Representatives as requested.

To complete compliance training and attestation online for Medicaid Provider Orientation Training, Cultural Competency Training and Health, Safety and Welfare (abuse, neglect and exploitation) Training, please follow the steps below:

1. Sign in to Availity Essentials at **www.availity.com**.
2. Select Payer Spaces – Humana.
3. Select the Resources tab.
4. Select Humana Compliance Events.
5. Select "I agree" to the notice that pops up to indicate you are leaving the Availity Essentials website.
6. If a security warning pops up indicating you are navigating to https://sso2.archer.rsa.com, choose "Yes" to proceed. You will enter Humana' secure compliance portal.
7. If directed to select a Humana Partner option, please select "Availity SSO." You also can select "Remember my selection" to bypass the question in the future.
8. Follow the onscreen instructions to add, review and accept the compliance events.
9. Select "Actions" and "Complete" and then "Save" and "Close."
10. All applicable events will show a status of "Review Complete."

## Provider training via Relias

As a Humana network provider, you can take advantage of Relias—a web-based continuing education library. Relias offers a variety of training modules and continuing education credits, in addition to BH training modules. Relias's training modules provide integrated information to support comprehensive care and address unique patient needs. Relias offers courses designed to help you succeed in the value-based healthcare delivery system.

To learn more about the courses referenced or for additional/alternative options, refer to the module library by visiting the **Relias website** at **https://hm.training.reliaslearning.com** or sign in to your Availity Essentials account at **www.availity.com**, then:

1. Select Humana under the Payer Services tab
2. Select the Resources tab
3. Select Relias training

For more information, please contact your provider relations representative.

# Chapter 6: Interpreter Services and Cultural Competency

## Interpreter services

Hospital and nonhospital providers are required to abide by federal and state regulations related to Sections 9 504 and 508 of the Rehabilitation Act, ADA, Executive Order 13166 and Section 1557 of the Affordable Care Act (ACA) in the provision of effective communication; this includes in-person or video-remote interpretation for deaf patients and over-the-phone interpretation with a minimum 150 languages available for non-English speakers. These services are available at no cost to the patient or member per federal law. For assistance in fulfilling this obligation, please call the Humana Concierge Service for Accessibility at **877-320-2233**.

## Understanding cultural competency

Humana recognizes cultural differences and the influence that race, ethnicity, language and socioeconomic status have on the healthcare experience and health outcomes. Humana is committed to developing strategies that eliminate health disparities and address gaps in care.

Communication is paramount in delivering effective care. Mutual understanding may be difficult during cross-cultural interaction between patients and providers. This may be attributed to miscommunication between providers and patients, language barriers, cultural norms, beliefs and attitudes that create barriers to patients seeking care. Providers can address gaps in healthcare with an awareness of cultural needs and improving communication with a growing number of patients, especially those from underserved communities.

Cultural competency in healthcare describes the ability to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural and linguistic needs. Services should be delivered in a culturally competent manner to all Medicaid managed care members—including those with limited English proficiency and diverse cultural and ethnic background, disabilities and regardless of sex. By doing so, we help increase understanding, appreciation, acceptance and respect for cultural differences and to develop understanding of how these differences influence relationships with Medicaid managed care members (as required by 42 CFR §438.206).

"Subculture" describes ethnic, regional, economic or social groups that exhibit characteristic behavior patterns that distinguish them from others within an embracing culture or society. Understanding the many different subcultures that exist within our own culture is also an important aspect of cross-culture healthcare.

## How to provide culturally competent care

Participating providers should provide services in a culturally competent manner including but not limited to, removing all language barriers to service and accommodating the special needs of the ethnic, cultural and social circumstances of the patient. Providers must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care including, but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the ADA and the Rehabilitation Act of 1973.

To address the health issues within different ethnicities, providers must work to understand the values, beliefs and customs of these different people. Some of the cultural aspects that may impact health behavior are:

- Eye contact – Many cultures use deferred eye contact to show respect. Deferred eye contact does not mean the patient is not listening.
- Personal space – Different cultures have varying approaches to personal space and touching. Some cultures expect more warmth and hugging when greeting people.
- Respect for authority – Many cultures are very hierarchical and view doctors with a lot of respect. These patients may feel uncomfortable questioning doctors' decisions or asking questions.
- Communication styles – In some cultures, direct communication is valued, while in others, indirect or nonverbal cues may be more significant. Understanding these nuances helps healthcare providers convey information effectively.
- Beliefs about health and illness – Traditional beliefs, such as the influence of spirituality or the preference for alternative medicine, can shape individuals' decisions about seeking and accepting medical care.
- Attitudes toward authority and decision-making – Some cultures prioritize shared decision-making, involving the patient and family, while others may place more emphasis on the authority of the healthcare provider.
- Perceptions of pain and suffering – Cultural variations in the expression and interpretation of pain may affect how patients communicate their symptoms and how healthcare providers assess and manage pain.
- Family dynamics – In certain cultures, family plays a central role in healthcare decisions. Understanding familial dynamics helps healthcare providers involve and respect the support systems around the patient.
- Healthcare practices and beliefs – Dietary preferences, traditional healing practices and health rituals can impact treatment adherence and the effectiveness of medical interventions.

- Language and health literacy – Language barriers can affect a patient's understanding of medical information, leading to potential misunderstandings or noncompliance with prescribed treatments.
- Cultural stigma and mental health – Stigmatization of mental health issues in some cultures may influence whether individuals seek help, affecting the diagnosis and treatment of mental health conditions.

## Clear communication

"Clear communication" involves effectively transmitting information in a way that is easily understood and respectful of diverse cultural backgrounds. Clear communication involves language considerations such as using plain language, avoiding medical jargon and providing translated materials when necessary, as well as understanding different communication styles, recognizing variations in direct and indirect communication and being attentive to nonverbal cues and body language. Active listening, demonstrating empathy and encouraging patients to share their perspectives and concerns play keys roles. Clarifying information and ensuring patient comprehension by asking open-ended questions contributes to clear communication, as well as respecting cultural norms, preferences regarding contact, personal space and touch. Adapting communication styles based on cultural backgrounds, tailoring information to align with cultural beliefs and values and addressing cultural health literacy levels are vital. Clear communication also emphasizes the use of interpreters to convey information accurately to patients with limited English proficiency, enhancing effective communication and care.

Clear communication is essential for establishing trust, promoting patient engagement and ensuring informed decision-making. It requires healthcare providers to be sensitive to cultural nuances, fostering a collaborative and respectful healthcare environment.

## Limited English proficiency

Limited English proficiency (LEP) describes how the degree to which a member's inability or a limited ability to speak, read, write or understand the English language affects effective interactions between the member and healthcare providers.

## Benefits of culturally competent care

Cultural competence in a hospital or healthcare system produces numerous benefits for the organization, patients and community. Organizations that are culturally competent have improved health outcomes, increased respect and mutual understanding from patients and increased participation from the local community. They also may have lower costs and fewer care disparities.

Cultural factors influence patients' health beliefs, behaviors and responses to medical issues. This section provides guidance for how to consider cultural differences as providers build effective relationships with their patients during shared decision-making.

## Enhancing cultural competency

To enhance cultural competency, providers should:

- Keep an open mind and remember each patient has a unique set of beliefs and values that may differ from theirs.
- Ask patients about their beliefs regarding their health condition (e.g., "What do you think caused the problem? What do you fear most about the sickness? Why do you think it started when it did?"). This information will allow providers to make the most of their interactions during shared decision-making.
- Recognize and understand the meaning or value of health prevention, intervention and treatment may vary greatly among cultures, specifically for BH.
- In addition to completing the required Humana Cultural Competency training, attend cultural competence training at their organization or through a continuing education program.
- Be aware of their own culture and how it can affect how they communicate with their patients.
- Reach out to cultural brokers to help learn more about the differences and similarities between cultures. Cultural brokers might include healthcare and social service workers and cultural group leaders. They can tell providers how to better address the patients they serve regarding cultural appropriateness, beliefs about health and barriers to communication. They can suggest resources providers can use to learn more about their patients' cultures.
- Know what they do not know. Providers will not be able to learn about every aspect of every patient's culture and they should not be afraid to let their patients know they are unfamiliar with their culture. Providers should invite their patients to explain what is important to them and how getting and staying well works in their community.
- Keep in mind that culture is not homogenous and there is great diversity among individuals—even in the smallest cultural group. Providers should also keep in mind culture changes over time.

## Providing culturally appropriate decision aids

To provide culturally appropriate decision aids, providers should:

- Ask patients about their learning preferences to help them present information better during shared decision-making.
- Find out if patients prefer materials in print, video or audio format.
- Ask patients if they would prefer for you to provide explanations by speaking, using a model, making a drawing or demonstrating how to do something. Patients may prefer information to be presented in a variety of ways.
- Make sure multimedia decision aids (videos, DVDs, CDs, audiotapes), other health resources for treatment and other intervention materials reflect the cultures of the patients served. When possible, offer decision aids, treatment summaries and educational materials that have culturally relevant descriptions of risks and benefits of treatment options. The best decision aids meet cultural and health literacy or plain language standards.

## Implicit bias

Bias consists of attitudes, behaviors and actions that are prejudiced in favor of or against 1 person or group compared to another. Implicit bias is a form of bias that occurs automatically and unintentionally, which nevertheless affects judgments, decisions and behaviors.

Implicit bias, a phrase that is not unique to healthcare, refers to the unconscious prejudice individuals might feel about another thing, group or person. In healthcare, implicit bias can shape the way medical providers interact with patients. Given that everyone is susceptible to implicit bias, these unconscious preconceptions can naturally seep into patient-provider communication.

Implicit bias can have adverse effects on the patient experience. By damaging patient-provider interactions, it can adversely impact health outcomes. Patients often can pick up on a provider's implicit bias and may report a poor experience because of it. Patients who pick up on implicit bias may feel less inclined to engage deeply with their care.

Eliminating implicit bias is a challenging task because most of us are not aware of our implicit biases. A strong education campaign can be a good first step to helping practitioners pick up on their own biases. The process of identifying and acknowledging implicit bias in healthcare is only in its infancy. But as more organizations commit to ending racial health disparities and working toward health equity, this will be an important step toward that end.

Actions providers can take to combat implicit bias include:

- Having a basic understanding of the cultures from which patients come
- Avoiding stereotyping patients; individuate them
- Understanding and respecting the magnitude of unconscious bias
- Recognizing situations that magnify stereotyping and bias
- Knowing the National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare (**National CLAS Standards**)
- Performing "teach back" (e.g., the National Patient Safety Foundation's "Ask Me 3®" educational program)
- Assiduously practicing "evidence-based medicine"
- Using techniques to de-bias patient care, which include training, intergroup contact, perspective-taking, emotional expression and counter-stereotypical exemplars

## Health equity

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices, overcome economic, social and other obstacles to health and healthcare, and eliminate preventable health disparities.

Differences in access, treatment and outcomes between individuals and across populations that are systemic, avoidable, predictable and unjust are particularly problematic. These types of differences

are often referred to as inequities or disparities. Inequities are the worst type of unwanted variation in a system—variation linked to the complicated history and reality of racism, classism, sexism, ableism, ageism and other forms of oppression. Healthcare providers have a role to play in healthcare systems and communities to remediate inequities. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices and the elimination of health and healthcare disparities.

## Health literacy

Health literacy describes a member's ability to obtain, process and understand basic health information and services needed to make appropriate decisions. More than a third of patients experience limited health literacy, which results in a lack of understanding of what's required to take care of their health.

Limited health literacy is associated with:

- Poor management of chronic diseases
- Poor understanding of and adherence to medication regimens
- Increased hospitalizations and poor health outcomes

Humana develops member communications based on health literacy and plain language standards per the federal Plain Writing Act of 2010. The reading ease of Humana written member materials is tested using the widely recognized Flesch-Kincaid
Readability tool.

Health literacy is a critical aspect of effective healthcare delivery, encompassing the ability of individuals to access, comprehend and apply health information to make informed decisions about their well-being. Healthcare providers play a pivotal role in promoting health literacy and ensuring optimal patient understanding.

To promote health literacy, materials should be written in plain language and include visual aids like diagrams or charts to enhance understanding. Tailoring communication approaches to accommodate cultural preferences, languages and technology accessibility ensures usability across different literacy levels. Informed consent procedures should be clearly explained in nontechnical terms, verifying comprehensive understanding before obtaining consent. This also fosters collaborative decision-making with patients about treatment that aligns with their preferences and values. Health education programs should include varying literacy levels and use multimedia tools to enhance engagement. Continual assessment of patient populations' health literacy levels is crucial, adjusting communication strategies based on individual needs. Additionally, team training for healthcare staff on effective commination techniques is fundamental.

By prioritizing health literacy, healthcare providers contribute to improved patient outcomes, increased patient satisfaction and a more equitable healthcare experience for all individuals.

# Chapter 7: Covered Services

## Covered services

Humana promptly provides, arranges, purchases or otherwise makes available to all of its members the full continuum of services required by its contract with DMAS. Humana maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.

## Medical services

Humana members are exempt from cost sharing and receive the benefits as described in the chart below.

| CCMC services | Coverage | Additional notes |
|---|---|---|
| **Medical services** | | |
| Abortions (induced) | Yes (limited) | Covered with prior authorization when the life of the mother is substantially endangered. |
| Adult vaccines | Yes | |
| Annual adult wellness exams | Yes | |
| Brain injury services case management | Yes | |
| Certified nurse midwife services | Yes | |
| Clinic services | Yes | |
| Clinical trials | Yes | |
| Colorectal cancer screening | Yes | |
| Court-ordered services | Yes | |
| Dental services | Yes (limited) | Dental services are covered under fee-for-service (see the **Dental services** section for details). |
| Dietary counseling | Yes | |
| Doula services | Yes | |
| Emergency services | Yes | |
| Emergency services – post-stabilization care | Yes | |

| CCMC services | Coverage | Additional notes |
|---|---|---|
| **Medical services** | | |
| Family planning services | Yes | |
| Gender dysphoria treatment services | Yes | |
| HIV testing and treatment counseling | Yes | |
| Home health services | Yes | |
| Hysterectomies | Yes | |
| Immunizations | Yes | |
| Hospital services (inpatient and outpatient) | Yes | |
| Laboratory, radiology and anesthesia services | Yes | |
| Lung cancer screening with low-dose computed tomography (LDCT) | Yes | |
| Mammograms | Yes | |
| Medical supplies and equipment | Yes | |
| Nutritional counseling | Yes (limited) | Covered for members with obesity or chronic disease. |
| Organ transplantation services | Yes | |
| Pap smears | Yes | |
| Personal care, Medicaid Works | Yes (limited) | Covered for Medicaid Works members. |
| Physician services | Yes | |
| Podiatry services | Yes | |
| Pregnancy-related services | Yes | |
| Prescription drugs | Yes | |
| Prostate specific antigen (PSA) and digital rectal exams | Yes | |
| Prosthetics/orthotics | Yes | |
| Reconstructive breast surgery | Yes | |
| Sterilizations | Yes | |
| Smoking cessation counseling | Yes | |
| Telemedicine services | Yes | |
| Therapy services | Yes | Includes audiology services, occupational therapy, physical therapy and speech pathology |
| Transportation services | Yes | Includes emergency and nonemergency transportation. |
| Tobacco cessation services | Yes | |

| CCMC services | Coverage | Additional notes |
|---|---|---|
| **Medical services** | | |
| Vision services | Yes | Routine eye exams covered once every 24 months.<br>Eyeglasses for members younger than 21 are covered. However, no more than one pair is allowed within 24-month period.<br>Contact lenses are only covered based on medical necessity if eyeglasses cannot accomplish the optometric treatment.<br>Repair of frames and lenses is normally limited to once every 12 months; if needed less than 12 months medical justification is required. |

## Behavioral health services

| CCMC services | Coverage | Additional notes |
|---|---|---|
| **Inpatient BH services** | | |
| Inpatient psychiatric hospitalization | Yes | |
| Temporary detention orders (TDOs) and emergency custody orders (ECO) | Yes | |
| **Outpatient BH services** | | |
| Electroconvulsive therapy | Yes | |
| Pharmacological management | Yes | |
| Psychiatric diagnostic evaluation | Yes | |
| Psychological/neuropsychological testing | Yes | |
| Psychotherapy | Yes | |
| Tobacco cessation | Yes | |
| **Mental health services (MHS) and residential treatment services (RTS)** | | |
| 23-hour crisis stabilization | Yes | |
| Applied behavior analysis | Yes | |
| Assertive community treatment | Yes | |
| Community stabilization | Yes | |
| Functional family therapy | Yes | |

| CCMC services | Coverage | Additional notes |
|---|---|---|
| **Mental health services (MHS) and residential treatment services (RTS)** | | |
| Intensive in-home assessment and services | Yes | |
| Mental health case management | Yes | |
| Mental health intensive outpatient | Yes | |
| Mental health – partial hospitalization program | Yes | |
| Mental health peer recovery support services | Yes | |
| Mental health skill-building assessment and services | Yes | |
| Mobile crisis response | Yes | |
| Multisystemic therapy | Yes | |
| Psychosocial rehabilitation assessment and services | Yes | |
| Residential crisis stabilization unit | Yes | |
| Therapeutic day treatment for children and adolescents | Yes | |
| **Inpatient and residential SUD treatment services** | | |
| Clinically managed high intensity residential services | Yes | |
| Clinically managed low intensity residential services | Yes | |
| Clinically managed population-specific high intensity residential services | Yes | |
| Medically managed intensive inpatient | Yes | |
| Medically monitored intensive inpatient services | Yes | |
| **Outpatient withdrawal management** | | |
| Ambulatory management with extended on-site monitoring | Yes | |
| Ambulatory withdrawal management without extended on-site monitoring | Yes | |
| ARTS intensive outpatient | Yes | |
| ARTS partial hospitalization | Yes | |

| CCMC services | Coverage | Additional notes |
|---|---|---|
| **Medication assisted treatment (MAT)** | | |
| Buprenorphine/Naloxone and Naltrexone in opioid treatment program | Yes (limited) | Covered in Department of Behavioral Health and Developmental Services (DBHDS)-licensed Community Service Boards (CSB) and private methadone clinics. |
| Buprenorphine/Naloxone and Naltrexone in office based American Society of Addiction Medicine (ASAM) | Yes | |
| Methadone in opioid treatment program | Yes (limited) | Covered in DBHDS-licensed CSBs and private methadone clinics. |
| **ARTS** | | |
| ARTS case management, outpatient and peer recovery support services | | |
| ARTS peer recovery support services | Yes | |
| Outpatient ARTS individual, family and group counseling services | Yes | |
| Screening, brief intervention and referral to treatment | Yes | |
| Substance use case management | Yes | |
| ARTS Intensive Outpatient Services | Yes | |
| ARTS Partial Hospitalization Program | Yes | |
| **BH services – FAMIS children** | | |
| Mental health services (inpatient and outpatient) | Yes | |

## FAMIS children medical services

| FAMIS children services | Coverage | Additional notes |
|---|---|---|
| **Medical services** | | |
| Abortions (induced) | Yes (limited) | Covered when the life of the mother is substantially endangered. |
| Case management services | Yes | |
| Chiropractic services | Yes | |
| Clinic services | Yes | |
| Dental services | Yes (limited) | Dental services covered. Routine dental services covered under fee-for-service. |

| FAMIS children services | Coverage | Additional notes |
|---|---|---|
| **Medical services** | | |
| Durable medical equipment | Yes | |
| Early intervention services | Yes | |
| Emergency services | Yes | |
| Family planning services | Yes | |
| Gender dysphoria treatment services | Yes | |
| Hearing aids | Yes | |
| Home health services | Yes | |
| Hospice services | Yes | |
| Hospital services (inpatient and outpatient) | Yes | |
| Immunizations | Yes | |
| Laboratory and x-rays services | Yes | |
| Lead testing | Yes | |
| Medical transportation | Yes | |
| Organ transplantation services | Yes | |
| Pap tests | Yes | |
| Pregnancy related services | Yes | |
| Prescription drugs | Yes | |
| Private duty nursing (PDN) services | Yes | |
| Prosthetics/orthotics | Yes | |
| Screening, diagnostics and preventive services | Yes | |
| Second opinions | Yes | |
| Telemedicine services | Yes | |
| Therapy services | Yes | Includes chemotherapy and radiation therapy, inhalation therapy, intravenous therapy and renal dialysis. |
| Vision services | Yes | Includes routine eye exam and eyeglasses or contacts. |

## Dental services

Dental services are provided to all Medicaid/FAMIS members through DentaQuest®, a dental benefits administrator contracted with DMAS. Members are not responsible for the cost of dental services received from a participating dental provider. Humana works with DMAS' Dental Administrator to authorize some services such as transportation to dental services, medication related to covered dental services and medically necessary anesthesia and hospitalization services that require dental care. For questions or more information about dental benefits, call **888-912-3456 (TTY: 800-466-7566)** Monday – Friday 8 a.m. – 6 p.m., Eastern time.

| Dental services | Coverage | Additional notes |
|---|---|---|
| **Covered medically necessary services for members younger than 21 (including pregnant members)** | | |
| Orthodontic procedures | Yes | Braces, if approved. |
| Fluoride | Yes | |
| Sealants | Yes | |
| Space maintainers | Yes | |
| Extractions | Yes | |
| Anesthesia | Yes | |
| Crowns (some caps) | Yes | |
| Root canal | Yes | |
| Filling | Yes | |
| Oral disease services | Yes | |
| **Covered services members 21 and older who are not pregnant:** | | |
| X-rays and exams | Yes | |
| Cleanings | Yes | |
| Fillings | Yes | |
| Root canal | Yes | |
| Gum-related treatment | Yes | |
| Dentures | Yes | |
| Tooth extractions and other oral surgeries | Yes | |
| Other appropriate general services such as anesthesia | Yes | |
| **Humana covered dental services for all ages** | | |
| Transportation and medications related to covered dental services | Yes | |
| Medically necessary anesthesia and hospitalization services | Yes | |
| Limited oral surgery | Yes (Limited) | |

## Emergency services

Humana covers and pays for emergency services until a member is stabilized regardless of whether the provider that furnishes the service is in- or out-of-network or has a service authorization. Humana covers out of area emergency services.

You are required to ensure adequate accessibility for healthcare 24 hours a day, 7 days a week. If a member is experiencing an emergency, they should call **911** for help or go to the closest emergency room (ER) or any other emergency setting when they are experiencing an emergency medical condition such as acute symptoms of sufficient severity (including severe pain).

Humana will not deny payment when a Humana representative instructs a member to seek emergency services or when a member had an emergency medical or BH condition, including cases in which the absence of immediate medical attention would not have had the outcomes as specified by the definition of "emergency medical condition."

The attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge and that determination is binding on Humana.

Humana does not:

- Limit what constitutes an emergency medical condition or BH condition on the basis of lists of diagnoses or symptoms
- Refuse to cover emergency services based on the ER provider, hospital, or fiscal agent not notifying the member's PCP, Humana, or applicable state entity of the member's screening and treatment within 10 calendar days of presentation for emergency services.

A member who has an emergency medical condition may not be held liable for:

- Payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member
- Charges for emergency services furnished by Humana' network or out-of-network providers

## Doula services

Humana covers community-based doula services to address many of the drivers of poor maternal and child health outcomes. Doulas are individuals who offer a broad set of nonclinical pregnancy-related services centered on continuous support throughout pregnancy and in the postpartum period. Doulas performing pre- and postpartum visits and delivery touchpoint services must be certified by Virginia Department of Health as a registered Medicaid provider and complete the federal and state screening processes. Please note that doulas must also be contracted with Humana, providers can find doulas participating in the network by visiting **Humana.com/FindADoctor**. For more information on contracting with Humana, please review **Chapter 16: Credentialing and Recredentialing of this provider manual**. For more information on how to become a state-certified Community Doula in Virginia, please visit **https://dmas.virginia.gov/media/4690/community-doula-benefit-overview-flyer.pdf**. The Doula Care Form can be found at **Humana.com/HealthyVA** or **https://dmas.virginia.gov/media/6517/va-medicaid-doula-care-form-01-31-2024.pdf**. The Doula Care Form must be submitted to Humana prior to initiating doula services.

## Early and Periodic Screening, Diagnostic and Treatment services

Early and periodic screening, diagnostic and treatment (EPSDT) services are covered for Humana members younger than 21. EPSDT provides coverage for all medically necessary services for children needed to correct physical and mental illnesses and conditions, or to maintain their health. FAMIS children are eligible to receive well baby and well-child services, but not all EPSDT services. A listing of some of the services covered under EPSDT appears below. Please reference **Chapter 8: EPSDT of this manual** for additional information.

| CCMC services | Coverage | Additional notes |
|---|---|---|
| **EPSDT services** | | |
| Assistive technology | Yes | |
| Case management for high-risk infants | Yes (limited) | Covered up to age 2 |
| Clinical trials | Yes | |
| Dental screenings | Yes | |
| Dental varnish | Yes | |
| Hearing services | Yes | |
| Immunizations | Yes | |
| Laboratory tests | Yes | |
| Lead testing | Yes | |
| Personal care services | Yes | |
| PDN | Yes | |
| Screenings | Yes | |
| Vision services | Yes | |
| Other medically necessary services | Yes | Includes medically necessary healthcare, diagnostic services and treatment and measures to correct or ameliorate medical conditions and/or physical or mental illness. |

## Early intervention services

Early intervention (EI) services are specialized rehabilitative services covered for children from birth to age 3. These services are designed to meet the developmental needs of each child and the needs of their family. For a list of covered EI services, reference the list below. Additional information about EI services can be found in **Chapter 8: EPSDT of this manual**.

| CCMC services | Coverage | Additional notes |
|---|---|---|
| **EI services** | | |
| Center-based EI services | Yes | |
| Developmental nursing | Yes | |
| Developmental service | Yes | |
| EI initial assessments for service planning and development and annual review of the individual family services plan (IFSP) | Yes | |
| EI occupational therapy | Yes | |
| EI physical therapy | Yes | |
| EI speech language pathology | Yes | |
| EI targeted case management/service coordination | Yes | |
| IFSP team treatment activities | Yes | Includes IFSP review meetings and assessments performed after the initial assessment for service planning. |
| Other medically necessary services | Yes | Includes providing families with information and training to enhance the development of the child and working with the child to promote normal development. |

## 24-hour Clinical Triage Line (behavioral health crisis, ARTS, nurse and care coordination line)

To better integrate behavioral and physical health operations in Virginia, Humana has partnered with Professional Management Enterprises, Inc. (PME) to provide the Clinical Triage Line to our members. The Clinical Triage Line is a direct-dial number answered live by qualified professionals who are trained to identify and triage crisis/emergency calls (e.g., medical, behavioral health, ARTS), nurse advice calls and care coordination. If a call requires escalation, the professional will connect the caller to a qualified clinician by conducting a warm transfer. Members can call the Clinical Triage Line at **888-445-8714**, 24 hours a day, 7 days a week.

### Behavioral health crisis services/ARTS

Humana provides coverage for BH crisis services including but not limited to, mobile- and community-based same-day crisis response services, which is consistent with the emergency and post-stabilization services provisions described above. Humana collaborates with BH crisis providers to ensure members receive timely discharge planning, including supporting members in obtaining community stabilization services, peer crisis support, outpatient BH services and any other support services that may be necessary at discharge. Humana is notified of all members who have utilized

the Clinical Triage Line. Upon notification that a member has utilized the Clinical Triage Line and/or a crisis service, a Humana care manager will conduct a post-crisis outreach as soon as possible, but no later than 24 hours after notification. During this follow-up, the care manager will conduct a BH assessment to ensure the member has the appropriate follow-up appointments scheduled, address any other needs and enroll the member in the Humana Care Management program, if not already enrolled.

### Nurse advice services

Members can speak with an experienced staff of registered nurses about health-related symptoms or medical questions. A nurse will assess the members' symptoms, offering evidence-based triage protocols and decision support using the Schmitt-Thompson Clinical Content triage system, the gold standard in telephone triage.

The nurse will educate the member about the benefits of preventive care and can make referrals to disease and care management programs. Nurses promote the relationship with the PCP by explaining the importance of the PCP's role in coordinating the member's care.

Through this service, nurses can:

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

When Humana receives notification of a member calling the Clinical Triage Line, a Humana care manager will contact the member based on the outcome of the call. During this follow-up, the care manager will conduct assessments to ensure the member has the appropriate follow-ups scheduled, address any other needs and enroll the member in the Humana Care Management program, if not already enrolled.

### Care coordination services

Additionally, any time a member calls the Clinical Triage Line for anything unrelated to BH crisis, ARTS or nurse advice, Humana will be notified to ensure the member's needs were fully addressed or require additional support from our Care Management team.

## Long-term services and supports services

LTSS is designed to assist individuals with health or personal needs, activities of daily living and instrumental activities of daily living. LTSS can be provided at home, in the community or in various settings, including nursing facilities (NFs).

DMAS operates two types of waivers, the Commonwealth Coordinated Care Plus home- and community-based care services (HCBS) waiver and the Developmental Disability (DD) waivers.

Members enrolled in the Commonwealth Coordinated Care Plus HCBS waiver receive waiver services through Humana as well as medically necessary non-waiver services. Members enrolled in the DD waivers are covered under Humana only for their medically necessary non-waiver services. A list of LTSS covered services appears below. Please reference **Chapter 10: LTSS of this manual** for additional information.

| Service | Coverage | Coverage for DD waiver members | Additional notes |
|---|---|---|---|
| **Facility-based services** | | | |
| Long-stay hospital services | Yes | Yes | |
| Nursing facility services | Yes | Yes | |
| Specialized care | Yes | Yes | |
| **Community-based services** | | | |
| Hospice services | Yes | Yes | |
| **Community-based services – HCBS waiver services** | | | |
| Adult day healthcare | Yes | No | |
| Assistive technology | Yes | No | |
| Environmental modifications | Yes | No | |
| Personal care | Yes | No | |
| Personal emergency response system | Yes | No | |
| Respite care | Yes | No | |
| Services facilitation | Yes | No | |
| Skilled PDN | Yes | No | |
| Transition services | Yes | No | |
| Other medically necessary services | Yes | No | |

## Non-emergency medical transportation services

Except for FAMIS children, Humana covers emergency, urgent and non-emergency medical transportation (NEMT) to ensure members have necessary access to and from providers of covered medical, BH, dental, Commonwealth Coordinated Care Plus HCBS waiver services and LTSS services in a manner that seeks to ensure the member's health, safety and welfare. Covered transportation services are available 24 hours a day, 365 days a year.

Transportation services can be requested by calling Humana' transportation broker at **877-718-4215**.

Humana' covered NEMT transportation services include the following modes of transportation:

- Nonemergency ground ambulance
- Public transit
- Stretcher vans

- Wheelchair vans
- Minivans
- Sedans
- Taxis
- Transportation network companies
- Volunteer drivers

Humana also provides the NEMT benefit to all carved-out services, as described earlier in this chapter, except for Developmental Disabilities (DD) Waiver services.

With prior approval from Humana, family and friends also can transport members and receive gas reimbursement to covered services. The transportation must be provided safely by a spouse, by the parent or guardian of a minor child or by the member. The family member or friend must call Humana through its NEMT broker at **877-718-4215** before transport to receive authorization and instructions to receive the gas reimbursement. The driver must have a valid operator's license, and there must be an available registered vehicle at the home. The vehicle must be in operable condition and available for use at the time of the appointment.

## Telehealth services

Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth differs from telemedicine because it refers to the broader scope of remote healthcare services used to inform health assessment, diagnosis, intervention, consultation, supervision and information across distance.

- **Telemedicine:** a service delivery model that uses real-time, two-way telecommunications to deliver covered physical and BH services for the purposes of diagnosis and treatment of a covered member. Telemedicine must include, at a minimum, the use of interactive audio and video telecommunications equipment (with a temporary exception for audio-only telecommunications) to link the member to an enrolled provider approved to provide telemedicine services at the distant (remote) site.
- **Remote patient monitoring (RPM):** the use of digital technologies to collect and securely transmit health data from patients in 1 location to health providers in a different location for analysis, interpretation, recommendation and management of a patient with a chronic or acute health illness or condition. These services monitor clinical patient data including, but not limited to, weight, blood pressure, pulse, pulse oximetry, blood glucose; treatment adherence monitoring; and communication of updates to the care plan with or without digital image upload.

## Services for American Indian/Alaska Native members

Services provided through Indian Healthcare Providers (IHCPs), including tribal clinic providers, are reimbursed through fee-for-service per the provider's agreement with DMAS. Humana ensures the following for our American Indian/Alaska Native (AI/AN) members:

- AI/AN members are offered the option to choose an IHCP as a PCP
- Out-of-network IHCPs can refer an AI/AN member to a network provider
- Any services provided by non-IHCPs are covered, including service referrals by IHCPs, except where otherwise carved out of the contract between Humana and DMAS

## Family planning services

Family planning services provide individuals and families with essential healthcare options to delay or prevent pregnancy, ensuring they can make informed reproductive choices. These services include:

- Resources to delay or prevent pregnancy
- Family planning exams
- Cervical cancer screening for women
- Sexually transmitted infection (STI) testing
- Lab services for family planning and STI testing
- Family planning education
- Counseling
- Preconception health
- Sterilization procedures
- Non-emergency transportation to family planning services
- U.S. Food and Drug Administration–` approved prescriptions
- Over-the-counter contraceptives

## Enhanced benefits

Humana' enhanced benefits offer services not covered in the Virginia Medicaid State Plan and Medicaid fee schedules.

In instances where an enhanced benefit is also a Medicaid-covered service, Humana will administer the benefit in accordance with any applicable service standards pursuant to Humana' contract, the Virginia Medicaid State Plan and any Medicaid coverage and limitations handbooks. Members will need to exhaust the covered benefits first before enhanced benefits become available.

For a full list of enhanced benefits Humana has committed to offering, please see the chart below.

| Enhanced benefits | |
|---|---|
| **Healthy families** | |
| **Convertible car seat or portable crib** | Pregnant members who enroll and actively participate in the HumanaBeginnings® care management program (complete a comprehensive assessment and at least 1 follow-up call with a HumanaBeginnings care manager) can select 1 convertible car seat or portable crib per infant, per pregnancy. |
| **Food as medicine – maternal care** | Up to 4 boxes of fresh fruit and vegetables per year for pregnant members that are between 2nd trimester to 60 days postpartum that are deemed food insecure.<br>Eligibility: Member must be pregnant or postpartum. Member must be enrolled in HumanaBeginnings.<br>Care manager approval required. |
| **Haircuts for Kids** | 2 haircuts for members in grades K-12 valued at $20 each |
| **Parent/guardian self-care allowance** | Reimbursement up to $40 per quarter for members who are a legal parent or guardian of children up to 12 months old to help cover the costs of childcare and enable new parents/guardians to spend time doing activities independently and relieve stress. |
| **Sports physicals** | 1 sports physical per year |
| **Youth academic support** | For members in grades K-12, access to online tutoring services up to 2 hours per week as well as ACT/SAT test preparation. |
| **Youth development and recreation** | Members can receive reimbursement of up to $250 annually for participation in activities such as:<br>• YMCA<br>• Swim lessons<br>• Computer coding classes<br>• Music lessons |
| **Preventive benefits** | |
| **Hearing services** | • 1 assessment for hearing aids every 3 years<br>• 1 hearing aid per ear and dispensing fee every 3 years<br>• 2 hearing aid fitting/checking visits every 3 years<br>• 60 batteries per hearing aid per year |

| Enhanced benefits | |
|---|---|
| **Preventive benefits** | |
| **Tobacco and vaping cessation coaching** | Tobacco and vaping cessation coaching focuses on helping members 12 and older stop using nicotine products. The program is designed as a monthly engagement for a total of 8 coaching calls, but the member has 12 months to complete the program if needed.<br>The program also offers support for both over the counter (OTC) and prescription nicotine replacement therapy (NRT) for members 18 and older. |
| **Vision services** | • 1 eye exam per year<br>• Up to $150 annual allowance for 1 set of glasses (frames and lenses) and/or contacts |
| **Weight management coaching** | Weight management coaching delivers weight-management intervention for members 12 and older. Upon receiving physician clearance, members can complete 6 weight-management coaching sessions with a health coach; approximately 1 call per month for 6 months. |
| **Addressing convenience and access to appropriate care** | |
| **OTC pharmacy allowance** | Up to $65 per quarter per household allowance enables members to purchase products that support appropriate care such as:<br>• Feminine products<br>• First aid equipment not requiring prescriptions<br>Unused amounts do not roll over to the next quarter. |
| **Pain management alternatives – chiropractic services** | Up to 12 annual chiropractor visits to manage chronic pain. |
| **Post-discharge meals** | 14 refrigerated home-delivered meals following discharge from an inpatient or residential facility. Limited to 4 discharges per year. |
| **Smartphone** | Humana members who qualify for the Federal Lifeline program can receive a free smartphone with monthly talk minutes, text and data. Smartphones can provide easy access to health-related information and enable members to stay connected to their care team and health plan. |

| Enhanced benefits | |
|---|---|
| **Addressing health related social needs and health equity** | |
| **Criminal expungement** | Members can receive reimbursement of up to $110 for criminal record expungement. |
| **Disaster preparedness meals** | 1 box of 14 shelf-stable meals before or after a natural disaster twice per year.<br>• Member must not live in a residential facility or NF.<br>• Virginia's governor must declare the disaster in the member's county for eligibility. |
| **Employment physical** | 1 employment physical per year. |
| **Financial literacy coaching** | Up to 6 life coaching sessions to members 16 and older to help them with their money management goals. |
| **Food as medicine for chronic conditions** | Up to 4 boxes of fresh fruit and vegetables per year. Member must be identified as food insecure or diabetic, with heart failure or hypertension.<br>Care manager approval required. |
| **GED testing** | GED test preparation assistance, including a bilingual advisor, access to guidance and study materials and unlimited use of practice tests. |
| **Nonmedical transportation** | Up to 30 round trips (or 60 one-way trips) up to 30 miles per year to locations such as social support groups, wellness classes, WIC and SNAP appointments and food banks. This benefit also offers transportation to locations providing social benefits and community integration for members such as community and neighborhood centers, parks, recreation areas and churches. |
| **Addressing quality of life** | |
| **Caregiver respite** | Members not covered by a waiver program may receive up to 240 hours of caregiver respite services per year. A 4-hour minimum is required per use.<br>Care manager approval required. |
| **Environmental modifications** | Members not covered by a waiver program can receive up to $5,000 per year benefit to offset the costs of making changes to the member's primary residence or vehicle that enables a higher level of independence.<br>Care manager approval required. |

| Enhanced benefits | |
|---|---|
| **Addressing quality of life** | |
| **Fall prevention kit** | Members who are at risk for falls can receive a fall prevention kit once per lifetime. Kit contains:<br>• Non-slip socks<br>• Reacher/grabber<br>• Bathmat<br>• Stair treads<br>The member must not reside in a residential facility or NF.<br>Care manager approval required. |
| **Home-based virtual assistance technology** | Members participating in our care management or disease management program with the following conditions:<br>• Social isolation<br>• Depression<br>• Memory loss<br>• Alzheimer's disease and related dementias (ADRD)<br>May be eligible to receive 1 artificial intelligence-enabled virtual assistance device. One device per lifetime, per member.<br>Care manager approval required. |
| **Personal Care Attendant Services** | Members not covered by a waiver program can receive up to 80 hours of personal care attendant services per year. A 4-hour minimum is required per use.<br>Care manager approval required. |
| **Personal Emergency Response System (PERS)** | Members not covered by a waiver program and in our care management or disease management programs can receive 1 PERS device per lifetime to provide round the clock emergency service.<br>The member must not reside in a residential facility or NF.<br>Care manager approval required. |
| **Photo album** | Humana provides 1 photo album annually to members with Alzheimer's disease or dementia.<br>Members must reside in a home and/or community-based setting.<br>Care manager approval required. |

# Go365 wellness program

Go365 for Humana® is a wellness program that offers members the opportunity to earn rewards for taking healthy actions. Most of the rewards are dependent upon Humana receiving a provider claim for services rendered. We recommend all providers submit claims on behalf of a member by Dec. 31 of each calendar year, which allows the member time to redeem their rewards. A member will have 90 days from one plan year to the next, assuming they remain continuously enrolled, to redeem rewards.

## Earning rewards for healthy behaviors

Members must download the Go365 for Humana mobile app and register with their Medicaid member ID to begin earning rewards. As members complete key healthy actions, rewards accumulate in their Go365 account. Those rewards can be redeemed in the Go365 Mall for e-gift cards to popular retailers.

Go365 is available to all members who meet the requirements of the program.

Members can qualify to earn rewards by completing 1 or more of the following healthy activities outlined in the table below. Please note that the below table does not include a comprehensive list of all healthy activities that qualify members to earn rewards. Minors up to 18 years old have their own Go365 accounts attached to their Humana member ID number, but the minor's parent or guardian is the account administrator.

| Healthy activity | Reward |
|---|---|
| **Be active** | |
| **Be active** | Members 19 and older earn $5 per quarter for completing 12 workouts, for a total of up to $20 annually. Members can complete an array of workouts that support their abilities, including chair exercises, achieving a set number of steps and completing a physical activity. |
| **Diabetes care** | |
| **Diabetic retinal eye exam** | Members 18+ with diabetes or a diabetes diagnosis earn $25 in incentives for a retinal exam annually. |
| **Diabetes screening** | Members 21+ with a diabetes diagnosis earn $40 in incentives for completing an HbA1c screening and blood pressure. |
| **Digital onboarding** | |
| **Digital onboarding** | Members earn $20 for downloading the Go365 for Humana app and completing registration once per lifetime |
| **Follow-up** | |
| **Behavioral health follow-up visit** | Members earn $50 per quarter ($200 annual maximum) when they receive follow-up care within 7 days after a hospital discharge for a diagnosis of select mental illnesses or intentional self-harm. |
| **High-intensity care of SUD follow-up visit** | Members earn $50 per quarter ($200 annual maximum) when they receive follow-up care within 7 days after discharge from inpatient care, residential treatment or detoxification visits. |

| Healthy activity | Reward |
|---|---|
| **Follow-up** | |
| **Transitions of care** | Members earn $25 per quarter, up to $100 annually, for completing a follow-up visit within 30 days of an inpatient, non-psychiatric discharge. |
| **Get involved** | |
| **Get involved** | Members earn $5 per quarter, up to $20 annually, for completing 4 social activities, including engaging in their community and/or volunteering. |
| **Haircuts for Kids** | |
| **Haircuts for Kids** | Members ages 5–20 receive a $20 Visa gift card to get their hair cut ($40 annual maximum). 2 redemption periods available: March-April and July-September. Upload a school registration form, school ID or class schedule in the app and receive a Visa gift card via email (not in Go365 Mall like all other rewards.) |
| **Maternal health** | |
| **Notification of Pregnancy (NOP)** | Pregnant members earn $25 for submitting a notification of pregnancy form prior to delivery ($50 annual maximum). (Members 13 and older must call in to notify Humana). |
| **Prenatal visits** | Pregnant members earn $10/prenatal visit, up to 10 visits, $100 maximum. |
| **Postpartum visits** | Postpartum members earn $25 in incentives for completing 1 postpartum visit within 7 to 84 days after delivery, up to 1 incentive per pregnancy. |
| **Screenings** | |
| **Bone density screening** | Members 65 and older earn $20 for completing a bone density screening once every 2 years. |
| **Breast cancer screening** | Members 40 and older earn $25 for completing a mammogram annually. |
| **Cervical cancer screening** | Members 21 and older earn $25 for completing a Pap test annually. |
| **Chlamydia screening** | Female members who are sexually active or receive provider recommendation earn $25 for completing chlamydia screening annually. |
| **Colorectal cancer screening** | Members 45 and older earn $25 annually for completing a colorectal cancer screening as recommended by their PCP. |
| **Medicaid Member Health Screening (MMHS)** | Members earn $50 for completing the Medicaid Member Health Screening (MMHS) within 30 days of Humana enrollment, once per lifetime. |

| Healthy activity | Reward |
|---|---|
| **Wellness Coaching** | |
| **Tobacco and vaping cessation coaching** | Members 12 and older earn $25 for completing 2 cessation coaching calls within 45 days of program enrollment and another $25 for completing the full 8-course program, up to $50 annually. Members 12 to 17 years old can participate, but parent or guardian must enroll and consent for the minor to engage in the program. Nicotine replacement therapy is available to members 18 and older. |
| **Weight Management Coaching** | Members 12 and older can work with a Wellness Coach over the phone to reach or keep a healthy weight. Members earn:<br>• $15 for completing the enrollment process<br>• $15 for completing Coaching, six calls total, within 12 months of enrolling |
| **Videos** | |
| **Fall prevention video** | Members 55 and older can earn $10 in incentives annually for completing education to reduce fall risk. |
| **Level of care video** | Members 19 and older earn $10 for watching a video on seeking care in appropriate settings annually. |
| **Safe sleep video** | Members earn $10 for completing education aimed at raising awareness to reduce sleep-related deaths in infants. Available to parents/guardians of members up to 2 years old. Video available on the minor's Go365 account. |
| **Vaccinations** | |
| **COVID-19 vaccine** | Members 6 months and older earn $20 for receiving the COVID-19 vaccine annually. Members upload a photo of their completed vaccination card to the Go365 app within 90 days of vaccination to earn rewards. |
| **Flu vaccine** | Members earn $20 for receiving the flu vaccine annually. |
| **HPV vaccine** | Members 9–13 years old earn $50 for completing the 2 doses of the HPV vaccine, once per lifetime. |
| **Wellness visits** | |
| **Well-baby visits (0-15 Months)** | Members up to 15 months old earn $10 per visit, up to 6 visits, up to $60 annually |
| **Well-child visits (16-30 Months)** | Members ages 16 –30 months old earn $10 per visit, up to 2 visits, up to $20 annually |
| **Annual wellness visit** | Members 3 and older earn $25 for completing a wellness visit annually. |

# Carved-out services

The services listed below are "carved-out" or covered under the Medicaid or CHIP State Plan but not by Humana. DMAS or its designee manage these services directly, on a fee-for-service basis.

| Carved-out service | Additional details |
|---|---|
| **The following services are carved-out as a part of CCMC services** | |
| **Christian Science Sanatoria facilities and nurses** | Members will be excluded from Managed Care participation when admitted to a Christian Science Sanatoria. |
| **Community intellectual disability case management** | Humana provides information and referrals as appropriate to assist members in accessing these services through the member's local community services board. |
| **Developmental disability support coordination** | Humana provides information and referrals as appropriate to assist members in accessing these services through the member's local community services board. |
| **Developmental disability waiver services (including when covered under EPSDT), targeted developmental disability case management and transportation to the waiver services** | |
| **Psychiatric residential treatment facility for children younger than 21 years old** | |
| **Routine dental services for adults and children** | Limited (please see **Dental services section** of this manual). All members needing dental care should be referred to DMAS' dental benefits administrator. |
| **Services provided through Tribal Clinic provider types** | Covered under fee-for-service Medicaid |
| **State geriatric hospital placements** | Individuals in Piedmont, Hiram Davis and Hancock state geriatric facilities are excluded from managed care participation. |
| **Therapeutic group home for children and adolescents younger than 21 years old** | |
| **The following services are carved-out as part of FAMIS children services** | |
| **Local education agency-based services** | Local education agency-based services are covered on a fee-for-service basis. However, Humana will not deny medically necessary services or therapies in the outpatient, home, or school setting if the child also receives local education agency-based services. |

| Carved-out service | Additional details |
|---|---|
| **The following services are carved-out as part of LTSS services** | |
| **Intermediate care facility/ individuals with intellectual disabilities (ICF/IID)** | Members receiving services in an ICF-IID will be excluded from managed long-term services and supports (MLTSS) participation. |
| **Program of all-inclusive care for the elderly (PACE) services** | Members in PACE will be excluded from managed care participation or have the right to transition from the managed care program to PACE, including outside their annual open enrollment period. |

## Excluded services

Humana will not pay for services or supplies received that are not covered by Medicaid.

| Excluded service | Additional details |
|---|---|
| **The following services are excluded as a part of CCMC services** | |
| **Assisted suicide** | Humana does not cover services related to suicide, euthanasia, mercy killings or any action that may secure, fund, cause, compel or assert/advocate a legal right to such services. |
| **Cosmetic services** | Cosmetic surgery is not covered when provided solely for the purpose of improving appearance. The exclusion of cosmetic surgery does not apply to congenital deformities or to deformities or to deformities due to recent injury. When surgery also restores or improves a physiological function, it is not considered cosmetic surgery. |
| **Experimental and investigational procedures** | For members younger than 21, clinical trials are not always considered to be experimental or investigational and must be evaluated on a case-by-case basis, including using EPSDT criteria as appropriate. |
| **Infertility treatments** | Services to treat infertility or services to promote fertility are not covered. |
| **The following services are excluded as a part of FAMIS children services** | |
| **Cosmetic services** | Cosmetic services are excluded except to correct deformity resulting from disease, trauma or congenital abnormalities, which cause functional impairment, or complete a therapeutic treatment as a result of such deformity. |
| **Court-ordered services** | Court-ordered services are excluded unless the service is medically necessary and is a FAMIS-covered service. |
| **EPSDT services, including EPSDT clinical trials** | |
| **Infertility treatments** | Services to treat infertility or services to promote fertility are not covered. |

| Excluded service | Additional details |
|---|---|
| **NEMT (Transportation services are not provided for routine access to and from providers of covered services)** | |
| **Psychiatric residential treatment services** | |
| **Temporary detention orders (TDOs)** | Humana will not cover inpatient psychiatric treatment as a result of a TDO outside the coverage guidelines described in the Cardinal Care Managed Care services agreement for inpatient BH services. |

# Chapter 8: Early and Periodic Screening, Diagnostic and Treatment

## EPSDT program overview

EPSDT is a benefit for members younger than 21 to ascertain, on an individual basis, their physical and mental defects and provide treatment to correct, ameliorate or prevent defects, physical and mental illnesses and conditions discovered by the screening services from worsening, regardless of whether the required service is a covered benefit. The EPSDT benefit includes periodic screenings (well visits) and interperiodic screenings as necessary, as well as vision, dental and hearing services. Any treatment service that is not otherwise covered under the State Plan for Medical Assistance can be covered for a child through EPSDT, as long as the service is allowable under Section 1905(a) of the Social Security Act.

