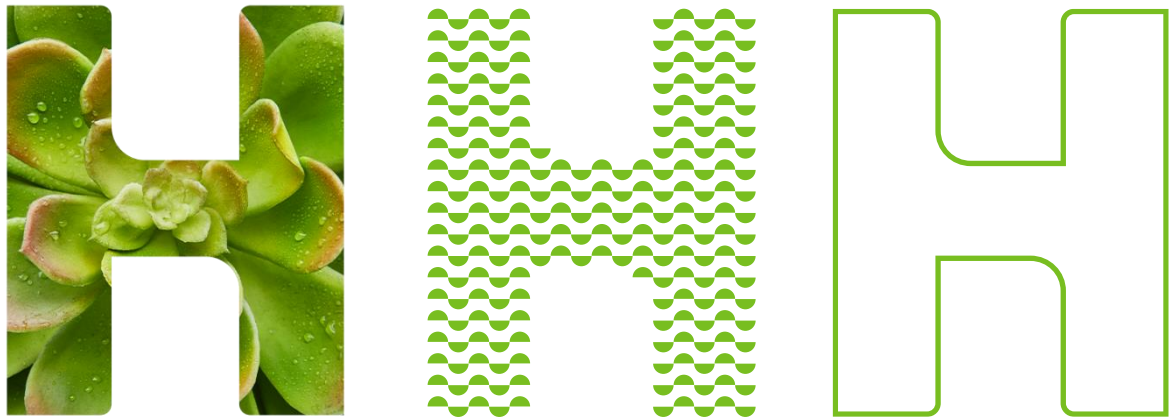
Humana.

CardinalCare
Virginia's Medicaid Program

# Provider Orientation and Training

## Information for Virginia Medicaid's Cardinal Care Managed Care program and FIDE SNP healthcare providers and administrators

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# About this provider orientation and training

**This provider orientation and training provides information and training on processes and requirements for the following plans that Humana offers in Virginia:**

## Humana®

This is a Medicaid plan for Virginians who are eligible to participate in Humana Healthy Horizons® in Virginia.

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

This is a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) for Virginians who are entitled to benefits under Medicare Parts A, B and D and are eligible to receive full Medicaid benefits through Humana Healthy Horizons in Virginia. It serves members statewide.

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

This is another FIDE SNP for Virginians who are entitled to benefits under Medicare Parts A, B and D and are eligible to receive full Medicaid benefits through Humana Healthy Horizons in Virginia. It serves members in Bristol City, Buchanan, Dickenson, Grayson, Lee, Norton City, Russell, Scott, Smyth, Tazewell, Washington, Wise and Wythe counties.

**All slides in this training are applicable to both Humana and Humana's FIDE SNPs in Virginia, unless stated otherwise. The FIDE SNP section at the end of this training is applicable to Humana's FIDE SNPs in Virginia only.**

# Welcome

Welcome and thank you for becoming a participating provider with Humana and/or Humana's FIDE SNPs in Virginia. Humana is a community-based health plan that serves Medicaid members throughout Virginia.

We strive to make it as easy as possible to do business with us. Developing a strong partnership facilitates high-quality care and respectful experiences for our members.

Our goal is to provide integrated care for our members. We focus on prevention and partnering with local providers to offer the services our members need to be healthy.

# About the Cardinal Care Managed Care program

On Oct. 1, 2023, Virginia combined its 2 existing managed care programs—Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0—into 1 unified managed care program known as Cardinal Care Managed Care (CCMC).

**What is Cardinal Care Managed Care?**

CCMC encompasses all health coverage programs, including Medicaid, Family Access to Medical Insurance Security (FAMIS) and Plan First. The overarching brand and program alignment includes managed care and fee-for-service members, with the goal of ensuring smoother transitions for individuals whose healthcare needs evolve over time.

**Eligible members include:**

- Infants, children or youth
- Pregnant individuals
- Medicaid expansion adults ages 19 to 64
- Older adults
- Children or adults with disabilities
- Those who receive Medicare benefits and full Medicaid benefits (dual-eligible members)
- Those who receive Medicaid long-term services and supports (LTSS)

More information can be found at **https://dmas.virginia.gov/for-providers/cardinal-care-transition** and by emailing the Cardinal Care Managed Care inbox at **ccmccontract@dmas.virginia.gov**.

# About Humana's FIDE SNPs

Humana's FIDE SNPs serve dual-eligible individuals throughout Virginia. We are committed to offering accessible and high-quality care to our members, and we are honored to partner with you in this mission.

A FIDE SNP is a type of Dual Special Needs Plan (DSNP), which is a type of Medicare Advantage 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 plan.

- FIDE SNPs are the most integrated type of dual special needs plan, 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. This ensures that members receive holistic and continuous care while minimizing out-of-pocket expenses.

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. 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**.

# Provider support and resources

# Humana deploys a concierge provider services team to enable a transparent and seamless provider experience

## Dedicated and local support

Every provider has a dedicated provider relations representative to help conduct business with Humana.

## Ease of doing business

We developed our processes to be clear and intuitive. We educate providers on how to submit claims, manage authorizations and more.

## Accessible tools and resources

We help providers access Humana tools and resources and partner with them to thrive in the Cardinal Care program.

Our provider partnerships allow us to deliver high-quality medical and behavioral managed care health services to eligible Virginia residents with Cardinal Care coverage.

**Please note that only providers enrolled in Humana's Medicaid network are assigned to a provider relations representative.**

# Provider support team

## Our provider support team is led by our Director of Provider Services.

**Your provider relations representative:**

- Serves as day-to-day, front-line relationship management
- Conducts provider training and education; communicates emerging trends and Humana policy updates
- Conducts ongoing meetings and technical assistance in one-on-one or group settings
- Assists to navigate resources and facilitates issue resolution
- Educates and translates available data to identify tangible and impactful interventions to improve quality performance

Virginia provider relations representative territory map
**Humana.com/HealthyVA**

Provider Services Center:
**844-881-4482**
Monday – Friday, 7 a.m. – 7 p.m., Eastern time

**Please note that only providers enrolled in Humana's Medicaid network are assigned to a provider relations representative.**

# Overview of Humana provider website

Visit **Humana.com/HealthyVA** for additional resources.

- Training calendar
- Provider resource guide
- Provider manual
- Provider relations representative contacts
- Availity Essentials™
- Pharmacy
- Claims and payments
- Prior authorization
- Behavioral health
- Training materials
- Communications and forms

# Availity Essentials

Availity Essentials is Humana' provider portal. Through Availity Essentials, providers can :

- Check eligibility and benefits
- Submit claims and check claim status
- Submit and view authorization requests and referrals
- View remittance advice
- Access electronic funds transfer (EFT) and electronic remittance advice (ERA) enrollment

Sign in to **Availity Essentials** (registration required).

From the Payer Spaces menu, select Humana.

From the Applications tab, select the ERA/EFT Enrollment app. (If you don't see the app, contact your Availity Essentials administrator.)

## Provider self-service portal from Humana

For Availity Essentials training, sign in to **Availity Essentials** > Select Help & Training > Select Get Trained to access Availity Essentials training materials.

# Humana key contacts

| Contact | Phone |
|---|---|
| **Provider Services** | **844-881-4482**<br>Monday – Friday, 7 a.m. – 7 p.m., Eastern time |
| **Member Services** | **844-881-4482 (TTY: 711)**<br>Monday – Friday, 8 a.m. – 8 p.m., Eastern time<br>(Self-service and voicemail options are available after normal business hours, weekends and holidays). |
| **Member interpreter services** | **877-320-2233**<br>24 hours a day, 7 days a week |
| **Clinical Intake Team (CIT)** | Call **844-881-4482** to be routed to the CIT, available Monday – Friday, 7 a.m. – 8 p.m., Eastern time |
| **Clinical Triage Line (Behavioral Health Crisis/ARTS and nurse 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>Monday – Friday, 8 a.m. – 4 p.m., Eastern time<br>Voicemail 24 hours a day, 7 days a week |

| Contact | Mailing address |
|---|---|
| **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 |
| **Member grievances and appeals** | **Humana**<br>Grievances and Appeals<br>P.O. Box 14163<br>Lexington, KY 40512-4163 |
| **Humana claims office** | **Humana**<br>Humana 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 |
| **Ethics Help Line** | **877-5-THE-KEY (877-584-3539)**<br>24 hours a day, 7 days a week |

# Contracting and credentialing

# Join the network

Humana
Healthy Horizons®
in Virginia

If you are interested in joining the Humana network, you can:

## Call

- **844-881-4482**,
  Monday – Friday, 7 a.m. – 7 p.m., Eastern time

## Email:

- Physical health providers:
  **VirginiaProviderUpdates@humana.com**
- Behavioral health providers:
  **VA_BH_Medicaid@humana.com**
- Home- and community-based services (HCBS) providers:
  **LTSSContracting@humana.com**

A dedicated contractor will walk you through the contracting process and collect your credentialing documentation.

**For information on joining our network to serve FIDE SNP members, please review the FIDE SNP section of this provider orientation.**

# Credentialing and recredentialing

## DMAS requirements

- To participate with Humana, all providers must enroll via the Virginia Department of Medical Assistance Services (DMAS) Provider Services Solution (PRSS) enrollment wizard. For PRSS portal inquiries, please call the PRSS Provider Enrollment Helpline at **804-270-5105** or **888-829-5373**, Monday – Friday, 8 a.m. – 5 p.m., Eastern time or email Provider Enrollment at **VAMedicaidProviderEnrollment@gainwelltechnologies.com**. PRSS portal training can be found on **Virginia Medicaid's website** under "How to Use the Provider Portal" section.
- You must have a valid National Provider Identifier (NPI) or atypical provider identifier (API) and must be screened, enrolled and periodically revalidated in DMAS' Medicaid Enterprise System (MES) PRSS. This rule applies to all provider types and specialties. Per 42 CFR §438.608(b), this provision does not require you to render services to fee-for-service beneficiaries.