Humana gives providers access to tools that can identify Humana-covered patients under their care who may have additional opportunities for care identified in Healthcare Effectiveness Data and Information Set (HEDIS®) measures related to EPSDT services, including well-child visits and immunizations. These tools and reports are updated on a regular basis.

Below are various links to different tool kits and resources:

- **Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening | Pediatrics | American Academy of Pediatrics**
- **Bright Futures Toolkit: Links to Commonly Used Screening Instruments and Tools | AAP Toolkits | American Academy of Pediatrics**

Additional information about EPSDT is available at **https://vamedicaid.dmas.virginia.gov**.

## EPSDT exam frequency

The Humana EPSDT Periodicity Schedule is updated frequently to reflect current recommendations of the American Academy of Pediatrics (AAP) and Bright Futures. To view updates to the schedule, please visit **www.aap.org**.

| | | |
|---|---|---|
| **Infancy** | | |
| Younger than 1 month | 2 months | 4 months |
| 6 months | 9 months | 12 months |
| **Early childhood** | | |
| 15 months | 18 months | 24 months |
| 30 months | 3 years | 4 years |
| **Middle childhood** | | |
| 5 years | 6 years | 7 years |
| 8 years | 9 years | 10 years |
| **Adolescence and young adults** | | |
| 11 years | 12 years | 13 years |
| 14 years | 15 years | 16 years |
| 17 years | 18 years | 19 years |
| 20 years | 21 years (through the end of the member's 21st birth month) | |

## EPSDT screenings

EPSDT screenings include comprehensive, periodic health assessments or screenings, from birth through age 20, at intervals as specified in the EPSDT medical periodicity schedule established by the AAP policy statements and clinical guidelines and as required by DMAS. EPSDT medical screenings include:

- A comprehensive health and developmental history, including assessments of both physical and mental health development to include reimbursement for developmental screens (Current Procedural Terminology [CPT®] 96110) rendered by providers other than the PCP
- A comprehensive unclothed physical examination, including:
  - Vision and hearing screening
  - Dental inspection
  - Nutritional assessment
  - Height/weight and Body Mass Index assessment; **and**

Humana requires pediatric PCPs to incorporate the use of a standardized developmental screening tool for children consistent with the AAP policy statements and clinical guidelines. AAP policy recommends surveillance (assessing for risk) at all well-child visits and screening using a standardized tool routinely. Developmental screenings must be documented in the medical record using a standardized screening tool.

- Appropriate immunizations according to age, health history and the schedule established by the ACIP for pediatric vaccines
  - Immunizations must be reviewed at each screening examination and necessary immunizations should be administered at the time of the examination. Humana must also cover COVID-19 vaccine counseling visits for children and youth under EPSDT.
- Appropriate laboratory tests
  - The following recommended sequence of screening laboratory examinations must be provided by Humana; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and must be obtained as necessary:
    - Hemoglobin/hematocrit;
    - Tuberculin test (for high-risk groups); **and**
    - Blood-lead testing including venous and/or capillary specimen (finger stick) in accordance with EPSDT periodicity schedules and guidelines using blood level determinations as part of scheduled periodic health screenings appropriate to age and risk and in accordance with the EPSDT schedule
      - ◊ A blood lead test result equal to or greater than 5 µg/dL obtained by capillary specimen (finger stick) must be confirmed using a venous blood sample.

Additionally, an oral inspection must be performed by the EPSDT screening provider as part of each physical examination for a child screened at any age. Tooth eruption, caries, bottle tooth decay, developmental anomalies, malocclusion, pathological conditions or dental injuries must be noted. The oral inspection is not a substitute for a complete dental evaluation provided through direct referral to a dentist.

Contracted PCPs or other screening providers must make an initial direct referral to a dentist when the child receives their 6 month/biannual screening. The dental referral must be provided at the initial medical screening on any child aged 3 or older, regardless of the periodicity schedule, unless it is known and documented the child is already receiving regular dental care. When any screening, even as early as the neonatal examination, indicates a need for dental services at any earlier age, a referral must be made for needed dental services.

Adolescents who are diagnosed with SUD should be referred to the appropriate provider with addiction treatment experience.

Humana monitors provider compliance with EPSDT services. Humana requires its network providers provide prompt notification either by calling Provider Services or via the provider portal to Humana in the event a screening for a member eligible for EPDST services reveals the need for other healthcare services and the provider is unable to make an appropriate referral for those services. Upon notification of the inability of a provider to make an appropriate referral for EPSDT services, Humana secures an appropriate referral and contacts the member to offer scheduling assistance and transportation for members lacking access to transportation.

## EPSDT hearing services

All newborn infants must be given a hearing screening after birth and before discharge from the hospital. Those children who did not pass the newborn hearing screening, those who were missed and those who are at-risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.

Periodic auditory assessments appropriate to age, health history and risk, which include assessments by observation (subjective) and/or standardized tests (objective), must be provided at a minimum at intervals recommended in DMAS' EPSDT periodicity schedule. At a minimum, these services must include diagnosis of and treatment for defects in hearing, including hearing aids. At a minimum, hearing screenings must include observation of an infant's response to auditory stimuli. A speech and hearing assessment must be part of each preventive visit.

## EPSDT vision services

Periodic vision assessments appropriate to age, health history and risk, which include assessments by observation (subjective) and/or standardized tests (objective), must be provided in accordance with DMAS' EPSDT periodicity schedule. Vision screening for infants must include, at a minimum, eye examination and observation of responses to visual stimuli. For older children, screening for visual acuity must be done. At a minimum, these services must include diagnosis of and treatment for defects in vision, including eyeglasses. Glasses to replace those that are lost, broken or stolen are also covered. A variety of lenses and frames are available to children receiving vision services in any setting.

## EPSDT clinical trials

Humana considers requests to participate in clinical trials on a case-by-case basis using EPSDT criteria when no acceptable or effective standard treatment is available for the child's medical condition. Healthcare providers must request authorization for member participation in EPSDT clinical trials.

## Blood-lead screening

In accordance with the Virginia "Reportable Disease" regulations at 12 VAC 5-90-215, Humana requires its contracted laboratories to report all "detectable" blood lead levels for its members to the local health department within 3 days. Lead reportable levels, consistent with 12 VAC 5-90-10, means any detectable blood lead level in children 15 years of age and younger and levels greater than or equal to 5 µg/dL in a person older than 15 years of age. Providers must report children's blood lead levels greater than or equal to 5 µg/dL using the EP-1 form located on **https://www.vdh.virginia.gov/**.

## EPSDT immunizations and vaccinations

You must render immunizations in accordance with the EPSDT periodicity schedule specified in the most current ACIP recommendations, concurrently with conducting the EPSDT screening.

All PCPs who administer childhood immunizations must enroll in the Virginia Vaccines for Children (VVFC) program, administered by the Virginia Department of Health. PCPs must not routinely refer Medicaid members to the local health department to receive vaccines. To the extent possible and as permitted by Virginia statute and regulations, providers must participate in the statewide immunization registry database.

For more information on how to enroll in VVFC, please visit **Virginia Vaccines for Children (VVFC) – Immunization**. For VFC enrollment, please visit **Enroll Now – Immunization**.

## Early intervention services

Early intervention services (EIS) are available to qualified individuals through EPSDT. Children may be eligible to receive EIS from birth to age 3. EIS are not medically indicated for children 3 and older. EIS are designed to meet the developmental needs of each child as well as the needs of the family related to enhancing the child's development. EIS are provided to children who have:

- A 25% developmental delay in 1 or more areas of development,
- Atypical development; **or**
- A diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

In Virginia, the EIS program is called "Infant and Toddler Connection of Virginia" and is managed by DBHDS. DBHDS contracts with 40 local lead agencies to facilitate implementation of local EIS statewide and is also responsible for certification of EI providers and service coordinators/case managers. EIS must be recommended by the child's PCP or other qualified EPSDT screening provider as necessary to correct or ameliorate a physical or mental condition. When a developmental delay has been identified by the provider for children younger than 3, appropriate referrals must be made to Infant and Toddler Connection and documented in the member's records.

Billing rules and third-party liability for EIS, including submission of the Decline to Bill form, should comply with the provider requirements as established in the provider manuals available on **https://vamedicaid.dmas.virginia.gov/**. DMAS' guidance on billing rules is described in previously published provider manuals available at **https://vamedicaid.dmas.virginia.gov/manuals**.

## Well-baby and well-child care

Humana covers all routine well-baby and well-child care recommended by the AAP Advisory Committee including routine office visits with screenings, health assessments, physical exams, routine lab work, age-appropriate immunizations, lead testing and investigation and well-child services. The provision of services must meet EPSDT and HEDIS scheduling.

The following services must be rendered for the routine care of a child:

- Well-child visits rendered at home, the office and other outpatient provider locations are covered at birth and on an ongoing schedule, according to the AAP recommended periodicity schedule
- Annual vaccinations, without limitations due to age and immunizations in accordance with the AAP recommended immunizations for children and adolescents
- Hearing screenings for all newborn infants before discharge from the hospital after birth. Those children who did not pass the newborn hearing screening, those who were missed and those who are at-risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist
- Periodic auditory assessments appropriate to age, health history and risk, which include assessments by observation (subjective) and/or standardized tests (objective). At a minimum, these services must include diagnosis of and treatment for defects in hearing, including hearing aids

## EPSDT referrals and treatment

You must make appropriate EPSDT referrals and document said referrals in the member's medical record. You must promptly notify Humana by calling Provider Services or submitting a referral through the provider portal if a screening for a member eligible for services under EPSDT reveals the need for other healthcare services, providers can reach out to case management for additional assistance on referring the member to the appropriate provider. Humana can then secure an appropriate referral and contact the member to offer scheduling assistance and transportation for members lacking access to transportation.

If you identify a developmental delay in a Humana member younger than age 3, appropriate referrals must be made to the Infant & Toddler Connection of Virginia for EI services and documented in the member's records.

## EPSDT medical necessity reviews

Humana determines whether a service is medically necessary for an individual child on a case-by-case basis, taking into account the particular needs of the child and fully considering EPSDT criteria. Humana considers the child's long-term needs, not just what is required to address the immediate presenting problem, as well as all aspects of a child's needs, including, but not limited to, nutritional, social development, mental health and SUDs. Humana will not issue a denial for a child's service until an individualized secondary medical necessity review has been completed.

EPSDT may provide other medically necessary healthcare, diagnostic services, treatment and measures as needed to correct or ameliorate defects and physical, mental and SUD, and conditions discovered or determined as necessary to maintain the child's current level of functioning, or to prevent the child's medical condition from getting worse including, but not limited to, private duty nursing. Humana covers medical services (even if experimental or investigational) for children per EPSDT coverage criteria if it is determined the treatment or item would be effective to correct or ameliorate the child's condition. Humana provides coverage for medically necessary care and services

under EPSDT, even if services are not available under the state's Medicaid Plan for the rest of the Medicaid population.

For more information on EPSDT, visit the CMS EPSDT website: **www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html**.

## EPSDT documentation requirements

Services provided under EPSDT are subject to the following documentation requirements, in addition to those outlined in **Medical records requirements section of this manual**:

- The medical record must indicate which age-appropriate screening was provided in accordance with the AAP and Bright Futures periodicity schedule and all EPSDT-related services, whether provided by the PCP or another provider
- Documentation of a comprehensive screening must, at a minimum, contain a description of the components utilized
- The medical record must indicate when a developmental delay has been identified by the provider and an appropriate referral has been made

## EPSDT PDN

Humana covers medically necessary PDN services for members younger than 21. Individuals who require continuous nursing who cannot be met through home health may qualify for PDN. EPSDT PDN differs from home health nursing. Under EPSDT PDN, the individual's condition must warrant continuous nursing care, including, but not limited to, nursing level assessment, monitoring of unstable conditions and skilled interventions. PDN for members younger than 21 enrolled in the Commonwealth Coordinated Care Plus HCBS waiver is covered through EPSDT and is not a covered Commonwealth Coordinated Care Plus HCBS waiver service.

## Member outreach and education on EPSDT

Humana educates and informs members identified as not utilizing the EPSDT benefit according to the EPSDT periodicity schedule and immunization schedule, as appropriate. Humana also will inform the members about the EPSDT benefit, the availability of screening services and that a formal request for an EPSDT screening is not required. Additionally, Humana notifies families when EPSDT screenings are due and contacts members eligible for EPSDT services to inform them of the benefit and assist with scheduling appointments.

# Chapter 9: Behavioral Health

## Clinical Triage Line (behavioral health crisis/ARTS, nurse and care coordination line)

To better integrate behavioral and physical health operations in Virginia, Humana is partnering with Professional Management Enterprises (PME) to provide a Clinical Triage Line (behavioral health/ARTS crisis and nurse line). For more information about this line, please review the prior **24-Hour Clinical Triage Line (behavioral health/ARTS crisis and nurse line) section of this manual**.

## Integration of physical and behavioral health

Humana recognizes the importance of having an integrated setting that addresses both physical and behavioral health to promote the well-being of our members. Humana' approach focuses on the PCP relationship to ensure there is 1 provider who has knowledge of the member's physical and behavioral healthcare needs. Members can receive behavioral healthcare via telehealth as appropriate and as they desire.

Humana appropriately facilitates referrals for members with a BH need to providers with demonstrated integrated care setting capabilities to include the use of telehealth to facilitate virtual or location.

## Coordination of medical care and behavioral healthcare

Network providers are required to coordinate care when members are experiencing BH conditions that require ongoing care. PCPs are required to:

- Provide basic BH services to members to include:
  - Screening for mental health and substance use issues during routine and emergency visits
  - Prevention and early intervention
  - Medication management
  - Treatment for mild to moderate BH conditions
- Follow up with BH providers to coordinate integrated and nonduplicitous care to the member
- Attempt to obtain necessary signed release of information for sharing of personal health information including compliance with 42 CFR Part II requirements around BH and SUD

BH providers are required to notify the PCP when a member initiates BH services after the following conditions are met:

1. Obtain signed release of information for sharing of PHI in compliance with 42 CFR Part II requirements around BH and SUD
    a. Providers should not share information with the member's PCP without obtaining signed release of information
2. Provide initial and summary reports to the PCP (after receiving above release of information)

## Coordination with BH care management

Humana recognizes members who experience complex BH needs often have strong, established relationships with their care providers. Rather than disrupt these relationships with our own personnel, our care management program structure incorporates and supports existing member case management services provided by our network providers, state agencies or community-based organizations.

Providers, members or other responsible parties can call Humana Provider Services at **844-881-4482** to verify available behavioral health and substance-use benefits and to seek a referral or direction for obtaining behavioral health and substance-use services. The Humana network focuses on improving the member's health through efforts aimed at increased well-being, using patient-centered, evidence-based practices. Our goal is to provide the level of care needed by the member in the least restrictive setting—the right care, at the right time, in the right setting.

# Chapter 10: Long-Term Services and Supports

## LTSS program overview

The LTSS model of care is designed to enable independence and aging safely in place. Our care team provides specialized face-to-face support for those with LTSS and psychosocial needs. Our LTSS program offers additional, evidence-based support to help our members live safe and healthy lives in the least restrictive setting of their choice. The LTSS program assists individuals with health or personal needs, activities of daily living and instrumental activities of daily living. LTSS can be provided at home, in the community or in various types of facilities, including NFs.

For questions or concerns regarding LTSS, please call Provider Services at **844-881-4482** to reach Humana associates with specialized training to support LTSS providers.

## LTSS/HCBS waiver contract submissions

Providers can submit contracts via:

- Phone number: **877-233-4705**, Monday – Friday, 7:30 a.m. – 6 p.m., Eastern time.
- Email: **LTSSContracting@humana.com**

## LTSS eligibility

LTSS may be provided in the home or community through a 1915(c) HCBS waiver. DMAS operates 2 types of waivers, the Commonwealth Coordinated Care Plus HCBS waiver and the DD waivers. Individuals enrolled in the Commonwealth Coordinated Care Plus waiver receive waiver services through Humana as well as medically necessary non-waiver services. Individuals enrolled in the DD waivers are covered only for their medically necessary nonwaiver services.

In accordance with Virginia Code §32.1-330, all individuals requesting the Commonwealth Coordinated Care Plus waiver or LTSS nursing facility (NF) services and supports must receive a LTSS screening to determine if they meet the level of care (LOC) needed for NF services. Details about LOC requirements appear in **the Department's Screening Manual for Medicaid-Funded Long-Term Services and Supports (LTSS)**.

In rare circumstances, individuals who are Medicaid-eligible for most services may be determined to not be eligible for LTSS. In this situation, LTSS providers can bill members for LTSS services as noncovered services as long as they have informed the member prior to LTSS admission that if the member is found to not be financially eligible for Medicaid-funded long-term services, the member will be held financially liable for the costs of long-term services.

## Commonwealth Coordinated Care Plus HCBS waiver

The Commonwealth Coordinated Care Plus HCBS waiver covers a comprehensive range of supports to individuals who are aged, disabled or who are technology dependent and rely on a device for medical or nutritional support. The Commonwealth Coordinated Care Plus HCBS waiver has two benefit plans: with PDN and without PDN. The HCBS waiver with PDN is for individuals who are technology dependent, have experienced loss of vital body function and require substantial and ongoing skilled nursing care. HCBS waiver services are excluded for individuals who are inpatients of a hospital, NF, ICF/IDD, inpatient rehabilitation, assisted living facility (licensed by VDSS that serve 5 or more individuals) or group home by DBHDS. Transition services may be available to individuals residing in some settings, if criteria are met. Certain Commonwealth Coordinated Care Plus HCBS waiver services are not available to individuals in an assisted living facility (ALF) with 4 or fewer individuals. This includes respite, PERS, adult day health care (ADHC), environmental modifications, assistive technology and transition services. Personal care services may be covered in the ALF setting but must not exceed 5 hours per day. HCBS waiver services must be offered in a setting that follows the CMS Home- and Community-Based Settings Final Rule. Humana provides Commonwealth Coordinated Care Plus HCBS waiver services, which may be provided through agency-directed (AD) or consumer-directed (CD) models or both. For more information on CD models please refer to the **consumer-directed care section within this chapter**.

When Commonwealth Coordinated Care Plus HCBS waiver services are terminated, a Humana care manager assesses and ensures the member's care plan includes the necessary supportive services, such as other covered services (e.g., home health, physical therapy, occupational therapy, durable medical equipment [DME]) community-based supports (e.g., home delivered meals, companion services) primary caregiver supports or Humana' enhanced benefits, to meet the member's care needs when waiver services are no longer in place. The Humana care manager will revise the member's individualized care plan (ICP) accordingly. This includes when a member transitions between LOC benefit plans.

## Service authorizations for LTSS

LTSS providers can request a service authorization by emailing the required documents to the LTSS Utilization Management department at **VAMCDLTSSUtilizationManagement@humana.com** or faxing the required documents to **502-508-1607**.

HCBS, a type of LTSS, require prior authorizations and are determined based on an individual's functional, medical and nursing needs. HCBS include adult day healthcare, assistive technology, environmental modifications, personal care services, PDN, PERS, respite care services, skilled respite care services, service facilitation and transition services.

## LTSS screening requirements

Individuals are not approved to receive Medicaid-funded LTSS without having a screening on file that confirms the individual meets NF LOC. The NF LOC refers to the specification of the minimum amount of assistance an individual requires to receive services in a community or institutional setting under the State Plan for Medical Assistance or to receive Commonwealth Coordinated Care Plus HCBS waiver services. Level of Care Reviews are performed periodically, but at least annually and consist of a review of the member's condition and service needs to determine whether the member continues to need a LOC specified by a waiver.

Details about the screening process and the criteria for meeting the LOC required for eligibility for LTSS can be found in DMAS' Screening Manual for Medicaid-Funded Long-Term Services and Supports (LTSS) on the Virginia Medicaid Provider Portal or on **https://vamedicaid.dmas.virginia.gov**.

A Medicaid LTSS screening team, which may be a community-based team, hospital or NF team (only for those individuals who were not eligible for Medicaid upon admission and are transitioning from skilled care to LTSS), conducts the screening using forms such as the Uniform Assessment Instrument (UAI) and the DMAS-96 (Medicaid LTSS Authorization Form). The LTSS screening team determines LOC needs and enters the member's screening information into electronic Medicaid LTSS screening (eMLS). The LTSS screening must successfully process and reflect a Medicaid LTSS authorization for LTSS to begin.

The LTSS screening includes the following documentation requirements referred to as the screening packet:

- UAI
- DMAS-95 MI/ID/RC (and DMAS-95 MI-ID/RC Supplement Form, Level II, if applicable) for individuals who select NF placement
- DMAS-96 (Medicaid Funded LTSS Authorization Form)
- DMAS-97 (Individual Choice – Home- and Community-Based Services or Institutional Care or Waiver Services Form)
- DMAS-108 (Adults) or DMAS-109 (Children) for individuals who are technology dependent and need PDN

The LTSS screening team must submit LTSS screening information to Humana for members who have screening determinations completed after enrolling in the managed care program.

Members enrolled in a waiver or a NF must undergo periodic (in accordance with waiver requirements), face-to-face reassessments of their condition and service needs. Humana works with NFs to coordinate reassessments (functional and medical/nursing needs) for continued NF placement, including the incorporation of all minimum data set guidelines/time frames for quarterly and comprehensive assessments, as well as ICP development.

## NF LOC

To receive NF care, specialized care, or long-stay hospital services, the member must meet the NF LOC. Admission requires a completed LTSS screening performed by a hospital or community team, prior to an NF admission. The NF LTSS screening team may complete the LTSS screening for individuals who apply for or request LTSS while receiving skilled nursing services in a setting not covered by Medicaid after discharge from an acute care hospital.

In accordance with Code of Virginia §32.1-330(G), if a member is admitted to a skilled NF without being screened but is subsequently determined to have been required to be screened prior to admission, then the NF LTSS screening team may conduct a screening after admission. In these circumstances, coverage of institutional LTSS will not begin until 6 months after the initial admission to the skilled NF. During this 6-month period, the nursing home in which the individual resides shall be responsible for all costs indicated for institutional LTSS that would otherwise have been covered by Humana, without accessing patient funds. Humana will begin coverage of such services 6 months after the date of admission to the skilled NF and as indicated through the eligibility determination.

To the extent that sufficient evidence is provided to indicate that the admission without screening was of no fault of the skilled NF, coverage of institutional LTSS will begin immediately upon the completion of the LTSS screening indicating NF LOC pending the financial eligibility determination.

NFs must notify Humana, using the DMAS-80 form, of admissions, discharges, or changes in LOC. If the DMAS-80 form is not received, Humana must enter the NF admission or discharge into the Virginia Medical Portal within 2 days of validating the member's NF status. The DMAS-80 form is also completed when a member has a change to their LOC or transitions between a skilled Medicare stay and custodial stay, completed no later than 5 days of notification. Specialized Care admissions must include the "change source code" to identify the LOC being authorized. Long-stay hospital admission must include the accurate provider NPI. Humana provides outreach and education to providers who do not notify us promptly of these changes.

## LTSS care settings

Humana ensures members are afforded the right to make informed choices about the settings in which they live and receive services. Members should receive care in the least restrictive setting to ensure their health, safety and welfare. At least annually and whenever the member expresses an interest in being discharged, Humana will review any and all options for discharge from the NF with the NF and the member or the member's authorized representative.

## Out-of-state/out-of-area facility placements

Humana limits out-of-state NF placements to providers who are also enrolled as a provider in the Medicaid fee-for-service program. For an out-of-state NF placement to be considered, the member's needs must not be met within the Commonwealth. Out-of-state facilities must meet all the standard licensing and certification requirements within that state and have an active license to operate within that state. Out-of-state placement into an NF will follow all established processes and procedures as those followed by in-state NFs.

Humana considers the needs of the member when the member cannot be adequately served in a facility located within the member's permanent area of residence. Relocation to a facility in another region is allowable when the member and/or the member's representative agree that it is in the member's best interest or there are no available beds in facilities able to meet the member's needs within the region of the member's residence.

## HCBS Waiver Service Providers

LTSS providers considered HCBS Waiver Service Providers and subject to 42 CFR §441.300 et al. must comply with 42 CFR §441.301(c)(4)-(5). Services may be delivered in a combination of service delivery models (agency-directed and consumer-directed) but must not be duplicative. Simultaneously billing personal care and respite care services is not permitted. Enrollment in hospice does not limit waiver services for members.

## Consumer-directed care

Humana provides Commonwealth Coordinated Care Plus HCBS waiver services, which may be provided through consumer-directed (CD) models. CD services afford individuals the opportunity to act as the employer in the self-direction of personal care or respite services. This involves the hiring, training, supervision and termination of self-directed personal care attendants.

A member may receive CD services along with agency directed (AD) services. A member receiving CD personal care services can also receive ADHC or agency-directed personal care. However, members cannot simultaneously receive multiple/duplicative services. Simultaneous billing of personal care and respite care services is not permitted. The choice of CD is made freely by the member or the authorized representative or caregiver if the member is not able to make a choice.

For both AD and CD care, the member must have a viable back-up plan (e.g., a family member, neighbor or friend willing and available to assist) in case the personal care aide, CD attendant or nurse cannot work as expected or terminates employment without prior notice. Humana works with the member and family to identify a back-up plan and document it on the ICP. The back-up plan may be the primary caregiver when the primary caregiver is not a paid attendant for the member. Members who do not have viable back-up plans are not eligible for AD or CD services until viable back-up plans have been developed. For AD care, the provider must make a reasonable attempt to send a substitute personal care aide. If this is not possible, the member must have someone available to perform the services needed.

Humana only reimburses Commonwealth Coordinated Care Plus HCBS waiver services when:

- The member is present;
- In accordance with an approved ICP;
- The services are authorized; **and**
- A qualified provider is providing the services to the member.

Services rendered to or for the convenience of other individuals in the household (e.g., cleaning rooms, cooking meals, washing dishes, doing laundry for the family) are not covered.

A Legally Responsible Individual (LRI) refers to parents of children younger than 18 and spouses who are legally responsible for the care of the individual receiving services. LRIs can be reimbursed for providing personal care or personal assistance services under certain conditions. Respite care is not available when there is an LRI providing personal care services.

## LTSS-specific billing and reimbursement policies

Humana will not reimburse an NF or Commonwealth Coordinated Care Plus HCBS waiver services provider for services provided to any members who are newly admitted to an NF or the Commonwealth Coordinated Care Plus HCBS waiver until all of the following have been completed:

1. A LTSS screening has been completed for the member by an appropriate screening team;
2. The screening has been entered into the eMLS record system; **and**
3. The individual is found to meet NF LOC criteria.

Payment is not made to the LTSS provider until Humana receives a copy of the screening. For those members who are not newly enrolled in an NF or Commonwealth Coordinated Care Plus HCBS waiver who do not have a screening, Humana notifies DMAS.

## Patient pay toward LTSS

Patient pay, which is calculated by DSS, must not be confused with a copay, deductible or coinsurance.

Patient pay is calculated for every individual receiving NF or waiver services unless it is not required based on eligibility category. Not every eligible individual will acquire a patient pay liability. When a member's income exceeds an allowable amount, they must contribute toward the cost of their LTSS.

After processing the claim, Humana will notate on the explanation of remittance (EOR) the amount of patient pay for which the member is responsible. You may not bill the member prior to receiving the EOR indicating the amount of patient pay for which the member is responsible. If Humana does not notate any patient pay amount on the EOR, you may not bill the member. Please see **the balance billing section of this manual** for additional information.

# Electronic visit verification

Electronic visit verification (EVV) verifies visit activity for in-home and in-community care services delivered. EVV offers a measure of accountability to ensure that individuals receive the care and services they need and are authorized to receive. Humana' claim processing system has edits in place that prevent claims for services that are not electronically verified and documented using an EVV system.

AD providers who bill for personal care and respite care services must use an EVV system that electronically verifies and collects data that meets the requirements consistent with the 21st Century Cures Act, Section 12006, 42 U.S.C. § 1396(b). In addition, the 21st Century Cures Act requires EVV for home health service providers. At a minimum, the EVV must capture in real time the following data elements for agency-directed personal care and respite services:

1. Type of service performed;
2. The member receiving the service;
3. Date of service;
4. Time the service begins and ends;
5. The location of service delivery at the beginning and the end of the service; **and**
6. Employee providing the service.

Additionally, the providers' EVV systems must:

1. Securely transmit all EVV raw data elements to Humana.
2. Limit authority to modify changes and modifications to service entries. If the time of service delivery needs to be adjusted, the start or end time may be modified by someone who has the provider's authority to adjust the attendant's hours. For AD providers, this may be a supervisor or the agency owner or designee who has authority to make independent verifications.
3. Support real time access to members (if member authentication is used) and providers.
4. Be compliant with the requirements of the ADA (as amended, 42 USC § 12101 et seq.) and HIPAA (P.L. 104-191).
5. Retain EVV data for at least 6 years from the last date of service or as provided by applicable federal and state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception is resolved. Policies regarding retention of records apply even if the provider discontinues operation.

Providers can connect their EVV platform with Humana' selected vendor platform, HHA Exchange. Providers utilize EDI connection to link their EVV platform with HHA Exchange, if preferred. Please contact **EDISupport@hhaexchange.com** if any questions or further guidance is needed.

## Quality management reviews for HCBS waivers and programs

Humana conducts quality management reviews (QMR) focused on the development and implementation of the plan of care for HCBS waivers and programs. Reviewers determine if the plan is person-centered, based on the assessment and whether it addresses the individual's needs and personal goals. Provider documentation of services is reviewed to determine if services were delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan and delivered by qualified providers. Quality management review details are discussed with the provider at an exit conference during the review and are further explained in a letter sent to the provider. For more information related to QMR corrective action, navigate to **the MES portal** (Development Disabilities Waivers) Chapter 6: Quality Management and Utilization Reviews.

# Chapter 11: Care management and care coordination

## Humana care management and care coordination model of care

Humana' equitable population health and care management model delivers whole-person, person-centered, trauma-informed and strengths-based interventions to members of all risk levels. Our stratification approaches deliver services and supports to members in accordance with their needs and risk levels, ranging from our most complex members, who require intensive care management with frequent contacts, to members with emerging risk and short-term needs, who benefit from one-on-one assistance from a care coordinator, have minimal or no health issues and who benefit from accessible wellness education, linkage with social services and outreach to close preventive care gaps.

Our guiding principles are:

- Person-centered
- Strengths-based
- Trauma-informed
- Locally integrated
- Integrated across services
- Equity-focused
- Disease prevention and self-management

Humana provides comprehensive and integrated care management services through medical and BH nurses, social workers, licensed BH professionals and outreach specialists. We provide personal member interaction and connect members with community-based resources to address HRSN such as food pantry access and utility assistance.

## Referring members to care management

If a provider identifies a Humana-covered patient they believe would benefit from care management, they can have their patient call Humana Member Services at **844-881-4482** or submit a referral on their behalf by calling Provider Services at **844-881-4482** or by emailing or faxing Humana using the contact information in the table below.

| Program | Email address | Fax number |
|---|---|---|
| Care management inquires and referrals | **VAMCDCareManagement@humana.com** | **888-241-3745** |
| SDOH and housing coordinators inquiries and referrals | **VAMCDSDOH@humana.com** | **877-310-2764** |
| Maternity (HumanaBeginnings) inquiries and referrals | **VAMCDMaternity@humana.com** | **877-245-1704** |

Humana encourages providers to refer members who might need individual attention to help them manage special healthcare challenges. Humana adheres to a no-wrong-door approach to care management referrals. Humana will assist with provider referrals, appointment scheduling and coordination of an integrated approach to the member's health and well-being by coordinating care between BH providers, PCPs and specialists.

## Accessing member care plans

Providers can review a member's ICPs and health assessments on Availity Essentials, with the member's prior approval. ICPs and health assessments are available upon request by emailing Humana' care management team at **VAMCDCareManagement@humana.com** or by fax at **888-241-3745**.

## Care management priority populations

Members may be identified as 1 of 3 priority population groups for assignment to care management (or care coordination, as appropriate): Mandatory High Priority, Mandatory Priority Populations or MCO Determined Priority. The difference between care management and care coordination is:

- **Care management –** Team-based, person-centered approach to managing patients' medical, social and behavioral conditions with consideration given to utilization trends, quality factors and provider performance
- **Care coordination –** The act of organizing patient care activities, available for all MCO members including those not identified for ongoing care management
  - Activities include ensuring an ongoing source of care, coordinating services between settings/ delivery systems and conducting initial screenings in accordance with 42 CFR § 438.208.

## Member acuity and intensity description

Members are stratified into care management categories depending on the acuity and intensity of their needs. Care management categories include:

- Wellness and promotion
- Care coordination
- Low intensity
- Moderate intensity
- High intensity

To understand which members may qualify for care management and care coordination services, please review the categories described below.

## Wellness and promotion

Most members fall into this category and manage their healthcare journey with minimal or no health issues, focusing on health maintenance and well-being through education on reducing health risks and change in behaviors. The care management contacts the member as needed. Interventions and activities include:

- Health and wellness education
- Closed-loop referral to social services
- Closure of care gaps

Humana encourages providers to partner with us to improve member health outcomes. Care management associates frequently reach out to providers to close care gaps and ensure our members receive health screenings and education, as needed.

## Care coordination

Members needing a lower level of support and who need short-term episodic management, including members who have unmet HRSN without significant healthcare needs as well as members enrolled in our Reproductive Health and Wellness, emergency department (ED) Diversion and Readmission Prevention programs fall into this category. Interventions and activities include:

- Short-term episodic management by a nonlicensed care coordinator
- Disease management
- Health and wellness education
- Healthcare navigation
- Closed-loop referral to social services

Humana values a collaborative approach to case management program. We encourage providers to participate in member care plan development or to contact us for assistance addressing members' healthcare challenges.

## Low, moderate and high intensity

Members in the low intensity category are those members who need increased support and have 1 or more chronic conditions or risk factors but no complications. These members need a moderate level of support. This includes members in DMAS' Mandatory and MCO-Determined Priority Populations.

Members in the moderate intensity category are those who need high levels of support and have multiple risk factors that, if left unmanaged, would progress in complexity and/or result in institutionalization, hospitalization or ED utilization. Members in this category include DMAS' Mandatory and MCO-Determined Priority Populations.

Members in the high intensity category are those with multiple or complex illnesses and with long-term needs that often include psychosocial concerns or barriers, as well as members transitioning between care settings or systems that require intensive, proactive care management. This includes members in DMAS' Mandatory High-Priority Population.

Interventions and activities for members in the high, moderate and low intensity categories include:

- Assigned care manager
- Comprehensive assessment, with a minimum of annual updates
- Care planning
- Ongoing contacts (ranging from weekly to biannually)
- Care manager-led interdisciplinary care team
- Coordination with providers and other payers
- Disease management
- Health and wellness education
- Closed-loop referral to social services
- Service coordination (LTSS only)

## Complex case management program

Complex case management refers to coordination of care and services provided to members who have experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Members in complex care management have the highest need and require the most focused attention to support their clinical care needs and to address HRSN.

## Care and disease management programs

Humana uses a holistic and fully integrated health management program using a multidisciplinary team to ensure the best and most comprehensive care for our members. Care and disease management programs include:

- Transitional care management
- Chronic condition management
- Neonatal intensive care unit (NICU) case management
- Transplant care management
- A maternity program, HumanaBeginnings (includes high-risk pregnancies with SUD and support during the postpartum period)
- Pediatric care management (e.g., PDN, adoption assistance, development disabilities, childhood obesity)

- BH and ARTS care management (e.g., serious mental illness, serious emotional disturbance, ARTS, adolescents with BH needs, justice involved)
- LTSS and ABD care management (NF and long stay hospital residents, Commonwealth Coordinated Care Plus waivers, members with I/DD with or without waiver, dual eligibles)

## Care management role and responsibilities

Care managers:

- Serve as a primary point of contact for integrated care management activities for members, in low- to high-intensity care management acuity levels
- Provide both telephonic and face-to-face support
- Provide education and care coordination support for pregnant and postpartum members (up to 12 months) of all risk levels
- Emphasize access to treatment, recovery support, overdose prevention and crisis response
- Provide education and coaching to support self-management and preventive care

Service coordinators:

- Provide specialized, hands-on support for members receiving LTSS, with a focus on addressing HRSN, providing psychosocial support and ensuring LTSS meets the member's service needs
- Provide care management and service coordination with a focus on aging in place, psychosocial supports and community integration

In addition to care managers and service coordinators, our Care Management team includes the following roles:

- **Community health workers (CHW):** Support highest risk, hardest-to-reach member cohorts, with a particular focus on members who may have a history of mistrust with the healthcare system
- **Housing specialists:** Support members with housing-specific needs
- **HRSN coordinators:** Provide hands-on, specialized support to members with complex HRSN
- **Regional transition care managers:** Assist members transitioning between settings, transitioning into the community and those who desire to remain in their community setting
- **Nutritionists/certified diabetes and education specialists:** Advise care managers and care coordinators on chronic condition management and provide direct, telephonic member support
- **Care coordinators:** Provide support to lower risk members based on their individualized needs

## MCO member health screening

All newly enrolled members receive the MCO Member Health Screening (MMHS), a two-part questionnaire that provides initial insight on members entering the program and the associated population. The MMHS also identifies opportunities for support, offering potential clinical pathways to improved health outcomes. The MMHS is utilized to determine a member's medical complexity and identify specific needs. It helps Humana identify whether the member should be in a priority population (members requiring care management under Cardinal Care based on the member's need and risk level) and may require care management. Additionally, elements from the MMHS are considered and incorporated into the member's ICP.

Humana makes best efforts to complete the MMHS for all newly enrolling members within 30 calendar days of the member's enrollment with Humana. You can access all assessments within the provider portal, with prior member consent.

The MMHS has 2 parts:

- Part 1 of the MMHS contains questions related to member's medical or BH conditions, functional impairments and intellectual or developmental disabilities.
- Part 2 of the MMHS contains questions regarding SDOH and in conjunction with part 1, will be used to determine whether the member receives care coordination or care management and the appropriate LOC management intensity (if applicable).

## ICPs

ICPs include elements such as:

- The member's goals, needs and preferences
- Their providers and other supports
- Plans to respond to member needs or prevent service disruption

Humana works with the member to revise the ICP every 6 months following the initial ICP and within 10 calendar days following any triggering event or as expeditiously as the member's condition requires.

## ICTs

Humana defines for each member, in a manner that respects the needs and preferences of the member, the individuals who make up the member's ICT. Each member's care needs (including any services addressing medical, BH, substance use, LTSS, early intervention and social needs) are integrated and coordinated within the framework of an ICT. Each ICT member has a defined role appropriate to their licensure and relationship with the member as identified in the ICP. We encourage members to identify individuals they would like on their care team. The ICT is person-centered, built on the member's specific preferences and needs and conducted with transparency, individualization, respect, linguistic and cultural competence and dignity. Care managers lead the

ICT meetings or conference calls. ICT meetings occur as contractually required or at the member's request. ICT members are kept up-to-date on the member's care and needs, even when they cannot attend meetings.

ICTs should include all entities rendering care and services as identified in the member's ICP and any of the following participants, at a minimum:

- PCP
- Other treating providers, as applicable
- BH clinician, as applicable
- LTSS provider(s) when the member is receiving LTSS
- Personal care/PDN provider for members receiving PC or PDN services under EPSDT
- Targeted case manager, if the member is receiving targeted care management services
- Dual-Eligible Special Needs Plan (D-SNP) or other plan care coordinator, as applicable
- Pharmacist, as applicable

As appropriate and at the discretion of the member, the ICT also may include any or all of the following participants:

- A representative from the Medicare plan, if applicable
- Registered nurse
- Specialist clinician
- Other professional and support disciplines, including social workers, community health workers and qualified peers
- Family members
- Other informal caregivers or supports
- Advocates
- State agency or other case managers

# Chapter 12: Quality Management

## Quality Improvement Program overview

Humana' Quality Assessment and Performance Improvement (QAPI) program is a comprehensive quality improvement program that encompasses clinical care, preventive care, population health management and our administrative functions. It is designed to monitor and evaluate—objectively and systematically—the quality, appropriateness, accessibility and availability of safe and equitable medical and behavioral healthcare and services. Strategies are identified and activities implemented in response to findings. Using a continuous quality improvement methodology, QAPI works to:

- Monitor system-wide issues
- Identify opportunities for improvement
- Determine the root cause of identified problems
- Explore alternatives and develop a plan of action
- Activate a plan, measure results, evaluate effectiveness of actions and modify the approach as needed

QAPI activities include monitoring clinical indicators or outcomes, quality-of-care complaints, utilization metrics, quality studies, HEDIS® measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results and medical record audits. The QAPI workplan and its annual evaluation include these activities. Humana' board of directors delegates a QAPI committee to monitor and evaluate the results of program initiatives and to implement corrective action when the results are less than desired or when areas that need improvement are identified. The QAPI Committee is accountable to Humana' executive management team.

The QAPI program goals include:

- Developing clinical strategies and providing clinical programs that look at the whole person while integrating behavioral and physical healthcare
- Identifying and resolving issues related to member access and availability of healthcare services
- Ensuring participating providers and other stakeholders are involved in the QAPI program
- Providing effective customer service for member and provider needs and requests
- Monitoring coordination and integration of member care across provider sites
- Providing a comprehensive strategy for population health management that addresses member needs across the continuum of care

- Providing mechanisms to assess the quality and appropriateness of care furnished to members with special healthcare needs
- Providing mechanisms to detect underutilization and overutilization
- Monitoring and promoting the safety of clinical care and service
- Promoting better communication between departments to improve service and satisfaction to members, practitioners, providers and associates
- Promoting improved clinician experience for providers and all clinicians to promote member safety, provider satisfaction and provider retention

QAPI program activities include:

- Developing clinical practice guidelines
- Performing medical record documentation reviews
- Analyzing HEDIS report results
- Assessing member satisfaction
- Requesting external quality reviews

Information regarding the QAPI program is available on request. To receive a written copy of Humana' quality program and its progress toward goals, providers can call Provider Services at **844-881-4482**.

## Quality measures

Humana monitors and evaluates provider quality, appropriateness of care and service delivery (or the failure to provide care or deliver services) to members using the following methods:

- **Quality improvement projects –** Ongoing measurements and interventions, significant quality of care improvement and service delivery in both clinical care and nonclinical areas are expected to have a favorable effect on health outcomes and member satisfaction
- **Member medical record reviews –** Medical record reviews to evaluate documentation patterns of providers and adherence to member medical record documentation standards
  - Medical records also can be requested when investigating complaints of poor quality or service or clinical outcomes. You must furnish member medical records to Humana for this purpose. Member medical record reviews are a permitted disclosure of a member's PHI in accordance with HIPAA guidelines. The record reviewers protect member information from unauthorized disclosure as set forth in the contract and ensures all HIPAA guidelines are enforced.
- **Performance measures –** Data collected on patient outcomes as defined by HEDIS or otherwise defined by the agency
- **Surveys –** CAHPS, provider satisfaction, BH surveys and special surveys implemented to support quality/performance improvement initiatives
- **Peer review –** Review of providers' practice methods and patterns to determine appropriateness of care

## Provider participation in the Quality Improvement Program

You are required to cooperate with Humana' quality improvement activities. You must participate in and contribute required data to Humana' quality improvement and other assurance programs, which includes providing member records for assessing quality of care and External Quality Review Organization (EQRO) activities. In addition, the HIPAA Privacy Rule of 45 CFR 164.506 and rules and regulations promulgated thereunder (45 CFR Parts 160, 162 and 164) permit a covered entity (provider) to use and disclose PHI to health plans without member authorization for treatment, payment and healthcare operations activities. Healthcare operations include, but are not limited to, conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing healthcare costs, care management and care coordination. You also must allow Humana to use your provider performance data as part of quality improvement activities.