## Humana credentialing process

- Providers must meet our standards for licensure, certification and credentialing. These standards apply to providers licensed by the state and those providers who received proper certification or training to perform medical and behavioral health services provisioned under the Humana provider contract.
- New provider applicants are notified within 10 days of receiving their application, by email, the MES Provider Enrollment Portal or carrier mail (as selected by the applicant), confirming receipt.
- At the time of application, credentialing, recredentialing and/or on request, the provider must disclose required information in accordance with 42 CFR §455 (Parts 101 through 106), percentage calculations, and requirements for disclosure of ownership, business transactions and information on persons convicted of crimes related to any federal healthcare programs.
- A new provider application is deemed complete within 30 days of receiving the application unless notice was provided that the application was incomplete. Credentialing applications are approved or denied within 60 days of receiving a completed application.

**For information on getting credentialed to serve FIDE SNP members, please review the FIDE SNP section of this provider orientation.**

# Contractual demographic changes

Providers are required to notify Humana of the following demographic changes 30 days prior:

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

You can notify us by:

**Medical providers:**

Email:
**VirginiaProviderUpdates@humana.com**

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**LTSS providers**

Email:
**LTSSContracting@humana.com**

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**Behavioral health providers:**

Email:
**VA_BH_Medicaid@humana.com**

# Member eligibility and enrollment

# Member eligibility

## Determination

Virginia DMAS determines a member's eligibility and provides eligibility information to Humana.

## Newborn coverage

Newborn coverage starts on the date of birth when the newborn's mother is a member of a Humana plan.

## Eligibility

If Humana members lose Medicaid eligibility but become eligible again within 60 days, they are automatically reenrolled in Humana and assigned the same primary care provider (PCP), if possible.

## Eligibility verification

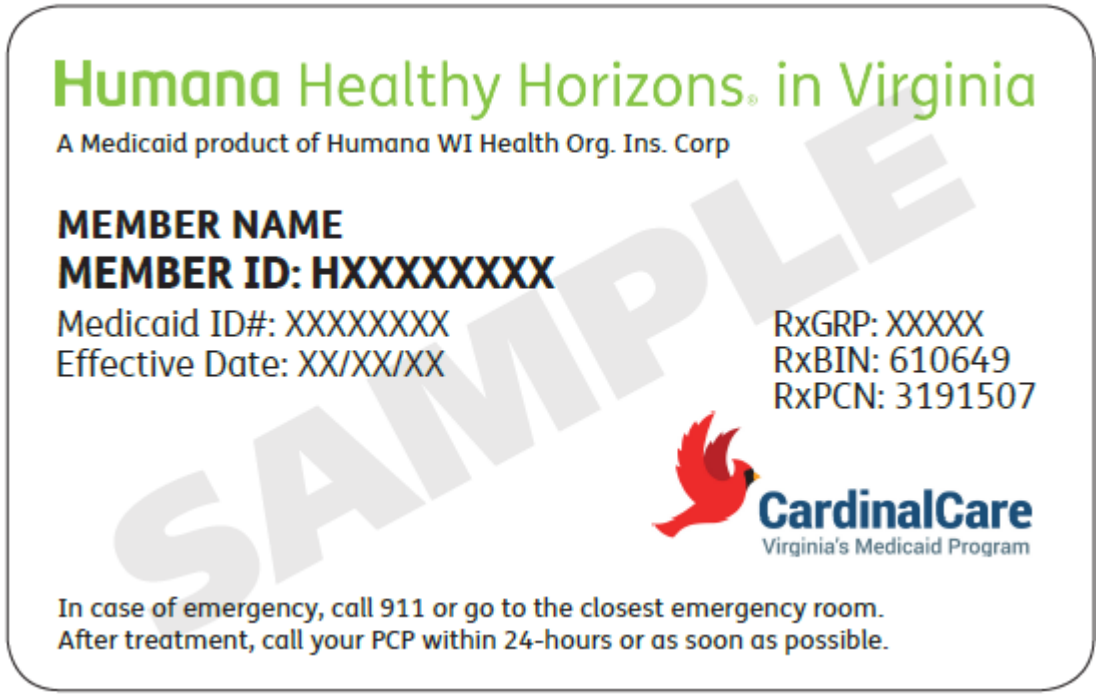
Prior to providing services (except during emergencies), providers are expected to verify member eligibility. Providers should ask for a member ID card prior to rendering services.

**For information on member eligibility for FIDE SNP members, please review the FIDE SNP section of this provider orientation.**

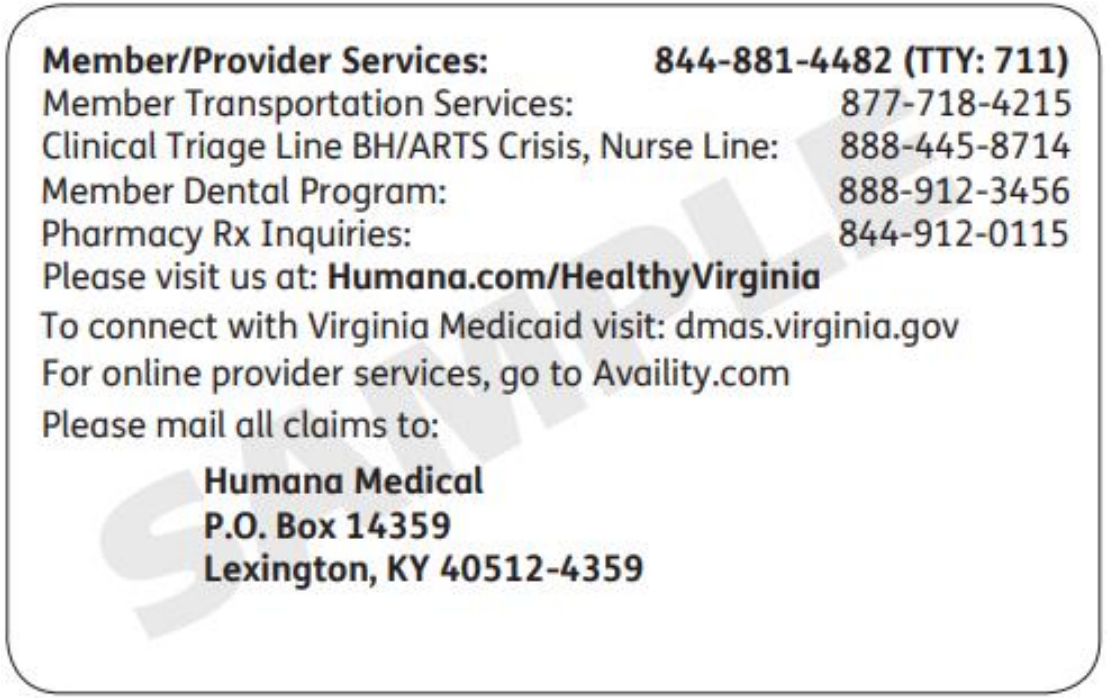
**You may verify member eligibility by signing in to Availity Essentials and navigating to Patient Registration, then selecting Eligibility and Benefits Inquiry.**

# Sample member ID card – Virginia Medicaid

**Card front**




**Card back**

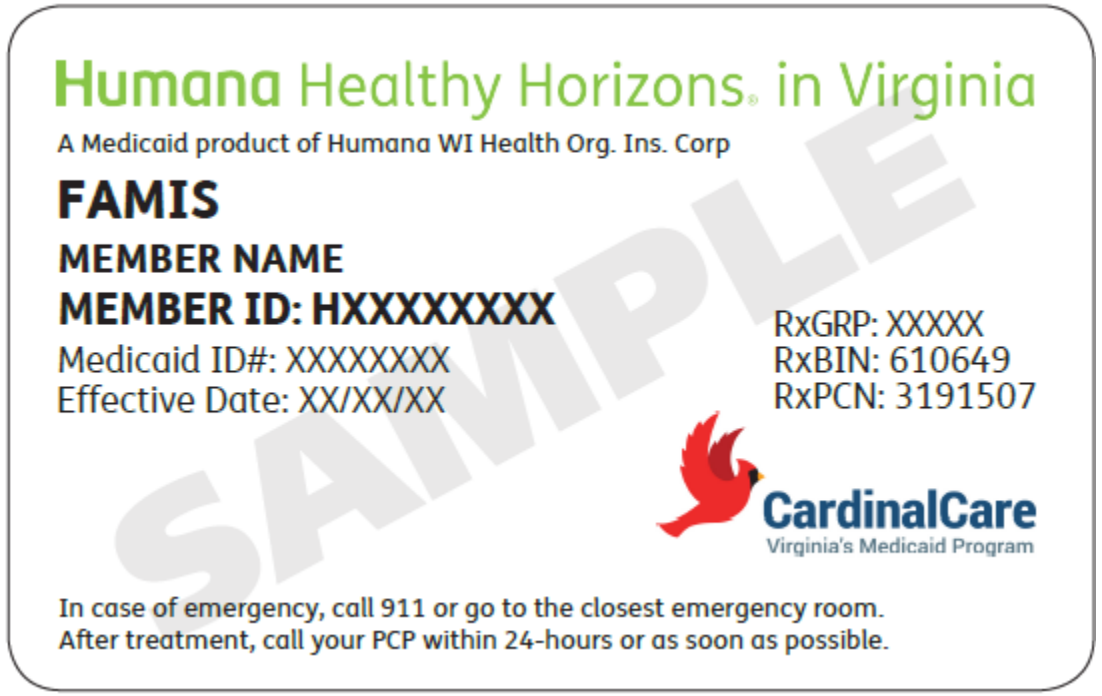



**Please note:** ID card design is not final and is subject to changes or updates. Samples are displayed on this slide for continuity.

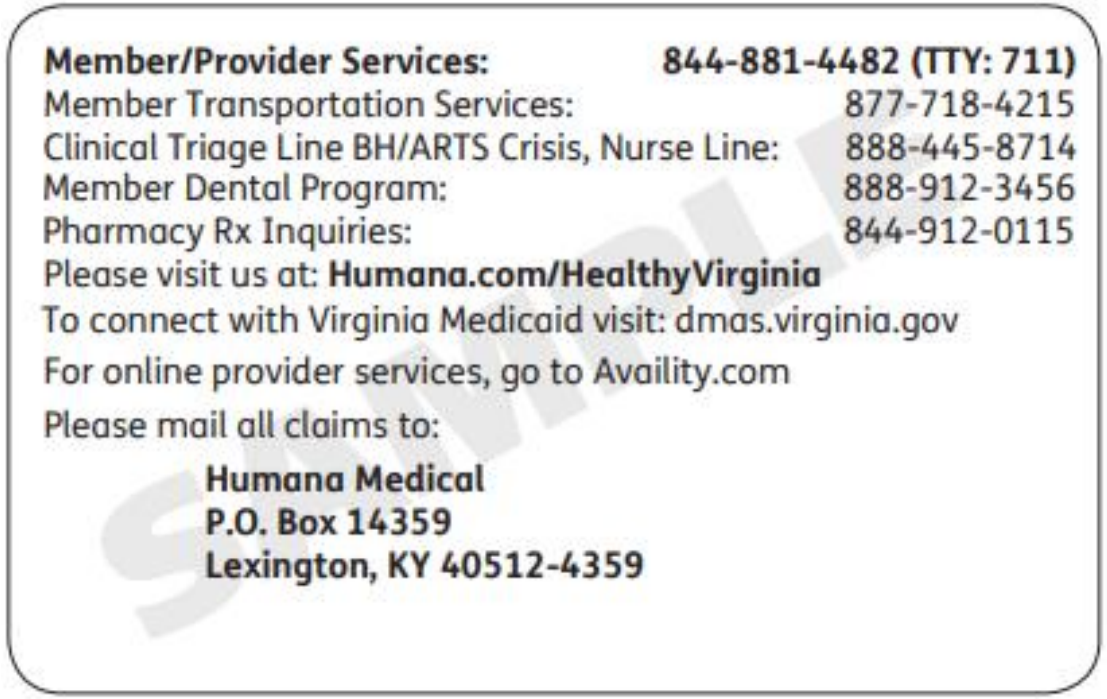
**For sample member ID cards for FIDE SNP members, please review the FIDE SNP section of this provider orientation.**

# Sample member ID card – Virginia Medicaid FAMIS

**Card front**




**Card back**

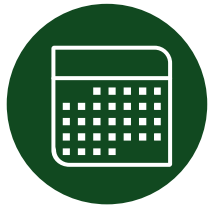



**Please note:** ID card design is not final and is subject to changes or updates. Samples are displayed on this slide for continuity.

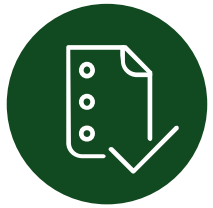
**For sample member ID cards for FIDE SNP members, please review the FIDE SNP section of this provider orientation.**

# PCP assignment and changes

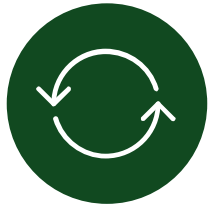
Humana offers each member the opportunity to choose a Humana-affiliated PCP to the extent open panel slots are available. Members can select a PCP from our provider directory. With the exception of dual-eligible members, Humana ensures each member has an assigned PCP at the date of enrollment.



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.



If a member does not choose a provider, Humana will choose a PCP based on language needs, age and sex, enrollment of family members, area of residence, and current/past provider relationships.



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.

**For information on PCP assignment and changes for FIDE SNP members, please review the FIDE SNP section of this provider orientation.**

# Claims

# Claim processing

Humana processes accurate and complete provider claims in accordance with its normal claims processing procedures that include, but are not limited to, **Humana.com/Edits**, **Humana.com/ClaimsPaymentPolicies** and applicable state and/or federal laws, rules and regulations.

Humana pays or denies, as appropriate, 90% of all clean claims submitted from healthcare providers within 30 calendar days of the date of receipt.

Humana pays or denies, as appropriate, 99% of all clean claims submitted from healthcare providers within 90 calendar days of the date of receipt.

Humana issues payment for a clean paper or electronic claim from 30 calendar days following receipt of the claim or the date on which Humana is in receipt of all information needed, including:

- A format required for the claim to constitute a clean claim
- Receipt of all documentation requested to determine that such claim does not contain any material defect, error or impropriety
- Enough information to make a payment determination

**For information on claim processing for FIDE SNP members, please review the FIDE SNP section of this provider orientation.**

# Timely filing requirements

Initial claims must be submitted within 365 calendar days from the date of service.

Corrected claims must be submitted within 180 calendar days from the date of the explanation of payment.

Claims are not paid if they have incomplete, incorrect or unclear information.

# Submitting electronic and paper claims

**Humana accepts electronic claims through these clearinghouses:**

- Humana's clearinghouse: **Availity Essentials**
- Additional commonly used clearinghouses:
  - **Change Healthcare®**
  - **TriZetto®**
  - **SSI Group**

When filing an electronic claim, providers should use payer ID 61101.

**Paper claims can be submitted on:**

- CMS-1500, formerly HCFA 1500 form
- AMA universal claim form, also known as the National Standard Format (NSF)
- CMS-1450 (UB-04), formerly UB92 form, for facilities

**Paper claims mailing address:**

**Humana Claims Office**
Humana
P.O. Box 14359
Lexington, KY 40512-4359

# Overpayments

If a provider identifies a claim that was overpaid, the overpayment should be reported and returned within 30 days of the payment identification. Overpayments can be reported via Availity Essentials.

**To report the overpayment:**

1. Sign in to Availity Essentials
2. Access the Claims Status application
3. Select “Identify Overpayment” at the top of the screen and follow the prompts

Humana provides written notice to the provider at least 30 calendar days before an adjustment for the overpayment is made. If a dispute is not received from the provider, adjustments to the overpayment are made on a subsequent reimbursement.

## Balance billing members

- Do not balance bill members or bill for missed appointments.
- State requirements and federal regulations prohibit providers from billing Humana members for medically necessary covered services except under very limited circumstances. Providers also may not bill members for missed and/or cancelled appointments.
- Humana monitors this billing policy activity based on complaints of billing from members. Failure to comply with regulations after intervention may result in both criminal charges and termination of your agreement with Humana.

**For more information on balance billing, please refer to your provider manual at Humana.com/HealthyVA.**

# Provider reconsiderations, appeals and complaints

# Provider reconsiderations

Provider reconsideration is the first step in the provider appeal process. A reconsideration represents your initial request for an investigation into a reduced or denied authorization or reimbursement for rendered services. Most issues are resolved at the reconsideration step. You have 60 calendar days from receiving written notification of the denial or reduction of an authorization, or the denial or reduction of claim reimbursement, to submit a reconsideration.

You can expect to receive a written resolution to your reconsideration request in no later than 30 calendar days from submission.

A reconsideration request may be filed using the following methods:

**In writing:**
Humana
Provider Reconsideration
P.O. Box 14359
Lexington, KY 40512-4359

# Provider appeals

If you are not satisfied with Humana' decision to deny or reduce an authorization or reimbursement of a claim, you can file a provider appeal and a reconsideration with DMAS thereafter.

**Informal and formal appeals via DMAS:**

There are 2 levels of sequential administrative appeal, the informal appeal and the formal appeal.

- Informal appeal is the first level appeal via DMAS. If the informal appeal is adverse, you can request a formal appeal.
- Formal appeal is the second level of appeal via DMAS.

**Before appealing to DMAS,** you first must exhaust Humana's reconsideration process. Providers in Humana's network may not appeal Humana's enrollment or terminations decisions to DMAS.

# 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 staff member or employee, or failure to respect the member's grievance.

**If you would like to submit a complaint, you can submit via:**

- Call: Provider Services at **844-881-4482**
- Email: **VAMedicaidProviderRelations@humana.com**
- Contact: Your provider relations representative

**Acknowledgement and resolution time frames**

- Verbal complaints are acknowledged over the phone.
- Written complaints are acknowledged within 7 business days of the complaint date.
- Complaints are resolved within 30 calendar days via written resolution.

**Please note that only providers enrolled in Humana's Medicaid network are assigned to a provider relations representative.**

# Utilization Management

# Utilization Management and prior authorization

Utilization Management (UM) includes prior authorization, concurrent reviews, discharge planning and other activities such as monitoring inpatient and outpatient admissions.

UM staff review services based on medical necessity, appropriateness of care and service, and existence of coverage.

Humana places limits on services according to Medicaid criteria, including medical necessity.

| | |
|---|---|
| **Prior authorization** | Prior authorization is the process through which healthcare providers obtain approval from the plan as to whether an item, drug or service will be covered. |
| **Requesting authorization** | • **Online:** Visit the provider portal at **Availity Essentials** to complete an authorization request.<br>• **Phone:** Call **844-881-4482** and follow the menu prompts for authorization requests, depending on your needs. |
| **List of services requiring prior authorization** | You can find a full list of services requiring prior authorization at **Humana.com/PAL**. Humana's list is subject to change. |

**For information on Utilization Management for FIDE SNP members, please review the FIDE SNP section of this provider orientation.**

# Specialist referrals and second opinions

**Specialist referrals**

Members may see any participating network provider, including specialists and inpatient hospitals. Humana does not require referrals from PCPs to see participating specialists; however, prior 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 if applicable benefit limits have not been exhausted.