BH providers must collect clinical outcomes data and make available BH clinical assessment, treatment planning and outcomes data for quality, utilization and network management purposes.

## Medical record requirements

As a network provider, you must make medical records for each member available to DMAS, the contracted EQRO and other DMAS designees upon request.

You must provide copies of member records and access to your premises to representatives of Humana, as well as duly authorized agents or representatives of DMAS, the U.S. Department of Health & Human Services and the state Medicaid Fraud Unit. You must preserve the full confidentiality of medical records in accordance with your provider agreement. You must forward medical records to Humana within 10 business days of Humana' request. Additionally, you must maintain and provide a copy of the member's medical records, in accordance with 42 CFR §438.208(b)(5), to members and their authorized representatives within no more than 10 business days of the member's request.

All member medical records must include the required elements pursuant to 42 CFR §§ 456.111 and 456.211, including but not limited to:

- **Member identification in the record:** Records should include the patient's name, date of birth, sex/gender identification, race, phone number, place of residence and responsible party (parent or guardian as applicable). In records where each element isn't present, use your clinical judgment to determine completeness by majority.
- **Primary language:** Use of the patient's primary language should be documented along with any need for communication assistance provided.
- **Complete medical history:** Medical history should be easily identifiable and include serious accidents, operations, illnesses and familial/hereditary disease. It should include medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed. For pediatric patients, past medical history includes prenatal care and birth information and childhood illnesses (members 11 years and younger). In records where each element isn't present, use your clinical judgment to determine completeness by majority.

- **Allergies:** Allergies or no known allergies (NKA) must be documented in a prominent location in the medical record. Medication and other adverse reactions must be listed if present.
- **After hours/hospital follow-up (if noted that member had these services):** Record should show documentation of ED and/or after-hours encounters, hospital reports including admission and discharge summaries and referrals/results outcomes.
- **Diagnostic testing:** Record should show documentation of lab, X-ray, imaging or other studies ordered. Results should be filed in the medical record and initialed by the primary care physician, thereby signifying review. Abnormal X-ray, lab and imaging study results should have an explicit notation in the medical record regarding follow-up plans and notification to patient of all results (positive and negative). In records where each element isn't present, use your clinical judgment to determine completeness by majority.
- All written denials of service and the reason for the denial
- **Immunization record:** A current record of immunizations should appear in the patient chart
- **Advance directives:** For members 18 and older: there should be evidence that the patient has been asked if he or she has an advance directive (written directions about health care decisions) and a yes or no response should be documented. If the response is yes, a copy of the advance directive must be included in the medical record.
- **Preventive screenings:** There is evidence that preventive screenings are offered or referred (example EPSDT, BCS, CCS, eye exam) and results/status of screenings addressed from previous visits are documented/addressed.
- **Each visit must include:**
  - Date of service
  - Location of service
  - Purpose of visit (or chief complaint)
  - Diagnosis of medical impressions
- **Physical exam (complete):** All body systems should be reviewed within 1 year of the first clinical encounter or all body systems must be reviewed upon first visit, including HEENT (head, eyes, ears, nose and throat), teeth, neck, heart, lungs, neurological and musculoskeletal. In records where each element isn't present, use your clinical judgment to determine completeness by majority.
- **Vital signs:** Height, weight, blood pressure and temperature must be documented
- Assessment of patient's findings
- Plan of treatment, diagnostic tests, therapies and other prescribed regimes
- Medications prescribed (All current medications, including dose and date of initial prescription or refills, should be present in the medical record) long-term medication reviewed and reconciled
- Health education provided

- Name, signature and title or initials of the provider rendering the service (if more than one person documents in the Medical Record, there must be a record on file as to what signature is represented by which initial)

If your contract with Humana terminates, you must maintain records for 10 years from the date your provider contract terminates.

## Value-based payment programs

Humana' value-based payment (VBP) programs include a broad set of payment strategies intended to improve healthcare quality, outcomes and efficiency in the communities we serve by linking financial incentives for providers to performance. Humana' VBP models offer you opportunities to earn additional incentives based on quality and/or cost of care measures. The programs are devised based on your panel size and engagement. PCPs managing a panel with a minimum of 30 Humana members as of the end of February and December of each calendar year may be eligible to participate in an upside-only pay-for-performance program with incentive payments for meeting quality measure goals. Quality (pay-for-performance) incentives are reviewed and reimbursed annually, 1 quarter in arrears to allow for reporting/data collection. PCPs with larger panels may also be eligible to participate in shared savings or 2-sided risk arrangements that are reconciled on an agreement-specific basis. We also offer a variety of VBP programs that target cost and quality for subsets of populations routinely seeking care outside of PCP offices. Our VBP models and strategy pertain to measurable outcomes that are meant to improve the health of populations, enhance the experience of care for individuals and align financial incentives at the provider level with DMAS' performance objectives for Humana. If interested, please reach out to your Provider Relations Representative for more information.

## Patient safety

Humana supports implementation of a complete range of patient safety activities. These activities include medical record legibility and documentation standards, communication and coordination of care across the healthcare network, utilization of evidence-based clinical guidelines to reduce practice variations, tracking and trending adverse events/quality of care issues and grievances related to safety and quality of care.

Patient safety is also addressed through adherence to clinical guidelines that target preventable conditions. Preventive services include:

- Regular checkups for adults and children
- Prenatal care for pregnant women
- Well-baby care
- Immunizations for children, adolescents and adults
- Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, tests for sexually transmitted diseases, Pap tests and mammograms

Preventive guidelines address prevention and/or early detection interventions and the recommended frequency and conditions under which interventions are required. Prevention activities are based on reasonable scientific evidence, best practices and member needs.

Prevention activities include distribution of information, encouragement to use screening tools and ongoing monitoring and measuring of outcomes. While Humana implements activities to identify interventions, the support and activities of families, friends, providers and the community have a significant impact on prevention.

## Preventive guidelines and clinical practice guidelines

Humana disseminates and monitors the use of clinical practice guidelines relevant to members that:

- Are based on valid and reliable clinical evidence or a consensus of healthcare professionals or in the relevant field
- Consider the needs of managed care members
- Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines including professional medical associations, voluntary health organizations and National Institutes of Health (NIH) centers
- Are congruent with current NCQA standards for establishing guidelines
- Do not contradict existing Virginia-promulgated regulations or requirements as published by the Departments of Social Services, Health, Health Professions, Behavioral Health and Developmental Services, Virginia Department of Health or other state agencies
- Prior to adoption, have been reviewed by Humana' medical director, as well as other contractor practitioners and network providers, as appropriate
- Are reviewed and updated, as appropriate or at least every 2 years
- Are reviewed and revised, as appropriate based on changes in national guidelines or changes in valid and reliable clinical evidence or consensus of healthcare professionals and providers

We strongly encourage you to review and consider these guidelines. You ultimately remain responsible for determining the applicable treatment for every individual. Clinical and practice guidelines are distributed to all new and existing providers through the following formats:

- Provider manual updates
- Provider newsletters
- Provider website

Clinical practice guidelines are available on **Clinical Practice Guidelines for Healthcare Providers**. You also can obtain preventive health and clinical practice guidelines through your Provider Relations Representative. Humana notifies you whenever changes are made.

## Critical incident reporting

A critical incident is any actual or alleged event or situation that threatens or impacts the physical, psychological or emotional health, safety or well-being of a member. Critical incidents include, but are not limited to, the following incidents: medication errors, theft, suspected physical, mental, verbal or sexual abuse or neglect, financial exploitation, sentinel events, quality of care incidents and other critical incidents. Other critical incidents include events or situations that create a significant risk to the physical or mental health, safety or well-being of a member not resulting from a quality-of-care issue and less severe than a sentinel event.

Quality-of-care incidents include any incidents that call into question the competence or professional conduct of a healthcare provider in the course of providing medical services and have adversely affected, or could adversely affect, the health or welfare of a member. These are incidents of a less critical nature than those defined as sentinel events.

Critical incidents must be identified that occur during:

- The provision of Medicaid-funded services to members in NFs, skilled/rehabilitative service, inpatient BH settings and inpatient SUD treatment facilities
- Participation in or receipt of mental health services, ARTS or Commonwealth Coordinated Care Plus HCBS waiver services in any setting (e.g., an adult day care center, a member's home, any other community-based setting)

You must comply with critical incident requirements. The critical incident reporting form must be used by all staff and network providers. You must report, respond to and document critical incidents in accordance with DMAS' requirements and 42 CFR § 438.330(b). You must report critical incidents within 24 hours. If the initial report of a critical incident is submitted verbally, the party (person/agency/entity) making the initial report must submit a follow-up written report to Humana within 48 hours.

You must report critical incidents involving children to at least 1 of the following entities:

- The local Department of Social Services in the county or city where the child resides or where the abuse or neglect is believed to have occurred
- The Virginia Department of Social Services' child abuse and neglect hotline:

  In Virginia: **800-552-7096**
  Out-of-state: **804-786-8536**
  TTY: **800-828-1120**

You must report critical incidents involving adults to at least 1 of the following entities:

- The local adult protective services office
- The Virginia Department of Social Services' hotline **888-832-3858**

You should also report critical incidents involving children or adults to Humana by submitting a Critical Incident Reporting Form that can be found at **Humana.com/HealthyVA**. Please submit the completed form 1 of the following ways:

- Fax at **877-313-7257;**
- Email at **VACriticalIncidents@humana.com**; **or**
- **https://Humana-6853.quickbase.com/db/bt7hyfwd4**

# Chapter 13: Utilization Management

## Utilization Management program overview

Utilization Management helps maintain the quality and appropriateness of healthcare services provided to Humana members. Utilization review determinations are based on medical necessity, appropriateness of care and service and existence of coverage. Humana does not reward providers or our staff for denying coverage or services. There are no financial incentives for Humana staff to encourage decisions that result in underutilization. Humana does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition. Humana establishes measures designed to maintain quality of services and control costs consistent with our responsibility to our members. Humana places appropriate limits on a service on the basis of criteria applied under the Medicaid state plan and applicable regulations, such as medical necessity. Humana places appropriate limits on a service for utilization control, provided the service furnished can reasonably be expected to achieve its purpose. Services supporting individuals with ongoing or chronic conditions or who require LTSS are authorized in a manner that reflects the member's ongoing need for such services and supports.

Humana' Utilization Management program:

- Ensures consistent application of review criteria for authorization decisions and involves consulting with the requesting provider when appropriate
- Reflects current NCQA accreditation standard
- Detects underutilization and overutilization of care
- Evaluates medical necessity, criteria used, information source and the processes used to review and approve or deny the provision of medical, mental health and SUD services

Members' health is always Humana' top priority. In the best interest of Humana' members and to promote positive healthcare outcomes, Humana supports and encourages continuity of care and coordination of care between medical providers as well as between BH providers.

Humana completes an assessment of satisfaction with the Utilization Management process on an annual basis, identifying areas for improvement.

# Utilization Management staff

The Utilization Management department performs all Utilization Management activities including prior authorization, concurrent review, discharge planning and other utilization activities. Humana monitors inpatient and outpatient admissions and procedures to ensure appropriate medical care is rendered in the most appropriate setting, using the most appropriate resources. Humana also monitors the coordination of medical care to ensure its continuity. Referrals to the Humana Care Management team are made, if needed.

Humana uses licensed healthcare professionals to make Utilization Management decisions. Any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested is made by an individual who has appropriate expertise in addressing the member's medical, BH or LTSS needs. For BH services, including mental health services, a clinical interpretation and clinical judgment from a mental health professional or physician is required for service authorization approvals or denials. Humana and its subcontractors do not provide compensation to Utilization Management staff in a manner so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any member.

You can contact the Utilization Management staff with any Utilization Management questions. For medical and BH inquiries, please call **844-881-4482**. Please keep the following in mind when contacting Utilization Management staff:

- Staff are available Monday – Friday, 8 a.m. – 5 p.m., Eastern time.
- Staff can receive inbound communication regarding Utilization Management issues after normal business hours.
- Staff are identified by name, title and organization name when initiating or returning calls regarding Utilization Management issues.
- Staff are available to respond to email inquiries regarding Utilization Management issues.
- Staff are accessible to answer questions about the Utilization Management process.

## Utilization Management criteria

Humana currently uses the following criteria to make both administrative and medical necessity determinations as appropriate for inpatient and outpatient medical, inpatient and outpatient BH, acute rehabilitation and skilled NF admissions:

- Federal statutes and regulations
- Virginia's State Plans for Medical Assistance Services and state Children's Health Insurance Program (CHIP); statutes and regulations
- The Department's 1915(b) Managed Care Waiver, 1915(c) HCBS Waivers, ARTS 1115 Waiver and FAMIS MOMS 1115 Waiver
- The Cardinal Care Managed Care Contract
- Cardinal Care Technical Manual, Cardinal Care Encounter Technical Manual, ARTS Technical Manual and other technical manuals

- Medicaid memos, bulletins and guidance as well as DMAS-issued memos, bulletins, manuals and other guidance documents
- DMAS Request for Proposal (RFP 13330, as amended), the Contractors Technical Proposal submission in its entirety, including any negotiation summaries and additional information provided during negotiations
- Professional Society Guidelines—Guided by published peer-reviewed literature (can supersede National and Plan-derived guidelines if specifically called out to be used e.g., ASAM)

For areas not addressed by Milliman Care Guidelines or ASAM, Humana uses state-approved medical necessity guidelines and criteria. Humana has Utilization Management decision-making criteria that are objective and based on medical evidence to determine the medical necessity and clinical appropriateness of medical, behavioral healthcare and pharmaceutical services requiring approval.

These guidelines are intended to allow Humana to provide all members with care consistent with national quality standards and evidence-based guidelines. These guidelines are not intended as a replacement for a provider's medical expertise; they are to provide guidance to providers related to medically appropriate care and treatment. You can access these clinical coverage policies in the provider portal or at **Medical and Pharmacy Coverage Policies** or '**Humana Physician News'** newsletter. You can also request prior authorization review criteria used to make a medical necessity determination by emailing **VAMCDUMCriteriaRequests@humana.com** or by calling Provider Services at **844-881-4482**.

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

Humana specifies what constitutes "medically necessary services" in a manner that is no more restrictive than the Medicaid FFS Medicaid program criteria, including, but not limited to, quantitative and non-quantitative treatment limits, as indicated in any laws, regulations and interpretations. Are no more restrictive than the CCMC program criteria, including, but not limited to, quantitative and non-quantitative treatment limits, as indicated in any laws, regulations and interpretations.

In accordance with § 438.236, Humana' medical necessity guidelines are evidence-based and at a minimum:

- Are based on valid and reliable clinical evidence or a consensus of providers in the particular field;
- Are adopted in consultation with contracting healthcare professionals in Humana' service area;
- Are developed in accordance with standards adopted by national accreditation organizations;
- Are updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice; **and**
- Are applied in a manner that considers the individual healthcare needs of the member.
- Are based on ASAM criteria for medical necessity determinations for all ARTS to any member or contracting provider upon request; **and**

Humana is responsible for covering services that address:

- The prevention, diagnosis and treatment of a member's disease, condition and/or disorder that results in health impairments and/or disability.
- The ability for a member to achieve age-appropriate growth and development.
- The ability for a member to attain, maintain, or regain functional capacity.
- In the case of EPSDT, correct, maintain or ameliorate a condition
- The opportunity for a member receiving LTSS to have access to the benefits of community living, to achieve person-centered goals and live and work in the setting of their choice.

## Service authorizations

Service authorizations are a type of program integrity activity that requires a provider to submit documentation to support the medical necessity of services before that claim is billed and processed for payment.

To find out which services require authorization, you can access the service authorization list at **Humana.com/PAL** or call the Clinical Intake Team (CIT) at **884-881-4482**.

You can sign up on **www.availity.com** to submit authorization requests online. You can also submit a request via the CIT phone line at **844-881-4482**.

### Service authorization timeliness standards

| Classification | Type | Timeliness | Extension |
|---|---|---|---|
| **Physical/Non-BH** | | | |
| **Urgent** | Concurrent | 72 hours (3 calendar days) | 14 calendar days |
| | Preservice (Expedited) | 72 hours (3 calendar days) | 14 calendar days |
| **Nonurgent** | Preservice (Standard) | 14 calendar days | 14 calendar days |
| **Post service** | Retrospective | 30 calendar days | 14 calendar days |
| **BH including mental health services and ARTS** | | | |
| **Urgent** | Concurrent | 72 hours (3 calendar days) | 14 calendar days |
| | Preservice | 72 hours (3 calendar days) | 14 calendar days |
| **Nonurgent** | Preservice | 14 calendar days | 14 calendar days |
| **Post service** | N/A | 30 calendar days | 14 calendar days |

### Standard service authorizations

Nonurgent requests are requests for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

For standard authorization decisions, Humana provides the decision notice as expeditiously as the member's health condition requires, not to exceed 7 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days if:

- The member or the provider requests extension; **or**
- Humana justifies to DMAS upon request that the need for additional information is in the member's interest.

If Humana meets the criteria set forth for extending the time frame for standard service authorization decisions, Humana will:

1. Give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if they disagree with that decision; **and**
2. Issue and carry out the determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

## Expedited service authorizations

Urgent/expedited requests are requests for medical care or services where application of the time frame for making nonurgent or non-life-threatening care determinations could:

- Seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment
- Seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request

For cases in which a provider indicates or Humana determines that following the standard time frame could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain or regain maximum function, Humana makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. Humana may extend the 72-hour time period by up to 14 calendar days if the member requests an extension or Humana justifies to DMAS upon request a need for additional information and how the extension is in the member's interest. For a member participating in a qualifying clinical trial, Humana expedites and completes a service authorization review related to the qualifying clinical trial within 72 hours, including when the qualifying clinical trial is performed by out of network or out of state providers.

In compliance with NCQA requirements, Humana always considers the following requests to be urgent requests and therefore will respond within 72 hours (3 business days):

- Mental health intensive outpatient programs
- Mental health partial hospitalization programs
- Physical and behavioral healthcare or services to accommodate transitions between inpatient and institutional setting to home/community.

### Service authorizations for Medicaid members younger than 21

In addition to the traditional review for medical necessity, service authorization requests for Medicaid members younger than 21 who do not meet Humana' general coverage criteria are reviewed under EPSDT criteria of correcting or ameliorating the child's conditions. Service authorization requests for individuals younger than age 21 cannot be denied, in-part or in-total, without completing the EPSDT secondary review. An adverse benefit determination on a service request for a child younger than age 21 is not issued until the case is first reviewed by a provider who has appropriate expertise in addressing the child's medical, BH or LTSS needs. Providers can contact care coordinators or care managers to explore alternative services, therapies and resources for members. Any denial notice, including for noncovered, out-of-network and/or experimental services, explains EPSDT criteria was applied and cites the reason the requested service was determined to not meet EPSDT criteria. The notice reflects a secondary review was performed using the EPSDT correct or ameliorate standard and explains how it was applied to the facts. The notice will provide instructions for how to submit a reconsideration for an adverse benefit determination.

### Services that do not require service authorization

Service authorization requirements do not apply to emergency care, family planning services, preventive services and basic prenatal care. A service authorization is also not required for hospice services, but Humana must establish the LOC needed for hospice services to begin. Humana also does not require service authorization for behavioral health SBIRT. To find out which services require authorization, you can access the service authorization list at **Humana.com/PAL** or call the CIT at **884-881-4482**.

## Notice of adverse benefit determinations

Members and requesting providers are sent written notice of any adverse benefit determination or adverse action. This notice informs members and providers of their rights to appeal through Humana as well as their rights to access DMAS' State Fair Hearing and provider appeal systems, after they have exhausted their appeals with Humana. Humana provides a timely written Notice of Adverse Benefit Determination to the requesting provider and the member for any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested.

- For termination, suspension or reduction of previously authorized Medicaid covered services, such notice is provided at least 10 calendar days in advance (plus 5 calendar days for mailing, for a total of 15 calendar days) of the date of its action.
- Notice is provided no later than the date of action for the exceptions noted in 42 CFR § 431.213.
- For denial of payment, notice is provided at the time of action.
- For standard service authorization decisions that deny or limit services, the notice is provided as expeditiously as the member's condition requires and within the time frames.

- For cases in which a provider indicates or Humana determines that following the standard authorization time frame could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain or regain maximum function, Humana makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service.
- Humana may extend the time frame for standard authorization decisions by 14 calendar days.

The written notice explains:

- The action Humana has taken or intends to take;
- The reasons (specific to the member and request) for the action, including the right of the member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria and any processes, strategies or evidentiary standards used in setting coverage limits;
- The citation to the law or policy supporting such action;
- A list of titles and qualifications, including specialties, of individuals participating in the authorization review;
- The member's or the member representative's right to file an internal appeal with Humana, including information on exhausting Humana' appeal processes and an explanation that the member and/or representative has a right to file an appeal with DMAS for a State Fair Hearing only after Humana' internal appeal process has been exhausted;
- The procedures for exercising the members rights to appeal;
- The right to request an expedited appeal, the circumstances under which expedited resolution is available and how to request it;
- If applicable, the member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued and the circumstances under which the member may be required to repay the costs of these services;
- The right to be represented by an attorney or other individual; **and**
- The written notice will be translated (upon request) for individuals who speak prevalent languages. Additionally, written notices will include language explaining that oral interpretation is available for all languages and how to access it.

Reviewers from Humana are available to discuss individual cases with attending providers on request. Clinical criteria and clinical rationale or criteria used in making utilization management determinations are available on request by contacting Humana' Utilization Management department by email at **VAMCDUMCriteriaRequests@humana.com**.

For more information on how a provider can submit an appeal please refer to **Chapter 15: Member and Provider Grievances, Appeals and Reconsiderations**.

## Concurrent review

Concurrent requests are requests in which the member is in the process of receiving the requested medical care or services, even if Humana did not previously approve the earlier care. Notice of decision is provided as expeditiously as the member's health condition requires, but no later than 1 business day after receiving all information, but not to exceed 72 hours from the date of request. You can sign up on **www.availity.com** to submit requests online. You can also submit a request via the CIT phone line at **844-881-4482**.

## Retrospective review

Service authorization is required to ensure services provided to Humana members are medically necessary and appropriately provided. Humana conducts retrospective reviews to determine whether authorization is granted for services rendered before a service authorization for the services was requested. If a provider does not obtain prior authorization before services are rendered, they have 90 days from the date of service, inpatient discharge date or receipt of the primary insurance carrier's explanation of payment (EOP) to request a retrospective review of medical necessity. Humana reviews and notifies providers of the determination within 30 days of the retrospective review request. Requests for retrospective review that exceed these time frames are denied and ineligible for appeal.

A request for retrospective review can be made by calling **844-881-4482** and following the appropriate menu prompts. Providers can also fax the request to **931-650-3709** for physical health and **931-650-3707** for behavioral health. Clinical information supporting the service must accompany the request.

## Peer-to-peer reviews

You can request a peer-to-peer consultation when Humana denies a prior authorization request. The peer-to-peer consultations will be conducted amongst healthcare professionals who have clinical expertise in treating the member's condition, with the equivalent or higher credentials as the requesting/ordering provider. The peer-to-peer consultation must clearly identify what documentation the provider must provide to obtain approval of the specific item, procedure or service; or a more appropriate course of action based upon accepted clinical guidelines.

If you would like to request a peer-to-peer discussion on a determination with a Humana provider reviewer, you should email **VAMCDP2Prequest@humana.com**, fax the request to **877-318-2425** or leave a voicemail at **844-881-4482**. The peer-to-peer request must be made within 5 business days of the determination.

## Discharge planning

Humana believes discharge planning is a key part of treatment and should begin at admission. Our Utilization Management staff review appropriateness of discharge planning as part of the clinical review to ensure the appropriateness of the member's transition plan from inpatient/higher levels

of care.

Humana is available to assist in the coordination of care when a member is being discharged from a facility or transferring from 1 LOC to another to ensure the member's successful transition. The inpatient Utilization Management nurse works with the member, their authorized representative, their PCP, their facility care team, a Humana transitions care manager and other providers, as appropriate.

In the event Humana is notified of a facility closure or license termination, we will collaborate with the Office of the Long-term Care Ombudsman, Department for Aging and Rehabilitation, the local Department of Social Services and other state agencies to ensure all member transfer and discharge rights are upheld.

Humana requires facilities treating members in inpatient psychiatric or substance use treatment settings ensure members are scheduled for outpatient follow-up or continuing treatment prior to their discharge. This treatment must be provided within 7 calendar days from the date of the member's discharge.

## Continuity of care

Humana allows members to continue seeing their out-of-network providers with reimbursement provided at the Medicaid FFS rate for the duration of the continuity of care period. Humana will not change a member's existing provider before the end of the continuity of care period, except in the following circumstances:

- The member requests a change;
- The provider chooses to discontinue providing services to a member as currently allowed by Medicaid;
- Humana or DMAS identify provider performance issues that affect a member's health or welfare; **or**
- The provider is excluded under state or federal exclusion requirements.

Humana contacts out-of-network providers who are providing services to members and provides them with information on becoming credentialed, in-network providers. If the provider does not join the network or the member does not select a new in-network provider, Humana facilitates a seamless transition to a participating provider (with the exception of NF residents). Members in an NF at the time of Cardinal Care program enrollment can remain in that NF as long as they continue to meet LOC criteria for NF care, unless they or their authorized representatives prefer to move to a different NF or return to the community. The only reasons for which Humana may require a change in NF are if:

- The member requests a change;
- The provider is excluded under state or federal exclusion requirements; **or**
- Due to 1 or more deficiencies that constitute immediate jeopardy to resident health or safety, per direction from DMAS, the Virginia Department of Health – Office of Licensure and Certification (OLC) or Adult Protective Services (APS). Such reasons are described in DMAS' Nursing Home Manual at **https://vamedicaid.dmas.virginia.gov/manuals**, Chapter IX, 42 CFR § 488.410, 12VAC30-20-251 and **www.vdh.virginia.gov/licensure-and-certification**.

## Medicaid hospital readmission policy

Hospital readmissions include cases when members are readmitted to a hospital for the same or a similar diagnosis within 30 days of discharge, excluding planned readmissions, obstetrical readmissions, admissions to critical access hospitals or in any case where the member was originally discharged against medical advice. If the member is readmitted to the same hospital for a potentially preventable readmission, then the payment for such cases is 50% of the normal rate, except that a readmission within 5 days of discharge must be considered a continuation of the same stay and must not be treated as a new case. Similar diagnoses must be defined as ICD diagnosis codes possessing the same first 3 digits.

## Post-stabilization services

Post-stabilization care services are covered services related to an emergency medical condition that are provided after a member is stabilized following an emergency to maintain, improve or resolve the member's condition. Post-stabilization services are covered in or out of network.

Humana covers post-stabilization care services obtained within or outside the Humana network that are not pre-approved by a plan provider or other Humana representative but are administered to maintain, improve, or resolve the member's stabilized condition under the following circumstances:

- The services are administered to maintain the member's stabilized condition within one hour of a request to Humana for pre-approval of further post-stabilization care services.
- Humana does not respond to a request for pre-approval within 1 hour
- Humana cannot be contacted
- The Humana representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, Humana will give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 42 CFR §422.113(c)(3) is met.

Humana is financially responsible for post-stabilization care services obtained within or outside Humana' network that are pre-approved by a plan provider or other Humana representative.

Post-stabilization services that Humana has not pre-approved will no longer be covered by Humana when a plan physician with privileges at the treating hospital takes over the member's care, a plan physician takes responsibility for the member's care through transfer, the Humana representative and the treating physician agree on the member's care plan, or when the member is discharged.

## Mental health services registrations and authorizations

Providers are required to complete registration (notification) for certain ARTS and mental health services. "Register" or "Registration" refers to your notification to Humana that an individual will receive services requiring a registration, but do not require service authorization. You are required to perform an

assessment as described in the **Mental Health Services Manual at vamedicaid.dmas.virginia.gov** prior to submitting a request for MHS. **The registration form is located on dmas.virginia.gov**.

Services that require a service authorization also must be requested using the appropriate forms. There are separate forms for initial authorization and continued stay. Please use the following forms:

- General mental health/BH services: **www.dmas.virginia.gov/for-providers/behavioral-health/provider-resources/**
- ARTS: **www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/authorization-and-registration/**

To find out which services require registration or authorization, you can access the service authorization list at **Horizons.com/PAL** or call CIT at **844-881-4482**.

Authorizations may be approved retroactively based on established provider enrollment contractual requirements after a provider has engaged a member in treatment to promote immediate entry into withdrawal management processes and addiction treatment. Humana responds to providers' service authorization submission via the ARTS uniform service authorization request form within 72 hours of the request for placement at all levels of care identified above.

## Specialist referrals

Humana members can seek care from any participating network provider, including specialists and inpatient hospitals. Humana does not require referrals from PCPs to see participating specialists. Humana allows members with special healthcare needs—determined through an assessment to need a course of treatment or regular care monitoring—to access a specialist directly as well. However, service authorization must be obtained for nonparticipating providers. Members can self-refer to any participating provider. PCPs do not need to arrange or approve these services for members, as long as applicable benefit limits have not been exhausted.

ARTS intensive outpatient, partial hospitalization programs and residential treatment services providers must assess and refer members for medication for treatment of opioid use disorder when appropriate.

## Second opinions

Humana provides coverage for a second opinion when requested by the member for the purpose of diagnosing an illness and/or confirming a treatment pattern of care. Humana provides for a second opinion from a qualified healthcare professional within the network or arranges for the member to obtain 1 outside the network, at no cost to the member. Humana may require an authorization to receive specialty care for an appropriate provider. However, Humana will not deny a second opinion request as a noncovered service. If you offer second opinions, you must follow all prior authorization requirements where applicable.

A second opinion is not required for surgery or other medical services. However, providers or members can request a second opinion at no cost. The following criteria should be used when selecting a provider for a second opinion:

- he provider must participate in the Humana network. If not, prior authorization must be obtained.
- The provider must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.
- The provider must be in an appropriate specialty area.

Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

For additional information or assistance with requesting second opinions, please call **844-881-4482**.

## Out-of-network services

Humana will arrange for out-of-network care if we cannot provide necessary covered services, a second opinion or if a network healthcare provider is unavailable. Humana coordinates payment with the out-of-network provider to confirm any cost to the member is not greater than it would be if the service were provided in-network.

Humana covers, pays for and coordinates all care when:

- When Humana has authorized services to be received from an out-of-network provider
- When emergency and family planning services are rendered to a member by a nonparticipating provider or facility
- When the member is given emergency treatment by such providers outside of the service area
- When the needed medical services or type of provider (in terms of training, experience and specialization), necessary supplementary resources or services furnished in facilities or by practitioners outside Humana' network are not available in network
- When Humana cannot provide the needed specialist within the distance standard of more than 30 miles in urban areas or more than 60 miles in rural areas
- During the member's continuity of care period when the member's provider is not part of the Humana' network, has an existing relationship with the member and has not accepted an offer to participate in Humana' network
- When DMAS determines the circumstance warrants out-of-network treatment
- When a provider is not a part of Humana' network, but is the primary provider of services to the member, provided that:
  - The provider has the opportunity to become a participating provider under the same requirements for participation in Humana' network as other network providers of that type
  - If the provider chooses not to join the network or does not meet the requirements to join, the member has the opportunity to transition to a participating provider within 60 calendar days (after being given the opportunity to select a provider who participates)
- The member's PCP or other provider determines the member needs related services that would subject the member to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network

- The only plan or provider available to the beneficiary does not, because of moral or religious objections, provide the service the member seeks

Humana requires out-of-network providers to coordinate with Humana for payment and ensure the cost to the member is no greater than it would be if the services were furnished within Humana' network. Humana reimburses out-of-network providers at the fee-for-service rate in effect on the date of service. For Commonwealth Coordinated Care Plus HCBS waiver and home health services, the rate includes the Northern Virginia differential.

For additional information or assistance with requesting out-of-network opinions, please call **844-881-4482**.

## Out-of-state services

Humana is not responsible for services obtained outside the Commonwealth, except under the following circumstances:

- The services are necessary emergency, crisis or post-stabilization services
- It is a general practice for members in a particular locality to use medical resources, including family planning, in another state
- The required services are medically necessary and not available in-network and within the Commonwealth
- While Humana is honoring a transition of care plan authorized by Humana, another MCO or DMAS until services can be safely and effectively transitioned to a provider in Humana' network within Virginia
- Enroll bordering out-of-state ambulance companies as needed for facility-to-facility transfers that occur within the bordering state boundaries. Virginia ambulance companies are not:
  - Permitted to transport members unless pick up or drop off addresses are located in Virginia
  - Allowed to transfer members within the boundaries of other states

# Chapter 14: Claims and Billing

## Claim submission

Claims must be submitted within 365 calendar days from the date of service. Corrected claims must be submitted 180 days from the date of explanation of payment (EOP). We do not pay claims with incomplete, incorrect or unclear information. Providers have 60 calendar days from the EOP to submit a claim dispute. Humana complies with the Affordable Care Act and ensures claims processing can collect data elements necessary for claims processing and information retrieval in accordance with the DMAS requirements.

Humana accepts electronic and paper claims. Providers are encouraged to submit routine claims electronically to take advantage of the following benefits:

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

Humana partners with Availity Essentials to allow providers to reference member and claim data for multiple payers using 1 sign-in. Availity Essentials provides the following services:

- Eligibility and benefits
- Referrals and authorizations
- Claim status
- Claim submission
- Submission of disputes and appeals
- Remittance advice

To learn more, call **800-282-4548** or visit **Availity.com**.

All claims (electronic and paper) must include the following information:

- Patient (member) name
- Patient address
- Insured's ID number: Be sure to provide the complete Humana member ID number for the patient
- Patient's birth date: Always include the member's date of birth so we can identify the correct member in case we have more than 1 member with the same name
- Place of service: Use standard CMS location codes

It is critical that all provider addresses and phone numbers on file with Humana are up to date to ensure timely claims processing and payment delivery. Please note that failure to include ICD-10 codes on electronic or paper claims will result in claim denial.

## State fee schedule and modifiers

The procedure fee file and CPT search page at **www.dmas.virginia.gov/for-providers/rates-and-rate-setting/** provides detailed information about all of the procedures, including rates, covered/noncovered designation, etc. Please refer to the frequently asked questions located at **www.dmas.virginia.gov/media/** for explanation of the characters in each field of the procedure fee file.

Modifiers should comply with the provider requirements as established in the provider manuals available on **www.vamedicaid.dmas.virginia.gov/manuals/**.

## NPI and TIN

The provider's NPI and Tax ID are required on all claims, in addition to provider taxonomy and specialty type codes (e.g., federally qualified health center, rural health center and/or primary care center) using the required claim type format (CMS-1500, UB-04 or Dental ADA) for the services rendered.

Humana may deny the claim if the NPI is not provided on the claim for payment or the ordering or referring provider is not credentialed by Humana, unless otherwise instructed by DMAS. Providers without an NPI should register with Availity Essentials as an atypical provider if they want to submit electronic claims.

## Claim forms

### CMS-1500 form

The CMS-1500 billing form is used to submit paper claims for professional services. Humana requires providers to use the CMS-1500 billing form when submitting paper claims.

Before submitting a claim, a provider should ensure all required attachments are included. All claims that involve other insurance must be accompanied by an explanation of benefits (EOB) or a remittance advice (RA) that clearly states how the claim was paid or the reason for denial.

### UB-04 form

The UB-04 form is used when billing for facilities services, including nursing home room and board, supportive living room and board, hospice and intermediate care facilities services.

## 5010 transactions

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

The following transactions are covered under the 5010 requirement:

- 837 Claims encounters
- 276/277 Claim status inquiry
- 835 ERA
- 270/271 Eligibility
- 278 Prior-authorization requests
- 834 Enrollment

## Unlisted CPT/HCPCS codes

If a procedure is performed that cannot be classified by a CPT or HCPCS code, please include the following information with an unlisted CPT/HCPCS procedure code on the claim form:

- A full, detailed description of the service provided
- A report, such as an operative report or a plan of treatment
- Other information that would assist in determining the service rendered

## Common submission errors and how to avoid them

Humana may reject claims because of missing or incomplete information. Common rejection or denial reasons include:

- Patient not found
- Subscriber not found
- Patient birthdate on the claim does not match that found in our records
- Missing or incorrect information, such as NPI, ZIP code, taxonomy
- Encounters with $0 value
- Invalid HCPCS code
- No authorization found

How to avoid these errors:

- Confirm patient information received and submitted is accurate and correct
- Ensure all required claim form fields are complete and accurate
- Obtain proper authorizations for rendered services
- Ensure billed amounts have a dollar value

If a claim is received, but additional information is required for adjudication, the claim may pend and a request in writing for the necessary information will be sent.

## Balance billing

Except for patient pay liability amounts for LTSS services as established by the local DSS, you must consider Humana' payment as payment in full and must not bill or balance bill any Humana members (D-SNPs or Medicaid) for Medicaid Covered Services provided during the member's period of Humana enrollment. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a member for any Medicaid-covered service provided is expressly prohibited. This includes those circumstances where the provider fails to obtain necessary referrals, service authorization or fails to perform other required administrative functions. However, if a member agrees in advance of receiving the service and in writing to pay for a non-Medicaid covered service, then Humana providers or Humana' subcontractor can bill.

# Code editing and payment policies

Humana processes accurate and complete provider claims in accordance with Humana' normal claims processing procedures, including, but not limited to, **claims processing edits** and **claims payment policies** and applicable state and/or federal laws, rules and regulations. See **Humana.com/Provider** to access a summary of changes to claims processing procedures; this summary of changes to claims processing procedures is not intended to be an exhaustive list.

Such claims processing procedures include review of the interaction of various factors. The result of Humana' claims processing procedures is dependent upon the factors reported on each claim. Accordingly, it is not feasible to provide an exhaustive description of the claims processing procedures, but examples of the most commonly used factors are:

- The complexity of a service
- Whether a service is one of multiple same-day services such that the cost of the service to the provider is less than if the service had been provided on a different day. For example:
  - 2 or more surgeries performed the same day
  - 2 or more endoscopic procedures performed the same day
  - 2 or more therapy services performed the same day
- Whether a cosurgeon, assistant surgeon, surgical assistant or any other provider who is billing independently is involved
- When a charge includes more than one claim line, whether any service is part of or incidental to the primary service provided or if these services cannot be performed together
- Whether the service is reasonably expected to be provided for the diagnosis reported
- Whether a service was performed specifically for the member
- Whether services can be billed as a complete set of services under 1 billing code

Humana develops claims processing procedures in our sole discretion based on our review of correct coding initiatives, national benchmarks, industry standards and industry sources such as the following, including any successors of the same:

- Virginia DMAS regulations, manuals and other related guidance
- Federal and state laws, rules and regulations, including instructions published in the Federal Register
- National Uniform Billing Committee (NUBC) guidance, including the UB-04 Data Specifications Manual
- American Medical Association's (AMA) CPT® and associated AMA publications and services
- CMS' HCPCS and associated CMS publications and services
- International Classification of Diseases (ICD)
- American Hospital Association's (AHA) Coding Clinic Guidelines
- Uniform Billing Editor
- American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services

- U.S. Food and Drug Administration (FDA) guidance
- Medical and surgical specialty societies and associations
- Industry-standard Utilization Management criteria and/or care guidelines
- Our medical and pharmacy coverage policies
- Generally accepted standards of medical, BH and dental practice based on credible scientific evidence recognized in published, peer-reviewed literature

Changes to any one of the sources may lead Humana to modify current or adopt new claims processing procedures.

These claims processing procedures may result in an adjustment or denial of reimbursement, a request for the submission of relevant medical records, prior to or after payment or the recoupment or refund request of a previous reimbursement. Providers can access additional information at **Humana.com/Provider**.

An adjustment in reimbursement as a result of claims processing procedures does not indicate the service provided is a noncovered service. You can submit a dispute request for any adjustment produced by these claims processing procedures by submitting a timely request to Humana. For additional information, see the **Provider Reconsiderations and Appeals section of this manual**.

Providers must report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. Claims indicating provider preventable conditions will not be paid.

Humana provides notification of upcoming code editing changes. New code editing rules and rationales for changes are published on the first Friday of each month at **Humana.com/Edits**.

## Timely filing requirements

Humana' timely filing requirement for all providers (in and out-of-network) is 365 days from the date of service. If the member has other coverage, the time frame for claim submission would begin on the date of payment or notification of nonpayment from the primary payer. If Medicare covers the service, the time frame begins on the date of adjudication of the Medicare claim. Humana makes available to providers an electronic means of submitting claims.

## Clean claim criteria

A clean claim is defined as a claim that can be processed without obtaining additional information from the provider of the service or from a third party. A clean claim has no defect or impropriety (including any lack of any required substantiating documentation) or circumstance requiring special treatment that prevents timely payments from being made on the claim under this title. See Sections 1816(c)(2)(B) and 1842(c)(2)(B) of the Social Security Act and 42 CFR §447.45(b). A clean claim includes a claim with errors originating from the Humana' claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

## Claim status

You can track the progress of submitted claims at any time through Availity Essentials, our provider portal at **Availity.com**. Claim status is updated daily and provides information on claims submitted in the previous 24 months. Searches by Humana member ID number, member name and date of birth or claim number are available.

You can get the following claim information on Availity Essentials:

- Reason for payment or denial
- Check number(s) and date
- Procedure/diagnostic
- Claim payment date
- Remittance advice

## Corrected claims submission

When mistakes are identified on a previously processed claim, a correction is submitted to reprocess or adjust the claim. Corrected claims can be submitted electronically through **Availity.com** or mail when provider is unable to submit electronically.

To prevent the corrected claim from rejecting as a duplicate, use the appropriate billing frequency code: Billing frequency 7 is used for replacement of prior claim (corrected claim).

The submitter must include the payer claim control number. This number can be obtained from the 835, if available.

## Claim processing and payment

Humana adheres to the following standards regarding timely claims processing for all providers:

1. Within 5 business days of receipt of a claim, Humana performs an initial screening and either rejects the claim or assigns a unique control number and enters it into the system for processing and adjudication.
2. Humana processes and pays or denies, as appropriate, 90% of all clean claims submitted within 30 calendar days of the date of receipt.
3. Humana pays or denies, as appropriate, 99% of all clean claims submitted within 90 calendar days of the date of receipt.
4. For certain types of providers and covered services, Humana complies with prompter pay requirements.
5. Humana Health Horizons adjudicates (pay or deny) all other claims within 12 months of the date of receipt (see 42 CFR §447.45 for time frame exceptions).

Humana pays providers within 30 days of the receipt of a clean claim for covered services rendered to a member unless there is a signed provider agreement with another acceptable time frame for payment. This does not apply to timelines required for exceptional services. Providers must accept Humana' payment as payment in full except for patient pay liability amounts for LTSS services as established by the local Department of Social Services.

Humana does not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid or SCHIP programs.

## Electronic Funds Transfer/ERA enrollment through Humana

You can get paid faster and reduce administrative paperwork with electronic funds transfer (EFT) and electronic remittance advice (ERA). Physicians and other healthcare providers can use Humana' EFT/ERA enrollment tool on Availity Essentials to enroll. To access this tool:

1. Sign in to Availity Essentials at **Availity.com** (registration required)
2. From the Payer Spaces menu, select Humana
3. From the Applications tab, select the EFT/ERA Enrollment app
    a. If the app isn't found, contact your Availity Essentials administrator to discuss your need for this tool.

When you enroll in EFT, Humana claim payments are deposited directly in the bank account(s) of your choice.

EFT payment transactions are reported with file format CCD+, which is the recommended industry standard for EFT payments. The CCD+ format is a National Automated Clearing House Association (ACH) corporate payment format with a single 80-character addendum record capability. The addendum record is used by the originator to provide additional information about the payment to the recipient. This format is also referenced in the ERA via the 835 data file. You should contact your financial institution if you want to receive this information.

**Please note:** Fees may be associated with EFT payments. You should consult their financial institution for specific rates.

The ERA replaces the paper version of the EOR. Humana delivers 5010 835 versions of all ERA remittance files compliant with HIPAA. Humana uses Availity Essentials as the central gateway for delivery of 835 transactions. You can access remittance through your clearinghouse or through the secure provider tools available in Availity Essentials.

Please note that fees may be associated with ERA transactions. You should consult their clearinghouse for specific rates.

## Provider preventable conditions and services (never events)

Humana' reimbursement for inpatient hospital services is based on the provider preventable conditions policy defined in 42 CFR §447.26. You must report provider preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition existed before that provider began treating the patient. Reductions in provider payment may be limited to the extent that the following apply:

- The identified provider preventable conditions would otherwise result in an increase in payment; **and**
- DMAS can reasonably isolate the portion of the payment directly related to treatment for and related to the provider preventable conditions for nonpayment.

Humana will not make a payment to a provider for provider preventable conditions that:

- Is identified in the state plan;
- Has been found by DMAS, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
- Has a negative consequence for the member;
- Is auditable; **and**
- Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Nonpayment of a provider preventable condition does not prevent access to services for the member.

## Claims processing when a member's health plan or coverage terminates or changes

### From Humana to another plan

In the event of a member's enrollment being terminated or changing from Humana to a different Medicaid plan, Humana may submit voided encounters and notify affected providers of adjusted claims via the following process:

1. Humana determines if claims were paid for dates of service for which the member was later identified as ineligible for Medicaid benefits through Humana.
2. Humana mails a notice to each affected provider of the recoupment process for claim(s) identified in the recoupment letter. The provider has at least 30 business days to respond to the notice.
3. Once the 30-business day window expires, Humana adjusts subsequent payment(s) for the affected provider(s) if there was not an attempt by the provider(s) to appeal the recoupment of payment or issue a refund check for the affected claims listed in the notice letter. This takes place within 10 business days.

4. After the recoupment is processed, either by adjusting subsequent payments to the provider or via a refund check from the provider, the recoupment receives a processed date stamp. Once this occurs, a voided encounter for the affected claims is submitted within 10 business days, assuming the original submitted encounter was previously accepted. Please note that if the original encounter was denied or rejected by DMAS, a void does not need to occur.

### From another plan to Humana

If a member was enrolled with another Medicaid plan and is now eligible with Humana, you are required to submit a copy of the explanation of payment that reflects recoupment of payment and documentation from the previous MCO to validate the original encounter was voided and accepted by DMAS.

These items are used to support overriding timely filing, if eligible. If a claim exceeds timely filing due to retro-eligibility from another Medicaid plan, you have 180 days (6 months) from the date of the accepted voided encounter to submit the claim to Humana to avoid timely filing denials.

## Newborn claims

All claims for newborns must be submitted using the newborn's Humana member ID number. Newborns are deemed eligible for Medicaid from their birth month plus 2 months (when renewal becomes necessary) with Humana. Do not submit newborn claims using the mother's identification numbers. In those instances, the claim is denied.

## Hysterectomies, sterilization and abortions

Hysterectomies, sterilization and abortion procedures and initial hospice claims submissions must have consent forms attached. Find the forms at **https://vamedicaid.dmas.virginia.gov/provider/forms#gsc.tab=0**.