**Please note:** ARTS, intensive outpatient, partial hospitalization program and residential treatment services (RTS) providers must assess and refer members for medication for treatment of opioid use disorder, when appropriate.

**Second opinions**

Members and providers may request a second opinion for surgery or medical services at no cost. The following criteria should be used when selecting a provider for a second opinion:

- The provider must participate in the Humana network. If an in-network provider is not available, Humana will arrange for the member to obtain the second opinion and facilitate the referral process.
- Providers must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.
- Providers must practice in an appropriate specialty area.

**For information on Utilization Management for FIDE SNP members, please review the FIDE SNP section of this provider orientation.**

# Care management and quality management

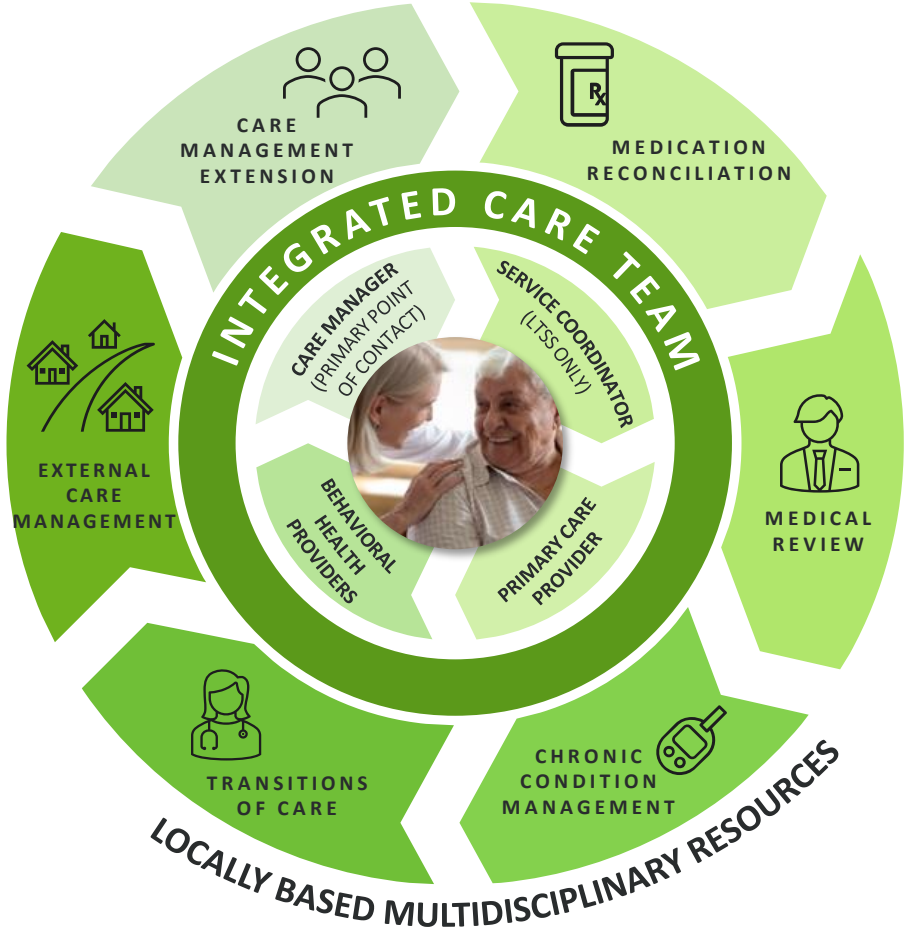
For information on the model of care for FIDE SNP members, please review the FIDE SNP section of this provider orientation.

# Care management model

Humana's 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 approach delivers services and supports to members to address their needs and risk levels. Members with complex health risks require intensive care management with frequent contacts; members with emerging risk and short-term needs benefit from one-on-one assistance from a care coordinator. Members with minimal or no health issues benefit from accessible wellness education, contact with social services and outreach to close preventive care gaps.

Our guiding principles:

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




More information about case management can be found in the provider manual on our website at **Humana.com/HealthyVA**.

# Care management

Humana coordinates care and population health services for our members.

Individualized care plans are person-centered and holistic, implementing services that address the member's physical care, behavioral health, community and social support needs.

**Care management and care coordination support members by:**

- Reducing admission and readmission risks
- Managing anticipatory transitions
- Reducing emergency room visits for nonurgent needs
- Reinforcing medical instructions and educating on disease processes
- Assessing and closing gaps associated with health-related social needs (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:

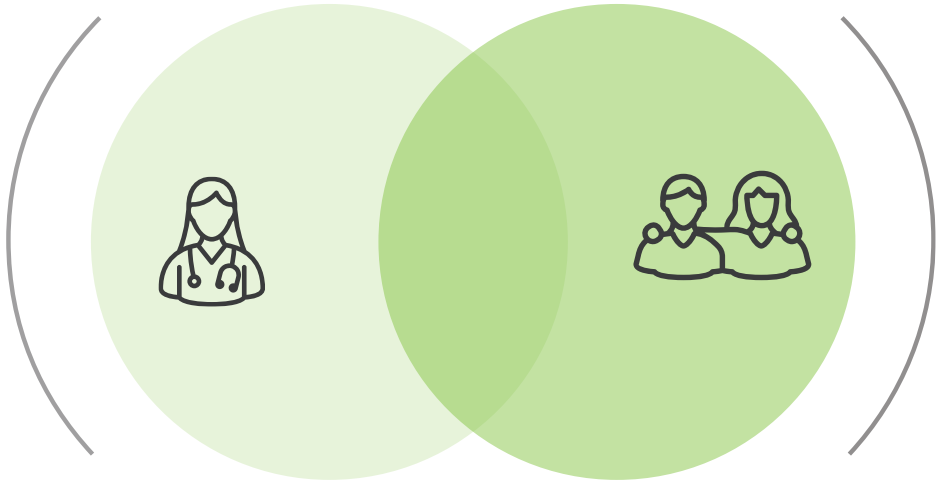
- Transitional care management
- Chronic condition management
- Neonatal intensive care unit (NICU) case management
- Transplant care management
- HumanaBeginnings® maternity program (includes high risk pregnancies with substance use disorder (SUD) and those postpartum through 12 months)
- Pediatric care management (e.g., private duty nursing (PDN), adoption assistance, development disabilities and childhood obesity)
- Behavioral health (BH) and ARTS care management (e.g., serious mental illness, serious emotional disturbance, adolescents with BH needs and justice involved individuals)
- LTSS and age, blind and disabled care management (e.g., nursing facility [NF] and long-stay hospital residents, CCC Plus waivers, members with intellectual and development disabilities (waiver and non-waiver) and dual-eligible individuals)

# Care management team capabilities

## Care management

Care coordinators, case managers, care managers and care coaches often are used interchangeably. Care coordinators manage strictly low-acuity members. Care managers can be:

- Registered nurses
- Licensed practical nurses
- Licensed clinical social workers
- Licensed professional counselors
- Master of social work
- Bachelor of social work



## Service coordinators

Service coordinators work with care managers to ensure LTSS members receive the services they need.

## Care management supporting roles

- Social determinants of health (SDOH) coordinators: telephonic
- Regional transition coordinators: telephonic and face-to-face
- Community health workers (CHW): telephonic and face-to-face
- Housing specialists: telephonic and face-to-face

# Individual care plans and integrated care team approach

Humana' care management team applies person-centered principles to support our members in regaining control over their lives and health. Whether a member has 1 major need or multiple complex needs, their care manager serves as their primary point of contact, working with the member's integrated care team (ICT) to deliver comprehensive support for the member's physical health, behavioral health, functional and social needs. Each member engaged in care management has an individual care plan (ICP) based on health risk assessment (HRA) output.

The member's ICP includes a member's strengths, needs, preferences and goals. ICP will be updated routinely based on member preference and requirements.

The ICP is initially created based on the member's risk, as follows:

- **Low:** Within 30 calendar days of a completed HRA (contract requirement: 60 days)
- **Moderate:** Within 30 calendar days of a completed HRA
- **High:** Within 7 calendar days of a completed HRA
- **Revisions:** Every 6 months and within 10 calendar days following a triggering event

# Care management participation and referrals

Humana encourages providers to participate in the development of a member's personalized ICP and actively participate in scheduled ICT conferences.

Member care plans and health assessments are viewable, with member consent, on Humana' provider portal, Availity Essentials.

Providers can contact Humana to refer members needing care management assistance:

| Programs | 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 |
| HumanaBeginnings (maternity) inquiries and referrals | VAMCDMaternity@humana.com | 877-245-1704 |

If a member needs access to a car, wheelchair van, stretcher services or nonmedical transportation:

- Call Modivcare at **877-718-4215.**

**For information on transportation services for FIDE SNP members, please review the FIDE SNP section of this provider orientation.**

# Quality management

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 to drive significant quality of care improvement in clinical and nonclinical areas
- **Member medical records reviews –** Documentation review to evaluate documentation patterns and note areas of improvement
- **Performance measures –** Data collected on patient outcomes
- **Surveys** – Consumer Assessment of Healthcare Providers and Systems (CAHPS®), provider satisfaction, behavioral health surveys
- **Peer reviews –** Review of provider practice methods

## Clinical resources

**Clinical practice guidelines**

A full listing of medical record requirements can be found in the provider manual at **Humana.com/HealthyVA**.