## Vaccinations and immunizations

Find information regarding reimbursement of immunizations at **www.vdh.virginia.gov/immunization**.

## Billing for doula services

Doulas can bill Humana directly for services, as long as the services were referred by a:

- Certified nurse midwife
- Certified psychiatric clinical nurse specialist
- Certified professional midwife
- Licensed clinical psychologist
- Licensed clinical social worker
- Licensed marriage and family therapist
- Licensed midwife
- Licensed professional counselor
- Licensed substance use treatment practitioner
- Nurse practitioner
- Physician
- Physician assistant

These licensed provider types are best positioned to ensure the member who accesses doula services also accesses key maternal and child health clinical services a physician or other licensed provider might provide acting within their scope of practice.

## Out-of-network claims

In the absence of an agreement between Humana and the provider, Humana pays out-of-network providers, including out-of-state providers, at the prevailing DMAS rate in existence on the date of service. This reimbursement must be considered payment in full to the provider or facility. Humana reimburses out-of-network providers and providers of emergency or urgent care the Medicaid fee-for-service (FFS) payment level for that service.

For out-of-network providers, all claims for emergency services are reimbursed at the applicable Medicaid FFS program rate in effect at the time the service was rendered. Humana does not deny payment for treatment obtained if a Humana representative instructs the member to seek emergency services or a member had an emergency medical condition, including cases of severe pain, psychiatric disturbances and/or symptoms of substance abuse in which the absence of immediate medical attention would not have had the following outcomes:

- Placing the members health (or, for a pregnant individual, the health of that individual or their unborn child) in serious jeopardy;
- Serious impairment to bodily functions; **or**
- Serious dysfunction of any bodily organ or part.

### Claims for members with temporary detention orders

A TDO is an order issued by a magistrate for a person who (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to themself or others as evidenced by recent behavior causing, attempting or threatening harm and other relevant information, if any or (b) suffer serious harm due to his lack of capacity to protect themself from harm or to provide for their basic human needs; (ii) is in need of hospitalization or treatment; and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment. If the member is 21–64 years old and goes into a private free-standing institution for mental disease (IMD) or a state free-standing IMD for a TDO, you should submit the TDO claim to the state TDO program.

## Coordination of benefits

Coordination of benefits (COB) allows plans that provide health and/or prescription coverage for a person with Medicare and/or other insurance to determine their respective payment responsibilities. In all circumstances, except for doulas where Medicaid is the primary payor, Medicaid is the payer of last resort.

Humana collects COB information for its members. This information helps ensure claims are paid appropriately and comply with federal regulations that Medicaid programs are the payer of last resort. While Humana tries to maintain accurate information at all times, numerous sources are relied upon for updated information periodically and some updates may not always reflect on Availity Essentials at **Availity.com**. Providers should ask Humana members for all healthcare insurance information at the time of service.

Providers can search for COB information on Availity Essentials at **Availity.com** by:

- Member number
- Medicaid number/Medicaid Management Information System number

Providers can check COB information for members active with Humana within the past 12 months.

## Third-party liability

Third-party liability (TPL) refers to the legal responsibility of third parties to pay healthcare costs before Medicaid. Medicaid is the payer of last resort except for doula services where Medicaid is the primary payer.

Providers are required to identify TPL coverage for a Humana-covered patient, including, but not limited to, Medicare, private healthcare insurance and long-term care insurance. Claims should be submitted to a patient's TPL coverage for payment before submitting to Humana. Humana reduces its payments based on TPL coverage payments made for covered services. If Humana pays a claim but it is later determined the claim should be first processed by a third party, Humana works to recover the liability from the responsible third party.

If Humana determines the probable existence of a TPL resource, the claim is processed as secondary coverage. If Humana cannot confirm a TPL resource is responsible for payment, the claim is denied.

When a member has TPL coverage, Humana covers the member's deductibles and coinsurance up to the maximum allowable reimbursement amount that would have been paid if the member did not have TPL. If the member's TPL coverage is a commercial MCO or HMO, Humana covers the full member copayment amount. Humana ensures a member with TPL is held harmless for payments and copayments for any Medicaid covered service. The only time a provider should bill a member with TPL coverage is when there is Patient Pay established by DSS toward LTSS services. For more information about LTSS Patient Pay, please see the **Patient pay toward LTSS section of this manual**.

If Humana receives a claim for prenatal services, including labor, delivery and postpartum care, where a TPL resource is likely liable, we will reject the claim and return it to the provider noting the third party we believe is legally responsible for the claim.

Humana claims will be paid and then Humana will bill the member's TPL coverage only for:

- Preventive pediatric services
- Child support claims, when a provider has waited 100 days from the date of service without receiving payment before billing Medicaid

When you bill Medicaid for preventive pediatric services or child support claims, you must certify you have either:

- Not billed the third party documented on the claim due to medical support enforcement; or
- Billed the third party documented on the claim but have not received payment or denial for the service from the third party within 100 days after the service was furnished. In this case, 100 days must elapse from the date of the service to the date of provider certification.

## Overpayments

Should an audit by Humana or an authorized state or federal official result in disallowance of amounts previously paid to a provider, the provider must reimburse Humana upon demand. You must not bill the member in these instances.

When you receive a payment from another carrier after receiving payment from Humana for the same items or services, it is considered an overpayment. Humana provides a 30-day written notice to you before an adjustment for overpayment is made. If we do not receive a dispute from you, we will adjust the overpayment on a subsequent reimbursement.

If you identify a claim has been overpaid, you must report the overpayment to Humana via Availity Essentials. You should locate the overpaid claim in the Claim Status application within the Availity Essentials portal and select the “Identify Overpayment” button at the top of the screen. You should then follow the prompts in Availity Essentials. You should return the overpayment within 60 days of identifying the overpayment and notify the MCO in writing of the reason for the overpayment.

You should not refund money paid to a member by a third party.

Humana is required to report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. Humanamust submit adjusted encounters reflecting any identified overpayments (regardless of whether they are recovered). Humana follows all retention policies for the treatment of recoveries of all overpayments from Humana to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.

- Humana complies with the process, timeframes and documentation required by the state for reporting the recovery of all overpayments promptly
- Humana complies with the process, timeframes and documentation the State requires for payment of recoveries of overpayments to the State in situations where Humana is not permitted to retain some or all of the recoveries of overpayments: Humana will report all recovery of all overpayments promptly to the State
- Humana will report recoveries of overpayments to the State in situations where Humana is not permitted to retain some or all the recoveries of overpayments:

Any overpayments for claims that were paid more than 3 years prior to the date that Humana formally notified the State of the overpayment will be retained by the State. If Humana has not recovered an overpayment within 1 year of being authorized to recover that overpayment, then the State is entitled to recoup and retain such overpayment. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

If a member agrees in advance of receiving the service in writing to pay for a service Medicaid does not cover, then a Humana provider or Humana subcontractor can bill.

## Suspension of provider payments

Humana will suspend payments to providers or subcontractors against whom DMAS has determined there to be a credible allegation of fraud. DMAS will issue payment suspension notices to providers.

# Chapter 15: Member and Provider Grievances, Appeals and Reconsiderations

## Overview of provider reconsiderations and appeals

For services that have been rendered, you have the right to appeal adverse actions. You must exhaust Humana' reconsideration process prior to filing an appeal with DMAS' Appeals Division, except in the case of an appeal of a payment suspension notice. Provider payment suspension notices are appealed directly to DMAS with no internal appeal to Humana.

## Provider reconsiderations

Humana has a reconsideration process in place and available to providers who want to challenge adverse benefit determination, made by Humana. The reconsideration is the first level of a provider appeal with Humana. Before appealing to DMAS, you must first exhaust Humana' reconsideration process. Providers in Humana' network may not appeal Humana' enrollment or termination decisions to DMAS.

If you have been denied or received reduced authorization for services rendered to a member enrolled with Humana in a Medicaid program, you can request a reconsideration. You must submit all reconsideration requests in writing and within 60 calendar days of the date of the adverse determination notification. Humana acknowledges receipt of each reconsideration request and ensures the individuals who make decisions on reconsiderations were not involved in any previous level of review or decision-making. You can present evidence and allegations of fact or law within the 60-day time frame. Before and during the reconsideration process, you can examine your case file, including any medical records and any other documents and records considered during the reconsideration process. Humana provides reconsideration decisions in writing.

### Provider reconsideration submission timeframes and procedures

Humana' reconsideration process includes the following elements:

1. Providers have 60 business days from receipt of adverse determination or reimbursement to submit a written request for reconsideration.
2. Humana acknowledges providers' reconsideration requests as soon as possible, but no later than 7 business days.
3. The provider has 15 calendar days to submit any additional supporting information.

Providers who would like to review their reconsideration/complaint case file should call Provider Services at **844-881-4482** so the inquiry can be documented and forwarded to the appropriate Provider Relations Representative for follow-up.

Reconsiderations can be submitted in writing to:

Humana
Provider Reconsideration
P.O. Box 14359
Lexington, KY 40512-4359

### Reconsideration decisions

You can expect to receive a written resolution to your reconsideration request no later than 30 calendar days from submission. The reconsideration resolution will provide details on the determination and outline how you can appeal to DMAS if you remain dissatisfied with the outcome.

## Provider appeals to DMAS

Medicaid providers have the right to appeal adverse decisions to DMAS. However, Humana' internal reconsideration process must be exhausted prior to a provider filing an appeal with the DMAS Appeals division. All provider appeals to DMAS must be submitted in writing and within 30 calendar days of Humana' last date of denial. You can find instructions for submitting an appeal on **DMAS' website**.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth Code 2.2-4000 et seq. and 12 VAC 30-20-500 et seq. There are 2 levels of sequential administrative appeal, the informal appeal and the formal appeal.

- The informal appeal decision will be issued within 180 calendar days of receipt of the notice of informal appeal. If the informal appeal decision is adverse to, you have the right to file a formal appeal with DMAS within 30 calendar days of your receipt of the DMAS informal appeal decision.
- The formal appeal shall identify each adjustment, patient, service date or other disputed matter you are appealing. Failure to file the formal appeal within the timeliness standard will result in an administrative dismissal. The hearing officer for the formal appeal will submit a recommended decision to the DMAS director with a copy to the provider within 120 calendar days of the filing of the formal appeal notice.

You can obtain further information on either the informal or formal appeals process by calling DMAS Appeals Division at **804-371-8488** or via email at **appeals@dmas.virginia.gov**.

## Provider complaints

A provider complaint is an expression of provider dissatisfaction about any matter other than an "adverse action." Possible subjects for complaints include, but are not limited to, claims or service authorization processing time, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Humana representative or failure to respect the member's

grievance. If you would like to submit a complaint, you can call Provider Services at **844-881-4482**, email **VAMedicaidProviderRelations@humana.com** or contact your Provider Relations representative.

- Verbal complaints are acknowledged over the phone.
- Written complaints are acknowledged within 7 business days of the complaint date.

Complaints will be resolved within 30 calendar days via written resolution.

## Overview of member grievances and appeals

This section outlines member grievance and appeal rights. This information is supplied so you can assist Humana members in this process, should they request it. You may assist members in filing a grievance or appeal when the member provides written consent. Please contact your Provider Relations representative if you have any questions about this process.

Humana provides appeal and grievance forms and/or written procedures to members or providers who wish to register written appeals or grievances. The member internal appeals process allows for expedited appeal decisions for members within 72 hours from receipt of the appeal request.

Members can call Member Services at **844-881-4482**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time to file a grievance or appeal. To file a grievance or appeal in writing, the member may send a letter to:

Humana
Grievances and Appeals
P.O. Box 14163
Louisville, KY 40512-4163

The grievance or appeal should include:

- Member's name, address, telephone number and Humana ID number
- Facts and details regarding the issue and the requested outcome
- The member's signature and date

Members can request assistance from Member Services, ombudsmen and independent advocacy services when filing grievances and appeals. A provider or other authorized person can also help the member during the grievance or appeal process.

## Member grievances

A member, an attorney or a member's authorized representative (e.g., provider, family member) acting on behalf of the member can file a grievance at any time, either orally or in writing. With the exception of an attorney, an authorized representative must have the member's written consent to file a grievance. Humana acknowledges receipt of each grievance. Grievances received orally may be acknowledged orally, though the resolution will be provided in writing.

### Resolution time frames

Humana resolves grievances and provides notice as expeditiously as the member's health condition requires, within state established time frames not to exceed 90 calendar days from the date Humana receives the grievance. If DMAS requires a member to seek redress through Humana' grievance system before DMAS makes a decision on the member's request for disenrollment, then Humana will complete review of the grievance in time to permit the disenrollment to be effective no later than the first day of the second month following the month in which the member requests disenrollment or Humana refers the request to DMAS.

### Determinations

In any case where the reason for the grievance or appeal involves clinical issues or is related to the denial of a request for an expedited resolution of an appeal, the decision makers are healthcare professionals with the appropriate clinical expertise in treating the member's condition or disease. Humana ensures that neither the individual nor a subordinate of any such individual who makes decisions on grievances or appeals was involved in any previous level of review or decision-making. Decision makers on member grievances and appeals consider all comments, documents, records and other information submitted by the member or the member's authorized representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

## Internal member appeals with Humana

Humana has only 1 level of appeal for members. A member, member's attorney or member's authorized representative (e.g., provider, family member) acting on behalf of the member wanting to appeal an adverse benefit determination can file an appeal, either orally or in writing, with Humana within 60 calendar days from the date on the notice of adverse benefit determination.

When processing an appeal, Humana will:

- Acknowledge the receipt of each appeal
- Provide the member a reasonable opportunity to present evidence and allegations of fact or law in-person as well as in writing. There is a limited time available for this, especially in the case of expedited resolution
- Provide the member and their representative the member's case file upon request, including medical records, other documents and records and any new or additional evidence considered, relied upon or generated by Humana or at the direction of Humana in connection with the appeal of the adverse benefit determination. This information will be provided free of charge and sufficiently in advance of the resolution time frame for standard (30 calendar days) and expedited (72 hours) appeals
- Consider the member, the member's representative or the estate representative of a deceased member as parties to the appeal

## Resolution time frames

Humana responds in writing to standard appeals as expeditiously as the member's health condition requires, not exceeding 30 calendar days from the initial date of receipt of the appeal. Humana may extend this timeframe by up to 14 calendar days if the member requests the extension or if we provide evidence satisfactory to DMAS that there is a need for additional information and that a delay in rendering the decision is in the member's interest.

If Humana extends the timeframe for an appeal not at the request of the member, Humana makes reasonable efforts to give the member prompt oral notice of the delay. In addition, Humana resolves the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. Within 2 calendar days, Humana gives the member written notice of the reason for the decision to extend the time frame and informs the member of the right to file a grievance if they disagree with that decision.

## Expedited appeals

Humana has an expedited review process for appeals when it is determined (with respect to a request from the member) or a provider indicates (when making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain or regain maximum function. Humana does not require a member—or a provider acting on behalf of a member—to follow an oral request for an expedited appeal with a written, signed appeal. Punitive action will not be taken against a provider who requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal is decided according to the time frame for standard resolution of appeals, and the member is given prompt oral notice of the denial. Within 2 calendar days of the oral notice of denial, the member is sent written notice of the reason for the decision to deny the request for an expedited appeal and informed of the right to file a grievance, if the member disagrees with that decision.

## Notice of resolution

Humana provides written notice and makes reasonable efforts to provide oral notice of the resolution of an expedited appeal within 72 hours from the initial receipt of the appeal. Humana may extend the time frame for expedited or standard appeals by up to an additional 14 calendar days, if the member requests the extension or if Humana provides evidence satisfactory to DMAS that there is a need for additional documentation and that a delay in rendering the decision is in the member's interest. For any extension not requested by the member, Humana makes reasonable efforts to give the member prompt oral notice of the delay and written notice within 2 calendar days of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if they disagree with that decision. Humana resolves appeals as expeditiously as the member's health condition requires and no later than the date the extension expires.

All Humana determinations on internal appeals are provided in writing and include the following information:

- The decision reached by Humana, including a specific discussion of the reason for any adverse benefit determination (specific to the member and the request), including citations of the policies, procedures and/or authority that support the decision;
- The date the member's appeal request was received;
- The date of the decision; **and**
- For appeals not resolved wholly in favor of the member:
  - The right to request an appeal of Humana' final denial through DMAS' State Fair Hearing process. The final denial letter clearly identifies that Humana' appeal process has been exhausted and includes the time frame for filing an appeal to DMAS, the submission methods and related address and phone numbers to file an appeal and lists pertinent statutes/regulations governing the appeal process;
  - The right to request an expedited state fair hearing, when taking the time for a standard appeal resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function and how to request it;
  - The right to request to receive benefits while the state fair hearing is pending and how to make the request, explaining that, the member may be held liable for the cost of those services if the state hearing decision upholds Humana' decision, to the extent that services were furnished or continued solely because of the requirements of this section;
  - A list of titles and qualifications, including specialties, of individuals participating in the appeal review;
  - The right to be represented by an attorney or other individual; **and**
  - Information on how to contact the Office of the State Long-Term Care Ombudsman, Department for Aging and Rehabilitative Services.

Members have the right to appeal Humana' appeal decision upholding its adverse benefit determination to DMAS by requesting a state fair hearing. However, Humana' appeal process must be exhausted or deemed exhausted due to Humana' failure to adhere to the notice and timing requirements prior to a member filing an appeal with DMAS' Appeals Division. The final appeal decision issued by Humana states the internal appeals process has been exhausted and provides state fair hearing or appeal information to DMAS. Denials of benefits offered by Humana that are not included under the state plan and not included in the capitation rate calculation are not appealable to a state fair hearing.

## State fair hearings

DMAS' member appeals, called state fair hearings, are conducted in accordance with 42 CFR §431 Subpart E and DMAS' Client Appeals regulations at 12 VAC 30-110-10 through 12 VAC 30-110-370. Adverse benefit determinations include reductions in service, suspensions, terminations and denials. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" is not an adverse benefit determination. Furthermore, Humana' denial of payment for Medicaid-covered services and failure to act on a request for services within required time frames can be appealed.

### Requesting a state fair hearing

Standard appeals can be requested orally or in writing to DMAS by the member or the member's authorized representative. Expedited appeals can be filed by telephone or in writing. The appeal can be filed at any time after Humana' internal appeal process is exhausted but must be requested no later than 120 calendar days from the date on Humana' appeal decision letter.

### State fair hearing time frames

Appeals to DMAS that do not qualify as expedited are resolved or a decision is issued by DMAS within 90 calendar days from the date the member filed the internal appeal with Humana. This time frame does not include the number of days the member subsequently took to file for a state fair hearing. The timeline for resolution or issuance of a decision in state fair hearing appeals may be extended for delays not caused by DMAS. Appeals to DMAS that qualify as expedited appeals are resolved within 72 hours or as expeditiously as the member's condition requires.

### State fair hearing decisions

DMAS' appeal decision is based on the totality of the documents submitted during the appeal, even if the documents were not available for review during the initial request.

If the appeal decision reverses a decision to deny, limit or delay services where such services were not furnished while the appeal was pending, Humana authorizes the disputed services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from the date Humana receives the notice reversing the decision. If the appeal decision reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, Humana pays for those services.

If the appeal decision remands the case back to Humana, Humana will follow the remand instructions, after which it will promptly issue a written notice to the member.

DMAS' final administrative appeal decision can be appealed through the court system by the member. However, the court review is limited to legal issues only. No new evidence is considered.

## Continuation of services

A member can request continuation of services during Humana' internal appeal and DMAS' State Fair Hearing. A determination on continuation of services will be made in accordance with 42 CFR § 438.420 and the regulations governing the managed care program. If the determination is made to continue benefits, Humana continues the member's benefits so long as all the requirements of 42 CFR § 438.420(b) are met. If the final resolution of the appeal upholds Humana' action and services to the member were continued while the internal appeal or state fair hearing was pending, Humana may recover the cost of the continuation of services from the member, in accordance with DMAS' policies on recovery.

# Chapter 16: Credentialing and Recredentialing

## Credentialing overview

Credentialing is the process of collecting, assessing and validating the qualifications and appropriateness of a provider to join Humana' network. Humana conducts credentialing and recredentialing activities utilizing guidelines established by the NCQA as required by DMAS. Humana credentials and recredentials all licensed independent providers including physicians, nonphysicians and organizational providers with whom it contracts and who fall within its scope of authority and action. A senior clinical staff person is responsible for oversight of the credentialing and recredentialing program. All providers requiring credentialing should complete the credentialing process prior to appearing in the provider directory. All credentials must be current at the time of the credentialing committee decision.

Humana credentials and recredentials providers for each of the following provider types:

- Acute care
- Primary care
- Mental health
- SUD treatment
- LTSS

Prior to consideration for eligibility in Humana, all providers must initiate enrollment through the **DMAS Provider Services Solution (PRSS) Enrollment Wizard**. PRSS refers to the Virginia Department of Medicaid's comprehensive information collected for all enrolled providers used to support the claims processing, management reporting and surveillance and utilization review functions of the healthcare plan.

1. All providers must initiate enrollment through the Virginia DMAS PRSS Enrollment Wizard. If you haven't already done so, complete enrollment on the **MES website**.
2. When you indicate interest in becoming contracted with Humana within the MES provider enrollment portal, Humana will retrieve your credentialing application from the MES portal and acknowledge receipt of your application within 10 days.
3. Certain documents are required when submitting an enrollment application for MCO credentialing. Details for each provider type, including a list of which documents are required, can be found under "Submitting your credentialing application." Your application will be reviewed for completeness. If an application is determined to be incomplete, Humana will notify you what is missing within 30 days from receipt of the application.

4. Humana will make a credentialing decision to approve or deny a new applicant's application within 60 days of receiving a complete application.
5. Providers receive a credentialing decision letter from Humana, notifying that credentialing process is complete.

## Key contacts for PRSS and MES Provider Portal support

PRSS training resources are available at **https://vamedicaid.dmas.virginia.gov/training**.

For questions related to training, please email **DMAS_VA_MESregistrations@briljent.com**.

For questions about the PRSS portal, please call the Virginia Medicaid Provider Enrollment Helpdesk at **804-270-5105** or **888-829-5373** or email **vamedicaidproviderenrollment@gainwelltechnologies.com**. Find training on how to use the PRSS portal at **https://vamedicaid.dmas.virginia.gov/training/providers** under "How to Use the Provider Portal."

## Individual provider credentialing

### Required information for individual provider credentialing

All providers must initiate enrollment with Virginia DMAS. Providers must complete the Virginia DMAS provider enrollment process at **https://vamedicaid.dmas.virginia.gov/training/providers**.

### Council for Affordable Quality Healthcare (CAQH) application for individual providers

Humana is a participating organization with CAQH. Prior to indicating interest in becoming contracted with Humana within the PRSS portals, providers should ensure Humana is able to access their credentialing application by completing the following steps:

1. Sign on to the CAQH website using your account information.
2. Select the Authorization tab.
3. Confirm Humana is listed as an authorized health plan; if not, please check the authorized box to add.

An up-to-date CAQH application, with status of complete or re-attested and access granted to Humana, is required. Information supplied must be complete and current on the credentialing application, including but not limited to:

- Practicing specialty
- NPI
- Contact name and email address used for credentialing purposes
- Current practice address, including suite number and fax number if applicable
- Licensure information for each state in which the provider provides care, as applicable by provider type
- Certification for specialized services, as applicable (e.g., EIS)

- Current Drug Enforcement Administration (DEA)/Controlled Dangerous Substance (CDS) certification information for each state in which the provider provides care, as applicable by provider type
- Hospital privileges or coverage arrangements, as applicable by provider type
- Work history with at least 5 years of continuous work history experience

The following supporting documentation should be included in a provider's CAQH application:

- Proof of current malpractice insurance with the minimum amount in accordance with state laws in which the provider provides care
- Summary of professional liability claim(s) pending or filed against the provider within the previous 5 years
  - Please include date of occurrence, summary of events, present status of the claim and amount paid, if applicable.
- Disclosure of ownership form

Failure to submit a complete application will result in a delay in completing or beginning the credentialing process. If Humana receives an incomplete application, we will notify the provider regarding what is missing within 30 days from receipt of the application.

## Credentialing/assessment and recredentialing/reassessment overview

### Medical and behavioral health: individual providers

The following section contains additional information regarding Humana' credentialing process for medical and BH providers, including an overview of provider types requiring credentialing/certifications, elements evaluated as part this process, overview of delegated credentialing requirements and disclosure of certain provider rights and responsibilities.

Evaluating providers included within the scope of credentialing for the Humana network includes, but is not limited to:

**Physical health providers**

- Physicians (M.D./D.O.)
- Oral surgeons
- Chiropractors
- Podiatrists
- Allied health providers
  - Advanced practice registered nurses (APRN)
  - Clinical nurse specialists (CNS)
  - Certified nurse midwives (CNM)
  - Physician assistants (PA)
- Dentists
- Optometrists
- Genetic counselors
- Registered dieticians

- Therapists
  - Speech language pathologists
  - Occupational
  - Physical
  - Audiologists
- Other medical providers who may be within the scope of credentialing and who are licensed, certified or registered by the state to practice independently or as required by state regulations. This category includes doctor of pharmacy providers who practice within a medical office setting, early intervention service providers and community doulas.

**BH providers**

- Psychiatrists and other physicians
- State-licensed doctoral or master's-level psychologists
- Licensed health service provider in psychology
- Licensed independent practice school psychologist
- State-licensed master's-level clinical social workers
- State-licensed master's-level clinical nurse specialists or psychiatric nurse practitioners
- State-licensed substance abuse treatment practitioners
- State-licensed master's-level licensed marriage and family therapists
- State-licensed master's-level mental health counselors
- Applied behavioral analysis therapists
- Other BH specialists who may be within the scope of credentialing and are licensed by the state to practice independently or as required by state regulations

The elements Humana uses to evaluate providers during credentialing and recredentialing include:

- **Credentialing application:** Signed and dated CAQH credentialing application, including supporting documents, signature not more than 120 days from the date inserted in the signature block
- **Licensure:** Unrestricted license issued by the appropriate licensing board for all states in which the provider offers services to members
- **DEA and/or a controlled substance registration:**
  - Unrestricted DEA in the practicing state, as applicable;
  - Unrestricted controlled substance registration (CSR) certificate issued by the state pharmaceutical licensing agency, as applicable
  - If the provider states in writing they do not prescribe controlled substances and that, in their professional judgment, the patients receiving their care do not require controlled substances, they are not required to have a DEA/CSR certificate; but providers must describe their process for handling instances when a patient requires a controlled substance.

- **Education and training**:
  - Successful completion of all training programs pertinent to one's practice
    - For M.D.s and D.O.s, successful completion of residency training pertinent to the requested practice type
    - For chiropractors, proof from a chiropractic college and completion of Doctor of Chiropractic medicine
    - For podiatrists, proof of graduation from podiatry school and completion of residency program for Doctor of Podiatric medicine
    - For APRNs, proof of graduation from an accredited master's degree program
    - For PAs, proof of graduation from an accredited master's degree program
    - For dentists and other providers who require or expect special training for requested services, successful completion of training program
- **Board certification:** Proof of board certification if the provider's application states they are board certified
- **Admitting privileges:**
  - Provider holds current clinical privileges in good standing at a participating facility, as applicable
  - If the provider does not hold admitting privileges, the provider must have an explanation of admitting arrangements applicable to their area of care.
- **Work history:**
  - Work history that includes a minimum of 5 years via curriculum vitae (CV) or included on the application
  - Explanation of gaps of 6 months or more
- **Malpractice insurance:** Current malpractice insurance coverage at the minimum amount in accordance with state laws in which the provider provides care
- **Malpractice history:** Explanation detailing all pending professional liability claims and claims resulting in settlements or judgments paid by or on behalf of the provider
- **NPI:** Provider must have an NPI verifiable via the National Plan and Provider Enumeration System (NPPES)
- **Virginia DMAS enrolled provider:**
  - MES provider enrollment portal
  - PRSS file
- **In good standing with regulatory agencies**
  - Providers or agents or managing employees of providers, are in good standing with and not debarred, suspended or otherwise excluded by federal, state or local agencies including:
    - Medicaid agencies, including the DMAS Public Record Search: **https://vamedicaid.vaxix.net/Search**

  - Medicare intermediaries, including:
    - CMS Medicare preclusion list
    - Health and Human Services – Office of Inspector General's List of Excluded Individuals/ Entities (LEIE)
    - General Services Administration (GSA)/System for Award Management (SAM)
    - State sanctions and restrictions on licensure
    - To the extent applicable, NPPES
    - Office of Foreign Assets Control (OFAC)
    - Social Security Administration Death Master File (SSADMF)
- **Performance indicators:** For recredentialing purposes only
  - Provider should demonstrate an acceptable performance record related to Humana members with no evidence of quality issues.
- **Demographics:** Verification providers are appropriately linked to group(s), as applicable and are enrolled at the appropriate service locations.
- **Disclosure of Ownership:**
  - CMS disclosure form CMS 1513
  - Virginia Department of Medicaid Services Disclosure of Ownership and Control Interest Statement
  - Humana' disclosure of ownership, business transactions and exclusions statement for providers

## Medical and behavioral health: hospital and ancillary providers

Evaluating providers included within the scope of credentialing for the Humana network includes, but is not limited to:

- Ambulatory surgical centers
- Birthing centers
- Clinical laboratories
- CSBs
- Dialysis centers/end-stage renal disease clinics
- DME/home medical equipment providers
- Federally qualified health centers (FQHCs)
- Health departments
- Hearing aid dealers
- Home health agencies
- Home infusion
- Hospice providers
- Hospitals
- Local education agencies (LEA)
- Local lead agencies
- Mobile X-ray clinics/freestanding X-ray clinics
- Outpatient physical therapy and speech pathology facilities
- Pharmacies
- Rehabilitation facilities/comprehensive outpatient rehabilitation facilities (CORF)
- Rural health clinics
- Skilled NFs/extended care facilities

Behavioral healthcare facilities providing mental health or substance abuse services in an inpatient, residential/extended care facility and ambulatory settings, including:

- Ambulatory detox
- Community mental health centers
- Crisis stabilization units
- Foster care homes
- Intensive outpatient programs
- Office-based opioid treatment programs (OBOT)
- Opioid treatment programs (OTP)
- Mental health services facilities
- Partial hospitalization
- Psychiatric residential treatment facilities
- SUD residential treatment facilities

The following elements are evaluated when credentialing and recredentialing organizational providers:

- **Organizational enrollment form:** Complete organizational assessment form
- **Licensure/Business License/Permit, as applicable:** As required by state, federal and local regulatory bodies in which the provider is currently licensed
  - Organizations requiring licensure must be in good standing with the appropriate licensing board.
- **Insurance coverage:** Current general/comprehensive/malpractice liability insurance coverage or participation in Federal Tort Program as applicable per state requirements
- **Eligible for Medicaid:** Provider demonstrates current eligibility for participation in Medicaid
  - Provider must be Virginia DMAS enrolled
  - Provider must not be sanctioned, excluded or debarred from participation in any Medicaid program
- **Eligible for Medicare:** Provider demonstrates current eligibility for participation in Medicare, as applicable
  - Must not be sanctioned, excluded or debarred from participation in Medicare
  - Verification the Provider has not opted-out of participation with Medicare
  - Verification the Provider does not appear on the CMS preclusion list
- **Free from sanctions, exclusion or debarment:** Verification the provider has not been sanctioned, excluded or debarred by the Office of the Inspector General (OIG), the System for Award Management (SAM) or any other disciplinary action by any federal, state or local entity identified by CMS
- **Clinical Laboratory Improvement Amendments (CLIA):** Verification that all independent laboratories and organizations billing for lab services meet CLIA regulations defined in 42 CFR 493.1809
- **On-site quality assessment:** Provider must supply evidence an on-site quality assessment has been conducted, as applicable.
  - Accreditation body – The organizational provider must supply a copy of the accreditation report or evidence from the Accreditation Body the Provider is accredited.
  - CMS or state quality review – If an organizational provider is not accredited, Humana may substitute a CMS or state review in lieu of performing its own onsite quality assessment.

Humana will verify an onsite quality assessment has been completed by a state agency or CMS by obtaining the assessment report or certification letter. The CMS or state review may not be more than 3 years old at the time of verification.

- Quality review conducted by Humana – If the CMS or state review is older than 3 years, Humana will conduct its own onsite quality review. If the state of CMS has not conducted a site review of the provider and the provider is in a rural area (as defined by the U.S. Census Bureau), Humana may choose not to conduct a site visit.

  **Note:** The Provider Office and Facility Location Survey tool is used in cases where a site visit is required.

- **NPI:** Provider must have an NPI verifiable via the National Plan and Provider Enumeration System (NPPES).
- **Disclosure of Ownership:**
  - Providers must comply with federal requirements on disclosure reporting to business transaction reporting and the full ownership and control information required as required by 42 CFR Part 455.
  - Humana will collect, store information disclosed in a searchable database, monitor individuals and entities disclosed in addition to the provider for adverse actions or offenses, take action as appropriate and report identified occurrences and actions to the state.
  - Acceptable forms to supply for disclosure of ownership, include:
    - CMS Disclosure Form CMS 1513
    - Humana' disclosure of ownership, business transactions and exclusions statement for providers
    - Department of Medicaid Assistance Services Disclosure of Ownership and Control Interest Statement
- **Performance indicators:** For recredentialing purposes only, providers should demonstrate an acceptable performance record related to Humana members with no evidence of quality issues.
- ARTS attestation and group roster, at initial credentialing and annually thereafter:
  - **ARTS Attestation Form for OBOT programs**
  - **ARTS OBOT Staff Roster**
- ARTS providers offering American Society of Addiction Medicine (ASAM) level of care 2.1 to 4.0:
  - Appropriate license issued by the Department of Behavioral Health & Development Services (DBHDS) for the level of care you are applying for

## Required information for organizational provider credentialing

All organizational providers must initiate enrollment with DMAS. If a provider hasn't already done so, they must complete the DMAS provider enrollment process at **https://vamedicaid.dmas.virginia.gov/training/providers**.

A complete organizational provider assessment application, including supporting documentation, is necessary to assess an organizational provider for network participation. A complete organizational provider assessment form must include:

- The provider's license, as applicable;
  - ARTS providers rendering ASAM level of care 2.1 to 4.0 must supply the appropriate license issued by DBHS for the level of care you are applying for;
- Accreditation letter, as applicable;
- CMS certification, as applicable;
- If not accredited or certified by CMS, evidence an on-site survey has been performed by a state agency within the previous 3 years;
- Malpractice insurance policy face sheet showing effective and expiration dates and limits of liability within amounts at the minimum amount in accordance with state laws in which the organization provides care;
- CLIA, as applicable;
- NPI;
- Disclosure of ownership;
- ARTS attestation and group roster, as applicable;

Failure to submit a complete application will delay Humana' ability to complete or begin the credentialing and contracting process. Organizational providers are notified within 30 days if the credentialing application is determined to be incomplete.

## LTSS providers

All LTSS providers requiring evaluation should complete the assessment process before appearing in the provider directory and provide care to members only after assessment is complete. LTSS providers are reassessed at least every 3 years thereafter.

Providers offering LTSS services must meet the VA DMAS assessment requirements. These services include, but are not limited to:

- Adult day care
- Assistive technology
- Environmental modifications
- Personal care services (skilled and nonskilled services)
- PERS
- Private duty nursing (agency or consumer directed)
- Respite care
- Service facilitation – consumer directed services
- Transition services and transition coordination

**Assessment for providers rendering LTSS services includes:**

- **Enrollment form:** Complete long-term care/HCBS provider assessment form
- **Licensure/business license/permit, as applicable:** Providers requiring licensure must be in good standing with the appropriate licensing board and free from sanction, exclusion or debarment.
- **Eligible for Medicaid:** Provider demonstrates eligibility for participation in Medicaid.
  - Providers must be DMAS enrolled
  - Must not be sanctioned, excluded or debarred from participation in any Medicaid program.
- **Free from sanctions, exclusion or debarment:** Verification the Provider has not been sanctioned, excluded or debarred by the OIG, the SAM or any other disciplinary action by any federal, state or local entity identified by CMS.
- **CLIA:** Verification that all independent laboratories and organizations billing for lab services meet CLIA regulations defined in 42 CFR 493.1809
- **NPI:** LTSS providers who do not have an NPI must have an atypical provider identifier issued by DMAS.
- **Disclosure of Ownership:**
  - Providers must comply with federal requirements on disclosure reporting to business transaction reporting and the full ownership and control information required as required by 42 CFR Part 455.
  - Humana will collect, store information disclosed in a searchable database, monitor individuals and entities disclosed in addition to the provider for adverse actions or offenses, take action as appropriate and report identified occurrences and actions to the state.
  - Acceptable forms to supply for disclosure of ownership, include:
    - CMS Disclosure Form CMS 1513
    - Humana' disclosure of ownership, business transactions and exclusions statement for providers
    - DMAS Disclosure of Ownership and Control Interest Statement
- **Performance indicators:** For recredentialing purposes only, provider should demonstrate an acceptable performance record related to Humana members with no evidence of quality issues. Individual Experience Survey (IES) is considered.

## Required information for LTSS provider credentialing

All providers offering LTSS services must initiate and complete enrollment with DMAS. If a provider hasn't already done so, they must complete the DMAS provider enrollment process at **https://vamedicaid.dmas.virginia.gov/training/providers**.

A complete LTSS provider assessment application, including supporting documentation, is necessary to assess a provider offering LTSS services for network participation. A complete LTSS provider assessment form must include:

- The provider's license, as applicable;
- Accreditation letter, as applicable;

- CMS certification, as applicable;
- Malpractice insurance policy face sheet showing effective and expiration dates and limits of liability within amounts at the minimum amount in accordance with state laws in which the organization provides care;
- CLIA, as applicable;
- NPI or atypical identifier issued by VA DMAS;
- Disclosure of ownership

Failure to submit a complete application will delay Humana' ability to complete or begin the credentialing and contracting process. LTSS providers are notified within 30 days if the credentialing application is determined to be incomplete.

## Ownership and control disclosure

All providers will be required to notify Humana on ownership and control for the following instances:

- Within 5 days prior to any change in ownership, concerning each person with ownership or control interest;
- When a provider or disclosing entity submits a provider application
- When a provider or disclosing entity executes a provider agreement with DMAS;
- Upon request of the DMAS during the revalidation of the provider's enrollment under §455.414; **and**
- Within 5 days prior to any change in ownership of a disclosing entity. The disclosure includes:
  - The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include as applicable primary business address, every business location and P.O. Box address.
  - Date of birth and Social Security number (in the case of an individual).
  - Other TIN (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has 5% or more interest.
  - Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5% or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child or sibling.
  - The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.
  - The name, address, date of birth and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

## Provider rights related to credentialing

Notification of provider rights is contained in the Provider Manual for Physicians, Hospitals and Other Healthcare Providers at **Humana.com/Publications**. Providers have the right to review information obtained to evaluate their credentialing application, attestation or CV and the right to correct erroneous information. Humana notifies providers when credentialing information obtained from other sources varies substantially from information provided by the provider. The provider should be notified within 7 days of the discrepancy. The notification indicates which part of the application is discrepant, the format for submitting corrections and the person to whom corrections should be submitted. If the application, attestation and/or CV must be updated, only the provider can attest to the update, a staff member cannot. The provider has 14 business days to respond to resolve the discrepancy. The receipt of any corrections should be documented in the credentialing file.

A provider has the right, upon request, to be informed of the status of their application. Humana responds to these requests in a timely manner. Once a provider application for initial credentialing has been approved or denied, the provider should be notified within 60 days. Credentialing denials will be communicated to the provider by the medical/dental director in writing, will include the reason(s) for the denial and should be provided within 60 days of denial.

Humana will make available all application and verification policies and procedures upon written request from the applying healthcare professional.

## Provider monitoring

Network providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. Humana initiates immediate action in the event the participation criteria are no longer met. Network providers are required to inform Humana of changes in status, including but not limited to, involvement in a medical malpractice suit; involuntary changes in hospital privileges, licensure or board certification; an event reportable to the National Practitioner Data Bank; federal, state or local sanctions; or member complaints.

## Reconsideration of credentialing/recredentialing decisions

Humana' Credentials Committee must notify a provider of a denial based on credentialing/certification criteria. The notice must inform the provider of the reasons for the denial and, in the case of a denial based on credentialing/certification criteria eligible for Credentials Committee reconsideration, provide notice of such opportunity to request reconsideration of the decision in writing within 30 days of the notice or sooner, as required by state or federal regulations. Unless otherwise noted, denials based on a failure to meet administrative criteria are final with no reconsideration rights. Where applicable, in the event such reconsideration is requested in a timely manner, the Credentials Committee may affirm, modify or reverse the initial decision. Humana notifies the applicant in writing of the Credentials Committee's reconsideration decision within 60 days. Providers who have been denied are eligible to reapply for network participation once they meet

the minimum health plan credentialing/certification criteria. To submit a reconsideration request, mail the reconsideration request, including all additional supporting documentation, to the medical director at:

**Humana**
Attn: Shoba Srikantan, M.D.
101 E. Main St.
Louisville, KY 40202

**Please note:** Providers who have denials due to missing DEA and/or proof of hospital privileges have 30 business days from the notification date to provide the missing documentation to Humana for review as a Category I file.

After reconsideration, the Credentials Committee may affirm, modify or reverse its initial decision. Humana notifies the applicant, in writing, of the Credentials Committee's reconsideration decision within 60 days. Reconsideration denials are final unless the decision is based on quality criteria; in those instances, a provider has the right to request a fair hearing. Providers who were denied are eligible to reapply for network participation once they meet Humana' minimum credentialing/certification criteria.

## Delegation of credentialing/recredentialing (applicable to medical and BH providers only)

Humana may delegate credentialing and recredentialing activities to organizations or entities that are able to demonstrate compliance with federal, state and accreditation requirements such as NCQA's. Humana retains the right to approve, suspend and terminate providers and sites where it has delegated decision-making.

When Humana elects to delegate credentialing and/or recredentialing, an approved written agreement outlining those delegated activities and any other responsibilities of the delegate should be signed before the delegate performs any delegated activities. The written agreement should be mutually agreed upon and contain:

- Humana' responsibilities, along with those of the delegated entity
- Description of the delegated activities
- Required minimum of semiannual reporting to Humana
- Process by which Humana evaluates the delegate's performance
- Remedies, including revocation of the delegation agreement, available to Humana if the delegated entity does not fulfill its obligations
- A statement that Humana retains the right to approve, suspend and terminate providers and sites where it has delegated decision-making

Prior to implementing delegation, the delegate's performance capacity is evaluated through the pre-delegation audit process to ensure the entity demonstrates compliance with the applicable federal, state and accreditation requirements. Once the delegation agreement is executed, the delegate's performance is evaluated annually to ensure the delegated entity remains compliant with applicable federal, state and accreditation requirements. Opportunities for improvement should be identified and followed up on at least once every 2 years.

If a delegate subdelegates credentialing to another entity, documentation verifying the delegate performs oversight and conducts annual audits is required, unless Humana chooses to conduct these activities itself. Complete listings of all providers credentialed and/or recredentialed are due from the delegate on a semiannual basis and reviewed by Humana.

# Chapter 17: Fraud, Waste and Abuse

## Fraud, waste and abuse overview

Fraud is generally defined as knowingly and willfully executing or attempting to execute a scheme or artifice to defraud any healthcare benefit program, or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by or under the custody or control of any healthcare benefit program. Fraud also includes any act that constitutes fraud under applicable federal or state law.

Waste is overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the healthcare system. Generally, waste is not considered a criminally negligent action but rather misuse of resources. However, patterns of repetitive waste, particularly when the activity persists after the provider has been notified the practice is inappropriate, may be considered fraud or abuse.

Abuse is payment for items or services when there is no legal entitlement to that payment and the individual or entity has not knowingly and/or intentionally misrepresented facts to obtain payment. Provider abuse is inconsistent with sound fiscal, business or medical practices. It also includes member practices that result in unnecessary cost to the Medicaid program.

For more information on annual training requirements related to fraud, waste and abuse, please review the **Provider training section of this provider manual**.

## Reporting fraud, waste and abuse

If you suspect fraud, waste or abuse in the healthcare system, you must report it to Humana and Humana will investigate. You have the option for your report to remain anonymous. To report suspected fraud, waste or abuse, contact Humana through 1 of the following methods:

- Special Investigations Unit (SIU):
  - Hotline: **800-614-4126**, Monday – Friday, 8 a.m. – 4 p.m., Eastern time, with voicemail access 24 hours a day, 7 days a week
  - Fax: **920-339-3613**
  - Email: **SIUReferrals@humana.com**
  - Mail: **Humana**
    Special Investigations Unit
    1100 Employers Blvd.
    Green Bay, WI 54344

– Special Investigations Referral Form Online: **Humana.com/legal/si-referral-form**

You can also report suspected fraud, waste or abuse through the Ethics Help Line. The Ethics Help Line is a tool created by NAVEX, a third-party vendor, to provide a confidential and anonymous way to report suspected violations and to get answers to questions about specific situations. It is available 24 hours a day, 7 days a week and is staffed by trained, external non-Humana associates. To report suspected fraud, waste or abuse through the Ethics Help Line, call **877-5-THE-KEY (877-584-3539)** or visit **www.ethicshelpline.com**.

You also can report suspected fraud, waste or abuse to the DMAS Fraud & Abuse Referral Hotline at **866-486-1971** or via email to **recipientfraud@dmas.virginia.gov**.

## Post-payment reviews

Humana or its designee conducts post-payment reviews of healthcare providers' records related to services rendered to Humana members. Post-payment reviews involve subjecting claims for services to evaluation after the claim has been adjudicated. During such reviews, you are asked to allow Humana access to the medical record and billing documents that support the charges billed. Post-payment reviews look for overutilization of services or other practices that directly or indirectly result in unnecessary costs. These reviews may result in claim reversal or partial reversal and claim payment recovery.

## Prepayment reviews

Humana or its designee conducts prepayment reviews of healthcare providers' records related to services rendered to Humana members. Prepayment review is a process in which Humana pends payment of a claim and then requests and reviews medical record documentation to support the billed claim prior to releasing the claim for payment. A healthcare provider's order must be present to support all charges, along with clinical documentation to support the diagnosis and services or supplies that were billed. Prepayment reviews look for overutilization of services or other practices that directly or indirectly result in unnecessary costs.

## Exclusion monitoring

Humana monitors provider sanctions, complaints and quality issues between credentialing cycles and ensures corrective actions are taken to address occurrences of poor quality. Providers are required to meet all state and federal participation statutes and requirements and should be aware of federal requirements regarding providers and entities excluded from participation in federal healthcare programs (including Medicare, Medicaid and CHIP programs) and the Federal Health and Human Services – Office of Inspector General online exclusions database. Humana is prohibited from contracting with providers who have been terminated from the Medicaid program by DMAS for fraud, waste and abuse, have been excluded from participation in federal healthcare programs or who have a relationship with excluded providers. Humana will initiate immediate action if the participation criteria are no longer met.