# Provider rights and responsibilities

# Provider rights and responsibilities

## Provider rights

Humana-contracted providers acting within the lawful scope of practice are not prohibited or restricted from advising or advocating on behalf of a member for any of the following:

- 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 non-treatment
- 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

## Provider responsibilities

Humana-contracted providers have the following responsibilities to their Humana-covered patients (not an inclusive list):

- Deliver primary care services and follow-up care
- Screen members for behavioral health disorders and conditions
- Refer members for specialty care, mental health services and other covered treatments
- Meet applicable appointment waiting time standards and after-hours coverage requirements
- Abide by members' rights and responsibilities, per the contract
- Provide physical access, reasonable accommodations and accessible equipment for members with physical or mental disabilities
- Accommodate interpreters
- Complete all annual required training
- Comply with all relevant federal and state laws including, when applicable, the Anti-Kickback Statute and prohibitions in using inducements to members, and in marketing and promotional activities, including provider promotional activities

To comply with the requirements of accrediting and regulatory agencies, Humana adopted certain responsibilities for participating providers.

For a full list of the provider rights and responsibilities, please refer to the provider manual (Chapter 5) at **Humana.com/HealthyVA.**

# Accessibility, availability standards and methods of identifying compliance

Participating PCP and medical/behavioral health specialists are required to ensure adequate accessibility for healthcare 24 hours a day, 7 days a week when medically necessary. An after-hours PCP telephone number must be available to members. Voicemail is not permitted.

Humana monitors providers to ensure compliance with timely access requirements through audits and surveys and takes corrective action for failure to comply.

Detailed information about accessibility and availability standards can be found within **Chapter 5** of the provider manual on our website at **Humana.com/HealthyVA**.

**For information on accessibility and availability standards for FIDE SNP members, please review the FIDE SNP section of this provider orientation.**

# Cultural and linguistic humility and competency

Cultural humility and competency in healthcare acknowledges and recognizes the distinctions and unique differences of care level needs that center on diverse values, beliefs and behaviors, inclusive of patients' social, cultural and linguistic needs.

Participating providers are expected to provide services in a culturally sensitive and competent manner, including removing language barriers to services and accommodating unique needs relating to the ethnic, cultural and social circumstances of the patient.

Services should be delivered in a culturally aware manner, fostering a connection to the broader context and considering factors such as race, ethnicity, culture and gender of Cardinal Care Managed Care members.

## Interpreter services

Providers are required to abide by federal and state regulations related to Sections 9 504 and 508 of the Rehabilitation Act, Americans with Disabilities 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 to non-English speakers. These services are available at no cost to the member per federal law.

**If you need help in fulfilling this obligation, please call 877-320-2233.**

# Required training and annual compliance

Visit **Humana.com/HealthyVA** for direct links to required training and information. Please refer to the steps listed on the right to complete attestation online.

- Fraud, waste and abuse
- Prevention, detection and report of abuse, neglect and exploitation
- Cultural humility, health equity and implicit bias training for Medicaid providers

## To complete your compliance training and attestation online

1. Sign in to **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 that you are navigating to **https://sso2.archer.rsa.com**, choose "Yes" to proceed. You will be entering Humana's secured 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," then "Save and Close."

All applicable events will show a status of "Review Complete."

# Fraud, waste and abuse

## Fraud

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. It includes any act that constitutes fraud under applicable federal or state law.

## Waste

The overutilization of services or other practices that, directly or indirectly, results in unnecessary costs to the healthcare system; generally the actions are not considered criminally negligent, but rather a misuse of resources.

## Abuse

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 fact to obtain payment. Provider abuse is inconsistent with sound fiscal, business or medical practices. Also includes member practices that result in unnecessary cost to the Medicaid program.

All information will be kept confidential. Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Humana has a zero-tolerance policy for retaliation or retribution against any person who reports suspected misconduct.

## Fraud, waste and abuse reporting requirement and reporting options

If you suspect or detect a fraud, waste and abuse violation, you are required to report it either to Humana or within your organization, which then must report it to Humana.

**Telephone**:

- Special Investigations Unit (SIU) hotline: **800-614-4126** (Monday – Friday, 8 a.m. – 4 p.m., Eastern time; 24/7 voicemail access)
- Ethics Help Line: **877-5-THE-KEY (84-3539 )**; 24/7 access)

**Email:**

- **SIUReferrals@humana.com**
- **ethics@humana.com**

**Web:**

- Special Investigations Referral Form Online: **Humana.com/legal/si-referral-form**
- Ethics Help Line reporting website: **www.ethicshelpline.com**

**Fax**:

- **920-339-3613**

Suspected fraud, waste and abuse can also be reported by calling the DMAS Fraud and Abuse Referral hotline at **866-486-1971** or emailing **Recipientfraud@dmas.virginia.gov**.

# Identifying and reporting member abuse, neglect and exploitation

## Abuse

The suspected or known physical or mental mistreatment of a member.

## Neglect

Repeated conduct or a single incident of carelessness, which 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.

## How to report?

Abuse, neglect or exploitation must be reported immediately on discovery and in accordance with state law.

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

**Reporting cases for children:**

- 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**
  - Hearing impaired: **800-828-1120 or 711**

**Reporting for adults:**

- The local adult protective services office
- The Virginia Department of Social Services toll-free hotline: 888-832-3858

Humana Provider Services: **844-881-4482**

# 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 the member. Critical incidents include, but are not limited to, the following:

- Medication errors
- Theft
- Suspected physical, mental, verbal or sexual abuse or neglect
- Financial exploitation
- Sentinel events*
- Quality of care incidents**
- Other critical incidents***

Critical incidents must be reported when they occur during the following:

- Medicaid-funded services delivered to members in the following settings:
  - Nursing facilities
  - Skilled/rehabilitative services
  - Inpatient behavioral health settings
  - Inpatient SUD treatment facilities
- Participation in or receipt of mental health services, ARTS, or CCC Plus HCBS waiver services in any setting (e.g., an adult day care center, a member's home or other community-based settings)

***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 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.

****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.

*****Other critical incident** – An event or situation that creates 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.

All providers must comply with critical incident requirements. The critical incident reporting form must be used by all staff and network providers. Network providers must report, respond to and document critical incidents in accordance with DMAS' requirements and 42 CFR § 438.330(b).

Network providers must report critical incidents within 24 hours.

If the initial report of a critical incident is submitted verbally, the party making the initial report must submit a follow-up written report to Humana within 48 hours. Providers should refer to the Critical Incident form found at **Humana.com/HealthyVA**.
For critical incident reporting please send written reports of clinical incidents to:

**Fax: 877-313-7257**

**Email:**
**VACriticalincidents@humana.com**

# Member rights and responsibilities, including grievances and appeals

# Member rights and responsibilities

## Rights

- 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
- Obtain information in a way they can easily understand including interpretation, written translation and auxiliary aids available free of charge
- Access healthcare and services in a timely, coordinated and culturally competent way

## Responsibilities

- Follow their member handbook, understand their rights and ask questions when they want to learn more or do not understand
- 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 member ID card whenever they get care and services
- Provide complete and accurate information about their medical history and their symptoms

A list of all the member rights and responsibilities can be found within the provider manual on our website at **Humana.com/HealthyVA**.

# Grievances and appeals

## Grievances

Members or their authorized representatives can file a grievance at any time, orally or in writing, if they are dissatisfied with Humana or any aspect of their care.

## Appeals

Members or their authorized representatives can file an oral or written appeal request within 60 calendar days of the date on the adverse benefit determination. Members can request assistance from Member Services by calling **844-881-4482**.

### Member grievances and appeals contact information

**Mail**
Humana
Grievance and Appeals
P.O. Box 14163
Lexington, KY 40512-4163

**Member Services**

**844-881-4482 (TTY: 711),** Monday – Friday, 8 a.m. – 8 p.m., Eastern time (Self-service and voicemail options are available after normal business hours, weekends and holidays).

**For information on the integrated grievances and appeals processes for FIDE SNP members, please review the FIDE SNP section of this provider orientation.**

# Grievances and appeals

**Grievances**

- A member's grievance is resolved as quickly as the member's health condition requires.
- If DMAS requires a member to seek redress through Humana' grievance system before DMAS reviews the member's request for disenrollment, then Humana completes 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.
- Grievances regarding all other matters are resolved within 90 calendar days from the date Humana receives the request.

**Appeals**

- Humana resolves appeals as quickly as the member's health condition requires.
- Standard appeals are resolved no later than 30 calendar days from the date the request is received.
- If the member's life, physical or mental health, or ability to attain, maintain or regain maximum function is at risk by following the standard appeal time frame, an expedited appeal can be requested.
- Expedited appeals are resolved within 72 hours of receipt.
- Humana may extend the appeal time frame by up to 14 calendar days if the member requests the extension or if Humana needs more information and extending the time frame is beneficial to the member.

## Medicaid state fair hearing

If the appeal decision is not fully in the member's favor, the member or the member's authorized representative can appeal to Virginia DMAS by requesting a state fair hearing. Medicaid state fair hearing requests must be filed within 120 calendar days from the date of Humana's appeal decision.

**Mail state fair hearing requests to:**

Virginia Department of Medical Assistance Services – Appeals Division
600 E. Broad Street
Richmond, VA 23219

Main phone: **804-371-8488**

**Fax your appeal request to:**
DMAS at **804-452-5454**

Submit requests online at **DMAS' appeals website**
or by email to **appeals@dmas.virginia.gov**.