Humana performs ongoing monitoring and appropriate interventions, including removal from the network, by collecting the following information and taking steps to remove providers upon identification of the adverse action(s):

- Medicare and Medicaid sanctions and exclusions, including the DMAS Public Record Search: **https://vamedicaid.vaxix.net/Search**
- List of Excluded Individuals and Entities (LEIE)/OIG
- Excluded Parties List System (EPLS)/SAM
- Sanctions or limitations on licensure
- Complaints
- Identified Adverse Event
- To the extent applicable, NPPES
- Office of Foreign Assets Control (OFAC)
- Social Security Administration Death Master File (SSADMF)

If you discover any exclusion information, you should immediately report this information to Humana at **844-881-4482**.

## Federal fraud, waste and abuse legislation

**False Claims Act (FCA) – 31 (U.S.C.) 3729-3733**

The FCA imposes liability on a person or company who, in connection with government programs including Medicaid, does any of the following:

- Knowingly presents or causes to be presented, a false or fraudulent claim for payment or approval;
- Knowingly makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim;
- Conspires with 1 or more parties to violate any applicable provision of the False Claims Act;
- Has possession, custody or control of property or money used or to be used, by the Government and knowingly delivers or causes to be delivered, less than all of that money or property;
- Is authorized to make or deliver a document certifying receipt of property used or to be used, by the government and, intending to defraud the government, makes or delivers the receipt without completely knowing the information on the receipt is true;
- Knowingly buys or receives as a pledge of an obligation or debt, public property from an officer or employee of the government or a member of the armed forces, who lawfully may not sell or pledge property; **and**
- Knowingly makes, uses or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government.

The FCA allows a person to bring a civil action for a violation of the FCA on behalf of themself and on behalf of the U.S. Government. The action must be brought in the name of the government.

The FCA also has Whistleblower Protection to protect any person who reports suspected fraud, waste and abuse from being retaliated against.

**Anti-Kickback Statute (AKS) – 42 U.S.C. 1320a-7b**

AKS prohibits anyone from knowingly and willingly offering, giving or receiving remuneration (directly or indirectly) in exchange for referrals of healthcare goods or services that will be paid for in whole or in part by Medicaid. The statute has safe harbors, which are specific practices or scenarios that are not subject to criminal or civil prosecution under AKS because they are unlikely to result in an improper inducement for referrals.

**Stark (Physician Self-Referral) Law – 42 U.S.C. 1395 nn**

The Stark Law prohibits a physician from making a referral for certain designated health services payable by Medicaid to an entity in which the physician (or a member of their immediate family) has an ownership or investment interest or with which the provider has a compensation arrangement, unless an exception applies.

**HIPAA**

In addition to establishing privacy, security and breach notification rules, HIPAA also broadened the scope of certain fraud and abuse laws and expanded the authority of the OIG to exclude persons and entities from participating in Medicare and Medicaid programs.

# Chapter 18: Pharmacy

## Prescription drug formulary

In accordance with 42 CFR § 438.10(i), Humana makes the following information available about our formulary in electronic or paper form:

- Which medications are covered (both generic and name brand); **and**
- What tier each medication is on.

Humana' formulary drug lists are available on Humana' website in a machine-readable file and format. This information is available through a central location on Humana' website. It is updated 7 days prior to the effective date of any approved changes to such information.

Humana allows access to all medically necessary nonformulary or nonpreferred drugs, other than those excluded from coverage.

If Humana administers a closed formulary, there is an exception process for circumstances where the formulary does not adequately accommodate members' clinical needs and a process for prescribing practitioners to submit information that supports exception requests.

## Formulary updates

Humana may add or remove drugs from the formulary throughout the year. Humana may also change Utilization Management requirements for covered drugs.

Notification of negative changes to the formulary and Utilization Management requirements are provided to all affected participating providers and members prior to the effective date of the change. Providers can view those changes and the current preferred drug list at **Provider.Humana.com/pharmacy-resources/tools/humana-drug-lists**. To view current medical and pharmacy coverage policies, please visit **Medical and Pharmacy Coverage Policies**.

## Pharmacy exclusions

Humana does not cover the following:

- Drugs used for anorexia or weight gain
- Drugs used to promote fertility
- Agents whose primary purpose is cosmetic, including but not limited to hair growth. Agents used in the treatment of covered gender dysphoria services are not primarily cosmetic

- Agents used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA
- All Drug Efficacy Study Implementation (DESI) drugs as defined by the FDA to be less than effective
- Compound prescriptions that include a DESI drug
- Drugs that have been recalled
- Experimental drugs or non-FDA-approved drugs, except for children and youth covered under EPSDT
- Any legend drugs marketed by a manufacturer that does not participate in the Medicaid Drug Rebate program

## Coverage limitations

Humana limits coverage:

- To a maximum of a 34-day supply of medication per prescription per member in accordance with the prescriber's orders and subject to the Board of Pharmacy regulations, unless otherwise stated below; **and**
- Of select maintenance legend and nonlegend drugs identified in the "DMAS 90 Day Medication Maintenance List" to a maximum of a 90-day supply per prescription per patient after 2 34-day or shorter duration fills.

Additionally, Humana covers prescriptions of contraceptives for up to a 12-month supply for beneficiaries in the Medicaid and CHIP programs.

## Preferred Drug List

The Common Core Formulary is a subset of Humana' formulary that includes all the preferred drugs from DMAS' Preferred Drug List (PDL). Humana may add drugs to the open therapeutic drug classes on DMAS' PDL/Common Core Formulary but will not remove drugs. Humana may also add drugs in therapeutic classes not on the Common Core Formulary.

The PDL identifies covered drugs and associated drug Utilization Management requirements, such as prior authorization, quantity limits, step therapy, etc.

- **Service authorization:** The medication must be reviewed using a criteria-based approval process prior to coverage decision.
- **Step therapy:** The member is required to utilize medications commonly considered first-line before using medications considered second- or third-line.
- **Drug safety limits:** Pharmacies should facilitate the appropriate, approved label use of various classes of medications (e.g., drug-drug interaction, opioid limits and therapeutic duplication).
- **Generic substitution:** Generic drugs should be dispensed when available. If using a particular brand name is determined to be medically necessary, service authorization must be obtained.

## Pharmacy and Therapeutics Committee

Humana and other health plans in the state are required to follow the Common Core Formulary and Utilization Management, which are developed by DMAS' Pharmacy and Therapeutics (P&T) Committee. For drugs in Common Core Formulary open drug classes, Humana reviews changes through Humana' P&T Committee. Humana' P&T Committee ensures safe, appropriate and cost-effective use of pharmaceuticals for Humana members. The P&T Committee serves in an evaluative, educational and advisory capacity to Humana' staff and participating providers in matters including, but not limited to, pharmacy requirements and the appropriate use of medications. Humana' P&T Committee meets at least quarterly and is comprised of physicians and pharmacists holding valid professional licenses. The committee includes at least 1 practitioner in each of the following specialties: pediatrics, gerontology/geriatrics and psychiatry. All individuals participating in the P&T Committee must complete a financial disclosure form annually, which is reviewable by DMAS upon request.

## Utilization Management for medications

Humana accepts telephonic, facsimile or electronic submissions of pharmacy service authorization requests that are delivered from e-prescribing systems, electronic health records (EHRs) and health information exchange platforms that utilize the National Council for Prescription Drug Programs' SCRIPT standards for service authorization requests. Humana has authorization procedures in place to allow you to access drugs outside of the formulary, if medically necessary.

Humana provides responses for all covered outpatient drug authorizations by telephone or other telecommunication device within 24 hours of a request for authorization. If Humana denies a request for service authorization or authorizes a service in an amount, duration or scope that is less than requested, Humana issues a Notice of Adverse Benefit Determination within 24 hours of the denial to the prescriber and the member. The Notice of Adverse Benefit Determination includes appeal rights and instructions for submitting an appeal.

Pharmacy services for children are reviewed in accordance with EPSDT requirements to cover medically necessary drugs based upon a case-by-case review of the individual child's needs, such as for off-label use.

## Requesting coverage determinations

You can request coverage determinations, such as medication prior authorization, step therapy, quantity limits and formulary exceptions, by:

- Obtaining forms at **Humana.com/PA**
- Submitting requests electronically by visiting **www.covermymeds.com/epa/Humana** or **www.availity.com**
- Faxing requests to **888-599-2730**
- Calling Humana Clinical Pharmacy Review (HCPR) at **800-555-CLIN (800-555-2546)**.

To find out which services require authorization, please review the preauthorization and notification lists at **Humana.com/PAL**.

## Emergency supply

A 72-hour emergency supply of a prescribed covered pharmacy service must be dispensed if the prescriber cannot readily provide authorization and the pharmacist, in their professional judgment consistent with the current standards of practice, determines the member's health would be compromised without the benefit of the drug. For unit-of-use drugs (e.g., inhalers, eye drops, insulin), the entire unit should be dispensed for the 72-hour supply.

## Interventions to prevent controlled substance use

You must understand the risk factors for opioid-related harms and provide management plan strategies to mitigate risk, including but not limited to checking the prescription drug monitoring program, benzodiazepine and opioid tapering tools, physician/patient opioid treatment agreements the offering of naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of SUD, higher opioid dosages or concurrent benzodiazepine use, are present.

Appealing adverse decisions regarding medication coverage

If Humana denies the member's coverage determination or formulary exception, you can ask for a review of the decision by making an appeal on behalf of the member. Please review the Member grievances and appeals in this manual or details on how to submit appeals.

## Peer-to-peer discussions

If you prefer to have a discussion with a Humana pharmacist or regional medical director, you may initiate a peer-to-peer request by calling 844-330-7734 and leaving a detailed message, including:

- Name of physician requesting the discussion and contact information (including a call-back number)
- Date and times available—must provide 2 1-hour time frames within the next 2 business days (example: Monday, Dec. 15, 2025, between 3 and 5 p.m., Eastern time.)

Please note, the P2P discussion is not considered part of the appeal process and depending on the outcome, you may still request a formal appeal with written authorization from the member if necessary.

## Pharmacy copayments

Humana does not impose copayments on any covered medications, prescription drugs or drug-related products billed through the pharmacy benefit.

## Network pharmacies

Our pharmacy directory gives providers a complete list of network pharmacies that have agreed to fill covered prescriptions for Humana members. Providers and members can access Humana' Pharmacy Directory at **Humana.com/PharmacyFinder** and members can use the Pharmacy Finder tool by signing in to **MyHumana.com**.

Members have access to Humana' mail-order pharmacy, CenterWell Pharmacy® and other available mail-order options that can be found on Pharmacy finder, which sends medications directly to the member's home. If a specialty medication is required, our specialty pharmacy, CenterWell Specialty Pharmacy®, may be able to assist. For additional information about these options please visit **CenterWellPharmacy.com** or call:

- **CenterWell Pharmacy: 800-379-0092**, Monday – Friday, 8 a.m. – 11 p.m., Eastern time. Saturday, 8 a.m. – 6:30 p.m., Eastern time.
- **CenterWell Specialty Pharmacy: 800-486-2668 (TTY: 711)**, Monday – Friday, 8 a.m. – 11 p.m., Eastern time. Saturday, 8 a.m. – 6:30 p.m., Eastern time.

## Medications administered in the provider setting

Humana covers medications administered in a provider setting, such as a physician office, hospital outpatient department, clinic, dialysis center or infusion center. Utilization Management requirements exist for many injectables. Humana may add or remove drugs from the preauthorization list (PAL) throughout the year. Providers can view those changes and the current PAL at **Humana.com/PAL**.

## Electronic prescribing

Through Humana' participation in the SureScripts® network, Humana' pharmacy benefit manager, eligibility, formulary and member medication history are available through every major EHR or e-prescribing vendor, including Allscripts, Epic, Cerner, athenahealth and DrFirst. Prescribers with EHR or e-prescribing can view real-time clinical information about the formulary, safety alert messaging and service authorization requirements.

## Continuity of care for new members

To ensure continuity of care upon enrollment for newly enrolled members, Humana permits members to continue to receive medications/refills authorized by DMAS (including DMAS' Drug Utilization Review Board) or another DMAS contractor during the continuity of care period. Transitional refills are provided for a minimum of 60 days, but may be provided for up to the duration of the prior service authorization up to a maximum of 12 months, at Humana' discretion, which covers a minimum of 60 days. Additionally, a member who is receiving a prescription drug at the time of enrollment that is not on Humana' formulary or PDL may continue to receive that drug if medically necessary.

## Medication Therapy Management

Humana offers a Medication Therapy Management (MTM) program that helps ensure patients achieve the best possible outcomes from their medications. The patient-centered MTM program promotes collaboration between the pharmacist, patient and prescriber to optimize safe and effective medication use. The goal of this program is to optimize therapeutic outcomes by focusing on safety, effectiveness, lower-cost alternatives and adherence. Prescribers with questions about the program can call Provider Services at **844-881-4482**.

## Over-the-counter health and wellness

Humana members have an expanded pharmacy benefit, which provides a $65/quarter allowance to spend on over-the-counter (OTC) health and wellness items.

Unused OTC allowances do not roll over to the next quarter. These items will be sent by CenterWell Pharmacy and can be submitted by phone, mail or by faxing in the order form to CenterWell Pharmacy. These items will be delivered by FedEx, UPS or the U.S. Postal Service within 10 to 14 working days after the order is made. There is no charge to the member for shipping. An order form and the full list of OTC health and wellness items available for members are available at **Humana.com**.

For questions about this mail-order service, please call: CenterWell Pharmacy at **855-211-8370 (TTY: 711)**, Monday – Friday, 8 a.m. – 11 p.m., Eastern time, and Saturday, 8 a.m. – 6:30 p.m., Eastern time.

## Patient Utilization Management and Safety Program

Humana has a Patient Utilization Management and Safety Program (PUMS) intended and designed to:

- Coordinate care
- Ensure members access and utilize services in an appropriate manner in accordance with all applicable rule and regulations
- Promote proper medical management of essential healthcare
- Limit overuse of benefits and reduce unnecessary costs to Medicaid while providing an appropriate LOC for the member

Members may be placed into a PUMS for 12 months when any of the following triggering events occur:

- Humana' utilization review of the member's past 12 months of medical and/or billing histories indicates the member may be accessing or utilizing healthcare services in excess of what is normally medically necessary, including the minimum specifications found in the **ARTS Technical Manual**;
- At the end of the 12-month period, the member must be re-evaluated by Humana to determine if the member continues to display behaviors or patterns that indicate the member should remain in the PUMS;
- Humana utilizes the Prescription Monitoring Program when evaluating PUMS members; **and**
- Medical providers or social service agencies provide direct referrals to DMAS or Humana.

Once a member meets the PUMS placement requirements, Humana may limit a member to a single pharmacy, PCP, controlled substances prescriber, hospital (for nonemergency hospital services only) and/or, on a case-by-case basis, other qualified provider types as determined by Humana and the circumstances of the member. Humana will limit a member to providers and pharmacies credentialed in the Humana network.

Members receive written notification from Humana stating they meet the criteria for PUMS. They have 15 calendar days of receiving the notification letter to choose a pharmacy and a provider from which to receive services or selections will be made for them. The member will receive a letter that provides:

- Name of the designated provider and/or pharmacy
- Instructions for requesting a change to the designated pharmacy and/or provider
- Reason for restriction
- Effective date of program enrollment
- Length of limitation
- Rights to appeal the decision
- Emergency after-hours prescription instructions

**Note:** Members diagnosed with cancer are exempt from PUMS.

# Chapter 19: Definitions and acronyms

## Definitions

**Abuse, member –** The suspected or known physical or mental mistreatment of a Humana member that must be reported immediately upon discovery.

**Abuse, provider –** Provider abuse occurs when provider practices are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. Abuse also includes member practices that result in unnecessary cost to the Medicaid program.

**Activities of daily living (ADLs) –** Personal care tasks such as bathing, dressing, toileting, transferring and eating/feeding. An individual's degree of independence in performing these activities is a part of determining the appropriate LOC and service needs. Also see instrumental activities of daily living (IADLs).

**Acute care –** Preventive care, primary care and other inpatient and outpatient medical care and behavioral healthcare provided under the direction of a physician for a condition having a relatively short duration.

**Acute care hospital –** Includes acute care hospitals, rehabilitation hospitals, a rehabilitation unit in an acute care hospital or a psychiatric unit in an acute care hospital.

**Addiction and recovery treatment services (ARTS) –** ARTS provide a comprehensive continuum of addiction and recovery treatment based on the ASAM Patient Placement Criteria. This includes:

- Inpatient services to include withdrawal management services;
- Residential treatment services;
- Partial hospitalization;
- Intensive outpatient treatment;
- Outpatient treatment including Medication Assisted Treatment (MAT);
- Substance use case management;
- Opioid use treatment service; **and**
- Peer recovery support services.

Providers will be credentialed and trained to deliver these services consistent with ASAM's published criteria and DMAS' medical necessity criteria using evidence-based best practices including Screening, Brief Intervention and Referral to Treatment (SBIRT) and MAT.

**Adjudicated claim –** A clean claim that has been paid in full, denied in full or denied in part by Humana or its subcontractors. Clean claims are considered to be paid on the date the payment is made via EFT or the date of the postmark on the envelope containing the check. Pended clean claims are not adjudicated.

**Administrative dismissal –** An administrative dismissal is:

- A provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or further informal appeal proceedings; **or**
- A member appeal dismissal made on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from Humana.

**Adoption assistance –** Adoption assistance is a social services program under Title XX of the Social Security Act that provides adoptive parents with the necessary assistance to adopt and care for a child with special needs and who meets eligibility criteria. It does not cover the full cost of raising the child. Rather, it supplements adoptive parents' resources.

**Adult day healthcare –** Adult day healthcare provides long-term maintenance or supportive services in a community-based day care program. It offers a variety of health, therapeutic and social services to meet the specialized needs of waiver individuals who are elderly or who have a disability and are at-risk of placement in an NF.

**Adverse action –** An adverse action is the denial, suspension or reduction in services or the denial or retraction, in whole or in part, of payment for a service already rendered.

**Adverse benefit determination –** An adverse benefit determination for members, pursuant to 42 CFR §438.400, means any of the following:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at 42 CFR §447.45(b) is not an adverse benefit determination
- The failure to provide services in a timely manner, as defined by DMAS
- The failure of Humana to act within the time frames provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals
- For a resident of a rural area with only 1 MCO, the denial of a member's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities

**Agency-directed services –** A model of service delivery where an agency is responsible for providing direct support staff, for maintaining individuals' records and for scheduling the dates and times of the direct support staff's presence in the individuals' homes.

**Alternate formats –** Member information provided in a format helpful to those who, for example, are visually impaired or have limited reading proficiency. Examples of alternate formats include Braille, large font, audio tape, video tape and information read aloud to a member.

**Ameliorate –** To improve a condition or prevent a condition from getting worse.

**American Indian/Alaska Native (AI/AN) –** AI/AN describes an individual, defined at Title 25 of the U.S.C. Sections 1603(c), 1603(f), 1679(b), who has been determined eligible, as an Indian, pursuant to 42 CFR §136.12 or Title V of the Indian Healthcare Improvement Act, to receive healthcare services from Indian Healthcare Providers (Indian Health Services, an Indian Tribe, Tribal Organization, Urban Indian Organization–I/T/U) or through referral under Contract Health Services. Also refer to the population referenced in 42 CFR §438.14.

**Appeal, member –** In accordance with 42 CFR § 438.400, a member appeal is defined as a request to DMAS for a state fair hearing of Humana' internal appeal decision to uphold the contractor's adverse benefit determination. After a member exhausts Humana' one-step internal appeal process, the member can appeal to DMAS. Member appeals to DMAS will be conducted in accordance with regulations at 42 CFR §431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

**Appeal, provider –** A request made by a provider—in- or out-of-network—to review Humana' reconsideration decision in accordance with the statutes and regulations governing the DMAS appeal process. After a provider exhausts Humana' reconsideration process, DMAS affords the provider the right to 2 administrative levels of appeal (informal appeal and formal appeal) with DMAS in accordance with the Virginia Administrative Process Act, Code of Virginia § 2.2-4000 et seq. and DMAS's provider appeal regulations, 12 VAC 30-20-500 et seq.

**Applied Behavior Analysis –** The practice of behavior analysis as established by the Virginia Board of Medicine in § 54.1-2900, defined as the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior. This includes the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

**Assertive community treatment (ACT) –** Intensive nonresidential treatment and rehabilitative mental health services provided in accordance with the fidelity model of ACT. Assertive community treatment provides a single, fixed point of responsibility for treatment, rehabilitation and support needs for clients with serious mental illness (SMI) whose needs have not been met by more traditional service delivery.

**Assess –** To evaluate an individual's condition, including social supports, health status, functional status, psychosocial history and environment. Information comes from the individual, family, significant others and medical professionals, as well as the assessor's observations.

**Assessment –** Processes used to obtain information about an individual, including their condition, goals, preferences, functional limitations, health status and other factors to determine which services, if any, should be authorized and provided. Assessment information supports the development of the person-centered ICP and the determination of whether an individual requires HCBS waiver services.

**Assistive technology –** Specialized medical equipment and supplies that enable individuals to increase their abilities to perform ADLs/IADLs and/or perceive, control or communicate with the environment in which they live or that are necessary for the proper functioning of the specialized equipment. This includes devices, controls or appliances specified in the ICP, but not available under the State Plan for Medical Assistance. Items should be cost-effective, portable and appropriate for the individual's assessed medical needs and deficits.

**Attendant –** An individual who provides consumer-directed personal assistance, respite or companion services through a consumer-directed model.

**Audit –** A formal review of compliance with a particular set of internal (e.g., policies and procedures) or external (e.g., laws and regulations) standards used as base measures.

Authorized representative – A person authorized to conduct the personal or financial affairs for an individual age 18 or older. Parents and other caretaker relatives can act on behalf of persons younger than 18.

**Balance billing –** Occurs when a provider bills a Medicaid member for the difference between the provider's charge and the allowed amount.

Behavioral health inpatient services – Acute psychiatric or SUD treatment services provided in a psychiatric unit of a general acute care hospital, a free-standing psychiatric setting (state or private).

Behavioral health outpatient services – Nonacute psychiatric services provided in a variety of non-facility-based settings including community settings.

**Behavioral health services –** Therapeutic services provided in inpatient and outpatient psychiatric and community mental health settings. Services provide necessary support and address mental health and behavioral needs to diagnose, prevent, correct or minimize the adverse effect of a psychiatric or substance use disorder.

**Building Independence (BI) Waiver –** A CMS-approved HCBS § 1915(c) waiver that provides support to individuals age 18 and older who live in their own homes/apartments with BI Waiver supports. Services may be complemented by nonwaiver funded rent subsidies and/or other types of support. The BI Waiver is administered collaboratively by DMAS and DBHDS.

Business days – Business days are Monday – Friday, 8 a.m. – 5 p.m., Eastern time, except for legal holidays and unless otherwise stated.

**Case management –** As described in the Social Security Act, § 1915(g)(2), case management services include those assisting individuals eligible under the state plan in gaining access to needed medical, social, educational and other services. Case management services do not include the direct delivery of an underlying medical, educational, social or other service for which an eligible individual has been referred. Payments for case management services may not duplicate payments made to public agencies under other program authorities for the same service.

**Care coordination –** Organizing patient care activities, available for all MCO members including those not identified for ongoing care management. Activities include ensuring an ongoing source of care, coordinating services between settings/delivery systems and conducting initial screenings in accordance with 42 CFR § 438.208.

**Care management –** A team-based, person-centered approach to manage patients' medical, social and behavioral conditions effectively and with consideration given to utilization trends, quality factors and provider performance.

**Care management contacts –** Instances when a care manager engages the member (or their guardian/caretaker, as appropriate) in 1 or more care management interventions. Contacts that are not required to be in person may be telephonic or via videoconference.

**Care management intensity –** LOC management services provided to the member that reflect care manager caseload requirements, assessment modality (e.g., in-person, telephonic or via videoconference) and care management contact requirements.

**Care manager –** The individual primarily responsible for delivering care management.

**Caregiver –** A person who helps care for someone who is ill, has a disability and/or has functional limitations and requires assistance. Unpaid or informal caregivers include relatives, friends or others who volunteer to help. Paid or formal caregivers provide services in exchange for payment for the services rendered.

**Carved-out services –** The subset of Medicaid-covered services for which Humana will not be responsible.

**Centers for Medicare & Medicaid Services (CMS) –** The federal agency responsible for the administration of Titles XVIII, XIX and Title XXI of the Social Security Act.

**Certified Community Behavioral Health Center (CCBHC) –** A comprehensive community BH center certified through SAMHSA that offers crisis, urgent and routine SUD and mental health services, care coordination, peer supports and screening and coordination with primary care. A CCBHC will provide access to same-day and next-day services and expanded service hours including evenings and weekends.

**Children and youth with special healthcare needs (CYSHN) –** Children and youth who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition(s). These members may need healthcare and related services of a type or amount over and above those usually expected for their age. These include, but are not limited to, children in the eligibility categories of foster care and adoption assistance (aid categories 076 and 072), youth who have aged out of the foster care system (Aid Category 70), children identified as Early Intervention (EI) participants, members identified as experiencing childhood obesity and others as identified through Humana' assessment or by DMAS.

**Children's Health Insurance Program (CHIP) –** An insurance program established and administered by a state, and jointly funded with the federal government, to provide child health assistance to uninsured, low-income children through a separate child health program, a Medicaid expansion program or a combination program.

**Claim –** An itemized statement of services rendered by healthcare providers that is billed electronically or on the HCFA 1500 or UB-92.

**Clean claim –** Consistent with 42 CFR §438 §447.45, a clean claim can be processed without obtaining additional information from the provider of the service or from a third party. A clean claim has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim under this title. See Sections 1816(c)(2)(B) and 1842(c)(2)(B) of the Social Security Act. A clean claim includes a claim with errors originating from Humana' claims system. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

**Clinical Laboratory Improvement Amendments (CLIA) –** The CLIA is a laboratory testing program regulated by CMS and implemented by the Division of Laboratory Services under the Center for Clinical Standards and Quality. CLIA covers approximately 254,000 laboratory entities. CLIA defines a clinical laboratory as any facility that performs laboratory testing on specimens obtained from humans for the purpose of providing information for health assessment and for the diagnosis, prevention or treatment of disease or impairment.

**Clinical trial (qualifying clinical trial) –** In accordance with SMD # 21-005, the terms clinical trial/ qualifying clinical trial include a clinical trial in any clinical phase of development conducted in relation to the prevention, detection or treatment of any serious or life-threatening disease or condition, as further defined in SMD#21-005.

**Coinsurance –** Coinsurance is the percentage of costs of a covered healthcare service the member pays after paying their deductible.

**Common Core Formulary –** The Common Core Formulary is a subset of Humana' formulary that includes all preferred drugs from DMAS' Preferred Drug List (PDL). Humana may add drugs to the therapeutic drug classes on DMAS' PDL/Common Core Formulary but will not remove drugs from it.

**Commonwealth Coordinated Care Waiver –** DMAS' home- and community-based waiver covers a range of community support services. The waiver is offered to older adults, individuals who have a disability and individuals who are chronically ill or severely impaired, having experienced loss of a vital body function and who require substantial and ongoing skilled nursing care. The individuals, in the absence of services approved under this waiver, would require admission to an NF or a prolonged stay in a hospital or specialized care NF. The Commonwealth Coordinated Care Plus HCBS waiver has 2 benefit plans: the standard benefit plan and the technology assisted benefit plan. Individuals who are enrolled in the technology assisted benefit plan are technology dependent and have experienced loss of a vital body function and require substantial and ongoing skilled nursing care.

**Community Service Board (CSB)/Behavioral Health Authority (BHA) –** A citizens' board established pursuant to Virginia Code §37.2-500 and §37.2-600 that provides mental health, developmental disability and SUD programs and services within the political subdivision or political subdivisions participating on the board. In all cases, the term CSB also includes BHA.

**Community stabilization –** Community stabilization refers to short-term services designed to support an individual and their natural support system following contact with an initial crisis response service. Interventions may include brief therapeutic and skill-building interventions, engagement of natural supports, interventions to integrate natural supports in the de-escalation and stabilization of the crisis and coordination of follow-up services.

**Complaint –** An expression of provider dissatisfaction about any matter other than an "adverse action." Possible subjects for complaints include, but are not limited to, claims or service authorization processing time, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Humana staff or associate, or failure to respect the member's grievance.

**Consumer Assessment of Healthcare Providers and Systems (CAHPS) –** A consumer satisfaction survey developed collaboratively by Harvard, RAND, the Agency for Healthcare Policy and Research, the Research Triangle Institute and Westat that has been adopted as the industry standard by NCQA and CMS to measure the quality of managed care plans.

**Consumer-directed employee/attendant –** A person employed by a Commonwealth Coordinated Care Plus HCBS waiver individual who receives services through the consumer-directed model or their representative. The consumer-directed employee/attendant is employed to provide approved personal care, companion services or respite care or any combination of these 3 services and they are exempt in Virginia from Workers' Compensation.

**Consumer-directed services –** HCBS (personal care and respite services) for which the Commonwealth Coordinated Care Plus HCBS waiver individual or their representative, as appropriate, is responsible for directing their own care and hiring, training, supervising and firing staff.

**Consumer-directed services facilitator (SF) –** The Medicaid enrolled provider responsible for supporting the Commonwealth Coordinated Care Plus HCBS waiver member or their representative, as appropriate. The facilitator ensures the development and monitoring of the ICP, provides attendant management training and completes ongoing review activities as required by DMAS for Commonwealth Coordinated Care Plus HCBS waiver members who are consumer-directing personal care and respite services.

**Continuity of Care –** Continuity of care activities ensure a member's safe and effective transitions do not result in a disruption of care between Medicaid fee-for-service, managed care contractors and/or contracted providers.

**Contractor –** A managed care health plan selected by DMAS and contracted by execution of a contract to participate in the Cardinal Care program.

**Coordination of Benefits (COB) –** Transmission from any entity to Humana for the purpose of determining the relative payment responsibilities of a health plan for healthcare claims or payment information.

**Copayment –** The portion of Medicaid-allowed charges the member is required to pay directly to the provider for a covered service or drug.

**Cost sharing –** A global term that encompasses coinsurance, deductibles, patient pay and copayments.

**Coverage decision letter –** This letter describes the member's required actions and rights in the unified appeals process, including the date the determination was made, the date the determination will take effect and language on continuation of benefits during appeal, as required under 42 CFR §422.631.

**Covered services –** Services Humana must cover for its enrolled members.

**Cover Virginia –** Virginia's telephonic customer service center and online portal providing statewide eligibility information and assistance for Medicaid FAMIS, newborns, Department of Corrections, Plan First, fee-for-service and other insurance options. Cover Virginia's website provides easy access to information about Virginia's FAMIS and Medicaid programs, including eligibility and how to apply. Staff at the Cover Virginia statewide customer service center at 855-242-8282 provide confidential application assistance and program information. Individuals can apply, report changes or renew an individual's coverage by calling Cover Virginia.

**Credentialing –** The process of collecting, assessing and validating the qualifications and appropriateness of a provider to join Humana' network. Humana conducts credentialing and recredentialing activities utilizing guidelines established by the NCQA as required by DMAS. Humana credentials and recredentials all licensed independent providers including physicians, nonphysicians and organizational providers with whom it contracts and who fall within its scope of authority and action. A senior clinical staff person is responsible for oversight of the credentialing and recredentialing program. All providers requiring credentialing should complete the credentialing process prior to appearing in the provider directory. All credentials must be current at the time of the credentialing committee decision.

**Crisis support services –** Services designed for individuals experiencing circumstances such as:

- Marked reduction in psychiatric, adaptive or behavioral functioning;
- An increase in emotional distress;
- Needing continuous intervention to maintain stability; **or**
- Causing harm to themselves or others.

Crisis support services provide intensive supports by trained and, where applicable, licensed staff in crisis prevention, crisis intervention and crisis stabilization for an individual who is experiencing an episodic behavioral or psychiatric event in the community that has the potential to jeopardize the current community living situation. This service is designed to prevent the individual from experiencing an episodic crisis that has the potential to jeopardize their current community living situation, to intervene in such a crisis or to stabilize the individual after the crisis. This service must prevent escalation of a crisis, maintain safety, stabilize the individual and strengthen the current living situation so the individual can be supported in the community beyond the crisis period.

**Critical incident –** Any actual or alleged event or situation that threatens or impacts the physical, psychological or emotional health, safety or well-being of the member. Critical incidents include but are not limited to: medication errors, theft, suspected physical, mental, verbal or sexual abuse or neglect, financial exploitation and sentinel events.

**Cultural competence –** The ability of healthcare providers and healthcare organizations to understand and respond effectively to a patient's cultural health beliefs, preferred languages, health literacy levels and communication needs.

**Deductible –** The dollar amount Humana may pay toward the cost of covered services for a dual-eligible member.

**Department of Behavioral Health and Developmental Services (DBHDS) –** The state agency responsible for coordination of BH, developmental disabilities and substance use services through the local CSBs. This agency has responsibility for the day-to-day operations of the Community Living Waiver, Family and Individual Supports Waiver and the Building Independence Waiver. DBHDS also serves as the state Lead Agency for Virginia's early intervention system and is responsible for certification of early intervention providers and service coordinators/case managers.

**Department of Medical Assistance Services (DMAS) –** The Virginia state agency that administers the Medicaid program under Title XIX of the Social Security Act and the Children's Health Insurance Program (known as FAMIS) under Title XXI of the Social Security Act.

**Developmental Disability (DD) waivers –** The CMS-approved HCBS §1915(c) waivers for individuals with developmental disabilities who are enrolled in either the BI, Community Living or the Family and Individual Supports waivers.

**Disease Management –** A system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.

**Disenrollment –** The process of changing enrollment from 1 contractor to another. This term does not refer to termination of eligibility in a Medicaid program.

**Doula (or community-based doula) –** An individual trained to provide extended, culturally congruent support to families throughout pregnancy to include antepartum, intrapartum, during labor and birth and up to 1 year postpartum. Community-based doulas provide an expanded set of services and play a crucial role in improving outcomes and experiences for communities most affected by discrimination and disparities in health outcomes.

**Drug Efficacy Study Implementation (DESI) –** A designation indicating drugs for which DMAS will not provide reimbursement because the drugs have been determined by the Food and Drug Administration (FDA) to lack substantial evidence of effectiveness.

**Dual-eligible individual –** A Medicare beneficiary who receives Medicare Part A, B and/or D benefits along with full Medicaid benefits. Individuals who receive both Medicare and Medicaid coverage but who are NOT eligible for full Medicaid benefits (e.g., individuals who qualify as Specified Low-Income Medicare Member (SLMBs), Qualified Medicare Member, Qualified Disabled and Working Individuals (QDWIs) or Qualifying Individuals (QIs)) are not included in the CCMC program.

**Dual-Eligible Special Needs Plan (D-SNP) –** A type of Medicare Advantage plan that enrolls only dual-eligible individuals in Medicare and Medicaid.

**Durable medical equipment (DME) –** Medical supplies, equipment and appliances suitable for use consistent with 42 CFR §440.70(b)(3) that treat a diagnosed condition or assist the individual with functional limitations.

**Early and Periodic Screening, Diagnostic and Treatment (EPSDT) –** Periodic screening, vision, dental and hearing services for Medicaid beneficiaries younger than 21. EPSDT also includes a federal requirement that compels state Medicaid agencies to cover services, products or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" a defect, physical or mental illness or condition (health problem) identified through routine medical screening

or examination. This requirement remains even if coverage for the same service/support is an optional or limited service under the state plan.

**Early intervention services (EIS) –** Services provided through Part C of the Individuals with Disabilities Education Act (20 USC § 1431 et seq.), as amended and in accordance with 42 CFR §440.130(d). EIS are designed to meet the developmental needs of children and families and to enhance the development of children from birth through the day before the 3rd birthday who have:

- A 25% developmental delay in 1 or more areas of development,
- Atypical development or
- A diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

Per 12 VAC 35-225-70, children are not eligible to receive EIS on or after their 3rd birthday. EIS provided in the child's natural environment to the maximum extent appropriate. EIS services are covered.

**Early Intervention Individualized Family Service Plan (IFSP) –** A written plan developed by the member's interdisciplinary team to provide early intervention supports and services to eligible children and families that:

1. Is based on evaluation for eligibility determination and assessment for service planning;
2. Includes information based on the child's evaluation and assessments, family information, results or outcomes and supports and services based on peer-reviewed research (to the extent practicable) necessary to meet the unique needs of the child and family and to achieve the results or outcomes; **and**
3. Is implemented as soon as possible once parental consent is obtained.
4. Electronic Visit Verification (EVV) – An EVV verifies visit activity for in-home and in-community care services delivered and offers a measure of accountability to ensure individuals receive the care and services they need and are authorized to receive.

**Emergency department care coordination –** Real-time communication and collaboration among hospital emergency departments, physicians, other healthcare providers and health plan clinical and care management personnel to improve outcomes for populations with high utilization of EDs as required by state law through the Virginia Emergency Department Care Coordination Program.

**Emergency medical or behavioral health condition –** In accordance with 42 CFR §438.114(a), Mental Health Parity rules in 42 CFR §438.910(b) and DMAS standards, an emergency medical or BH condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant individual, the health of that individual or their unborn child) in serious jeopardy; serious impairment to body functions; or serious dysfunction of any bodily organ or part; or with respect to a pregnant individual who is having contractions, (1) that there is inadequate time to effect a safe transfer to another hospital before delivery or (2) that transfer may pose a threat to the health or safety of the pregnant individual or the unborn child.

**Emergency medical transportation –** Medically necessary ambulance transportation to the nearest appropriate facility where prompt medical services are provided in an emergency such as accident, acute illness or injury.

**Emergency room/department –** An area of a hospital staffed and equipped for the treatment of people who require immediate medical care and/or services.

**Emergency services –** Covered inpatient and outpatient services rendered by participating or nonparticipating providers qualified to furnish these services, which are needed to evaluate or stabilize an emergency medical condition pursuant to 42 CFR §438.114.

**Encounter –** Any covered or enhanced service received by a member through Humana or its subcontractor.

**Encounter data –** Data collected by Humana that documents the healthcare and related services a member receives. These services include, but are not limited to, professional services, medical supplies or equipment and medications. Encounter data is collected on an individual member level and includes the person's Medicaid ID number. It is also specific in terms of the provider, the medical procedure and the date the service was provided. DMAS and the federal government require plans to collect and report this data. Encounter data is a critical element of measuring managed care plans' performance and holding them accountable to specific standards for healthcare quality, access and administrative procedures.

**Enhanced benefits or services –** Services offered by Humana to members in addition to services covered by the contract between Humana and DMAS. DMAS will not pay for enhanced services.

**Enrollment –** The completion of approved enrollment forms by or on behalf of an eligible person and assignment of a member to an MCO by DMAS.

**Enrollment broker –** An independent entity that enrolls members in Humana' health plan and is responsible for the operation and documentation of a toll-free member service helpline. The responsibilities of the enrollment broker include, but are not limited to member education and enrollment along with assistance and tracking of member's grievance resolution.

**Excluded entity –** Any provider or subcontractor excluded from participating in Humana' health plan as defined by federal requirements set forth in 42 CFR §438.610.

**Excluded services –** Services not covered under the Medicaid benefit.

**Expedited appeal –** The accelerated process by which Humana must respond to an appeal by a member if a denial of care decision by Humana may jeopardize life, physical or mental health or ability to attain, maintain or regain maximum function.

**External appeal –** An appeal, subsequent to Humana' appeal decision, to the state fair hearing process for Medicaid-based adverse decisions.

**External quality review –** Analysis and evaluation by an External Quality Review Organization of aggregated information on quality, timeliness and access to the healthcare services an MCO or its contractors furnish to Medicaid members, as defined in 42 CFR §438.320.

**External Quality Review Organization (EQRO) –** An organization that meets the competence and independence requirements set forth in 42 CFR §438.354 and performs external quality review and other external quality review related activities as set forth in 42 CFR§ 438.358.

**Family and Individual Supports Waiver –** The CMS-approved home- and community-based §1915(c) waiver designed to provide services and supports in the community rather than in an ICF/IID. Participants include individuals up to 6 years old who are at developmental risk and individuals 6 and older who have a DD and meet the ICF/IID LOC criteria. This waiver supports children and adults living with families, friends or in their own homes, including supports for those with some medical or behavioral needs.

**Family planning –** Services that delay or prevent pregnancy. Coverage of such services must not include services to treat infertility or services to promote fertility. Family planning services must not cover payment for abortion services and no funds will be used to perform, assist, encourage or make direct referrals for abortions.

**FAMIS –** Comprehensive health coverage for uninsured children ages 0–18 not eligible for Medicaid, with family income at or below 200% of the FPL (plus a 5% disregard). FAMIS is the Commonwealth's CHIP program, also referred to as Title XXI, administered by DMAS and jointly funded by the state and federal governments.

**FAMIS MOMS –** Uninsured, pregnant and postpartum members of any age, ineligible for Medicaid, with family income at or below 200% of the federal poverty level (plus a 5% disregard). FAMIS MOMS is part of Virginia's CHIP program and authorized under a Section 1115 CHIP waiver. The benefit package is aligned with that of Medicaid pregnant individuals.

Federally Qualified Health Centers (FQHCs) – Facilities as defined in 42 CFR §405.2401(b), as amended.

**Fee for service –** The traditional healthcare payment system in which physicians and other providers receive a payment for each unit of service they provide. This method of reimbursement is not used by DMAS to reimburse Humana under the terms of the contract between Humana and DMAS.

**Formulary –** A list of drugs Humana has approved. Prescribing some of the drugs on the list may require service authorization. DMAS has developed a Preferred Drug List (PDL) that must be a subset of Humana' formulary that includes all the preferred drugs from DMAS' PDL.

**Fraud –** The intentional deception or misrepresentation made by a person or entity with the knowledge the action could result in payment of an unauthorized benefit. Fraud also includes any act that constitutes fraud under applicable federal or state law.

**Grievance –** In accordance with 42 CFR §438.400, a grievance means an expression of dissatisfaction about any matter other than an adverse action or adverse benefit determination. Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the member's rights.

**Guardian –** An adult legally responsible for the care and management of a minor child or another adult.

**Healthcare Effectiveness Data and Information Set (HEDIS) –** A tool developed and maintained by the NCQA used to measure performance on dimensions of care and service to maintain and/or improve quality.

**Health disparities –** Health disparities refer to fair and just opportunities to be as healthy as possible, requiring reducing and eliminating disparities in health and its determinants adversely affecting excluded or marginalized groups that have been excluded or marginalized, including poverty, discrimination and their consequences, including powerlessness, lack of access to good jobs with fair pay, quality education and housing and safe environments.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA) –** Title II of HIPAA requires standardization of electronic patient health, administrative and financial data; unique health identifiers for individuals, employers, health plans and healthcare providers; and security standards protecting the confidentiality and integrity of individually identifiable health information past, present or future.

**Health record –** Any written, printed or electronically recorded material maintained by a healthcare entity providing health services to an individual concerning the individual and the services provided. It also includes the substance of any communication made by an individual to a healthcare entity in confidence during or in connection with the provision of health services. Information otherwise acquired by the healthcare entity about an individual in confidence and in connection with the provision of health services to the individual is also part of the health record. (Code § 32.1-127.1:03).

**Health-related social needs (HRSN) –** Conditions in the places where people live, learn, work and play that affect a wide range of health and quality-of-life risks and outcomes.

**Home- and community-based services (HCBS) waivers –** Home- and community-based services authorized under a §1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be authorized to receive 1 or more of these services either solely or in combination, based on the documented need for the service or services to avoid institutional (NF) placement. The 1915(c) waivers are 1 of many options available to states to allow the provision of long-term care services in home- and community-based settings under the Medicaid program. States can offer a variety of services under a HCBS waiver. Waivers can provide a combination of standard medical services and nonmedical services. Standard services include but are not limited to: case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential) and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

**Home healthcare –** Healthcare services a person receives in the home including nursing care, home health aide services and other services.

**Homeless –** In accordance with 42 U.S.C., 254b, an individual experiencing homelessness is an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations and an individual who is a resident in transitional housing. A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or nonpermanent situation.

**Hospice –** As defined in § 32.1-162.1 of the Code of Virginia, hospice is a coordinated program of home and inpatient care provided directly or through an agreement under the direction of an identifiable hospice administration providing palliative and supportive medical and other health services to terminally ill patients and their families. Patients younger than 21 years old are permitted to continue to receive curative medical services even if they also elect to receive hospice services. A hospice utilizes a medically directed interdisciplinary team to meet the physical, psychological, social, spiritual and other special needs experienced during the final stages of illness and during dying and bereavement. Hospice care must be available 24 hours a day, 7 days a week.

**Indian Healthcare Provider (IHCP) –** An IHCP, per 42 CFR § 438.14, is a healthcare program, including tribal clinic providers and providers of contract health services (CHS), operated by the Indian Health Service or by an Indian Tribe, Tribal Organization or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Healthcare Improvement Act (25 U.S.C. § 1603). Also refer to the definition of AI/AN.

**Individualized Care Plan (ICP) –** A Humana comprehensive written document developed with the member through person-centered planning that specifies the member's services and supports—both formal and informal. The ICP incorporates the member's strengths, skills, needs, preferences and goals along with all aspects of their care needs including, but not limited to, medical, behavioral, social and LTSS.

**Informal support –** Support provided by a member's social network and community, such as family, friends, faith-based organizations, etc. and is typically unpaid.

**Institution for mental disease (IMD) –** In accordance with 42 CFR §435.1010, an IMD is a private or state-run hospital, NF or other institution of more than 16 beds primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. An institution for mental disease is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases and whether it is licensed as such. An institution for individuals with intellectual disabilities is not an IMD. A State IMD or State Mental Hospital is a hospital, psychiatric institute or other institution operated by the DBHDS that provides care and treatment for persons with mental illness.

**Instrumental activities of daily living (IADLs) –** Activities such as meal preparation, shopping, housekeeping, laundry and money management. The extent to which an individual requires assistance in performing these activities is assessed in conjunction with the evaluation of LOC and service needs. Also see ADLs.

**Intensive in-home services (IIH) for children/adolescents younger than 21 –** Time-limited interventions provided in the member's residence and when clinically necessary in community settings. IIH services are specifically designed to improve family dynamics as well as provide modeling and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members. IIH services promote psychoeducational benefits in the home setting of a member who is at-risk of being moved outside the home or who is being transitioned to home from an out-of-home placement due to a documented medical need.

**Interdisciplinary care team (ICT) –** A team of professionals who collaborate to develop and implement a person-centered ICP built on the individual's specific preferences and needs. The plan is designed to deliver services with transparency, individualization, respect, linguistic and cultural competence and dignity that meets the member's medical, behavioral, LTSS, early intervention and social needs. ICTs include the Humana care manager and may include physicians, physician assistants, LTSS providers, nurses, specialists, pharmacists, BH specialists, early intervention care managers/providers, social workers and other appropriate entities for the individual's medical diagnoses and health condition, comorbidities and community support needs. ICTs employ both medical and social models of care.

**Internal appeal –** A request to Humana by a member, a member's authorized representative or healthcare provider—acting on behalf of the member and with the member's written consent—for review of Humana' adverse benefit determination. The internal appeal is the only level of appeal with Humana and must be exhausted by a member or deemed exhausted according to 42 CFR §438.408(c)(3) before the member can initiate a state fair hearing.

**Investigation –** Related to program integrity activities, an investigation is a review of the documentation of a billed claim or other attestation by a provider to assess appropriateness or compliance with contractual requirements. Most investigations involve the review of medical records to determine if the service was correctly documented and appropriately billed. DMAS reserves the right to expand upon any investigation.

**Inquiry –** An oral or written communication, usually received by our Member Services department or telephone helpline representative, made by or on the behalf of a member that may be:

- Questions regarding the need for additional information about eligibility, benefits, plan requirements or materials received, etc.
- Provision of information regarding a change in the member's status such as address, family composition, etc.
- A request for assistance such as selecting or changing a PCP assignment, obtaining translation or transportation assistance, obtaining access to care, etc.
- Inquiries are not expressions of dissatisfaction.

**Laboratory –** A place where tests take place for the purpose of providing information for the diagnosis, prevention or treatment of disease or impairment or the assessment of the health of human beings, which meets the requirements of 42 CFR §493.3, as amended.

**Legal holiday –** The 12 specific days of any calendar year when state offices are closed. Humana may elect to be closed for legal holidays. Legal holidays do not include time off that may be appropriated to state employees by the Governor legislature.

**Level of care (LOC) –** The specification of the minimum amount of assistance an individual requires to receive services in a community or institutional setting under the State Plan for Medical Assistance or to receive Commonwealth Coordinated Care Plus HCBS waiver services.

**Level of care review –** The periodic, but at least annual, review of a member's condition and service needs to determine whether the member continues to need a LOC specified by a waiver. Also referred to as Level of Care Review Instrument (LOCERI). More information about LOCERI, including the Level of Care User Guide and Tutorial, is available on the Virginia Medicaid Web Portal, Provider Resources tab. Also see the definition for NF annual reassessment.

**Limited English proficient (LEP) –** In accordance with 42 CFR §438.10, potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak or understand English may be eligible to receive language assistance for a particular type of service, benefit or encounter.

**List of Excluded Individuals and Entities (LEIE) –** When the OIG excludes a provider from participation in federally funded healthcare programs, information about the provider appears on the LEIE. This information includes the provider's name, address, provider type and reason for exclusion. The LEIE updates monthly and is available to search or download on the OIG website. To protect sensitive information, the downloadable information does not include unique identifiers such as Social Security numbers, employer identification numbers or NPIs.

**Local education agency –** A local public school division governed by a local school board, a state-operated program that is funded and administered by the Commonwealth of Virginia or the Virginia School for the Deaf and the Blind that has enrolled with DMAS as a provider of Local Education Agency-Based Services.

**Local education agency-based services –** State plan-approved healthcare services rendered to member students in a school setting by qualified providers employed or contracted by a DMAS-enrolled Local Education Agency Provider. Claims for these services are processed as FFS and the local education agency is reimbursed using a reconciled cost-based methodology. These services are carved out of the managed care contracts.

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**Long-stay hospital –** Hospitals that provide a slightly higher LOC than NFs. DMAS recognizes 2 facilities that qualify the individual for exemption as long-stay hospitals: Lake Taylor Transitional Care Hospital in Norfolk and Hospital for Sick Children Pediatric Center in Washington, D.C.

**Long-term services and supports (LTSS) –** Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses. These services and supports have the primary purpose of helping the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a NF or other institutional setting.

**MAGI adults (also known as the Medicaid expansion group) –** A population that includes adults who are 19–64 years old, with incomes up to 138% of the federal poverty level (133% plus a 5% income disregard), who do not have Medicare and who are not otherwise eligible for a Medicaid mandatory coverage group. Low-income families, qualified pregnant women and children, individuals eligible under the aged, blind and disabled groups are examples of mandatory eligibility groups, as described in 12 VAC 30-30-10.

**Managed care organization (MCO) or managed care plan –** An organization that offers managed care health insurance plans (MCHIP), as defined by Virginia Code § 38.2-5800, which means an arrangement for the delivery of healthcare in which a health carrier undertakes to provide, arrange for, pay for or reimburse any of the costs of healthcare services for a covered person on a prepaid or insured basis that

- Contains 1 or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of healthcare services between the health carrier and 1 or more providers with respect to the delivery of healthcare services; **and**
- Requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier.

Any health maintenance organization as defined in Virginia Code § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in Virginia Code § 38.2-3407 or preferred provider subscription contracts as defined in Virginia Code § 38.2-4209 must be deemed to be offering 1 or more MCHIPs. For the purposes of this definition, the prohibition of balance billing by a provider must not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan must encompass only 1 provider network or set of provider networks. Additionally, for the purposes of the contract between Humana and DMAS and in accordance with 42 CFR §438.2, an entity that has qualified to provide the services covered under the contract between Humana and DMAS to qualifying members must be as accessible (in terms of timeliness, amount, duration and scope) as those services are to other individuals within the area served and meets the solvency standards of 42 CFR §438.116.

**MCO Member Health Screening (MMHS) –** DMAS' screening tool consisting of a two-part questionnaire all newly enrolled Cardinal Care members must receive. Results from completed questionnaires provide initial insight on members entering the program and the associated population and identifies opportunities for supports, offering potential clinical pathways to improved health outcomes.

**Managed care program –** As defined in 42 CFR §438.2, a managed care delivery system operated by a state as authorized under Sections 1915(a), 1915(b), 1932(a) or 1115(a) of the Act.

**Managing employee –** In accordance with 42 CFR §455 Subpart B, a managing employee means a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

**Mandatory high priority population –** Members who Humana must assign to receive high intensity care management.

**Mandatory priority population –** Members who Humana must assign to receive care management.

**Marketing –** In accordance with 42 CFR §438.104, marketing means any communication from an MCO to a Medicaid member who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the member to enroll in that MCO's Medicaid product or either to not enroll in or to disenroll from another MCO's Medicaid product.

**Marketing materials –** Materials produced in any medium, by or on behalf of Humana, used by Humana to communicate with individuals, members or prospective members that can reasonably be interpreted as intended to influence individuals to enroll or re-enroll with Humana.

**MCO-determined priority population –** Members who Humana must assign to receive either care management or care coordination, at Humana' discretion.

**Medicaid contract –** The MCO agreement between DMAS and Humana under which Humana provides administrations for Medicaid services to eligible Virginia residents.

**Medicaid member –** Any individual enrolled in the Virginia Medicaid program.

**Medicaid Works Program –** A voluntary Medicaid plan option that enables workers with disabilities to earn higher income and retain more in savings or resources than usually allowed by Medicaid.

**Medically needy –** Individuals who meet Medicaid covered group requirements but have excess income. A medically needy determination requires a resource test and includes pregnant women, children younger than 18, foster care and adoption assistance and those in ICF/IIDs up to age 21, ABD up to age 21. Parents and caretaker relatives do not qualify under medically needy.

**Medically necessary or medical necessity –** Per Virginia Medicaid, medically necessary or medical necessity refers to an item or service provided for the diagnosis or treatment of a member's condition consistent with standards of medical practice and in accordance with Virginia Medicaid policy (12 VAC 30-130-600) and EPSDT criteria (for those younger than 21) and federal regulations as defined in 42 CFR § 438.210 and 42 CFR § 440.230.

**Member –** A person enrolled with Humana to receive services under the provisions of the contract between Humana and DMAS.

**Member handbook –** A document provided by Humana prior to the first day of the month in which the member's enrollment starts.

**Member medical record –** Documentation containing medical history, including information relevant to maintaining and promoting each member's general health and well-being, as well as any clinical information concerning illnesses and chronic medical conditions.

**Mental Health Partial Hospitalization Programs –** Standard, short-term, nonresidential, medically directed services for adult and youth members who require intensive, highly coordinated, structured and interdisciplinary ambulatory treatment within a stable environment that is of greater intensity than Intensive outpatient, mental health skill building or psychosocial rehabilitation.

**Mental health professional –** In accordance with the Virginia Department of Health Professions (DHP), a mental health professional is a person who, by education and experience, is professionally qualified and licensed by the Commonwealth to provide counseling interventions designed to facilitate an individual's achievement of human development goals and remediate mental, emotional or behavioral disorders and associated distresses that interfere with mental health and development. See Virginia Administrative Code for more information.

**Minimum data set (MDS) –** The MDS is part of the federally mandated process for assessing individuals receiving care in certified NFs to record their overall health status regardless of payer source. The process provides a comprehensive assessment of individuals' current health conditions, treatments, abilities and plans for discharge. The MDS is administered to all residents upon admission, quarterly, yearly and whenever there is a significant change in an individual's condition. Section Q is the part of the MDS designed to explore meaningful opportunities for NF residents to return to community settings. All Medicare- and Medicaid-certified NFs were required to use the MDS 3.0.

**Model of care –** A comprehensive plan that describes Humana' population; identifies measurable goals for providing high quality care and improving the health of the enrolled population; describes Humana' staff structure and care management roles; describes the interdisciplinary care team; system of disseminating the model to Humana staff and network providers; and, provides other information designed to ensure Humana provides services that meet the needs of members.

**National Committee for Quality Assurance (NCQA) –** A nonprofit organization committed to assessing, reporting on and improving the quality of healthcare provided by organized delivery systems.

**National Provider Identifier (NPI) –** A national health identifier for all healthcare providers, as defined by CMS. The NPI is a numeric 10-digit identifier, consisting of 9 numbers plus a check-digit. It is accommodated in all electronic standard transactions and many paper transactions. The assigned NPI does not expire. All providers who provide services to individuals enrolled in this contract will be required to have and use an NPI.

**Network provider –** Any provider, group of providers or entity that has a network provider agreement with a MCO or a subcontractor and receives Medicaid or CHIP/FAMIS funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP or PAHP. A network provider is not a subcontractor by virtue of the network provider agreement.

**Noncovered services –** Services not covered by DMAS and, therefore, not included in covered services as defined in the Virginia State Plan for Medical Assistance or state regulations.

**Nonparticipating provider –** A healthcare entity or healthcare professional not in Humana' participating provider network.

**Notice –** A written statement that meets the requirements of 42 CFR §438.404.

**Nursing facility (NF) –** Any licensed skilled NF, skilled care facility, intermediate care facility, nursing care facility or NF, whether free-standing or a portion of a free-standing medical care facility. This includes, but is not limited to, a facility that is certified for participation as a Medicare or Medicaid provider or both, pursuant to Title XVIII and Title XIX of the United States Social Security Act, as amended and the Code of Virginia, §32.1-137.

**NF annual reassessments –** Annual reassessments (functional and medical/nursing needs) for continued NF placement, including the incorporation of all MDS guidelines.

**NF LTSS screening team –** NF staff trained and certified in the use of the LTSS screening tool who are responsible for performing LTSS screenings for individuals who apply for or request LTSS while receiving skilled nursing services in a setting not covered by Medicaid and after discharge from a hospital. NF LTSS screening staff must include at least 1 registered nurse and physician, but may include a social worker or other members of the interdisciplinary team. The authorization or denial for Medicaid LTSS (DMAS-96 form) must be signed and attested to by the screener(s) and a physician.

**Ombudsman –** The independent state entity that will provide advocacy and problem-resolution support for Cardinal Care managed care participants and serve as an early and consistent means of identifying systemic problems.

**Ongoing care management –** The act of providing regular, ongoing support to address a member's healthcare needs, functional needs, accessibility needs, social needs, strengths and supports, goals and other characteristics in alignment with the member's ICP and regular courses of treatment.

**Open enrollment –** The time frame in which members are allowed to change from 1 MCO to another, without cause, at least once every 12 months per 42 CFR §438.56(c)(2) and (f)(1).

**Out-of-network –** Out-of-network coverage is coverage provided outside of the established Humana network; medical care rendered to a member by a provider not affiliated with Humana or contracted with Humana or its Subcontractors.

**Outcomes –** As defined in 42 CFR §438.320, outcomes are changes in patient health, functional status, satisfaction or goal achievement that result from healthcare or supportive services.

**Overpayment –** As defined in 42 CFR §438.2, an overpayment is any payment made to a network provider by an MCO to which the network provider is not entitled to under Title XIX of the Act or any payment to an MCO by a state to which the MCO is not entitled to under Title XIX of the Act.

**Partial hospitalization services (ASAM Level 2.5) –** Partial hospitalization services are defined as a minimum of 20 hours per week and at least 5 service hours per service day of skilled treatment services with a planned format, including individual and group psychotherapy, SUD counseling, medication management, education groups, occupational and recreational therapy and other therapies. Withdrawal management services may be provided, as necessary.

**Participating provider –** Healthcare providers, hospitals, home health agencies, clinics and other places that provide healthcare services, medical equipment and LTSS that are contracted with Humana. Participating providers are also "in-network providers" or "plan providers."

**Patient pay –** When an individual's income exceeds an allowable amount, the member must contribute toward the cost of their LTSS. This contribution, known as the patient pay amount, is required for individuals who are not covered through MAGI adult (Medicaid expansion) and who reside in an NF (skilled or custodial) or are enrolled in a home- and community-based waiver. Patient pay is required to be calculated for every individual (including AI/AN) although not every eligible individual will end up having to pay each month. The process for collecting patient pay amounts is outlined in your provider agreement.

**Payer of last resort –** The Medicaid program by law is intended to be the payer of last resort; that is, all other available third-party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual-eligible for Medicaid.

**Person-centered planning –** Person-centered planning is a process, directed by an individual or their family/caregiver, as appropriate, intended to identify the needs, strengths, capacities, preferences, expectations and desired outcomes for the individual.

**Personal care services (EPSDT) –** Services designed to assist children younger than 21 who meet the criteria for EPSDT Personal Care as defined in the EPSDT Personal Care Services Supplement with ADLs, IADLs, medically necessary supervision and monitoring of self-administered medications. The child's need for assistance with ADLs due to a health condition must be documented by the child's PCP on the EPSDT Functional Status Assessment Form (DMAS-7). The form must be completed and signed by a physician, physician's assistant or nurse practitioner and updated every year. EPSDT Personal Care criteria is utilized for children not enrolled in Commonwealth Coordinated Care Plus HCBS waiver. For members enrolled in Commonwealth Coordinated Care Plus HCBS waiver, including those members younger than 21 years old, personal care will be provided under the waiver. As such Commonwealth Coordinated Care Plus HCBS waiver criteria and forms are used to determine personal care hours for these members.

**Personal care services (non-EPSDT) –** A range of support services that includes assistance with ADLs/IADLs, access to the community and self-administration of medication or other medical needs and the monitoring of health status and physical condition provided through the AD or CD model of service. Personal care services must be provided by PCAs or attendants within the scope of their licenses or certifications, as appropriate.

**Physician services –** Care provided by an individual licensed under state law to practice medicine, surgery or BH.

**Plain language –** Language written in a manner that can be understood by any audience.

**Plan (health plan) –** An organization made up of doctors, hospitals, pharmacies, providers of long-term services and other providers. It also has care managers to help members manage all their providers and services. They all work together to provide needed care.

**Plan First –** The Medicaid FFS family planning program designed to reduce unplanned pregnancies, increase spacing between births, reduce infant mortality rates and reduce the rates of abortions due to unintended pregnancies. Individuals not eligible for full benefit Medicaid or FAMIS/FAMIS MOMS who have income between 138% and less than or equal to 200% of the federal poverty level (plus a 5% disregard) and meet citizenship and identity requirements may be eligible for Plan First.

**Post-payment –** Post-payment refers to subjecting claims for services to evaluation after the claim has been adjudicated. This activity may result in claim reversal or partial reversal and claim payment recovery.

**Post-stabilization care services –** As defined at 42 CFR §438.114(a), post-stabilization care services are covered services related to an emergency medical condition provided after a member is stabilized to maintain the stabilized condition or to improve or resolve the member's condition.

**Potential member –** A Medicaid member who is subject to mandatory enrollment (42 CFR §438.2).

**Prepayment review –** A type of program integrity activity that requires a provider to submit additional documentation to support a billed claim before that claim is processed for payment. Prepayment review is often focused on a claim type, a provider type or a specific provider based on an indication that additional scrutiny is needed. It may be used after identifying an area/provider that presents a program integrity risk or prior to evidence of risk to mitigate potential issues.

**Prevalent language –** When 5% or more of Humana' enrolled population in any participating region is non-English speaking and speaks a common language other than English, the language is referred to as the prevalent language.

**Previously authorized –** As described in 42 CFR §438.420, in relation to continuation of benefits, previously authorized means a prior approved course of treatment and is best clarified by the following example: If Humana authorizes 20 visits and then later reduces this authorization to 10 visits, this exemplifies a "previously authorized service" that is being reduced. Conversely, "previously authorized" does not include the example whereby:

1. Humana authorizes 10 visits;
2. The 10 visits are rendered; **and**
3. Another 10 visits are requested but are denied by Humana.

In this case, the fact that Humana had authorized 10 visits on a prior request for authorization is not germane to continuation of benefits requirements for previously authorized services that are terminated, suspended or reduced.

**Prescription drug coverage –** Prescription drugs or medications covered (paid) by the health plan. Some over-the-counter medications are covered.

**Prescription drugs –** Drugs or medications that, by law, can be obtained only by means of a physician's prescription.

**Primary care –** As defined in 42 CFR §438.2, primary care refers to all healthcare services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician or other licensed practitioner as authorized by DMAS, to the extent the furnishing of those services is legally authorized in the state.

**Primary caregiver –** The person who consistently assumes the role of providing direct care and support of the member to live successfully in the community without compensation for providing such care.

**Primary care provider (PCP) –** A practitioner who provides preventive and primary medical care for eligible members and who certifies service authorizations and referrals for all medically necessary specialty services. PCPs can include pediatricians, family and general practitioners, internists, obstetrician/gynecologists and specialists who perform primary care functions such as surgeons, clinics including, but not limited to health departments, FQHCs, Rural Health Clinics, etc.

**Priority population –** Priority population refers to members requiring care management under Cardinal Care based on the member's need and risk level.

**Privacy –** Privacy refers to requirements established in the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996 and implementing Medicaid regulations, including 42 CFR §§431.300 through 431.307, as well as relevant Virginia privacy laws.

**Private duty nursing (PDN) –** Nursing care services available for children younger than 21 under EPSDT that consist of medically necessary skilled interventions, assessment, medically necessary monitoring and teaching of those who are or will be involved in nursing care for the individual. PDN differs from both skilled nursing and home health nursing because the nursing is provided continuously as opposed to the intermittent care provided under either skilled nursing or home health nursing services.

**Program integrity –** The process of identifying and referring any suspected fraud or abuse activities or program vulnerabilities.

**Program of All-inclusive Care for the Elderly (PACE) –** PACE provides the entire spectrum of medical (preventive, primary, acute) and LTSS to their members without limit as to duration or dollars. PACE participants are excluded from the CCMC program.

**Protected health information (PHI) –** Individually identifiable information, including demographics, that relates to a person's health, healthcare or payment for healthcare. HIPAA protects individually identifiable health information transmitted or maintained in any form or medium.

**Provider –** As defined in 42 CFR §438.2, a provider is any individual or entity engaged in the delivery of services, or ordering or referring for those services, and legally authorized to do so by the state.

**Provider contract –** An agreement between Humana and a provider that describes the conditions under which the provider agrees to furnish covered services to members. DMAS has approved all provider contract templates for Medicaid-funded services between Humana and a provider.

**Provider network –** A network of healthcare and social support providers, including but not limited to PCPs, nurses, nurse practitioners, physician assistants, care managers, specialty providers, BH/substance use providers, community and institutional long-term care providers, pharmacy providers and acute providers employed by or under subcontract with Humana. Also see Network provider.

**Provider preventable condition –** (also called provider preventable event) – A condition that

- Meets the requirements of an "Other Provider Preventable Condition" pursuant to 42 CFR §447.26(b); **and/or**
- A hospital acquired condition or a condition occurring in any healthcare setting that has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines, has a negative consequence for the beneficiary and is auditable.

DMAS' policy regarding Provider Preventable Conditions is set out in 12 VAC 30-70-201 and 12 VAC 30-70-221.

**Psychosocial rehabilitation services –** A treatment program of 2 or more consecutive hours per day provided to groups of adults in a nonresidential setting. Members must demonstrate a clinical need for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities. This service provides education to teach the member about mental illness, SUD and appropriate medication to avoid complication and relapse and

opportunities to learn and use independent skills and to enhance social and interpersonal skills within a consistent program structure and environment.

**Psychiatric residential treatment facilities –** Psychiatric residential treatment facilities refer to the same facilities as defined in 42 CFR §483.352 and are a 24-hour, supervised, clinically and medically necessary, out-of-home active treatment programs designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive and training needs of an individual younger than 21 years old to prevent or minimize the need for more intensive treatment.

**Qualifying Commonwealth Coordinated Care Plus HCBS waiver services –** Qualifying services can be authorized as stand-alone services. Qualifying services include: ADHC, personal care, respite and PDN services. The following Commonwealth Coordinated Care Plus HCBS waiver services are not qualifying waiver services: AT, EM and PERS and must be authorized in conjunction with at least 1 qualifying Commonwealth Coordinated Care Plus HCBS waiver service.

**Quality –** As defined in 42 CFR §438.320, as it pertains to external quality review, quality refers to the degree to which Humana increases the likelihood of desired outcomes of its members through:

1. Its structural and operational characteristics;
2. The provision of services consistent with current professional, evidenced-based-knowledge; **and**
3. Interventions for performance improvement.

**Quality improvement program –** A program with structure, processes and related activities designed to achieve measurable improvement in processes and outcomes of care. Improvements are achieved through interventions that target healthcare providers, practitioners, contracted health plans and/or members.

**Quality of care incident –** Any incident that calls into question the competence or professional conduct of a healthcare provider in the course of providing medical services and has adversely affected or could adversely affect, the health or welfare of a member. These are incidents of a less critical nature than those defined as sentinel events.

**Reassessment –** For members enrolled in a waiver or an NF, reassessment is the periodic (in accordance with waiver requirements), face-to-face review of a member's condition and service needs.

**Reconsideration –** A provider's request for review of an adverse action. Humana' reconsideration decision is a prerequisite to a provider's filing of an appeal to DMAS' Appeals Division.

**Registered nurse (RN) –** A person licensed or certified in Virginia as an RN or holds a RN/LPN license with multistate privilege recognized by Virginia in accordance with §54.1-3040.1 et. seq., of the Code of Virginia.

**Rehabilitation services and devices –** Services and devices used in to help the member recover from an illness, accident or major operation.

**Remand –** The return of a case by DMAS' hearing office to Humana for further review, evaluation and action.

**Residential Crisis Stabilization Unit –** Residential crisis stabilization units serve as diversion facilities from inpatient hospitalization by providing short-term, 24 hours a day, 7 days a week, facility-based psychiatric/substance-related crisis evaluation and brief intervention services. The service supports individuals experiencing abrupt and substantial changes in behavior noted by severe impairment or acute decompensation in functioning.

**Respite services –** Services provided to individuals who are unable to care for themselves because of the absence of or need for the relief of unpaid caregivers who normally provide the care. Respite services can refer to skilled nursing respite or unskilled respite.

**Rural health clinic –** A rural health clinic is a facility as defined in 42 CFR §491.2, as amended.

**Safety net providers –** Providers who organize and deliver a significant level of healthcare and other related services to Medicaid, FAMIS, uninsured and other vulnerable populations.

**Screening –** Screening is the process to:

- Evaluate the functional, nursing and social supports of individuals referred for screening for certain long-term services requiring NF eligibility;
- Assist individuals in determining what specific services the individual needs;
- Evaluate whether a service or a combination of existing community services are available to meet the individual's needs; **and**
- Provide a list to individuals of appropriate providers for Medicaid-funded NF or home- and community-based care for those individuals who meet NF LOC.

**Sentinel event –** A patient safety event involving a sentinel death (not primarily related to the natural course of the illness or underlying condition for which the member was being treated or monitored by a medical professional at the time of the incident) or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function that leads to permanent or severe temporary harm. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

**Serious mental illness (SMI) –** The term used to refer to individuals 18 and older who have severe and persistent mental or emotional disorders that seriously impair their functioning in such primary aspects of daily living as personal relations, self-care skills, living arrangements or employment. This includes individuals who are seriously mentally ill and who have also been diagnosed as having a substance abuse disorder or developmental disability. The population is defined along 3 dimensions—diagnosis, level of disability and duration of illness—all of which must be met to meet the criteria for serious mental illness.

**Service authorization (SA) –** A program integrity activity that requires a provider to submit documentation to support the medical necessity of services before that claim is billed and processed for payment. Prepayment review is often focused on controlling utilization of specific services by a predetermination the service is medically necessary for an individual.

**Service authorization request –** A Humana member's request for the provision of a service.

**Specialist –** A doctor who specializes in treating certain diseases, health problems or conditions. This does not include a primary care or pediatric doctor.

**Stabilized –** As defined in 42 CFR §489.24(b), stabilized means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer (including discharge) of the individual from a hospital or, in the case of a pregnant individual who is having contractions, that the individual has delivered the child and the placenta.

**State fair hearing –** DMAS' evidentiary hearing process for member appeals. The member can appeal any adverse internal appeal decision rendered by Humana to DMAS' appeals division. DMAS conducts evidentiary hearings in accordance with regulations at 42 CFR §431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

**State institution for mental disease or state-run IMD or state mental hospital –** A hospital, psychiatric institute or other institution operated by the DBHDS that provides care and treatment for persons with mental illness.

**State Plan for Medical Assistance (state plan) –** The comprehensive written statement submitted to CMS by DMAS describing the nature and scope of the Virginia Medicaid program and giving assurance it will be administered in conformity with the requirements, standards, procedures and conditions for obtaining federal financial participation. DMAS has the authority to administer the state plan for Virginia under Code of Virginia § 32.1-325, as amended.

**State plan substituted services (in lieu of services) –** Alternative services or services in a setting that are not included in the state plan or not normally covered but are medically appropriate, cost-effective substitutes for state plan services (for example, a service provided in an ambulatory surgical center or sub-acute care facility, rather than an inpatient hospital). Humana does not require a member to use a state plan substituted service/"in lieu of" arrangement as a substitute for a state plan covered service or setting, but may offer and cover such services or settings as a means of ensuring appropriate care is provided in a cost-efficient manner.

**Store-and-forward –** A term used in telehealth, when prerecorded images, such as X-rays, video clips and photographs are captured, then forwarded to, retrieved, viewed and assessed by a provider. Some common applications include teledermatology where digital pictures of a skin problem are transmitted and assessed by a dermatologist; teleradiology where X-ray images are sent to and read by a radiologist; and teleretinal imaging where images are sent to and evaluated by an ophthalmologist to assess for diabetic retinopathy.

**Subcontract –** A written contract between Humana and a third party, under which the third party performs any 1 or more of Humana' obligations or functional responsibilities.

**Subcontractor –** An individual or entity that has a contract with Humana to perform part of the responsibilities under the contract between Humana and DMAS that relates directly or indirectly to the performance of Humana' obligations under its contract with the state. For subcontracts that require the subcontractor be responsible for the provision of covered services, the subcontractor must be considered both a subcontractor and a network provider for the purposes. A network provider is not a subcontractor by virtue of the network provider agreement with Humana.

**Substance use disorder (SUD) –** Per 12VAC30-130-5020, SUD means a substance-related addictive disorder, as defined in the DSM-5 with the exception of tobacco-related disorders and non-substance-related disorders, marked by a cluster of cognitive, behavioral and physiological symptoms indicating the individual continues to use, is seeking treatment for the use of or is in active recovery from the use of alcohol or other drugs despite significant related problems.

**Telehealth –** The use of telecommunications and information technology to support remote or long-distance physical and behavioral healthcare services. Telehealth is different from telemedicine because it refers to the broader scope of remote healthcare services used to inform health assessment, diagnosis, intervention, consultation, supervision and information across distance and it is not restricted to modalities that involve real time, two-way interaction (see "Telemedicine" below). Telehealth incorporates technologies such as telephone, facsimile machines, electronic, email systems, remote patient monitoring devices and store-and-forward applications, which are used to collect and transmit patient data for monitoring and interpretation.

**Telemedicine –** A service delivery model that uses real time two-way telecommunications to deliver covered physical and BH services for the purposes of diagnosis and treatment of a covered member. Telemedicine must include, at a minimum, the use of interactive audio and video telecommunications equipment to link the member at an originating site to an enrolled provider approved to provide telemedicine services at a distant (remote) site.

**Temporary Detention Order (TDO) –** An involuntary detention order by sworn petition to any magistrate to take into custody and transport for needed mental health evaluation and care or medical evaluation and care of a person who is unwilling or unable to volunteer for such care. A magistrate is authorized to order such involuntary detention on an emergency basis for short periods, pursuant to 42 CFR §441.150 and Code of Virginia § 16.1-336 et seq and § 37.2-809 et seq. Different temporary detention statutes apply for adults and juveniles.

**Therapeutic group home –** A congregate residential service providing 24-hour supervision in a community-based home having 8 or fewer residents.

**Therapeutic day treatment (TDT) for children and adolescents –** A combination of psychotherapeutic interventions combined with evaluation, medication education and management, opportunities to learn and use daily skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control and appropriate peer relations) and individual, group and family counseling offered in treatment programs of 2 or more hours per day.

**Third-party liability (TPL) –** Any entity (including other government programs or insurance) that is or may be liable to pay all or part of the medical cost for injury, disease or disability of a Medicaid member.

**Transportation network companies (TNC) –** Companies that provide prearranged rides for compensation using a digital platform that connects passengers with drivers using a personal vehicle. TNC drivers are referred to as TNC partners. For more information visit the DMV website.

**Triggering event –** Any occurrence that suggests a change in a member's condition or status that places the member at a higher risk of harm or jeopardizes their health, safety and welfare.

**23-hour crisis stabilization –** 23-hour crisis stabilization provides a period of up to 23 hours in a community-based facility that provides assessment and stabilization interventions to individuals experiencing a BH crisis. This service should be accessible 24 hours a day, 7 days a week and is indicated for those situations wherein an individual is in an acute crisis and requires a safe environment for observation and assessment prior to determination of whether admission to an inpatient or residential crisis stabilization unit setting is necessary.

**Urgent care –** Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an emergency medical/BH condition, but that are the result of an unforeseen illness, injury or condition for which medical/BH services are immediately required. Urgent care is appropriately provided in a clinic, physician's office or hospital emergency department if a clinic or physician's office is inaccessible. Urgent care does not include primary care services or services provided to treat an emergency medical condition.

**Urgent medical condition –** A medical (physical, mental or dental) condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within 24 hours could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily function;
- Serious dysfunction of any bodily organ or part; **or**
- In the case of a pregnant individual, serious jeopardy to the health of the fetus.

**Utilization Management –** The process of evaluating the necessity, appropriateness and efficiency of healthcare services against established guidelines and criteria.

**Value-based payment (VBP) –** A broad set of payment strategies intended to improve healthcare quality, outcomes and efficiency by linking financial incentives to performance. Measurement is based on a set of defined outcome metrics of quality, cost and patient-centered care.

**Virginia Uniform Assessment Instrument (UAI) –** The standardized multidimensional assessment instrument completed by the Screening Team that assesses an individual's physical health, mental health, psychosocial and functional abilities to determine if an individual meets the NF LOC.

**Volunteer driver –** An individual who transports members in a vehicle and meets the driver, insurance, vehicle inspection and other safety requirements of a contracted driver and who accepts occasional trips (e.g., long-distance trips or recovery trips) from Humana in exchange for gas and/or mileage reimbursement.

**Waste –** The rendering of unnecessary, redundant or inappropriate services and medical errors and/or incorrect claim submissions. Generally, waste is not considered a criminally negligent action but rather misuse of resources. However, patterns of repetitive waste, particularly when the activity persists after the provider has been notified the practice is inappropriate, may be considered fraud or abuse.

# Acronyms and abbreviations

| Acronyms and abbreviations | |
|---|---|
| **ABD** | Aged, blind and disabled population |
| **ADHC** | Adult day healthcare |
| **AI/AN** | American Indian/Alaska Native |
| **AIDS** | Acquired immune deficiency syndrome |
| **ARTS** | Addiction and recovery treatment services |
| **ASAM** | American Society of Addiction Medicine |
| **CAHPS®** | Consumer Assessment of Healthcare Providers and Systems |
| **CAQH** | Council for Affordable Quality Healthcare |
| **CCMC** | Cardinal Care Managed Care |
| **CFR** | Code of Federal Regulations |
| **CLIA** | Clinical Laboratory Improvement Amendments |
| **CMS** | Centers for Medicare & Medicaid Services |
| **CPT®** | Current Procedural Terminology |
| **CSB** | Community Service Board |
| **CSR** | Controlled Substance Registration |
| **DBHDS** | Department of Behavioral Health and Developmental Services |
| **DD** | Developmental disability |
| **DEA** | Drug Enforcement Administration |
| **DESI** | Drug Efficacy Study Implementation |
| **DMAS** | Department of Medical Assistance Services |
| **DME** | Durable medical equipment |
| **DSM** | Diagnostic and Statistical Manual of Mental Disorders |
| **D-SNP** | Dual-Eligible Special Needs Plan |
| **DSS** | Department of Social Services |
| **EFT** | Electronic funds transfer |
| **EHR** | Electronic health record |
| **EI** | Early intervention |
| **EIS** | Early intervention services |
| **EOR** | Explanation of review |
| **EPSDT** | Early and Periodic Screening, Diagnostic and Treatment |

| Acronyms and abbreviations | |
|---|---|
| **EQRO** | External Quality Review Organization |
| **ERA** | Electronic remittance advice |
| **EVV** | Electronic visit verification |
| **FAMIS** | Family Access to Medical Insurance Security |
| **FDA** | Food and Drug Administration |
| **FFS** | Fee-for-service |
| **FQHC** | Federally Qualified Health Center |
| **HCBS** | Home- and Community-Based Care Services |
| **HEDIS** | Healthcare Effectiveness Data and Information Set |
| **HIPAA** | Health Insurance Portability and Accountability Act of 1996 |
| **HIV** | Human immunodeficiency virus |
| **IADL** | Instrumental activities of daily living |
| **ICF** | Intermediate care facility |
| **ICP** | Individualized care plan |
| **ICT** | Interdisciplinary care team |
| **ID** | Identification |
| **IFSP** | Individual Family Service Plan |
| **IHCP** | Indian Healthcare Provider |
| **IID** | Individuals with intellectual disabilities |
| **I/T/U** | Indian Tribe, Tribal Organization or Urban Indian Organization |
| **IMD** | Institution for mental disease |
| **LEIE** | Listing of Excluded Individuals and Entities |
| **LOC** | Level of care |
| **LOCERI** | Level of Care Review Instrument |
| **LTSS** | Long-term services and supports |
| **MCHIP** | Managed care health insurance plans |
| **MCO** | Managed care organization |
| **MDS** | Minimum data set |
| **MES** | Medicaid enterprise system |
| **MHS** | Mental health services |
| **MMHS** | MCO member health screening |
| **MTM** | Medication therapy management |

| Acronyms and abbreviations | |
|---|---|
| **NCQA** | National Committee for Quality Assurance |
| **NEMT** | Nonemergency medical transportation |
| **NF** | Nursing facility |
| **NPI** | National Provider Identifier |
| **OIG** | Office of Inspector General |
| **PACE** | Program of All-Inclusive Care for the Elderly |
| **PAL** | Preauthorization list |
| **PCP** | Primary care provider |
| **PHI** | Protected health information |
| **PRSS** | Provider Services Solution |
| **PUMS** | Patient Utilization Management and Safety Program |
| **RN** | Registered nurse |
| **SAM** | System for Award Management |
| **SCHIP** | State Children's Health Insurance Program |
| **SMI** | Serious mental illness |
| **SUD** | Substance use disorder |
| **TDO** | Temporary detention order |
| **TNC** | Transportation network company |
| **TPL** | Third-party liability |
| **TTY/TDD** | Teletype/Telecommunication Device for the Deaf |
| **UAI** | Uniform Assessment Instrument |
| **USC** | United States Code |
| **VAC** | Virginia Administrative Code |
| **VBP** | Value-based payment |
| **VVFC** | Virginia Vaccines for Children Program |

# FIDE SNP Appendix

## FIDE SNP Appendix Section 1: Introduction to Humana's FIDE SNPs in Virginia

### About this appendix

In this appendix, you will find information about processes and requirements specific to Humana's Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) in Virginia. Wherever applicable, we will refer back to our Virginia Medicaid and FIDE SNP Provider Manual or Medicare Provider Manual, available at Humana.com/Publications, to streamline our provider educational materials.

This appendix is revised annually—and more often as needed—to provide new information and updates. The web-based version will represent the latest update.

### About Humana's FIDE SNPs in Virginia

A FIDE SNP is a type of Dual Eligible Special Needs Plan (DSNP), which is a type of Medicare Advantage (MA) plan designed for individuals who are eligible for both Medicare and full Medicaid benefits. In addition to the Medicare plan benefits, FIDE SNP members also receive all Virginia Medicaid benefits under the Humana Healthy Horizons in Virginia plan. FIDE SNPs are the most integrated type of DSNP, offering coverage under a single legal entity that contracts with both Medicare and Medicaid. FIDE SNPs provide a comprehensive range of services, including primary and acute care, long-term services and support (LTSS), behavioral health services, and prescription drug coverage. Humana offers 2 FIDE SNPs in Virginia to serve dual-eligible individuals:

- Humana Dual Fully Integrated H2875-001 (HMO-POS D-SNP), which serves members statewide.
- Humana Dual Fully Integrated H2875-003 (HMO D-SNP), which serves members in the following counties:
  - Bristol City
  - Buchanan
  - Dickenson
  - Grayson
  - Lee
  - Norton City
  - Russell
  - Scott
  - Smyth
  - Tazewell
  - Washington
  - Wise
  - Wythe

FIDE SNPs offer many benefits to individuals who are eligible for both Medicaid and Medicare to facilitate their ability to navigate complex health insurance systems and receive the services and supports they need to thrive and live healthy lives. These benefits include:

- Receiving integrated and cobranded materials, such as member ID cards, benefit determinations, enrollment documents and provider directories
- Coordination of benefits across Medicaid and Medicare, including care management services (e.g., FIDE SNP members have one care manager who manages both their Medicaid and Medicare benefits)
- Aligned enrollment with their Medicaid and Medicare coverage, meaning that their benefits are managed by the same health insurance company, which improves coordination and care management across Medicaid and Medicare benefits

There are several other types of SNP products, as defined by CMS, which target different populations and member needs. This appendix applies only to Humana's FIDE SNPs in Virginia, Humana Dual Fully Integrated H2875-001 and Humana Dual Fully Integrated H2875-003. All other SNP products are out of scope for this appendix, including all Humana Gold Plus plans and Humana Together in Health. If you are serving a member in one of these plans, and need more information, please refer to Humana's Medicare Manual on our website at **Provider Publications | Humana**.

## Joining our network to serve FIDE SNP members

If you are not yet participating in our network but are interested in joining, please reach out to us by calling Provider Services at **844-881-4482**, Monday – Friday, 7 a.m. – 7 p.m., Eastern time or emailing one of the following email addresses, depending on your provider type:

- Physical health providers: **VirginiaProviderUpdates@humana.com**
- Behavioral health providers: **VA_BH_Medicaid@humana.com**
- Home- and community-based services (HCBS) providers: **LTSSContracting@humana.com**

To provide Medicare-covered services to FIDE SNP members, you must enroll in our Virginia Medicare Health Maintenance Organization (HMO) provider network, and to provide Medicaid-covered services to our FIDE SNP members, you must enroll in our Virginia Medicaid provider network. To join our Virginia Medicaid provider network, you must first enroll with DMAS through their **Provider Services Solution (PRSS) enrollment wizard**. Unless you only provide services that are only covered by Medicaid, such as HCBS, we highly recommend that you enroll in both networks to improve access to care and continuity of care for your FIDE SNP patients, as well as to optimize the provider experience. By enrolling in both networks, you will also be eligible to receive a single explanation of remittance and single payment from Medicaid and Medicare for your Humana FIDE SNP-enrolled patients. However, you do not have to enroll in our Medicaid network to receive reimbursement for Medicare cost share amounts covered by Medicaid. Our contracting team will support you throughout the contracting and credentialing process to join both networks.

Before serving FIDE SNP members, you must also be credentialed. For information about credentialing and recredentialing, you should refer to the credentialing chapter of the Medicaid portion of this manual as well as the credentialing section of our **Medicare Provider Manual**, available at **Humana.com/Publications**.

## Helpful websites

Providers can obtain additional information and resources for Humana's FIDE SNP in Virginia by visiting **Humana.com/HealthyVA** and H**umana.com/Publications**. Providers have access to:

- Claim resources
- Health and wellness program resources
- **Making it Easier tutorials**
- Medicare Provider Manual
- Pharmacy Provider Manual
- Provider publications (including newsletters and program updates)
- Quality resources
- Virginia Medicaid Provider Manual

For help or more information regarding web-based tools, please call Provider Services at **844-881-4482** Monday – Friday, 7 a.m. – 7 p.m., Eastern time.

You may also review **CMS' website** for more information on DSNPs as well.

## Provider portal

Humana has partnered with **Availity Essentials** to give providers access to member and claim data for multiple payers using 1 platform and login. With Availity Essentials, providers can:

- Submit claims and view claim status
- Check eligibility and benefits
- Submit and view authorizations and referrals
- Submit appeals
- View remittance advice
- Access electronic funds transfer (EFT) and electronic remittance advice (ERA) enrollment
- Access training

You should follow the same processes to perform any of the above functions for a Humana FIDE SNP member as you would for a Humana Medicaid or Medicare member. For example, you may verify member eligibility for a Medicaid, Medicare or FIDE SNP member by:

- Signing in to **Availity Essentials**
- Navigating to Patient Registration
- Selecting Eligibility and Benefits Inquiry

To learn more about Availity Essentials, call **800-282-4548** Monday – Friday, 8 a.m. – 8 p.m., Eastern time or visit **Availity.com**.

## Accreditation

The National Committee for Quality Assurance (NCQA) review process examines Humana's quality improvement program structure, tests quality improvement processes and looks for evidence that quality improvement activities have resulted in measurable improvement in Humana's performance is designed to measure plan and provider performance on a number of measures to produce a consumer report card. The information collected from managed care plans is published to assist consumers in choosing a healthcare plan, physicians and other healthcare providers. Specific HEDIS measures may change annually to reflect medical advances and to identify new areas in which to focus improvement efforts.

Humana prepares information for NCQA based on data obtained from participating providers in the form of claims or encounter records. In addition to gathering HEDIS data administratively via claims and encounters, Humana also encourages submission of supplemental data. For example, one HEDIS measure is to determine if members with diabetes receive an annual dilated eye examination. The percent of diabetic members who meet HEDIS criteria and have an encounter reported for a dilated retinal eye examination is reported. If there is no report of such an examination, the member is identified as needing an examination. Humana may remind members of the importance of the examination, assist in scheduling an appointment or help overcome their barriers to receiving the examination. The type of outreach the member receives is based upon consumer insights and history of completing a dilated eye examination. Periodically, the Humana quality management department may visit provider offices to review medical records of members and to collect data.

URAC (originally known as Utilization Review Accreditation Commission) is a nonprofit organization founded in 1990 to establish standards for the healthcare industry by providing a method of evaluation and accreditation for a variety of healthcare organizations, including health plans, utilization management organizations, pharmacy benefit managers and others. There are more than 20 accreditation and certification programs—some that review the entire organization, such as the health plan standards, and some that focus on a single functional area in an organization, such as case management or credentialing. Any organization that meets the standards, including hospitals, HMOs, PPOs, TPAs and provider groups, can seek accreditation.

# FIDE SNP Appendix

## FIDE SNP Appendix Section 2: Member eligibility and enrollment

### Member eligibility

Humana's FIDE SNP in Virginia is a type of Medicare plan that enrolls individuals who are entitled to benefits under Medicare Parts A, B and D and are eligible to receive full Medicaid benefits through Virginia's Cardinal Care Managed Care (CCMC) Medicaid program. This includes Full Benefit Dual Eligible (FBDE) members such as:

- Qualified Medicare Beneficiary Plus (QMB+): An individual who is entitled to Medicare and meets the federal income standard of income equal to or less than 100% of the federal poverty level (FPL) and is determined eligible for full Medicaid coverage.
- Special Low Income Medicare Beneficiary Plus (SLMB+): An individual who is entitled to Medicare and meets the federal income standard of income greater than 100% but less than 120% of the FPL and who also meets though a spend-down.
- Other FBDE: An individual who is entitled to Medicare, does not meet the income or resource criteria for QMB+ or SLMB+, but is eligible for full Medicaid coverage either categorically or through optional coverage groups based on Medically Needy status, special income levels for institutionalized individuals, or home and community-based waivers.

All Humana FIDE SNP members are protected from balance billing, meaning that they may not be billed or charged any coinsurance or copay for any covered services provided.

By enrolling in Humana's FIDE SNP, dual-eligible individuals can receive both of their Medicare and Medicaid benefits under one plan. Medicare is available to people who are age 65 or older, younger than 65 with a qualifying disability, or have end stage renal disease, permanent kidney failure requiring dialysis or a kidney transplant. To review eligibility requirements for the CCMC program, please review the **member enrollment and eligibility chapter of the Medicaid portion of this manual**.

### Deeming period

If a member experiences changes to their Medicaid eligibility level or loses Medicaid eligibility, the member is placed into the deeming period. During the deeming period, the member's Medicare FIDE SNP benefits and primary care provider (PCP) remain the same; however, the member does not have any Medicaid benefits. During the time the member is in the deeming period, the amount applied to cost share will be paid under the Humana Medicare plan. Members have up to 6 months to regain

qualifying Medicaid eligibility and remain in the FIDE SNP. If the member does not regain qualifying Medicaid eligibility during those 6 months, they will be disenrolled from the FIDE SNP. As a reminder, you are encouraged to verify a patient's eligibility via Availity Essentials before providing services.

## Verifying member eligibility

Before providing all non-emergency services, you must verify member eligibility. You should ask members to present an identification (ID) card each time services are rendered. If you are not familiar with the member seeking care and cannot verify the person as a Humana member, you should ask to see photo ID. Eligibility can be verified through **Availity Essentials** Member Registration Eligibility and Benefits Inquiry.