**For information on the integrated grievances and appeals processes for FIDE SNP members, please review the FIDE SNP section of this provider orientation.**

# Continuation of benefits

While the state fair hearing or appeal is pending, Humana continues paying for the member's benefits if all the following conditions are met:

- The member timely files the request for an appeal or state fair hearing.
- 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.
- The member timely files a request for continuation of benefits within 10 calendar days of Humana' notice of adverse benefit determination or by the intended effective date of the proposed adverse benefit determination, whichever is later.

If the member receives a continuation or reinstatement of benefits while the appeal or state fair hearing is pending, Humana continues to cover the benefits until 1 of the following occurs:

- The member withdraws the appeal or state fair hearing.
- A state fair hearing officer issues a decision that is adverse to the member.

The member may be liable for the cost of any continued benefits while the appeal or state fair hearing is pending if the final decision upholds Humana' initial determination.

**For information on the integrated grievances and appeals processes for FIDE SNP members, please review the FIDE SNP section of this provider orientation.**

# Covered services

# Covered services

Humana offers a variety of benefits. Covered services include, but are not limited to:

- Behavioral health and Addiction and Recovery Treatment Services (ARTS)
- Clinical services, including preventive care, palliative care and diagnostic services
- Clinical trials
- Dietary and tobacco cessation counseling
- Emergency services
- Emergency ambulance and nonemergency medical transportation
- Home health services
- Immunizations
- Inpatient and outpatient hospital services
- Laboratory, radiology and anesthesia services
- Mammograms, pap tests, colorectal and lung cancer screenings
- Medical supplies and equipment, including prosthetics/orthotics
- Physical and occupational therapies
- Speech pathology and audiology services
- Pregnancy services, including doula and certified nurse midwife services
- Prescription drugs
- Telemedicine services
- Vision services

## Enhanced benefits

Enhanced benefits are services offered by Humana and are approved in writing by DMAS. Humana's enhanced benefits include, but are not limited to, the following:

- Caregiver respite
- Convertible car seat or portable crib
- Criminal record expungement
- Disaster preparedness meals
- Employment physical
- Environmental modifications
- Fall prevention kit
- Fresh produce box – chronic conditions
- Food as medicine – maternal care
- General Educational Development (GED®) Test
- Haircuts for Kids program
- Hearing services
- Over-the-counter pharmacy allowance
- Post discharge meals
- Sports physical
- Youth academic support

**Note:** For a full list of covered services, please refer to our provider manual, located on our website at **Humana.com/HealthyVA**.

**For information on covered services for FIDE SNP members, please review the FIDE SNP section of this provider orientation.**

# Go365 member rewards program

Humana members can earn rewards for completing healthy actions through Go365 for Humana®. To get started, members download the Go365 for Humana app from the Apple App Store® or Google Play®.

Providers can help members obtain rewards by submitting claims on their behalf by the end of the member's plan year (Dec. 31) so members have time to redeem the rewards. They have 90 days from one plan year to another, assuming they remain continuously enrolled, to redeem their rewards.

Go365 is available to all members who meet the requirements of the program. A full listing of eligible healthy activities that earn rewards can be found in your Provider Manual.

More information about Go365 and member rewards can be found in the provider manual or on our website at **Humana.com/HealthyVA**.

**For information on the Go365 member rewards program for FIDE SNP members, please review the FIDE SNP section of this provider orientation.**

# Behavioral health referral process

PCPs might encounter a member who needs behavioral health (BH) services during their visit.

- Should a member identify as such, the PCP may refer the member to **Humana.com/FindADoctor** to utilize the provider directory.
- Humana' provider directory allows members to search by specialty or condition to find the appropriate provider for their needs.
- Providers and/or members also can connect with a care manager by calling **844-881-4482** for assistance with their BH needs.

Members are eligible to self-refer to BH services, including ARTS.

Humana provides coverage for BH crisis services including, but not limited to, mobile- and community-based same-day crisis response services. Humana collaborates with BH crisis providers to ensure members receive timely discharge planning, including support in obtaining community stabilization services, peer crisis support, outpatient BH services and other support services that may be necessary at discharge. Humana is notified when a member utilizes the Clinical Triage Line (i.e., Behavioral Health Crisis/ARTS, crisis and nurse care coordination line).

More information about behavioral health services can be found within the provider manual on our website at **Humana.com/HealthyVA**.

# BH registrations and prior authorization

Humana providers are required to use Virginia DMAS forms to complete registration (notification) or prior authorization for certain ARTS and mental health services listed below.

## Registrations

"Register" or "Registration" refers to the provider's notification to Humana that an individual will receive services that require registration, but do not require service authorization. Providers are required to perform an assessment as described in the **Mental Health Services Manual** prior to submitting a request for mental health services. The registration form is located on **DMAS' website**.

## Prior authorization

Services that require prior 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: **Training and Resources (virginia.gov)**
- ARTS: **ARTS - Service Authorization and Registration (virginia.gov)**

To find out which services require registration or authorization, you can call the Clinical Intake Team (CIT) at **844-881-4482** or you can access the service prior authorization list (PAL) at **Humana.com/PAL**.

The following ARTS require a service authorization to qualify for reimbursement:

- Intensive outpatient (ASAM Level 2.1)
- Partial hospitalization (ASAM Level 2.5)
- ASAM Level 3 residential services (ASAM Level 3.1, 3.3, 3.5, 3.7)

Humana does not require service authorization for Screening, Brief Intervention and Referral to Treatment (ASAM Level 0.5) services, Outpatient Services (ASAM Level 1.0), or services provided by a contractor-credentialed opioid treatment program or preferred office-based addiction treatment organization.

# BH provider coordination

Humana PCPs are required to coordinate care for members who experience BH conditions that require ongoing care.

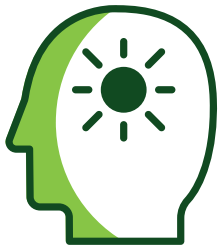
**PCPs are required to:**

- Provide 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
- Request consultation and refer affected members to specialized BH services for severe or chronic BH conditions
- Follow up with BH providers to coordinate integrated and nonduplicative care for the member
- Obtain the necessary signed release of information for sharing personal health information, including compliance with 42 CFR Part II requirements around BH and SUD

**BH providers are required to:**

- Ensure members are seen within 7 days of discharge from an inpatient psychiatric admission
- Notify the PCP when a member initiates BH services with the provider
- Obtain the signed release of information for sharing personal health information, in compliance with 42 CFR Part II requirements around BH and SUD, prior to sharing information with the PCP
- Provide initial and summary reports to the PCP (after receiving the signed release of information referenced above)
- Refer members with known or suspected and/or untreated physical health problems or disorders to their PCP for examination and treatment
  - BH providers may only provide physical healthcare services if they are licensed to do so

# BH crisis resources for members



**Phone:**

- National Alliance on Mental Illness (NAMI) Helpline
  **800-950-6264**
- National Suicide Line
  **988**
- Humana Clinical Triage Line
  **888-445-8714**

**Websites:**

- **NAMI Virginia**
- **FindTreatment.gov**
- **988**
- **Mental Health America of Virginia**
- **Substance Abuse and Mental Health Services Administration (SAMHSA)**

# BH provider resources

As a Humana-contracted healthcare provider, you can take advantage of Relias®, a web-based continuing education library.

Relias offers more than 300 modules to choose from and over 575 continuing education credits, in addition to BH training. Relias' training modules provide integrated information to support comprehensive care and address unique patient needs.

Relias offers courses designed to help you succeed in the emerging value-based healthcare delivery system.

**To access the trainings:**

1. Visit the **Relias website** or sign in to your **Availity Essentials** account.
2. Select Humana under the Payer Services tab.
3. Select the Resources tab.
4. Select Relias Training.

**For more information, please contact your provider relations representative**

BH resources such as screening, evaluation tools, Healthcare Effectiveness Data and Information Set (HEDIS®) and education links can be found at **Humana.com/HealthyVA**.

# Early and Periodic Screening, Diagnosis and Treatment screenings

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) medical screenings include:

- A comprehensive health and developmental history, including assessments of both physical and mental health development to include reimbursement for developmental screenings (Common Procedure Terminology [CPT®] code 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
  - The use of a standardized developmental screening tool for children by pediatric primary care providers consistent with American Academy of Pediatrics' (AAP) policy statements and clinical guidelines
- Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practice for pediatric vaccines
  - Immunizations must be reviewed at each screening examination, and necessary immunizations should be administered at the time of the examination.
- 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)
  - Blood lead testing, including venous and/or capillary specimen (e.g., finger stick) in accordance with EPSDT periodicity schedules and guidelines

## Referrals for ESPDT

- Appropriate referrals must be made and documented in the member's medical records for EPSDT.
- Prompt notifications to Humana if a screening for a member eligible for EPDST services reveals the need for other healthcare services. If referrals are unable to be coordinated for those services, Humana can make appropriate referrals and coordinate with the member to offer scheduling assistance and transportation for members lacking access to transportation.
- If a developmental delay is identified in a Humana member 3 years or younger, appropriate referrals must be made to Infant and Toddler Connection of Virginia for early intervention services and documented in the affected member's record.

# EPSDT exam frequency

The Humana EPSDT periodicity schedule is updated frequently to reflect current recommendations from the  AAP and Bright Futures.

| 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 adulthood** | | |
| 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) | |

To view updates to the schedule, please visit **aap.org/brightfutures**.

# EPSDT services

**Hearing services**

- All newborn infants must be given a hearing screening after birth and before discharge from the hospital. Those children who do 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 by DMAS.
- 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.

**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 the 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 also are covered. A variety of lenses and frames are available to children receiving vision services in any setting.

**Immunizations and vaccinations**

- Providers must render immunizations in accordance with the EPSDT periodicity schedule specified in the most current Advisory Committee on Immunization Practices (ACIP) recommendations, concurrently with the conduct of the EPSDT screening.
- All PCPs who administer childhood immunizations must enroll in the Virginia Vaccines for Children Program (VVFC), administered by the Virginia Department of Health. For more information on how to enroll in VVFC, please visit the **VVFC website**. For VVFC enrollment, please visit the **VVFC enrollment website**.

# 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 but are not medically indicated for children aged 3 and older.

EIS are designed to meet the developmental needs of each child and the needs of the related family to enhance the child's development and are provided to children who have:

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

The EIS program is called the Infant and Toddler Connection of Virginia and is managed by the Department of Behavioral Health and Developmental Services (DBHDS). DBHDS contracts with 40 local lead agencies to facilitate implementation of local EIS statewide and is responsible for certification providers and service coordinators/case managers.

- Services 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 is identified by a provider in a Humana-covered patient younger than age 3, appropriate referrals must be made to the Infant and Toddler Connection of Virginia and must be documented in the patient's records.

## EIS resources

All individual practitioners providing EIS must be certified through the DBHDS. For more information, please refer to Appendix G of the EIS DMAS manual.

The EIS manual for DMAS can be found on DMAS' website at **https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library**.

# Long-term services and supports overview and eligibility

Long-term services and supports (LTSS) are designed to assist individuals with health or personal needs, activities of daily living, and instrumental activities of daily living over a period of time. LTSS can be provided at home, in the community or in various types of facilities, including NF.

## 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 Developmental Disability (DD) waivers. Individuals enrolled in the Commonwealth Coordinated Care Plus waiver receive waiver services through Humana as well as medically necessary nonwaiver services. Individuals enrolled in the DD waivers are covered only for their medically necessary nonwaiver services.

More information about LTSS can be found on our website at **Humana.com/HealthyVA**.

# LTSS screening requirements

- Individuals are not eligible to receive Medicaid-funded LTSS without a screening on file that confirms the individual meets NF level-of-care requirements. Details about the screening process and the criteria for meeting the level of care required for LTSS eligibility can be found in DMAS' Screening Manual for Medicaid-Funded LTSS at **https://dmas.virginia.gov/**.
- The LTSS screening process is automated via DMAS' electronic Medicaid LTSS Screening (eMLS) record system. The eMLS system is a mandatory, paperless, automated payment and tracking system for all entities contracted by DMAS to perform LTSS screenings. DMAS requires all LTSS screenings to be entered by the appropriate screening team into the eMLS system.
- A Medicaid LTSS Screening team can consist of a community-based team, hospital or NF. The LTSS Screening team determines the level of care and enters the information via the eMLS.
- For members who complete screening determinations after enrolling in the managed care program, LTSS screening information must be submitted to Humana by the LTSS screening team. The required documentation list can be found on the right side of this slide under LTSS screening documentation requirements.
- 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 individualized care plan development.

## LTSS screening documentation requirements

- Uniform Assessment Instrument (UAI)
- DMAS-95 MI/ID/RC (and DMAS-95 Authorization Form); MI-ID/RC Supplement Form, Level II, if applicable, for individuals who select NF placement
- DMAS-96 (Medicaid Funded LTSS)
- 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 private duty nursing

# LTSS care settings and care management

## Care settings

Humana ensures that 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 help ensure their health, safety and welfare. At least annually and whenever the member expresses an interest in being discharged, Humana reviews with the NF and the member or the member's authorized representative all options for discharge from the NF.

## Care management

When CCC Plus HCBS waiver services are terminated, a Humana care manager assesses and ensures the member's care plan includes the necessary supportive services, including other covered services (e.g., home health, physical therapy, occupational therapy, durable medical equipment), 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 revises the member's ICP accordingly. This includes instances when a member transitions between level-of-care benefit plans.

# LTSS authorization and service delivery

## Authorizations

LTSS providers can request a service authorization by emailing the required documents to the LTSS UM department at **VAMCDLTSSUtilizationManagement@humana.com** or by faxing the required documents to 502-508-1607. A service authorization is not required for hospice services, but Humana must establish the level of care needed before hospice services begin.

## Service delivery model

A member may receive consumer-directed services along with agency-directed services. The services may be delivered in a combination of both delivery models but must not be duplicative. Simultaneously billing personal care and respite care services is not permitted. The choice in the service delivery model is made freely by the member or an authorized representative/caregiver when the member is not able to make a choice.

## Adult day health center

Care managers must conduct the Individualized Experience Survey (IES) for all members attending an adult day health center (ADHC) facility for 2 months. The IES is conducted in conjunction with the level of care review instrument (LOCERI) assessment on an ongoing basis and must be included as part of the plan of care.

# LTSS communication of changes and services

## NF, specialized care and long-stay hospital

NFs must notify Humana, using the DMAS-80 form, for admissions, discharges or changes in level of care. If a completed 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 also should be completed for members who experience a change to their level of care or transition between a skilled Medicare stay and custodial stay, completed no later than 5 days after notification. Specialized care admissions must include the "change source code" to identify the level of care being authorized. Long-stay hospital (LSH) admissions must include an accurate provider NPI. Humana provides outreach and education to providers who do not properly notify Humana of these changes.

## NF or HCBS services

Members must have an LTSS screening to reimburse an NF or CCC Plus HCBS waiver service provider for services to any of their members who are newly admitted to a NF. Humana must validate an LTSS screening was completed, an eMLS record was entered, and that the member meets the nursing facility level of care (NFLOC) criteria. Payment is not made to an LTSS provider until Humana receives a copy of the screening.

# LTSS provider responsibilities and patient pay

## Provider responsibilities

LTSS providers also are considered HCBS waiver service providers and are subject to 42 CFR §441.300, et al., and are required to comply with 42 CFR §441.301(c)(4)-(5).

## Patient pay toward LTSS

- Patient pay refers to the member's obligation to pay toward the cost of LTSS if the member's income exceeds certain thresholds. Patient pay, which is calculated by the local Department of Social Services, must not be confused with a copay, deductible or coinsurance.
- Patient pay must be 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.
- The patient pay amounts are provided to Humana by the state.

## Provider contracting LTSS services

Phone:

**877-233-4705**
Monday – Friday,
7:30 a.m. – 6 p.m., Eastern time

Email:

**LTSSContracting@humana.com**

# Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs)

# Who can care for Humana FIDE SNP members?

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. 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:

- Physical health providers: **VirginiaProviderUpdates@humana.com**
- Behavioral health providers: **VA_BH_Medicaid@humana.com**
- Home- and community-based services (HCBS) providers: **LTSSContracting@humana.com**

Before serving FIDE SNP members, you must also be credentialed. For information about credentialing and recredentialing, you should refer to the credentialing chapter of **Humana's Virginia Medicaid and FIDE SNP Provider Manual**, available at **Humana.com/HealthyVA**, as well as the credentialing section of our Medicare Provider Manual, available at **Humana.com/Publications**.

# FIDE SNP eligibility and enrollment

# FIDE SNP eligibility requirements

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 Humana Healthy Horizons in Virginia. This includes Full Benefit Dual Eligible (FBDE) members such as:

- Qualified Medicare Beneficiary Plus (QMB+)
- Special Low Income Medicare Beneficiary Plus (SLMB+)
- Other FBDE

By enrolling in Humana's FIDE SNP, dual-eligible individuals can receive both of their Medicare and Medicaid benefits under one plan. 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.

Medicare is available to people who:

- Are age 65 or older
- Are younger than 65 with a qualifying disability
- Have end stage renal disease, permanent kidney failure requiring dialysis or a kidney transplant

To review Humana Healthy Horizons in Virginia eligibility requirements, please review **Humana's Virginia Medicaid and FIDE SNP Provider Manual**.

# Deeming period and verifying eligibility

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 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 remaining 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. Eligibility can be verified through **Availity Essentials** → Patient Registration → Eligibility and Benefits Inquiry.

# FIDE SNP member enrollment

Members can enroll into a Humana FIDE SNP by working with an enrollment broker or a licensed Medicare agent. 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 one of the following 13 counties may be enrolled in our H2875-003 FIDE SNP:
  - Bristol City
  - Buchanan
  - Dickenson
  - Grayson
  - Lee
  - Norton City
  - Russell
  - Scott
  - Smyth
  - Tazewell
  - Washington
  - Wise
  - Wythe
- Members with a residential address in any Virginia county may enroll in our H2875-001 FIDE SNP.

FIDE SNP members undergo exclusively aligned enrollment, which means that when a member enrolls in a 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.
- 60 days before the Medicare eligibility effective date, Humana mails the member a letter advising that they will be default enrolled into the Humana FIDE SNP plan.

Members are advised that they have the right to opt-out of default enrollment up to the day before the Medicare eligibility effective date.

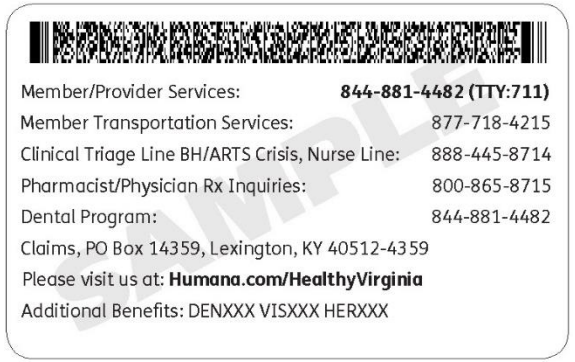
# FIDE SNP member ID cards

All new Humana members receive a single, integrated member ID card. Humana FIDE SNP members do not need separate ID cards for Medicaid and Medicare. Please ask Humana members to present their ID card at the time of service. Photos of sample member ID cards appear below.