## Member enrollment

Members can enroll into a Humana FIDE SNP by working with an enrollment broker or a licensed Medicare agent. All brokers/agents have completed Department of Medical Assistance Services (DMAS) enrollment broker training prior to working in Virginia and annually thereafter. Eligibility begins on the first day of each calendar month for members joining Humana. Depending on their residential address, members may be enrolled into one of two FIDE SNPs:

- Members with a residential address in any Virginia county may enroll in our H2875-001 FIDE SNP.
- Members with a residential address in one of the following 13 counties may enroll in our H2875-003 FIDE SNP:
  - Bristol City
  - Buchanan
  - Dickenson
  - Grayson
  - Lee
  - Norton City
  - Russell
  - Scott
  - Smyth
  - Tazewell
  - Washington
  - Wise
  - Wythe

## Exclusively aligned enrollment

Exclusively aligned enrollment means the full dual eligible member's DSNP Medicare plan provider is the same as the member's Medicaid managed care organization (MCO). The member has Humana for both their Medicare and their Medicaid benefits, so when a member enrolls in the Humana FIDE SNP, the state automatically enrolls them into the Humana plan within a month of their enrollment in our FIDE SNP.

## Default enrollment

Following CMS approval, the Virginia FIDE SNP will utilize the CMS default enrollment process. This process will enroll current Humana members who are newly eligible for both Medicare Part A and Part B for the first time into a Humana FIDE SNP.

90 days before the Medicare eligibility effective date, Virginia Cardinal Care mails default enrollment eligible individuals a letter advising that they will be default enrolled into a Humana FIDE SNP. Members are advised within this letter that they have the right to opt-out of default enrollment up to the day before the Medicare eligibility effective date.

60 days before the Medicare eligibility effective date, Humana mails the member a letter advising that they will be default enrolled into a Humana FIDE SNP. Members are advised that they have the right to opt-out of default enrollment up to the day before the Medicare eligibility effective date and may:

- Remain on original Medicare with Humana.
- Enroll with a different health plan provider's FIDE SNP.
  - Using exclusively aligned enrollment, Virginia Medicaid will switch the Medicaid MCO provider.
- Enroll into a Humana general enrollment Medicare Advantage (MA)/Medicare Advantage Prescription Drug (MAPD) plan, Humana ISNP (Institutional and Institutional Equivalent), or Humana CSNP (Chronic Condition) with Humana.
- Enroll into a competitor's Medicare general enrollment MA/MAPD plan, ISNP or CSNP with Humana as the Medicaid MCO.

## PCP choice and assignment

Humana offers each FIDE SNP member the opportunity to choose a Humana-affiliated PCP to the extent open panel slots are available. FIDE SNP members can select a PCP from our integrated provider directory, inclusive of Medicaid and Medicare providers, at **Humana.com/FindADoctor**. If eligible members do not request an available PCP prior to the 25th day of the month prior to the enrollment effective date, then Humana assigns the new member to a PCP within our network, taking into consideration known factors such as:

- Current or past provider relationships
- Language needs
- Age and sex
- Enrollment of family members (e.g., siblings)
- Area of residence

Humana notifies the member in writing, on or before the effective date of enrollment with Humana, of their PCP's name, location and office phone number.

## PCP changes

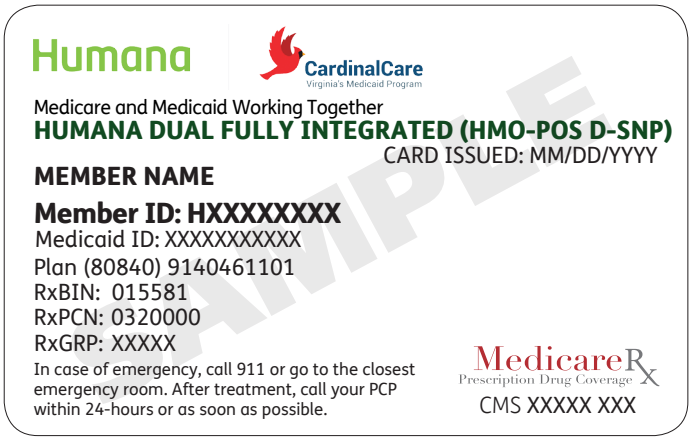
Members have the option to change to another participating PCP as often as needed. PCP changes are effective on the first day of the month following the requested change. Humana members can select a new PCP or be assigned one by request when Humana has terminated a PCP or when a PCP change is ordered as a part of the resolution to a formal grievance proceeding. When a member changes PCPs, Humana provides assistance with ensuring the member's medical records or copies of them are available to their new PCP within 10 business days from receipt of the medical record request.

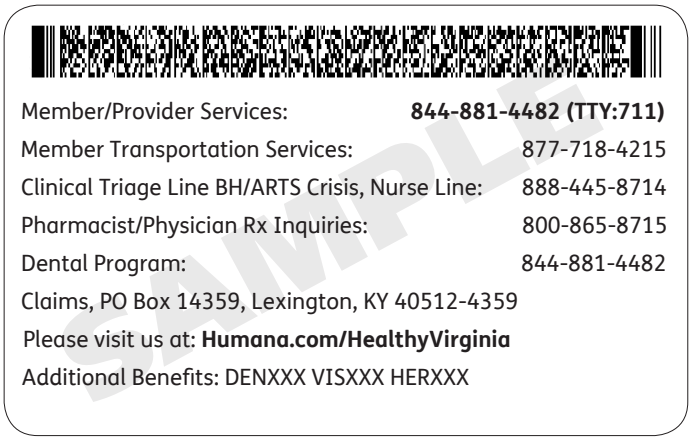
## Member ID cards

All new Humana FIDE SNP members receive a single, integrated member ID card. Humana FIDE SNP members do not need separate ID cards for Medicaid and Medicare. A new card is issued only if the information on the card changes, the card is lost, or an additional card is requested. The member ID

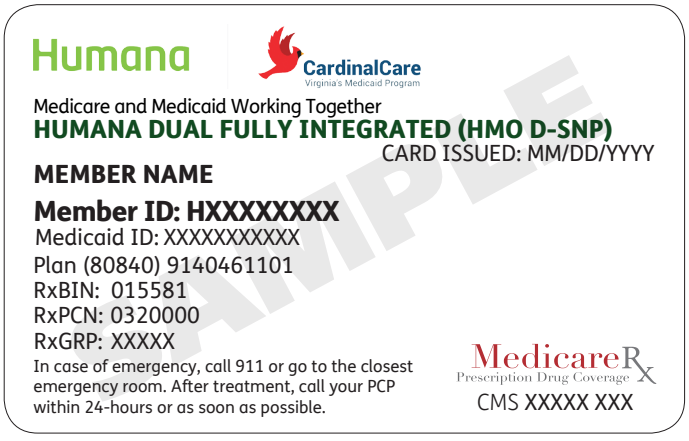
card is used to identify a Humana member but does not guarantee eligibility or benefits coverage because members may disenroll from Humana or lose Medicaid eligibility at any time. Therefore, it is important to verify member eligibility prior to rendering any service. Sample images of the Humana FIDE SNP member ID cards are included below:

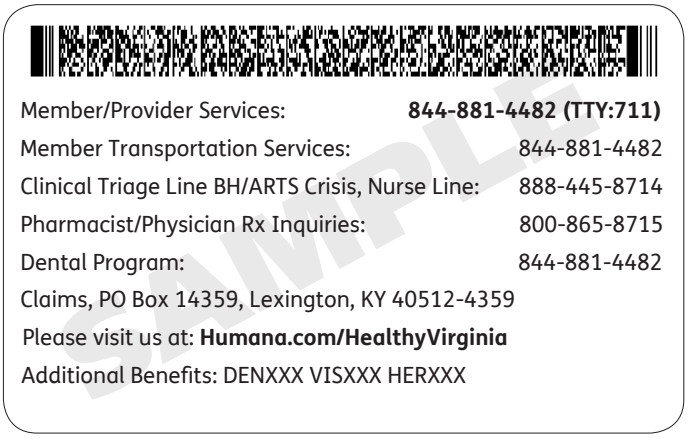
**Sample Humana Dual Fully Integrated H2875-001 (HMO-POS D-SNP) member ID card front and back:**




**Sample Humana Dual Fully Integrated H2875-003 (HMO D-SNP) member ID card front and back:**




If a member requires a new ID card, they can call Member Services at **844-881-4482** Monday – Friday,8 a.m. – 8 p.m., Eastern time.

## Member welcome kit

Each new member receives a new member kit and an ID card. New member kits are mailed separately from the ID card. The new member kit contains:

- Quick Start Guide booklet
- Applicable member forms and a postage-paid return envelope for ease of returning forms
- A hard copy notice (self-mailer postcard) to use to request a one-time printed copy of plan materials (e.g., summary of benefits, evidence of coverage, formulary, provider/pharmacy directory)

## Member disenrollment

Members may be disenrolled from Humana for several reasons. Humana, the state, or CMS can initiate disenrollment, which may be initiated for the following:

- Unauthorized use of a member ID card
- Use of fraud or forgery to obtain medical services
- Disruptive or uncooperative behavior to the extent that it seriously impairs the ability to deliver care to the member or to other patients
- Death of member
- Loss of Medicare entitlement to Part A and/or Part B
- Humana's contract is terminated, or Humana reduces its service area, excluding the member
- Member permanently moves outside the service area, is away from the service area for more than 6 consecutive months, or is incarcerated and, therefore, out of the area
- Member is not lawfully present in the United States
- The SNP member loses special needs status and does not reestablish SNP eligibility prior to the expiration of the period of deemed continued eligibility

Please notify Provider Services at **844-881-4482** Monday – Friday, 7 a.m. – 7 p.m., Eastern time if 1 or more of these situations occur.

# FIDE SNP Appendix

## FIDE SNP Appendix Section 3: Member rights and responsibilities

Humana requires our staff and affiliated providers to comply with any applicable federal and state laws that pertain to member rights. Humana complies with:

- Title VI of the Civil Rights Act of 1964 as implemented at 45 CFR Part 80
- The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR Part 91
- The Rehabilitation Act of 1973
- Title IX of the Education Amendments of 1972 (regarding education programs and activities)
- Titles II and III of the Americans with Disabilities Act
- Section 1557 of the Patient Protection and Affordable Care Act
- All federal and state laws and regulations regarding privacy and confidentiality
- Rules of accrediting and regulatory agencies concerning member rights

The rights and responsibilities listed below, though not intended to be exhaustive, remind members and providers of their complementary roles in maintaining a productive relationship.

### Member rights

Members have the right to:

- Be free from discrimination based on race, color, ethnic or national origin, age, sex, sexual orientation, gender identity and expression, religion, political beliefs, marital status, pregnancy or childbirth, health status or disability
- Be treated with courtesy and respect, with appreciation for their dignity and protection of their right to privacy
- Understand the healthcare information they receive
- Interpretation, written translation and auxiliary aids are available at no cost
- Access healthcare and services in a timely, coordinated and culturally competent way
- Receive information from their provider and health plan about treatment choices and have a candid discussion of appropriate or medically necessary treatment options, regardless of cost or benefit coverage
- Participate with providers in all decisions about their healthcare, including the right to say “no” to any treatment offered

- Ask their health plan for help if their provider does not offer a service because of moral or religious reasons
- Discuss their medical record with their physician and receive, upon request, a copy of that record and ask for it to be changed or corrected in accordance with state and federal law
- Have their medical records and treatment be confidential and private
  - Humana will only release their information if it is allowed under federal or state law or if it is required to monitor quality of care or protect against fraud, waste and abuse.
- Live safely in the setting of their choice
- If a member or someone they know is being abused, neglected or financially taken advantage of, they should call their local DSS or Virginia DSS at **888-832-3858**.
- Receive information on their rights and responsibilities and exercise their rights without being treated poorly by their providers, Humana or DMAS
- Make recommendations regarding the member rights and responsibilities policy
- Be free from any restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- File appeals and complaints and ask for a state fair hearing
- Exercise any other rights guaranteed by federal or state laws (the Americans with Disabilities Act, for example)
- Be provided with information about their plan, its services and benefits, its providers and the rights and responsibilities of members
- Choose a PCP from our network of affiliated providers and change to another PCP in the Humana network
- Request a practitioner that has the same race, ethnicity and/or language as themselves if there is a practitioner available in their network
- Have a candid discussion with their provider about appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Expect reasonable access to medically necessary healthcare services, regardless of gender, race, national origin, religion, physical abilities or source payment
- File a formal complaint or appeal, as outlined in Humana's grievance procedure, and expect a response to that complaint within a reasonable period of time
- Expect Humana to adhere to all privacy and confidentiality policies and procedures
- Receive services that are provided in a culturally competent manner
- Receive treatment for any emergency medical condition
- Select an in-network provider and not be balance billed for medically necessary covered services
- Receive an explanation of benefits (EOB) and discuss that EOB with Humana
- File a claim or have a claim filed by a provider on their behalf
- Request and receive an organization determination from Humana regarding the services or treatment being requested, in the event that MA members disagree with their physician about a denial of service

## Member responsibilities

Members have the responsibility to:

- Follow their member handbook, understand their rights and ask questions when they do not understand or want to learn more
- Treat their providers, Humana staff and other members with respect and dignity
- Choose their PCP and, if needed, change their PCP
- Schedule appointments, arrive on time for scheduled visits and notify their healthcare provider if they must cancel or be late for a scheduled appointment
- Carry their Humana ID card with them at all times and use it while enrolled in the plan, including by showing it whenever they get care and services
- Give the plan and their healthcare provider (to the best of their ability) complete and accurate information needed for their care about their medical history and their symptoms
- Understand their health problems and participate in developing agreed-upon treatment goals with their healthcare provider
- Work with their care manager and care team to create and follow a care plan that is best for them
- Invite people to their care team who will be helpful and supportive to be included in their treatment
- Tell Humana when they need to change their care plan
- Get covered services from the Humana network when possible
- Get approval from Humana for services that require a service authorization
- Use the emergency room for emergencies only
- Pay for services they get that are not covered by Humana or DMAS
- Report suspected fraud, waste and abuse
- Call Humana Member Services at **844-881-4482** Monday – Friday, 8 a.m. – 8 p.m., Eastern time to let them know if:
  - Their name, address, phone number or email have changed
  - Their health insurance changes (from their employer or workers' compensation, for example) or they have liability claims, like from a car accident
  - Their member ID card is damaged, lost or stolen
- Read and be aware of all material distributed by the plan explaining policies and procedures regarding services and benefits
- Obtain and carefully consider all information they may need or desire to give informed consent for a procedure or treatment
- Be considerate and cooperative in dealing with Humana providers and respect the rights of fellow members
- Express opinions, concerns or complaints in a constructive manner

- Inform Humana of any change in their contact information, such as address or phone number, even if these changes are only temporary
- Follow healthcare facility rules and regulations affecting patient care and conduct
- Follow the plans and instructions for care that they have agreed upon with their providers

# FIDE SNP Appendix

## FIDE SNP Appendix Section 4: Provider rights and responsibilities

### Provider responsibilities and responsibilities overview

You are expected to treat members with respect. Our members should not be treated differently than patients with other healthcare insurance. For more information, please refer to the **provider rights and responsibilities chapter of the Medicaid portion of this manual**. A variety of topics are covered such as:

- Americans with Disabilities Act (ADA) requirements
- Nondiscrimination
- Advanced directives
- Health Insurance Portability and Accountability Act (HIPAA)
- Provider training, including information on Cultural Competency and Health, Safety and Welfare trainings
- Identifying and reporting member abuse, neglect and exploitation
- Member billing/missed appointments

### Critical incident reporting

You also have the responsibility to report critical incidents. For information on reporting critical incidents, please refer to the **quality management chapter of the Medicaid portion of this manual**.

### Liability insurance

Upon request, all providers must provide Humana with evidence of insurance coverage in accordance with their agreement's requirements.

### Access to care standards

Providers in our Medicaid provider network must comply with Medicaid access to care standards as outlined in the **provider rights and responsibilities chapter of the Medicaid portion of this manual**. Providers in our Medicare provider network must implement procedures and make reasonable efforts to ensure that:

- Patients are seen by a clinician within 15 minutes of the patient's appointment time.
- Routine and follow-up appointments are made within 30 calendar days.

- Urgent appointments are made within 24 hours, 7 days a week.
- Urgently needed services are provided immediately for Medicare members.
- Emergency appointments are made immediately (arrange for on-call or after-hours coverage), 24 hours a day, 7 days a week.
- The standards consider the member's need and common waiting times for comparable services in the community. Examples of reasonable standards for primary care services are:
  - Urgent or emergency services – immediately;
  - Services that are not emergency or urgently needed, but in need of medical attention – within 1 week; **and**
  - Routine and preventive care – within 30 days.

Providers in both our Medicaid and Medicare provider networks must comply with both our Medicaid and Medicare access to care standards.

## Provider training

In addition to the training requirements and resources outlined in the **provider rights and responsibilities chapter of the Medicaid portion of this manual**, providers serving FIDE SNP members must complete our Special Needs Plans Training for Physicians annually which covers an overview of the model of care. To access the training and obtain additional information about the model, please refer to **Humana.com/ProviderCompliance**.

Identifying and reporting fraud, waste and abuse

For information on identifying and reporting fraud, waste and abuse, please review the **fraud, waste and abuse chapter of the Medicaid portion of this manual**.

## Marketing

Marketing and promotional activities, including provider promotional activities, must comply with all relevant federal and state laws, including, when applicable, the antikickback statute, which is a civil monetary penalty prohibiting inducements to members.

## CMS requirements

Humana is responsible for including certain CMS MA-related provisions in the policies and procedures distributed to the providers that constitute Humana's health services delivery network. The following table summarizes these provisions, which can be accessed online by visiting **Code of Federal Regulations on the U.S. Government Printing Office website**.

| Summary of CMS requirements | CFR42 (section) |
|---|---|
| Safeguard privacy and maintain records accurately and timely | 422.118 |
| Permanent "out of area" members to receive benefits in continuation area | 422.54(b) |
| Prohibition against discrimination based on health status | 422.110(a) |
| Pay for emergency and urgently needed services | 422.100(b) |

| Summary of CMS requirements | CFR42 (section) |
|---|---|
| Pay for renal dialysis for those temporarily out of a service area | 422.100(b)(1)(iv) |
| Direct access to mammography and influenza vaccinations | 422.100(g)(1) |
| No copay for influenza and pneumococcal vaccines | 422.100(g)(2) |
| Agreements with providers to demonstrate "adequate" access | 422.112(a)(1) |
| Direct access to women's specialists for routine and preventive services | 422.112(a)(3) |
| Services available 24 hours a day, 7 days week | 422.112(a)(7) |
| Adhere to CMS marketing provisions | 422.80(a), (b), (c) |
| Ensure services are provided in a culturally competent manner | 422.112(a)(8) |
| Maintain procedures to inform members of follow-up care or provide training in self-care as necessary | 422.112(b)(5) |
| Document in a prominent place of an individual's medical record if that individual has executed an advance directive | 422.128(b)(1)(ii)(E) |
| Provide services in a manner consistent with professionally recognized standards of care | 422.504(a)(3)(iii) |
| Continuation of benefits provisions (may be met in several ways, including contract provision) | 422.504(g)(2)(i);<br>422.504(g)(2)(ii);<br>422.504(g)(3) |
| Payment and incentive arrangements specified | 422.208 |
| Subject to applicable federal laws | 422.504(h) |
| Disclose to CMS all information necessary to (1) administer and evaluate the program (2) establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services | 422.64(a)<br>422.504(a)(4)<br>422.504(f)(2) |
| Must make good faith effort to notify all members affected by the termination of a provider contract 30 calendar days before their termination by plan or provider | 422.111(e) |
| Submit data and medical records and certify completeness and truthfulness | 422.310(d)(3)-(4)<br>422.310(e)<br>422.504(d)-(e)<br>422.504(i)(3)-(4)<br>422.504(l)(3) |
| Comply with medical policy, quality improvement and medical management | 422.202(b)<br>422.504(a)(5) |
| Disclose to CMS quality and performance indicators for plan benefits regarding disenrollment rates for beneficiaries enrolled in the plan for the previous two years | 422.504(f)(2)(iv)(A) |
| Notify providers in writing for reason of denial, suspension and/or termination | 422.202(d)(1) |

| Summary of CMS requirements | CFR42 (section) |
|---|---|
| Provide 60-day notice (terminating contract without cause) | 422.202(d)(4) |
| Comply with federal laws and regulations including, but not limited to, federal criminal law, the False Claims Act (31 U.S.C. et Seq.) and the anti-kickback statute (section 1128B(b) of the act) | 422.504(h)(1) |
| Prohibition of use of excluded practitioners | 422.752(a)(8) |
| Adhere to appeals/grievance procedures | 422.562(a) |

## List of provider rights and responsibilities

You should consider the following rights and responsibilities when caring for Humana FIDE SNP members:

- Have a professional degree and a current, unrestricted license to practice medicine in the state in which your services are regularly performed.
- Agree to comply with Humana's quality assurance, quality investigation and peer review process, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures established and revised by Humana.
- Be credentialed by Humana and meet all credentialing and recredentialing criteria as required.
- Not be on the HHS Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE) or the General Service Administration's System of Award Management (SAM) debarment list.
- Not be on the CMS preclusion list (MA providers).
- Provide documentation on your experience, background, training, ability, malpractice claims history, disciplinary actions or sanctions, and physical and mental health status for credentialing purposes.
- Possess a current, unrestricted Drug Enforcement Administration (DEA) certificate, if applicable, and/or a state Controlled Dangerous Substance (CDS) certificate or license, if applicable.
- Have a current Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.
- Be a medical staff member in good standing with a participating network hospital(s) if you make plan-member rounds and have no record of hospital privileges having been reduced, denied or limited, or if so, provide an explanation that is acceptable to the plan.
- Inform Humana in writing within 24 hours of any revocation or suspension of your Bureau of Narcotics and Dangerous Drugs number and/or of suspension, limitation or revocation of your license, reduction and/or denial of hospital privileges, certification, CLIA certificate or other legal credential authorizing you to practice in any state in which you are licensed.
- Inform Humana immediately of changes in licensure status, tax identification numbers, National Provider Identifier (NPI), telephone numbers, addresses, status at participating hospitals, provider status (additions or deletions from provider practice), loss or decrease in amounts of liability insurance below the required limits and any other change which would affect your participation status with Humana.

- Not discriminate against members as a result of their participation as members, their source of payment, age, race, color, national origin, religion, sex, sexual preference, health status or disability.
- Not discriminate in any manner between Humana members and non-Humana members.
- Inform members regarding follow-up care or provide training in self-care.
- Assure the availability of physician services to members 24 hours a day, 7 days a week (required for HMO PCPs and all MA providers).
- Arrange for on-call and after-hours coverage by a participating and credentialed Humana physician (required for HMO PCPs and all MA providers).
- Refer Humana members with problems outside of your normal scope of practice for consultation and/or care to appropriate specialists contracted with Humana on a timely basis, except when participating providers are not reasonably available or in an emergency.
- Refer members only to participating providers, except in an emergency.
- Admit members only to participating network hospitals, SNFs and other facilities and work with hospital-based physicians at participating hospitals or facilities in cases of need for acute hospital care, except when participating providers or facilities are not reasonably available or in an emergency.
- Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Humana member, subscriber, or enrollee other than for copayments, deductibles, coinsurance, other fees that are the member's responsibility under the terms of their benefit plan, or fees for noncovered services furnished on a fee-for-service basis. Non-covered services are services not covered, or services excluded in the member's plan.
- For a MA plan member, you may only collect for a service not covered under the terms of the applicable member plan if you followed the procedures outlined in the Utilization Management/ Preauthorization (Prior Authorization) section of **Humana's Medicare Provider Manual**.
- Provide services in a culturally competent manner (e.g., removing all language barriers; arranging and paying for interpretation services for limited English proficient LEP and the deaf and hard of hearing or blind or partially sighted) as required by state and federal law. Care and services should accommodate the special needs of ethnic, cultural and social circumstances of the patient. Additional information and resources are made available by the U.S. Department of Health and Human Services, Office of Minority Health at **https://thinkculturalhealth.hhs.gov/**
- Provide access to healthcare benefits for all Humana members in a manner consistent with CMS requirements for any Humana MA member.
- For MA members who have end- stage renal disease (ESRD), complete the Chronic Renal Disease Medical Evidence Report, which is provided by the Social Security office when the provider becomes aware of the disease. The form must be completed and returned to the Social Security office and the ESRD Network. Mail the form to:

  **Humana**
  Attn: Medicare Reconciliation Department – ESRD Unit Waterside Building
  101 E. Main St.
  Louisville, KY 40202

- Provide or arrange for continued treatment to all members including, but not limited to, medication therapy, upon expiration or termination of the agreement.
- Help guarantee accessibility of services to members by maintaining a ratio of members to full-time equivalent (FTE) physicians as follows:
  - 1 physician FTE for 1,500 Medicaid members.
- Retain all agreements, books, documents, papers and medical records related to the provision of services to members as required by state and federal laws and in accordance with relevant Humana policies.
- Treat all member records and information confidentially and not release such information without the written consent of the member, except as indicated herein, or as allowed by state and federal law, including HIPAA regulations.
- Upon request of Humana, provide an electronic, automated means, at no cost, for Humana and all Humana-affiliated vendors acting on behalf of Humana to access member clinical information including, but not limited to, medical records, for all payer responsibilities including, but not limited to, case management, utilization management, claims review and audit and claims adjudication.
- Transfer copies of medical records for the purpose of continuity of care to other Humana providers upon request and at no charge to Humana, the member or the requesting party, unless otherwise agreed upon.
- Provide copies of, access to and the opportunity for Humana or its designee to examine your office books, records and operations of any related organization or entity involving transactions related to health services provided to members. A related organization or entity is defined as having:
  - Influence, ownership or control; **and**
  - Either a financial relationship or a relationship for rendering services to the primary care office.

  The purpose of this access is to help guarantee compliance with all financial, operational, quality assurance and peer review obligations, as well as any other provider obligations stated in the agreement or in this manual. Failure by any person or entity involved, including the provider, to comply with any requests for access within 10 business days of receipt of notification will be considered a breach of contract. For records related to Humana MA enrollees, this access right is for the time stipulated in the agreement or the time period since the last audit, whichever is greater.
- To the extent applicable to the physician, assume full responsibility to the extent of the law when supervising/ sponsoring, whether through a protocol, collaborative or some other type of agreement, physician assistants, advanced practice registered nurses, nurse practitioners and all other healthcare professionals required to be supervised or sponsored, whether through a protocol, collaborative or some other type of agreement under applicable federal and state law in order to treat members.
- Submit a report of an encounter for each visit when the member is seen by you. Encounters should be submitted electronically or recorded on a CMS-1500 claim form and submitted according to the time frame listed in the agreement.

- Meet the requirements of all applicable state and federal laws and regulations, including Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act and the Rehabilitation Act of 1973.
- Perform services under the agreement consistent and in compliance with Humana's contractual obligations under its MA contract(s).
- Cooperate with and assist Humana in our efforts to comply with our MA contract(s) and/ or MA rules and regulations and assist Humana in complying with corrective action plans necessary for Humana to comply with such rules and regulations.
- Submit complete member referral information when applicable and in a timely manner to Humana via electronic means or telephone.
- Notify Humana of scheduled surgeries/procedures requiring inpatient hospitalization.
- Notify Humana of any material change in your performance of delegated functions, if applicable.
- Notify Humana of your termination 60 days prior to the effective date of termination.
- Not be excluded from participating in Medicare.
- Cooperate with an independent review organization's activities pertaining to the provision of services for Medicare enrollees in an MA plan and Medicaid members. Respond expeditiously to Humana's requests for medical records or any other documents to comply with regulatory requirements and to provide any additional information about a case in which a member has filed a grievance or appeal.
- Abide by the rules and regulations and all other lawful standards and policies of the plan(s) with which you are contracted, including Humana's.
- Adhere to **Ethics Every Day for Contracted Healthcare Providers and Business Partners**.
- Understand and agree that nothing contained in the agreement or this manual is intended to interfere with or hinder communications between providers and members regarding a member's medical condition or available treatment options or to dictate medical judgment.
- For providers who participate in MA networks and who participate in Original Medicare, abide by the guidelines set out in Humana's Rules of Participation for MA Networks. A paper copy can be obtained upon request.
- For providers who have downstream agreement(s) with physicians or other providers who provide services to Humana members, agree to provide a copy of said agreement(s) to Humana upon request (financial information is not requested).
- Abide by all state and federal laws regarding confidentiality, privacy and disclosure of medical records or other health and enrollment information.
- Submit a claim on behalf of the member in accordance with timely filing laws, rules, regulations and policies.
- Agree to pay court costs and/or legal fees incurred by Humana or the member to enforce the terms of this provision.

- Understand and agree that provider performance data can be used by Humana.
- Not require members to select and pay for any type of "concierge medicine" program to receive services, items and/or benefits covered by the applicable Humana plan from the provider. Humana considers concierge medicine programs to include any practice management model under which a provider charges each patient a monthly, annual or other periodic fee in exchange for enhanced practice services over and above those services that are covered under the member's health benefit plan, or charges such a fee before agreeing to provide any medical services to a patient. You may offer a concierge medicine program to members, provided that any such program meets the following requirements:
  - You accept Humana's reimbursement as payment in full for all services that are covered services under the member's health benefit plan and you are prohibited from holding Humana members liable for the payment of such services, except for member cost-sharing authorized under the plan.
  - Any fees paid by members for your concierge medicine program cannot be in exchange for services that are covered services under the member's health benefit plan. You must be accessible and available to members consistent with Humana's participating provider requirements including, but not limited to, those requirements outlined in this manual, your participation agreement with Humana and those requirements outlined by any applicable state or federal law, including but not limited to those requirements outlined by CMS under the Medicare Managed Care Manual MMCM, Ch. 4, Section 110.1.1, regardless of whether a member chooses to participate in the provider's concierge medicine program. You shall ensure that quality of care will not be adversely impacted if a member chooses not to participate in your concierge medicine program.
  - You are prohibited from offering a concierge medicine program in any way that discriminates against members.
  - A member's choice to participate in your concierge medicine program must be entirely voluntary. You are prohibited from inappropriately coercing or pressuring a member to participate in a concierge medicine program.
  - Any concierge medicine program agreement with a member must: (a) inform the member that the program is optional and that they do not have to select and pay for the program to receive healthcare services from the provider that are covered services under their health benefit plan; (b) list the fee or fees and the added services, items and/or benefits included in the program; and (c) inform the member that the selection of, and payment for, the program is solely for services, items and/or benefits in addition to services that are covered services under their health benefit plan.
- Ensure confidentiality of family planning services in accordance with the Medicaid Contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act.
- As applicable, abide by the terms of the Medicaid contract for the timely provision of emergency and urgent care. Emergency services shall be available 24 hours a day and 7 days a week; urgent care appointments and symptomatic office visits shall be available as soon as the symptom demands but in no event more than 24 hours of the member's request. Where applicable, providers

must agree to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency department Memorandums of Understanding signed by Humana in accordance with the Medicaid Contract.

- Not create barriers to access to care by imposing requirements on members that are inconsistent with the provision of medically necessary and covered Medicaid services.
- Except in the case of death or illness, agree to notify Humana at least 30 days in advance of disenrollment and agree to continue care for your panel members for up to 30 days after such notification, until another provider is chosen or assigned.
- Meet Humana standards for licensure, certification and credentialing.
- In accordance with requirements set forth in 1932(d)(6) and 1173(b) of the Social Security Act, each provider rendering covered services must have a unique NPI in accordance with the system set up under Section 1173(b) of the Social Security Act. This rule applies to all provider types and specialties.
  - Providers must use these identifiers when submitting data to Humana. The NPI is provided by CMS, which assigns the unique identifier through its National Plan and Provider Enumeration System.
- At the time of application to become part of Humana's network, credentialing and/or recredentialing and/or upon request from Humana, you must disclose required information for disclosure of ownership interests, business transactions and information on persons convicted of crimes related to any federal healthcare programs.
- Screen your directors, officers, employees and contractors initially and on a monthly basis against the Exclusion Lists to determine whether any of your employees/contractors have been excluded from participating in Medicare, Medicaid, State Children Health Insurance Program (SCHIP) or any federal healthcare programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. You must immediately report to Humana any exclusion information upon discovery. You must accept and acknowledge that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to members.
- Be screened, enrolled (including signing a DMAS Medicaid provider participation agreement) and periodically revalidated in DMAS' Medicaid Enterprise System (MES) Provider Services Solution (PRSS). This does not require you, as a Humana network provider, to render services to fee-for-service (FFS) beneficiaries.
- If you are only providing Medicare services to dual eligible Cardinal Care members enrolled in the Humana Cardinal Care Medicaid plan, you are not required to enroll in MES PRSS.
- If you are an out-of-network provider, you are not required to submit an application and enroll as a provider in PRSS. However, Humana registers all providers outside our network using the PRSS non-par participation registration (NPPR) file.
- Maintain records for 10 years from the date your provider contract terminates.
- Provide copies of member records and access to your premises to representatives of Humana, as well as duly authorized agents or representatives of DMAS, the U.S. Department of Health and Human Services and the State Medicaid Fraud Unit. You must agree otherwise to preserve the full

confidentiality of medical records in accordance with applicable state and federal laws.

- Maintain and provide a copy of the member's medical records, in accordance with 42 CFR §438.208(b)(5), to members and their authorized representatives as required by Humana and within no more than 10 business days of the member's request.
- Forward medical records to Humana within 10 business days of Humana's request.
- Submit utilization data for members enrolled with Humana in the format specified by Humana, consistent with Humana obligations to DMAS, as related to quality improvement and other assurance programs as required.
- Promptly provide or arrange for the provision of all services required under the provider agreement. This provision must continue to be in effect for subcontract periods for which payment has been made even if you become insolvent until such time as the members are withdrawn from assignment to the provider.
- Should an audit by Humana or an authorized state or federal official result in disallowance of amounts previously paid to a provider, you must reimburse Humana upon demand. You shall not bill the member in these instances.
- Not bill a member for medically necessary services covered under the Medicaid Contract and provided during the member's period of Humana enrollment. This provision shall continue to be in effect even if Humana becomes insolvent. However, if a member agrees in advance of receiving the service and in writing to pay for a non-Medicaid covered service, then Humana, providers or Humana subcontractor can bill.
- Comply with federal contracting requirements described in 42 CFR Part 438.3, including identification of/nonpayment of provider preventable conditions, conflict of interest safeguards, inspection and audit of records requirements, physician incentive plans, recordkeeping requirements, etc.
- Report fraud, waste and abuse.
- Report critical incidents.
- Providers who bill for personal care and respite care services must commit to using an electronic visit verification system.
- Complete annual trainings which include:
  - General Compliance (Ethics Every day and Compliance policy)
  - Fraud, waste and abuse
  - Medicaid provider orientation training
  - Cultural competency
  - Health, safety and welfare (abuse, neglect and exploitation)
  - Special needs training which covers the model of care

In addition to the responsibilities for all providers, PCPs are also responsible, at a minimum, for:

- Managing and coordinating the medical and behavioral healthcare needs of members to ensure all medically necessary services are made available in a timely manner.
- Referring patients to subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available.
- Maintaining a medical record of all services rendered by the PCP and a record of referrals to other providers and any documentation provided by the rendering provider to the PCP for follow-up and/or coordination of care.
- Developing a plan of care to address a patient's risks and medical needs.
- Working with Humana care managers to develop plans of care for members receiving care management services.
- Conducting screens to determine whether the member needs behavioral health services for common behavioral issues, including, but not limited to:
  - Depression
  - Anxiety
  - Trauma/adverse childhood experiences
  - Substance use
  - Early detection
  - Identification of developmental disorders/delays

# FIDE SNP Appendix

## FIDE SNP Appendix Section 5: Covered services

### Covered services

In this section, you will find a brief summary of the benefits and services covered by Humana's FIDE SNPs in Virginia for our FIDE SNP members. This is not a comprehensive list of all services covered for FIDE SNP members. For a comprehensive list of all services covered by Medicare, you can check benefits at **Availity Essentials** (registration required) or call Humana Provider Services at **844-881-4482** Monday – Friday, 7 a.m. – 7 p.m., Eastern time. For a comprehensive list of Medicaid plan services, please review the **covered services chapter of the Medicaid portion of this manual**.

Please note that Humana offers 2 FIDE SNP plans in Virginia:

- Humana Dual Fully Integrated H2875-003 (HMO D-SNP), which is available for FIDE SNP members in Bristol City, Buchanan, Dickenson, Grayson, Lee, Norton City, Russell, Scott, Smyth, Tazewell, Washington, Wise and Wythe.
- Humana Dual Fully Integrated H2875-001 (HMO-POS D-SNP), which is available for FIDE SNP members in all Virginia counties.

Unless otherwise stated, all benefits in the table below are available to members enrolled in both the HMO D-SNP and HMO-POS D-SNP.

| Covered service | Limitations, exceptions and additional benefit information |
|---|---|
| **Adult Day Health Services** | Humana covers these services if a member is found to be eligible through the LTSS screening process. Prior authorization requirements may apply. |
| **Ambulance services** | Ambulance services for other cases (non-emergent) must be approved by Humana. In cases that are not emergencies, Humana may pay for an ambulance. The member's condition must be serious enough that other ways of getting to a place of care could risk their life or health. Prior authorization requirements may apply. |
| **Ambulatory surgical center services** | Prior authorization requirements may apply. |
| **Care management services** | Care management services are provided to all Humana FIDE SNP members. Care management provides a more intensive level of service if the member's health requires it. |

| Covered service | Limitations, exceptions and additional benefit information |
|---|---|
| **Chiropractic services** | For members enrolled in the HMO-POS D-SNP only, Humana covers only manual manipulation of the spine to correct subluxation. Other services performed by a chiropractor are not covered. Prior authorization requirements may apply. |
| **Dental check-ups and preventive care** | Cardinal Care provides a full range of dental care for both children and adults through DentaQuest, its Medicaid Dental Benefits Administrator. Contact **888-912-3456** for information or visit **Dentaquest.com**. |
| **Diabetes supplies and services** | For all people who have diabetes (insulin and non-insulin users). Prior authorization requirements may apply. |
| **Diagnostic radiology services** | Prior authorization requirements may apply. |
| **Dialysis services** | Certain drugs for dialysis are covered under a member's Medicare Part B drug benefit. Prior authorization requirements may apply. |
| **Emergency room services** | Members may use any emergency room if they reasonably believe they need emergency care. They do not need prior authorization, and the hospital does not have to be in-network.<br>Members are covered for emergency care world-wide. If they have an emergency outside of the U.S. and its territories, they will be responsible to pay for the services rendered upfront. |
| **Emergency transportation** | In emergency situations, emergency transportation includes ground (ambulance) and air (airplane and helicopter) transportation. The transportation will take the member to the nearest place that can give them care. |
| **Glasses or contact lenses** | Coverage for eyeglasses is limited to members under age 21 except as a supplemental benefit. |
| **Hearing screenings** (including routine hearing exams) | Diagnostic hearing and balance evaluations performed to determine if the member needs medical treatment are covered as outpatient care when furnished by a physician, audiologist or other qualified provider. Prior authorization requirements may apply. |
| **Home health care services and personal care attendant services** | Cardinal Care provides up to 80 hours of personal care attendant services per year. Prior authorization requirements may apply.<br>• Covered for the HMO-POS D-SNP only |

| Covered service | Limitations, exceptions and additional benefit information |
|---|---|
| **Home health services** | Humana covers home health services, including nursing care, rehabilitation therapies and home aide services. Additionally, the Commonwealth Coordinated Care Plus (CCC Plus) Waiver provides coverage for other LTSS such as private-duty nursing services. Members should consult with their care team to request a LTSS screening for the CCC Plus Waiver.<br><br>Prior to receiving home health services, a provider must certify that the member needs home health services and will order home health services to be provided by a home health agency. The member must be homebound. HCBS services may require a prior authorization. |
| **Home services such as cleaning or housekeeping or home modifications such as grab bars** | Home modifications may be covered by Cardinal Care through the CCC Plus Waiver. Modifications may be made to the member's primary residence or primary vehicle and must enable them to function with greater independence. Prior authorization requirements may apply. |
| **Inpatient and outpatient care and community-based services for people who need mental health services** | Humana provides coverage for inpatient and outpatient mental health services including, but not limited to, crisis intervention and psychiatric hospitalization, case management, therapeutic and rehabilitative services, and residential treatment. |
| **Inpatient hospital care** | Prior authorization requirements may apply. |
| **Lab tests and diagnostic procedures, such as blood work** | Prior authorization requirements may apply. |
| **Medical equipment for home care** | Humana covers all medically necessary durable medical equipment (DME) covered by original Medicare. The most up-to-date list of suppliers is available on our website at **Humana.com/FindADoctor**. Prior authorization requirements may apply. |
| **Medicare Part B prescription drugs** | Part B drugs include drugs given in a provider's office, some oral cancer drugs and some drugs used with certain medical equipment. |
| **Medicare Part D prescription drugs** | There may be limitations on the types of drugs covered. How much members pay for a drug depends on whether they get the drug from:<br>• A network retail pharmacy<br>• A pharmacy that is not in Humana's network (we cover prescriptions filled at out-of-network pharmacies in limited situations only)<br>• The plan's mail-order pharmacy |

| Covered service | Limitations, exceptions and additional benefit information |
|---|---|
| **Mental health services** | Humana provides coverage for a full range of inpatient and outpatient mental health services, including substance use disorder services. Certain telehealth mental health specialty services may be covered under physician/practitioner services. |
| **Non-emergency medical transportation** | Cardinal Care covers non-emergency medical transportation. |
| **Nursing home care** | Cardinal Care provides coverage for nursing home care. Prior authorization requirements may apply. |
| **Occupational, physical or speech therapy** | Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices and Comprehensive Outpatient Rehabilitation Facilities (CORFs). Prior authorization requirements may apply. |
| **Orthotics** | Prior authorization requirements may apply. |
| **Vision care** | Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. |
| **Outpatient hospital services, including observation** | Unless the provider has written an order to admit the member as an inpatient to the hospital, the member is an outpatient. Even if the member stays in the hospital overnight, they might still be considered an outpatient. Prior authorization requirements may apply. |
| Podiatry services | Covered services include:<br>• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)<br>• Routine foot care for members with certain medical conditions affecting the lower limbs<br>Prior authorization requirements may apply. |
| **Preventive care** | There is no coinsurance, copayment or deductible for members eligible for Medicare-covered preventive services. |
| **Prosthetic services** | Humana provides coverage for medically necessary prosthetics for children under age 21 and for adults and children when recommended as part of an approved intensive rehabilitation program. Devices (other than dental) that replace all or part of a body part or function. Prior authorization requirements may apply. |
| **Provider or surgeon care** | Prior authorization requirements may apply. |
| **Radiation therapy** | Prior authorization requirements may apply. |

| Covered service | Limitations, exceptions and additional benefit information |
|---|---|
| **Rehabilitation services** | Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices and CORFs. Prior authorization requirements may apply. |
| **Respite care** | Humana covers respite care, including inpatient respite care, if a member is found to be eligible through the LTSS screening process. |
| **Restorative and emergency dental care** | Cardinal Care provides coverage for restorative and emergency dental care. Braces for adults over age 21 are not covered. Contact DentaQuest at **888-912-3456** for coverage information or visit **Dentaquest.com**. |
| **Tobacco cessation** | All medically necessary tobacco cessation services, including pharmacotherapy and counseling. |
| **Skilled nursing care** | Humana provides coverage for skilled and intermediate nursing facility care. Members are covered for up to 100 medically necessary days per benefit period. Prior hospital stay is not required. A new benefit period will begin on day 1 when the member first enrolls in a MA plan, or when they have been discharged from skilled care in a skilled nursing facility for 60 consecutive days. Prior authorization requirements may apply. |
| **Specialist care** | Prior authorization requirements may apply. |
| **Substance use disorder services** | Through the Cardinal Care Addiction and Recovery Treatment Services (ARTS) program, Humana provides coverage for a full range of addiction treatment services, including outpatient and intensive outpatient services, case management, residential and opioid treatment services. If a member needs ARTS, they should call the ARTS line at 888-445-8714. Calls to this number are free 24 hours a day, 7 days a week. Prior authorization requirements may apply for Humana benefits. |
| **Transportation to medical appointments and services** | Includes transportation to services covered by Medicare. |
| **Urgent care** | Urgently needed services are not emergency care. Members do not need prior authorization and the urgent care center does not have to be in-network. |
| **Visits to treat an injury or illness** | Prior authorization requirements may apply. |
| **"Welcome to Medicare"** (preventive visit 1 time only) | Humana covers the Welcome to Medicare preventive visit only within the first 12 months the member has Medicare Part B. |

| Covered service | Limitations, exceptions and additional benefit information |
|---|---|
| **Wellness visits, such as a physical** | A member's first annual wellness visit can't take place within 12 months of their Welcome to Medicare preventive visit. However, they don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after they have had Part B for 12 months. |
| **Wheelchairs, crutches, walkers, nebulizers, oxygen equipment and supplies** | Humana provides coverage for wheelchairs, crutches and walkers, as well as a wide range of other DME items. DME coverage is based on medical necessity and has no maximum benefit limits.<br>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at **Humana.com/FindADoctor**.<br>Prior authorization requirements may apply. |

## Enhanced benefits and mandatory supplemental benefits

In addition to covered services, Humana Medicaid-enrolled members have access to enhanced benefits, and Humana Medicare-enrolled members have access to mandatory supplemental benefits. FIDE SNP members have access to both enhanced benefits and mandatory supplemental benefits. For a list of some of the enhanced benefits and mandatory supplemental benefits offered to Humana FIDE SNP members, please see the table below. Please note that this may not be an exhaustive list.