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

### Card front


### Card back

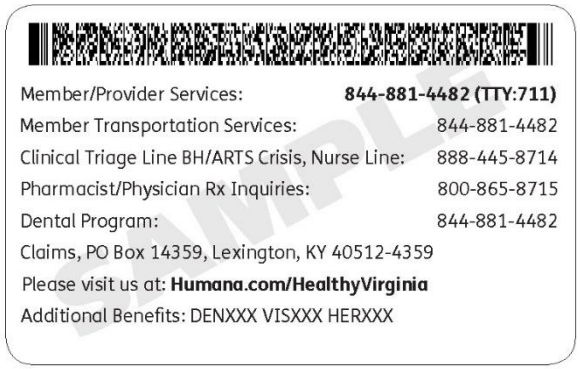



**Not an Official PDF**

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

### Card front


### Card back




**Not an Official PDF**

**Please note:** ID card design is not final and is subject to changes or updates. Samples are displayed on this slide for continuity.

# 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 such known factors 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.

Members have the option to change to another participating PCP as often as needed.

# FIDE SNP rights and responsibilities

# 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

A list of FIDE SNP member rights and responsibilities is included in the member rights and responsibilities section of the **FIDE SNP Appendix** of **Humana's Virginia Medicaid and FIDE SNP Provider Manual.**

# Provider rights and responsibilities

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 Humana's **Virginia Medicaid and FIDE SNP Provider 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

You also have the responsibility to report critical incidents. For information on reporting critical incidents, please refer to the quality improvement chapter of **Humana's Virginia Medicaid and FIDE SNP Provider Manual**.

For information on identifying and reporting fraud, waste and abuse, please review the fraud, waste and abuse chapter of our **Virginia Medicaid and FIDE SNP Provider Manual**.

A list of additional provider rights and responsibilities to consider when caring for Humana FIDE SNP members is included in the provider rights and responsibilities section of the **FIDE SNP Appendix** of **Humana's Virginia Medicaid and FIDE SNP Provider Manual**.

# Model of care

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 National Committee for Quality Assurance (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 Health Risk Assessments (HRAs) to identify risk needs
- Developing a plan of care to address identified needs
- Providing access to an interdisciplinary care team

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 Humana's **Virginia Medicaid and FIDE SNP Provider Manual.**

# Access to care standards

Providers in our Medicaid provider network must comply with Medicaid access-to-care standards as outlined in the Access to Care Section of **Humana's Virginia Medicaid and FIDE SNP Provider 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 a day, 7 days a week.
- Urgently needed services are provided immediately for Medicare members.
- Emergent 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.

# FIDE SNP covered services

# Covered services

In the covered services section of the **FIDE SNP Appendix** of **Humana's Virginia Medicaid and FIDE SNP Provider Manual**, you will find a brief summary of the benefits and services covered for our FIDE SNP members. The list provided 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 on **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 **Humana's Virginia Medicaid and FIDE SNP Provider Manual**.

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 covered services section of the **FIDE SNP Appendix** of our **Virginia Medicaid and FIDE SNP Provider Manual**. Please note that this may not be an exhaustive list.

# 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. Please review the covered services section of the **FIDE SNP Appendix** of **Humana's Virginia Medicaid and FIDE SNP Provider Manual** for a list of eligible healthy activities that FIDE SNP members can earn rewards for.

# Non-emergent transportation services

For members enrolled in either our HMO-DSNP 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 (TTY: 711)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time (Self-service and voicemail options are available after normal business hours, weekends and holidays) for transportation and benefit information and vendor coordination.

# Pharmacy services


Humana FIDE SNP members have access to an integrated formulary that includes both their Medicaid and Medicare pharmacy benefits. Information on our formularies and Humana's 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 claims

# FIDE SNP claim submission and status

All FIDE SNP member claims are submitted to one integrated claims address, removing the requirement for the provider 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 chapter of **Humana's Virginia Medicaid and FIDE SNP Provider 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 and payment

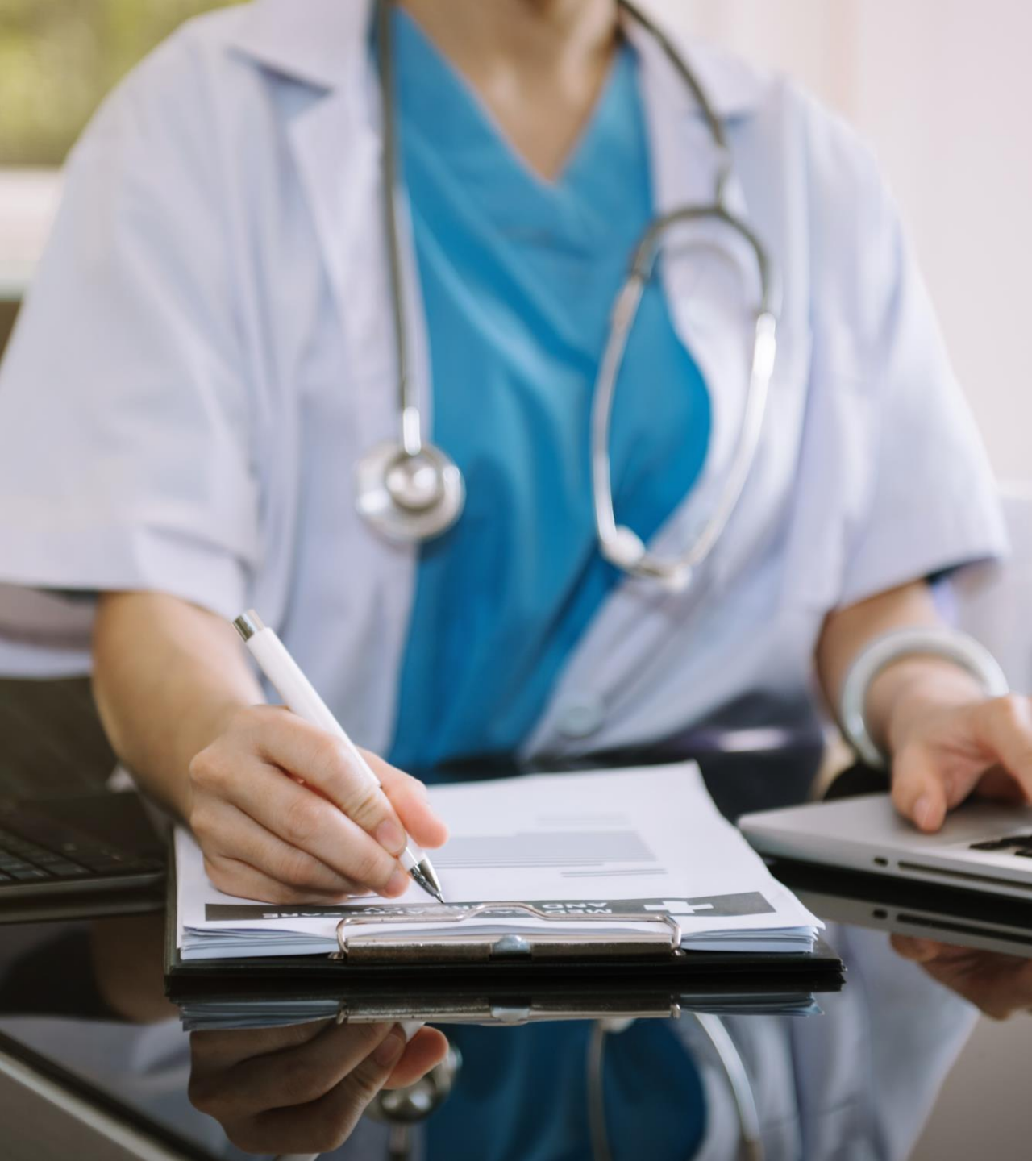
**Claim processing:** When you submit a claim for a FIDE SNP member, the claim is first reviewed for Medicare coverage, then for Medicaid coverage. You do not have to bill both Medicare and Medicaid when you submit a claim for a FIDE SNP member, unless the member is receiving Medicaid services via fee-for-service 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).

**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 chapter of **Humana's Virginia Medicaid and FIDE SNP Provider Manual**.

- 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.

*Timely Filing Requirements of 365 days from date of service and 180 days for corrected claims from the date of explanation of payment*

# FIDE SNP 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 for FIDE SNP members

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 **844-880-4482** to request a copy. Please note that this Preauthorization List (PAL) is specific to Humana's Virginia FIDE SNPs.

Online requests are encouraged through Availity Essentials, our secure, payer-agnostic provider portal, but prior authorizations can be requested through any of the following methods:

- Submit through Availity Essentials at **Availity.com** (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 the seriousness of a patient's condition.

# Prior authorization for outpatient surgery and hospital admissions

**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

# 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 approval 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.

# 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.
- **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 and out-of-network services

## 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 a referral.

You can view the status of your prior authorization requests by visiting **Availity Essentials**. 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.

## 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.

# 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

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 on **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.

# FIDE SNP member grievances, appeals and state fair hearings

# Member grievances

Humana has an integrated grievance and appeal process for our Virginia FIDE SNP members.

## 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

# Member grievances (cont'd)

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

Humana has an integrated grievance and appeal process for our Virginia FIDE SNP members.

## Appeals

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.

# Member appeals (cont'd)

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.

# Filing grievances and appeals for FIDE SNP members

Members can file a grievance or appeal verbally by calling Humana Member Services at **844-881-4482 (TTY: 711)**; Monday – Friday, 8 a.m. – 8 p.m., Eastern time (Self-service and voicemail options are available after normal business hours, weekends and holidays). To file a grievance or appeal in writing, the member may send a letter to:

Humana
Grievance 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

# Thank you

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