| Benefit | Covered by | Description |
|---|---|---|
| **Caregiver respite** | Medicaid | Members not covered by a waiver program may receive up to 240 hours of caregiver respite services per year. A 4-hour minimum is required per use. Care manager approval required. |
| **Medicare benefit:** Chiropractic services (HMO D-SNP) | Medicare | **Medicare benefit:** For members enrolled in the HMO D-SNP only, there is a $0 copay for routine chiropractic visits, up to 12 visit(s) per year. Prior authorization requirements may apply. |
| **Medicaid benefit:** Pain Management Alternative – Chiropractic Services (HMO-DSNP and HMO-POS D-SNP) | Medicaid | **Medicaid benefit:** Members enrolled in both the HMO-DSNP and HMO-POS D-SNP are covered for up to 12 annual chiropractor visits to manage chronic pain.<br>**Note:** The Medicare benefit must be exhausted before the member can use the Medicaid benefit. |

| Benefit | Covered by | Description |
|---|---|---|
| **Chronic Condition Care Assistance** | Medicare | Available to eligible members who demonstrate a need to receive additional assistance with a qualifying medical, primarily health-related, or non-primarily health-related expense that supports the member's care plan goals. Eligibility will be considered for members with certain qualifying chronic conditions, who are currently participating in care management and who meet the program criteria. Benefits are limited to $500 per year and are coordinated by care management. There is no coinsurance, copayment, or deductible to participate.<br>• Covered for members enrolled in the HMO-POS D-SNP only |
| **Convertible car seat or portable crib** | Medicaid | Pregnant members who enroll and actively participate in our HumanaBeginnings® care management program and complete a comprehensive assessment and at least 1 follow-up call with a HumanaBeginnings care manager can select 1 convertible car seat or portable crib per infant per pregnancy. |
| **Criminal expungement** | Medicaid | Members age 21 and older can receive reimbursement of up to $110 for criminal record expungement once per lifetime. |
| **Disaster preparedness meals** | Medicaid | 14 shelf-stable meals up to twice per year. This aims to reduce members' anxiety and uncertainness in the face of natural disaster.<br>The Governor must declare the disaster in the member's county of residence to be eligible for the meals. |
| **Employment physical** | Medicaid | 1 employment physical per year. |
| **Environmental modifications** | Medicaid | Members not covered by a waiver program can receive up to a $5,000 per year benefit to offset the costs of making changes to their primary residence or vehicle that enable a higher level of independence. Potential uses may include a handrail or grab bar, widening a doorway, installing a walk-in shower or the maintenance of these items. |
| **Fall prevention kit** | Medicaid | Members who are at risk for falls may receive a fall prevention kit once per lifetime. Kit contains:<br>• Non-slip socks<br>• Non-slip bathmat<br>• Reacher/grabber<br>• Stair treads<br>Member must not reside in a residential facility or nursing facility. Care manager approval required. |

| Benefit | Covered by | Description |
|---|---|---|
| Financial literacy coaching | Medicaid | Up to 6 life coaching sessions for members age 16 and older to help them with their money management goals. |
| GED testing | Medicaid | GED test preparation assistance in both English and Spanish, including an advisor, access to guidance and study materials, and unlimited use of practice tests. Test preparation assistance is provided virtually to allow for maximum flexibility and includes test pass guarantee to provide members multiple attempts at passing. Available for members 16 and older. |
| Healthy food produce box | Medicaid | Up to 4 boxes of in-season, nutritious, fresh food annually with care manager approval.<br>Member must be living with conditions such as diabetes, heart failure, COPD, chronic kidney disease, end-stage renal disease, cancer, HIV or a serious mental illness (SMI). |
| Healthy Options Allowance | Medicare | There is no coinsurance, copayment or deductible to participate. Members have a $225 monthly allowance on the Humana Spending Account card to use for essentials they need to support their health. This allowance can be used to buy approved products from participating retail locations like:<br>• Groceries (produce, fruit, bread, meat, dairy, etc.)<br>• Personal care items (toothpaste, shampoo, body soap, deodorant, etc.)<br>• Over the counter (OTC) health and wellness items (vitamins, first aid, pain relief medicine, incontinence supplies, etc.)<br>• Home supplies (toilet paper, paper towels, bathroom cleaner, laundry detergent, etc.)<br>• Household assistive devices (grab bars, raised toilet seats, reaching aids, etc.)<br>• Pet supplies (includes pet food, pet litter, flea shampoo, etc. and excludes grooming services, veterinary bills, and pet prescriptions)<br>This allowance can be used to pay for approved services, such as:<br>• Monthly living expenses (phone payments, rent/ mortgage, utilities, internet, etc.) |

| Benefit | Covered by | Description |
|---|---|---|
| | | • Non-medical transportation costs (public transportation, taxi, Uber, Lyft, etc.)<br>• Pest control services<br>This also covers OTC drugs. There may be limitations on the types of drugs covered. |
| **Medicare hearing benefit:** Hearing aids (as well as fittings and associated accessories and supplies) | Medicare | **Medicare benefit:** Up to 2 TruHearing-branded prescription hearing aids every 3 years (1 per ear every 3 years). Benefit is limited to the TruHearing Advanced prescription hearing aids, which come in various styles and colors.<br>Advanced hearing aids are available in rechargeable style options. Members must see a TruHearing provider to use this benefit. Members should call **844-255-7144** to schedule an appointment (for **TTY**, dial **711**). |
| **Medicaid hearing benefit:** Hearing services | Medicaid | **Medicaid benefit:** Members age 21 and older can take advantage of 1 hearing exam per year, 1 hearing aid per ear every 3 years, 2 hearing aid fitting/checking visits every 3 years, 60 batteries per year.<br>**Note:** The Medicare benefit must be exhausted before the member can use the Medicaid benefit. |
| **HMO Travel** | Medicare | Covered services must be provided by providers within the national Medicare HMO or SNP network. If a member is planning to travel outside of their service area and anticipates needing to use the HMO Travel Benefit, it is recommended that they notify their PCP. |
| **Home-based virtual assistance technology** | Medicaid | Members participating in our care management or disease management programs are eligible to receive 1 artificial intelligence-enabled virtual assistance device. One device per lifetime, per member.<br>Members must have one of the following conditions:<br>• Social isolation<br>• Depression<br>• Memory loss<br>• ADRD (Alzheimer's disease and related dementias) |

| Benefit | Covered by | Description |
|---|---|---|
| **Medicare meal benefit:** Meal benefit | Medicare | **Medicare benefit:** Humana Well Dine® meal program. After a member's inpatient stay in either a hospital or a nursing facility, they may be eligible to receive 2 home delivered meals per day for 7 days (up to 14 meals). Meals must be requested within 30 days of discharge from their inpatient stay. Limited to 4 times per year. |
| **Medicaid benefit:** Post-discharge meals | Medicaid | **Medicaid benefit:** 14 pre-cooked, home-delivered meals that can be stored in the refrigerator following an inpatient or residential facility admission up to 4 times per year.<br>Note: The Medicare benefit must be exhausted before the member can use the Medicaid benefit. |
| **OTC pharmacy allowance** | Medicaid | Up to $65 per quarter per household allowance enables members to purchase products that support appropriate care such as:<br>• Feminine products<br>• First aid equipment that do not require prescriptions. |
| **Parent/guardian self-care allowance** | Medicaid | Reimbursement for up to $40 per quarter for members that are a legal parent or guardian for children up to 12 months old to help cover the costs of childcare and enable our new parents/guardians to spend time doing activities independently and relieve stress. |
| **Personal care attendant services** | Medicaid | Members not covered by a waiver program may receive up to 80 hours of personal care attendant services per year. A 4-hour minimum is required per use. Care manager approval required. |
| **Personal emergency response system (PERS)** | Medicaid | Members not covered by a waiver program and in our care management or diseases management programs may receive 1 PERS device per lifetime to provide round-the-clock emergency service. The member must not reside in a residential facility or nursing facility. Care management approval required. |
| **Photo album** | Medicaid | Humana provides members living with Alzheimer's or Dementia 1 photo album annually. |
| **Podiatry services** | Medicare | Routine foot care for members with certain medical conditions affecting the lower limbs up to 12 visits per year<br>• For members enrolled in the HMO D-SNP only |

| Benefit | Covered by | Description |
|---|---|---|
| **Post-discharge personal home care** | Medicare | $0 copay for a minimum of 4 hours per day, up to a maximum of 80 hours per year for certain in-home support services following a discharge from a skilled nursing facility or from an inpatient hospitalization.<br><br>Qualified aides can offer assistance performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs) within the home.<br><br>• ADLs are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.<br><br>• IADLs are activities related to independent living. They include preparing meals, picking up pre-paid curbside/ drive-through orders, performing light housework, laundry, dishes, and/or using a telephone.<br><br>A member must be receiving assistance with a minimum of 1 ADL to receive assistance with any IADL. Services must be initiated within 30 days of a discharge event and utilized within 60 days of discharge for each qualifying event up to the maximum annual allowance. |
| **Produce box for maternal care** | Medicaid | Up to four boxes of in-season, nutritious, fresh food annually to pregnant members from their second trimester to 60 days postpartum that are deemed food insecure. Member must participate in HumanaBeginnings. |
| **Restorative and emergency dental care** | Medicare | Most dental services are covered in and out-of-network at a $0 copayment until the combined maximum allowable benefit is reached annually. Note: The allowance cannot be used on fluoride, cosmetic services and implants.<br><br>• HMO-POS D-SNP has a maximum allowable benefit of $4,000<br><br>• HMO D-SNP has a maximum allowable benefit of $3,000<br><br>The mandatory supplemental dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at Humana.com Find care. |
| **SilverSneakers® fitness program** | Medicare | Basic fitness center membership including in-person and digital fitness classes. |

| Benefit | Covered by | Description |
|---|---|---|
| **Smartphone** | Medicaid | With a smartphone, members have easy access to health-related information and can stay connected to their care team and health plan. Any member who qualifies for the Federal Lifeline program will be eligible to receive a free smartphone with monthly talk minutes, text and data. |
| **Sports physical** | Medicaid | 1 sports physical per year |
| **Youth academic support** | Medicaid | Members in grades K-12 have access to online tutoring services for up to 2 hours per week as well as ACT/SAT test preparation. |
| **Youth development and recreation** | Medicaid | Members age 4-18 years old can receive reimbursement for up to $250 annually for participation in activities such as:<br>• YMCA<br>• Boys and Girls Club<br>• Swim lessons<br>• Computer coding classes<br>• Music lessons |

## Go365 by Humana wellness program for FIDE SNP members

FIDE SNP members have a different wellness and rewards program than Medicaid members through Humana called Go365 by Humana®. The way that members access and engage with the program will vary. Key differences of the wellness program for our FIDE SNP members include:

- Members engage with the program online. They will sign in to Go365.com to get started, view eligible healthy activities, engage with our health and wellness resources and view and redeem their rewards. There is no app for FIDE SNP members.
- The rewardable activities are different for our FIDE SNP members. See below for a list of eligible healthy activities that FIDE SNP members can earn rewards for.

| Preventive activities | Reward value |
|---|---|
| **Annual wellness visit** | $25 |
| **Mammogram** | $30 |
| **Colorectal screening** | $30 |
| **Diabetic bundle:** (complete all 4 screenings for $40 reward)<br>Kidney urine test, kidney blood test, hemoglobin HbA1c test, diabetic eye exam | $40 |

| Connect and Learn activities | Reward value |
|---|---|
| • Enroll and onboard for new members and returning members who register online for the first time.<br>• Update and/or confirm email address in Go365 for existing members<br>• Social and health education (attend a health education or art class, participate in an athletic event, social club or religious gathering or event) | $5 per month, $20 annual maximum |

| Exercise and Fitness activities | Reward value |
|---|---|
| Complete a minimum of 12 workouts per month, tracked via SilverSneakers® fitness device, online or paper-based tracker (minimum of 5,000 steps/day). Other physical activities may include golfing, swimming, Zumba and yoga. | $5 for completing 12 workouts in a month, $60 annual maximum |

If members have questions about the Go365 program, they can call the number on the back of their Humana ID card. If a member disenrolls from a Humana FIDE SNP and enrolls with another MCO, their Go365 rewards will be forfeited. If a member leaves a Humana FIDE SNP and enrolls with a Humana Medicaid plan that includes Go365, they can call the number on the back of their Humana ID card within 90 days of their plan end date to redeem any remaining rewards.

## Non-emergent transportation services

For members enrolled in either our HMO D-SNP or HMO-POS D-SNP, non-emergency and routine medical transportation are covered. Depending on the specific transportation need, FIDE SNP the member is enrolled in and their transportation benefit utilization history, members may access transportation through our Medicare transportation vendor, CareCar, or our Medicaid transportation vendor, ModivCare. Members should call Humana Member Services at **844-881-4482** available 7 days a week, 8 a.m. – 8 p.m., Eastern time for transportation and benefit information and vendor coordination.

## Behavioral health

For information on behavioral health, please refer to the **behavioral health chapter of the Medicaid portion of the Medicaid portion of this manual**.

## LTSS

For information on LTSS, please refer to the **LTSS chapter of the Medicaid portion of this manual**. Please note that Medicare LTSS benefits will be utilized before Medicaid LTSS benefits.

There are circumstances where individuals with Medicare may also have a patient pay responsibility towards skilled nursing facility care. For example, a member could have a cost share responsibility if the Medicare payment is lower than the Medicaid allowable amount for the same service. In this circumstance, the member is responsible for the difference in the Medicare payment and Medicaid allowable charges, up to the Member's DSS-calculated patient pay amount.

## Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

For information on EPSDT, please refer to the **EPSDT chapter of the Medicaid portion of this manual**.

## Family planning services

Methods of family planning including but not limited to barrier methods, oral contraceptives, vaginal rings, contraceptive patches and long-acting reversible contraceptives are covered for Virginia FIDE SNP members.

# FIDE SNP Appendix

## FIDE SNP Appendix Section 6: Utilization management and utilization review

### FIDE SNP Utilization Management and utilization review program

Humana's Utilization Management and utilization review (UM/UR) program for FIDE SNP members is managed by one department that is trained to understand both Medicaid and Medicare benefits covered for Virginia FIDE SNP members. The FIDE SNP UM/UR department performs all UM/UR activities for FIDE SNP members, including prior authorization, concurrent review and discharge planning.

### Prior authorizations

All FIDE SNP-covered services that require prior authorization from Humana should be authorized before the service is delivered. To determine which FIDE SNP-covered services require prior authorization, please review our Humana Dual Fully Integrated Plan Preauthorization and Notification list at **Humana.com/PAL** under the Medicare tab or call **844-881-4482** to request a copy. Please note that this Preauthorization List (PAL) is specific to Humana's Virginia FIDE SNPs.

Requests for preauthorization should be made as soon as possible but at least 14 days in advance of the service date. It is important to request prior authorization as soon as you know that a Humana-covered patient requires a service on the Preauthorization and Notification List. The member, their PCP or their provider may initiate a request for services. Online requests are encouraged through **Availity Essentials**, our secure, payer-agnostic provider portal, but prior authorizations or notification requests can be requested through any of the following methods:

- Sign in to **Availity Essentials** (registration required). For select services, you can answer a series of questions when requesting the preauthorization. If approved, you will receive notification immediately. If pended for further review, you can attach relevant clinical information to the request to expedite the process.
- Submit a business to business or batch Health Care Services Review and Response transaction (278) via EDI.
- Use our interactive voice response system (IVR) by calling **800-523-0023**. You should call this number if a request needs to be expedited due to the seriousness of a patient's condition.

When prior authorization is requested for a service rendered in the same month, FIDE SNP member enrollment is verified at the time the request is received. When the service is to be rendered in a subsequent month, authorization is given contingent on member eligibility on the date of service. You

must verify enrollment on the date the service is to be rendered. Humana is not able to pay claims for services provided to ineligible members.

For more information on prior authorizations for pharmacy services, please refer to the Medicare pharmacy provider manual on Humana's website at **Pharmacy Forms and Manuals - Humana**.

**Services that do not require prior authorization for FIDE SNP members**

Humana does not require prior authorization for the following services when provided to FIDE SNP members:

- Any services for emergency medical conditions as defined in 42C.F.R §§ 422.113(b)(1) and 438.114(a) (which includes emergency behavioral health care)
- Urgent care sought outside of the service area
- Urgent care under unusual or extraordinary circumstances provided in the service area when the contracted medical provider is unavailable or inaccessible
- Vaccines and immunizations provided to members at local health departments

There may be additional services for which Humana does not require prior authorization, the above is not intended to be an exhaustive list.

**Information required for a preauthorization request or notification**

Information required for a preauthorization request or notification may include, but is not limited, to:

- Member's ID number and date of birth
- Relationship to subscriber
- Date of actual service or hospital admission
- Type of service
- Place of service
- Service quantity
- Procedure codes, up to a maximum of 10 per authorization request
- Date of proposed procedure, if applicable
- ICD Diagnosis codes (primary and secondary), up to a maximum of 6 per authorization request
- Service location
- Type of authorization—inpatient or outpatient
- Tax ID Number (TIN) and National Provider Identifier (NPI) number of requesting provider
- TIN and NPI of treatment facility where service is being rendered
- TIN and NPI of the provider performing the service
- Name and telephone number of all providers indicated
- Attending physician's telephone number
- Relevant clinical information
- Discharge plans

Submitting all relevant clinical information at the time of the request will facilitate a quicker determination

### Prior authorization request review process

If additional clinical or other information is needed to determine medical necessity, Humana will request the relevant information. When requesting necessary information, at least 1 attempt is completed, including via telephonic outreach and/or fax. The request will clearly indicate what additional information is required to complete the prior authorization request. Humana may request additional clinical information to complete the medical necessity review, when needed, but will not request documentation that would change the authorized services or hours.

### Notification of prior authorization decisions

When submitting a service authorization request for a service that is covered by both Medicare and Medicaid, Humana first adjudicates the request by using our Medicare medical necessity criteria. If any service is not approved under Medicare for the amount, duration, or frequency requested, Humana will review to determine if the service can be approved by Medicaid using the Medicaid medical necessity criteria. After adjudicating the request using both the Medicare and Medicaid medical necessity criteria, we notify the requesting provider of the decision. For any adverse benefit determinations, Humana sends the member a written notice, called a Coverage Decision Letter, on an integrated organization determination within the applicable standard or expedited time frames outlined below.

- **Standard time frame:** For standard prior authorization decisions, Humana provides a decision as expeditiously as the member's health condition requires, but no later than 14 calendar days following authorization request date. The time frame for a standard authorization request may be extended up to 14 calendar days if you or the member requests an extension, or if Humana justifies, in writing, to DMAS a need for additional information and how the extension is in the member's best interest. Written notice of the extension will be provided to the member and will include the reason for the extension and the member's right to file a grievance.
- **Expedited time frame:** For cases in which you indicate, or Humana determines, that following the standard time frame could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function, Humana will complete an expedited authorization decision within 72 hours and provide notice as expeditiously as the member's health condition requires. If a request needs to be expedited due to the seriousness of a patient's condition, please call **844-881-4482**.

## Referrals

Similarly to Medicaid members, if a FIDE SNP member requires specialized treatment beyond the scope of a PCP, the member may see an in-network specialist for consultation and/or treatment without a referral from their PCP. However, if a member requires medically necessary services from a nonparticipating provider, you need to request referral. You can view the status of your referral requests by visiting **Availity Essentials**. The status of a referral can be verified by accessing **Availity Essentials** or by calling **800-523-0023**. After the member has been treated by a specialist, the specialist's findings, diagnosis and recommendation for treatment should be sent to the member's PCP. The specialist also must submit claim/encounter data to Humana.

## Facility closure or license termination

In the event Humana is notified of a facility closure or license termination, we will collaborate with the Office of the Long-term Care Ombudsman, Department for Aging and Rehabilitation, the local Department of Social Services and other state agencies to ensure all member transfer and discharge rights are upheld.

## Retrospective review

A retrospective review is a request for a review for authorization of care, a service or a benefit for which an authorization is required but not obtained before the delivery of the care, service or benefit. On request, Humana only allows for a retrospective authorization submission after the date of service when a prior authorization is required but not obtained. When submitting a retroactive authorization request, please include the following documentation:

- Patient name and Humana ID number
- Authorization number of the previously authorized service for the related request
- Clinical information supporting the service

When retrospective review is required, providers must include clinical information to perform a medical necessity review. Elective ambulatory or inpatient services on Humana's Preauthorization and Notification List for which precertification did not occur before providing the service are not eligible for retrospective review.

A retrospective review request for inpatient and outpatient services for FIDE SNP members can be submitted via Availity Essentials or by contacting Availity Essentials directly at **800-282-4548** Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

For requests submitted via Availity Essentials or by fax, you can check the status online at **Availity Essentials**. You can see the authorization status along with the authorization number associated with the request. Some outpatient authorization requests may auto-approve if the procedure code is not listed on our online Humana Dual Fully Integrated Plan Preauthorization and Notification list at **Humana.com/PAL**.

Humana notifies the requesting provider and provides written notice of all determinations that deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested. For adverse benefit determinations, Humana will notify the member by letter with a copy to you at the address on file. Written notification for approved service requests is not provided unless requested.

## Medical necessity criteria and reviews

All decisions to approve or deny services for FIDE SNP members are based on eligibility, coverage and medical necessity criteria. Humana does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition. Humana establishes measures designed to maintain quality of services and control costs consistent with our responsibility to our members. Humana places appropriate limits on a service on the basis of criteria applied under the Medicaid state plan and applicable regulations, such as medical necessity.

The fact that a provider has prescribed, recommended or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service. Humana places appropriate limits on a service for utilization control, provided the service furnished can reasonably be expected to achieve its purpose. Services supporting individuals with ongoing or chronic conditions or who require LTSS are authorized in a manner that reflects the member's ongoing need for such services and supports.

Authorization is based on medical necessity and is contingent on eligibility, benefits and other factors. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Humana places appropriate limits on a service for utilization control, provided the service furnished can reasonably be expected to achieve its purpose. Services supporting individuals with ongoing or chronic conditions or who require LTSS are authorized in a manner that reflects the member's ongoing need for such services and supports.

You can request the clinical rationale or criteria used in making Utilization Management determinations for a FIDE SNP member through the same methods as you would for a Medicaid member.

## Out-of-network services

On notification of authorization from a referring provider, Humana will arrange out-of-network care if we are unable to provide necessary covered services or ensure the second opinion of an in-network provider. Humana may authorize other out-of-network services to promote access to services and continuity of care.

# FIDE SNP Appendix

## FIDE SNP Appendix Section 7: Care management

### Overview of care management for FIDE SNP members

FIDE SNP members are assigned to one care manager who coordinates and integrates all their care, including services and supports covered by both Medicaid and Medicare. This streamlines the member's experience with care management compared to having 2 separate care managers for Medicaid and Medicare.

Humana FIDE SNP members have access to the same care management programs and care managers as Humana Medicaid members. All FIDE SNP members are assigned to a care manager. FIDE SNP members may be identified as 1 of 3 priority population groups for assignment to care management: Mandatory High Priority, Mandatory Priority Populations or MCO Determined Priority. For information about referring members to care management, accessing member care plans, completing member health screenings, and participating in interdisciplinary care teams, please refer to the **care management chapter of the Medicaid portion of this manual**.

### Model of care approach

As provided under section 1859(f)(7) of the Social Security Act, every SNP, including FIDE SNPs, must have a model of care (MOC) approved by the NCQA. The MOC provides the basic framework under which each SNP will meet patient needs. It serves as the foundation for promoting SNP quality, care management and care coordination processes.

Humana's MOC has 4 goals:

- To improve member outcomes by coordinating care and ensuring care transitions
- To improve member access to and utilization of services and benefits
- To increase members' satisfaction with their healthcare experience and health status
- To ensure cost-effective service delivery

Humana achieves these goals by:

- Conducting HRAs to identify risk needs
- Developing a plan of care to address identified needs
- Providing access to an interdisciplinary care team

Humana's FIDE SNP MOC includes, but is not limited to, the following elements:

- Providing the full scope of care coordination services for all members by stratifying them into an initial care management level of service
- Conducting a Member Health Screening (MMHS) and health assessments such as post discharge emergency department or inpatient assessment to identify the member's needs
- Review all available historical information, including information from other Medicare payer sources, claims data, and external records such as care plans and referrals
- Evaluate and ensure members are placed within the most appropriate risk level and ensure they are receiving care coordination to meet their needs
- Provide access to quality healthcare and support to all members based on an individualized assessment of care needs
- Monitor for changes in condition or needs that warrant adjustment in the member's care coordination level of service
- Include processes and systems of care that engage members and family members in person-centered care management and culturally competent care
- Ensure seamless transactions between levels of care and care settings, addressing all barriers to accessing appropriate services to support member health

All contracted providers serving SNP members must review and attest to our SNP Training for Physicians, which includes information on our MOC. To access the training and obtain additional information about the model, please refer to **Humana.com/ProviderCompliance**. For more information on our Virginia FIDE SNP model of care, please review the **care management chapter of the Medicaid portion of this manual**.

# FIDE SNP Appendix

## FIDE SNP Appendix Section 8: Quality management and improvement

### FIDE SNP Quality Assessment and Performance Improvement Program overview

CMS, NCQA, URAC, AAAHC accreditation programs and DMAS require that Humana oversees a Quality Assessment and Performance Improvement (QAPI) program inclusive of Medicare, Medicaid, LTSS, dual eligible and SNP lines of business and products. The purpose of our QAPI program is to continually monitor, evaluate and improve the healthcare services our members receive as well as the processes, procedures and performance results generated by clinical and other business areas that support quality of clinical care, safety of clinical care, quality of service and member experience. Humana's QAPI program is a comprehensive quality improvement program that encompasses clinical care, preventive care, population health management and our administrative functions. It is designed to monitor and evaluate—objectively and systematically—the quality, appropriateness, accessibility and availability of safe and equitable medical and behavioral healthcare and services. We identify strategies and implement activities in response to findings. Using a continuous quality improvement methodology, our QAPI program works to:

- Monitor system-wide issues
- Identify opportunities for improvement
- Determine the root cause of identified problems
- Explore alternatives and develop a plan of action
- Activate a plan, measure results, evaluate effectiveness of actions and modify the approach as needed

QAPI program activities, which are included in the QAPI workplan and its annual evaluation, include monitoring clinical indicators or outcomes, quality-of-care complaints, utilization metrics, quality studies, Healthcare Effectiveness Data and Information Set (HEDIS®) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results and medical record audits. Humana's board of directors delegates a QAPI committee to monitor and evaluate the results of program initiatives and to implement corrective action when the results are less than desired or when areas that need improvement are identified. The QAPI Committee is accountable to Humana's executive management team.

The QAPI program goals include:

- Developing clinical strategies and providing clinical programs that look at the whole person while integrating behavioral and physical healthcare
- Identifying and resolving issues related to member access and availability of healthcare services
- Ensuring participating providers and other stakeholders are involved in the QAPI program
- Providing effective customer service for member and provider needs and requests
- Monitoring coordination and integration of member care across provider sites
- Providing a comprehensive strategy for population health management that addresses member needs across the continuum of care
- Providing mechanisms to assess the quality and appropriateness of care furnished to members with special healthcare needs
- Providing mechanisms to detect underutilization and overutilization
- Monitoring and promoting the safety of clinical care and service
- Promoting better communication between departments to improve service and satisfaction to members, practitioners, providers and associates
- Promoting improved clinician experience for providers and all clinicians to promote member safety, provider satisfaction and provider retention

QAPI program activities include:

- Developing clinical practice guidelines
- Performing medical record documentation reviews
- Analyzing HEDIS report results
- Assessing member satisfaction
- Requesting external quality reviews

Information regarding the QAPI program is available on request. To receive a written copy of Humana's quality program and its progress toward goals, providers can call Provider Services at **844-881-4482** Monday – Friday, 7 a.m. – 7 p.m., Eastern time.

## Quality measures

Humana monitors and evaluates provider quality, appropriateness of care and service delivery (or the failure to provide care or deliver services) to members using the following methods:

- **Quality improvement projects –** Ongoing measurements and interventions
  - Significant quality of care improvement and service delivery in both clinical care and nonclinical areas are expected to have a favorable effect on health outcomes and member satisfaction
- **Member medical record reviews –** Medical record reviews to evaluate documentation patterns of providers and adherence to member medical record documentation standards

  - Medical records also can be requested when investigating complaints of poor quality or service or clinical outcomes. You must furnish member medical records to Humana for this purpose. Member medical record reviews are a permitted disclosure of a member's protected health information (PHI) in accordance with HIPAA guidelines. The record reviewers protect member information from unauthorized disclosure as set forth in the contract and ensures all HIPAA guidelines are enforced.
- **Performance measures –** Data collected on patient outcomes as defined by HEDIS or otherwise defined by DMAS
- **Surveys –** CAHPS, provider satisfaction, behavioral health surveys and special surveys implemented to support quality/performance improvement initiatives
- **Peer review –** Review of providers' practice methods and patterns to determine appropriateness of care

Humana uses the measures above to help measure Medicare patients' experiences with their health plans and the entire healthcare system, which CMS uses a five-star quality rating system to measure. Humana's goal is to support physicians by identifying care opportunities that will improve the health outcomes and care experience of your patients.

## Provider participation in the QAPI Program

You are required to cooperate with Humana's quality improvement activities. You must participate in and contribute required data to Humana's quality improvement and other assurance programs, which includes providing member records for assessing quality of care and External Quality Review Organization (EQRO) activities. In addition, the HIPAA Privacy Rule of 45 CFR 164.506 and rules and regulations promulgated thereunder (45 CFR Parts 160, 162 and 164) permit a covered entity (provider) to use and disclose PHI to health plans without member authorization for treatment, payment and healthcare operations activities. Healthcare operations include, but are not limited to, conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing healthcare costs, care management and care coordination. You also must allow Humana to use your provider performance data as part of quality improvement activities.

Behavioral health providers must collect clinical outcomes data and make available behavioral health clinical assessment, treatment planning and outcomes data for quality, utilization and network management purposes.

Participating providers serving FIDE SNP members must agree to allow and assist Humana with our performance of the following quality investigations activities:

- Quality-of-care occurrences and adverse events reporting: You must report unexpected quality-of-care occurrences and adverse events involving members to the Quality-of-Care Investigations team at **HumanaHealthHorizonsVirginia@humana.com**. Quality-of-care occurrences and adverse events may also be reported by Risk Management and Humana clinical associates. Cases are reviewed and, as applicable, referred to the peer-review process, as required by law and accrediting agencies.

- **CMS Quality Improvement Organization (QIO):** QIO oversees the MAPD plans and collaborates with the plans for quality improvement activities.
- **Member grievances:** Oral and written member grievances pertaining to quality of care may be referred to the Quality-of-Care Investigations team for review.

You shall participate in Humana's quality review program as requested. Humana routinely reviews the quality of its providers, investigates concerns as they arise and may request additional information and/or remediation from you. You must agree to comply with Humana's requests for information and any remediation plan.

Humana encourages providers to participate in CMS and Health and Human Services QI initiatives, the Chronic Care Improvement Program, and Humana's quality improvement initiatives.

## Medical record requirements

As a network provider, you must make medical records for each member available to DMAS, the contracted EQRO and other DMAS designees upon request.

You must provide copies of member records and access to your premises to representatives of Humana, as well as duly authorized agents or representatives of DMAS, the U.S. Department of Health and Human Services and the state Medicaid Fraud Unit. Humana provider representatives must have access to the provider's office records and operations. This access allows Humana to monitor compliance with regulatory requirements. Each provider office must maintain complete and accurate medical records for all Humana-covered patients receiving medical services in a format and for time periods as required by the following:

- Applicable state and federal laws
- Licensing, accreditation and reimbursement rules and regulations to which Humana is subject
- Accepted medical practices and standards
- Humana's policies and procedures

Your medical records must be available for utilization, risk management, peer review studies, customer service inquiries, grievances and appeals processing, claims disputes, quality investigations of potential quality-of-care concerns, compliance audits and other initiatives Humana might be required to conduct. To comply with accreditation and regulatory requirements, Humana may periodically perform a documentation audit of some provider medical records. You must meet 85% of the requirements for medical record keeping with a goal of 90%, or per applicable state and federal requirements if more stringent.

You must respond to the Humana member grievance and appeal unit expeditiously with submission of required medical records to comply with time frames established by CMS and/or the state department of insurance for processing grievances and appeals. Only those records for the time period designated on the request should be sent. A copy of the request letter should be submitted with the copy of the record. The submission should include test results, office notes, referrals, telephone logs and consultation reports. Medical records should not be faxed to Humana unless the provider can ensure confidentiality of those medical records.

For HMO plans, if a Humana-covered patient changes their PCP for any reason, the provider must transfer a copy of the patient's medical record to the patient's new PCP at the request of the plan or patient. The agreement states whether the original or a copy of the medical record must be sent. If a provider terminates, the provider is responsible for transferring the patients' medical records. Charges for copying medical records are considered a part of office overhead and are to be provided at no cost to Humana-covered patients and Humana, unless state regulations or the agreement stipulate otherwise.

Providers can submit relevant medical records to Humana several ways, including but not limited to:

- Humana's Medical Records Management application on Availity Essentials at **Availity.com**
- Mail to: **Humana Medical Records Management**
  P.O. Box 14167
  Lexington, KY 40512-4167

You must preserve the full confidentiality of medical records in accordance with your provider agreement. To be compliant with HIPAA, you should make reasonable efforts to restrict access and limit routine disclosure of PHI to the minimum necessary to accomplish the intended purpose of the disclosure of patient information. You must forward medical records to Humana within 10 business days of Humana's request. Additionally, you must maintain and provide a copy of the member's medical records, in accordance with 42 CFR §438.208(b)(5), to members and their authorized representatives within no more than 10 business days of the member's request.

All member medical records must include the required elements pursuant to 42 CFR §§ 456.111 and 456.211, including but not limited to:

- **Member identification in the record:** Records should include the patient's name, date of birth, sex/gender identification, race, phone number, place of residence and responsible party (parent or guardian as applicable). In records where each element isn't present, use your clinical judgment to determine completeness by majority.
- **Primary language:** Use of the patient's primary language should be documented along with any need for communication assistance provided.
- **Complete medical history:** Medical history should be easily identifiable and include serious accidents, operations, illnesses and familial/hereditary disease. It should include medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed. For pediatric patients, past medical history includes prenatal care and birth information and childhood illnesses (members 11 years and younger). In records where each element isn't present, use your clinical judgment to determine completeness by majority.
- **Allergies:** Allergies or no known allergies must be documented in a prominent location in the medical record. Medication and other adverse reactions must be listed if present.
- **After hours/hospital follow-up (if noted that member had these services):** Record should show documentation of emergency department and/or after-hours encounters, hospital reports including admission and discharge summaries and referrals/results outcomes.

- **Diagnostic testing:** Record should show documentation of lab, X-ray, imaging or other studies ordered. Results should be filed in the medical record and initialed by the primary care physician, thereby signifying review. Abnormal X-ray, lab and imaging study results should have an explicit notation in the medical record regarding follow-up plans and notification to patient of all results (positive and negative). In records where each element isn't present, use your clinical judgment to determine completeness by majority.
- All written denials of service and the reason for the denial
- **Immunization record:** A current record of immunizations should appear in the patient chart.
- **Advance directives:** For members age 18 and older, there should be evidence that the patient has been asked if they have an advance directive (written directions about health care decisions) and a "yes" or "no" response should be documented. If the response is "yes", a copy of the advance directive must be included in the medical record.
- **Preventive screenings:** There is evidence that preventive screenings are offered or referred (example EPSDT, BCS, CCS, eye exam) and results/status of screenings addressed from previous visits are documented/addressed
- Each visit must include:
  - Date of service
  - Location of service
  - Purpose of visit (or chief complaint)
  - Diagnosis of medical impressions
- **Physical exam (complete):** All body systems should be reviewed within 1 year of the first clinical encounter or all body systems must be reviewed upon first visit, including HEENT (head, eyes, ears, nose and throat), teeth, neck, heart, lungs, neurological and musculoskeletal. In records where each element isn't present, use your clinical judgment to determine completeness by majority.
- **Vital signs:** Height, weight, blood pressure and temperature must be documented.
- Assessment of patient's findings
- Plan of treatment, diagnostic tests, therapies and other prescribed regimes
- Medications prescribed (All current medications, including dose and date of initial prescription or refills, should be present in the medical record) long-term medication reviewed and reconciled.
- Health education provided
- Name, signature and title or initials of the provider rendering the service (if more than one person documents in the Medical Record, there must be a record on file as to which signature is represented by which initial)

If your contract with Humana terminates, you must maintain records for 10 years from the date your provider contract terminates.

## Clinical practice guidelines

Patient safety is addressed through adherence to clinical guidelines that target preventable conditions.

Preventive guidelines address prevention and/or early detection interventions and the recommended frequency and conditions under which interventions are required. Prevention activities are based on reasonable scientific evidence, best practices and member needs.

Prevention activities include distribution of information, encouragement to use screening tools and ongoing monitoring and measuring of outcomes. While Humana implements activities to identify interventions, the support and activities of families, friends, providers and the community have a significant impact on prevention.

Humana disseminates and monitors the use of clinical practice guidelines relevant to members that:

- Are based on valid and reliable clinical evidence or a consensus of healthcare professionals or in the relevant field
- Consider the needs of managed care members
- Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines including professional medical associations, voluntary health organizations and National Institutes of Health centers
- Are congruent with current NCQA standards for establishing guidelines
- Do not contradict existing Virginia-promulgated regulations or requirements as published by the Departments of Social Services, Health, Health Professions, Behavioral Health and Developmental Services, Virginia Department of Health or other state agencies
- Prior to adoption, have been reviewed by Humana's medical director, as well as other contractor practitioners and network providers, as appropriate
- Are reviewed and updated, as appropriate or at least every 2 years
- Are reviewed and revised, as appropriate based on changes in national guidelines or changes in valid and reliable clinical evidence or consensus of healthcare professionals and providers

We strongly encourage you to review and consider these guidelines. You ultimately remain responsible for determining the applicable treatment for every individual. Clinical and practice guidelines are distributed to all new and existing providers through the following formats:

- Provider manual updates
- Provider newsletters
- Provider website

Humana's clinical practice guidelines are available on our website at **Clinical Practice Guidelines for Healthcare Providers**. You also can obtain preventive health and clinical practice guidelines through your Provider Relations representative. Humana notifies you whenever changes are made.

## Quality management reviews for HCBS waivers and programs

For information on quality management reviews for HCBS waivers and programs, please refer to the **quality management chapter of the Medicaid portion of this manual**.

# FIDE SNP Appendix

## FIDE SNP Appendix Section 9: Pharmacy

### Pharmacy overview

Humana FIDE SNP members have access to an integrated formulary that includes both their Medicaid and Medicare pharmacy benefits. Information on our formularies and pharmacy processes can be found in the Medicare pharmacy provider manual on Humana's website at **Pharmacy Forms and Manuals - Humana**. The manual includes information on the following:

- How to join our network
- Contact information
- Eligibility verification
- Drug coverage
- Claims procedures
- Controlled substances
- Medicare claims coverage
- Long-term care
- Home infusion billing procedures
- Compound claims
- Medication Therapy Management program
- Pharmacy audit and compliance
- Complaint system
- Price source and maximum allowable cost information

# FIDE SNP Appendix

## FIDE SNP Appendix Section 10: Claims and billing

### FIDE SNP claim submission and status

All FIDE SNP member claims are submitted to one integrated claims address, removing the requirement for you to have to identify what should be submitted to Medicare vs. what should be submitted to Medicaid. You can submit claims, both initial and corrected, as well as check status of claim submission for FIDE SNP members via Availity Essentials. Please review the **claims and billing chapter of the Medicaid portion of this manual** for more information on submitting electronic and paper claims, as well as:

- Tips for avoiding common claims submission errors
- NPI and TIN
- Clean claims
- Submitting claims for hysterectomies, sterilizations, abortions, immunizations and vaccinations
- Provider preventable conditions and services
- Timely filing requirements (Humana's timely filing requirement for all providers, including in and out-of-network providers, is 365 days from the date of service, and 180 days from the date of explanation of payment for corrected claims)

### FIDE SNP claim processing

When you submit a claim for a FIDE SNP member, the claim is first reviewed for Medicare coverage, then for Medicaid coverage. You do not have to bill both Medicare and Medicaid when you submit a claim for a FIDE SNP member, unless the member is receiving Medicaid services via fee-for-service Medicaid. In this scenario, you would need to submit a claim to Humana first and then submit the explanation of remittance (EOR) you receive from Humana to DMAS (or another MCO if applicable).

### FIDE SNP claim payment

When you submit a claim for a FIDE SNP member, regardless of if the claim is adjudicated and paid by Medicaid only, Medicare only, or both Medicare and Medicaid, you will receive one EOR and one payment. Your EOR will explain payments made by Medicaid and Medicare, as applicable. For information on signing up to receive electronic payments and electronic remittance advice, as well as overpayments and suspension of provider payments, please review the **claims and billing chapter of the Medicaid portion of this manual**.

## Cost sharing protections

You are prohibited from imposing cost-sharing requirements on Humana FIDE SNP members that would exceed the amounts permitted under the Virginia State Plan for Medical Assistance. Except for patient pay liability amounts for LTSS services as established by the local DSS, you must consider Humana's payment as payment in full and must not bill or balance bill any Humana FIDE SNP members for covered services provided during the member's period of Humana enrollment.

# FIDE SNP Appendix

## FIDE SNP Appendix Section 11: Provider reconsiderations, appeals and complaints

### Provider reconsiderations, appeals and complaints

As a provider, you have the right to:

- File a reconsideration request if you are dissatisfied with an adverse benefit determination received for a FIDE SNP member before or after the service has been rendered
- File an appeal with DMAS if you are dissatisfied with Humana's response to your reconsideration request
- File a complaint (also called a provider grievance) if you are dissatisfied with any matter other than an adverse benefit determination.

Only non-contracted providers can file a reconsideration request for a payment denial, and they must provide an executed Waiver of Liability to file a reconsideration request. Humana-contracted providers must use Humana's dispute process and do not have access to an independent review entity.

Reconsiderations, appeals and complaints for FIDE SNP members can be submitted in writing to:

**Humana**
Provider Reconsideration
P.O. Box 14359
Lexington, KY 40512-4359

Complaints can also be submitted verbally to Humana Provider Services at **844-881-4482**
Monday – Friday, 7 a.m. – 7 p.m., Eastern time.

# FIDE SNP Appendix

## FIDE SNP Appendix Section 12: Member grievances, appeals and state fair hearings

### Filing grievances and appeals

Humana has an integrated grievance and appeal process for our Virginia FIDE SNP members. Members can file a grievance or appeal verbally by calling Humana Member Services at **844-881-4482** 7 days a week, 8 a.m. – 8 p.m., Eastern time. To file a grievance or appeal in writing, the member may send a letter to:

**Humana**
Grievances and Appeals
P.O. Box 14163
Lexington, KY 40512-4163

The grievance or appeal request should include:

- Member's name, address, telephone number and Humana ID number
- Facts and details regarding the issue and the requested outcome
- The member's signature and date

We identify and remove any communication barriers that can impede members or representatives from filing grievances and appeals. We facilitate the request to file or respond to an appeal for a member who has a communication challenge affecting their ability to communicate or read through the following means:

- The **TTY** line is available for the hearing impaired.
- A translation service is used to facilitate a cultural or linguistic request for members who are unable to speak or read English.
- Extra accommodations are made for any member with special needs who is unable to follow the standard process.

## Member grievances

Members and their authorized representatives have the right to file a grievance at any time if they are dissatisfied with any matter other than an adverse action or adverse benefit determination. An authorized representative must have the member's written consent to file a grievance. Humana acknowledges the receipt of each grievance.

Possible subjects for grievances include, but are not limited to:

- The quality of care or services provided
- Aspects of interpersonal relationships such as the rudeness of a provider or employee
- Failure to respect the member's rights

Humana resolves standard grievances and provides notice as quickly as the member's health condition requires, but no later than 30 calendar days from the date of receipt. Humana will expedite the grievance processing and provide a resolution within 24 hours if the grievance is regarding any of the following:

- Humana's decision to extend the resolution timeframe for an integrated organization determination or for an integrated appeal
- Humana's denial of a request to expedite an integrated organization determination or an integrated appeal

The time frame for resolving a grievance can be extended by 14 calendar days if the member or their authorized representative requests an extension, or if Humana justifies the need for an extension and the extension is in the best interest of the member. If Humana extends the time frame for a grievance not at the request of the member, Humana will make reasonable efforts to give the member prompt oral notice of the delay. Humana will also send written notice of the decision to extend the time frame within 2 calendar days and inform the member of the right to file a grievance if they disagree with that decision.

## Member appeals to Humana

A member, the member's attorney or the member's authorized representative (e.g., provider, family member) acting on behalf of the member can file an appeal request, either orally or in writing. Humana cannot process a grievance or appeal from a member's authorized representative without an executed Appointment of Representative form. A provider can also file an appeal on behalf of the member, when the request is not a request for expedited payment. Appeal requests must be received within 60 calendar days after receipt of the adverse organization determination, unless the appellant can demonstrate good cause. The date of the receipt of the adverse organization determination is presumed to be 5 calendar days after the date of the integrated organization determination notice. If the appeal is received after the allowed timeframe, the request will be reviewed to determine whether a good cause circumstance exists that prevented the appeal from being filed in a timely manner. Good cause should be provided in writing and state why the request was not filed on time.

Humana resolves standard appeals and provides notice as quickly as the member's health condition requires, but no later than 30 calendar days from the date of receipt. Humana acknowledges the receipt of each appeal.

Humana has an expedited review process for integrated appeals when it is determined (with respect to a request from the member) or a provider indicates (when making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain or regain maximum function. Expedited appeals are resolved as quickly as the member's health condition requires, but no later than 72 hours after Humana receives the request.

In instances where the member's request for an expedited appeal is denied, the appeal is decided according to the time frame for standard resolution and the member is given prompt oral notice of the delay. Additionally, within 2 calendar days, the member is sent written notice of the reason for the decision to deny the request for an expedited appeal and is informed of the right to file a grievance if the member disagrees with that decision.

Punitive action will not be taken against a provider who requests an expedited resolution or supports a member's integrated appeal.

Humana may extend the time frame for expedited or standard appeals by up to 14 calendar days if the member or their authorized representative requests the extension, or if Humana justifies the need for additional documentation and the delay is in the member's best interest. For any extension not requested by the member, Humana will make reasonable efforts to give the member prompt oral notice of the delay and written notice within 2 calendar days of the reason for the decision to extend the time frame. The member will also be informed of the right to file a grievance if they disagree with the decision to extend the time frame.

## Next level appeals

Humana provides an integrated appeal decision notice. If the result of the appeal is for Humana to uphold, in whole or in part, its adverse benefit determination involving Medicare, the issues that remain in dispute are reviewed and resolved by an Independent Review Entity (IRE), which is an independent, outside entity that contracts with CMS. The IRE will review the appeal decision, decide whether it is correct and issue a written determination. If the IRE reverses Humana's decision to deny, limit, or delay services that were not furnished while the appeal was pending, we will effectuate a service reversal by the IRE within 72 hours, but no later than 14 calendar days. Furthermore, we will effectuate a payment reversal by the IRE within 30 calendar days.

If Humana upholds, in whole or in part, its adverse benefit determination involving Medicaid, the member or their authorized representative may request a State Fair Hearing within 120 calendar days of the date on Humana's notice of appeal resolution.

The appeal decision letter will provide the reason(s) for the adverse determination and explain the next level of the Medicare and/or Medicaid appeal process. The available next level appeal rights vary depending on whether the service or item being requested is covered under Medicare, Medicaid or if there is overlapping coverage. The appeal decision is binding on all parties unless it is appealed to the next applicable level. If the member pursues the appeal in multiple forums and receives conflicting decisions, Humana is bound by, and will act in accordance with, the decision that is most favorable to the member.

## Continuation of benefits

A member or their authorized representative can request continuation of services that are being reduced or terminated during the appeal and state fair hearing process if the following conditions are met:

- The appeal involves the termination, suspension or reduction of previously authorized services.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not yet expired.

Continuation of services must be requested within 10 calendar days from the date on the appeal decision letter, or before the date we said services would be reduced, suspended, or terminated, whichever is later.

If the member receives a continuation or reinstatement of their benefits while the appeal or state fair hearing is pending, Humana will continue the benefits until one of the following occurs:

- The member or authorized representative withdraw the appeal or state fair hearing request.
- A state fair hearing officer issues a decision that is adverse to the member.

If the final resolution of the state fair hearing upholds Humana's action and services to the member were continued while the appeal or state fair hearing was pending, Humana may recover the cost of the continuation of services from the member, in accordance with DMAS' policies on recovery.