# Notable changes

This overview is provided to list the key points of notable changes and the sections in which they are detailed.

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## Training topics

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**Training topics are based on the following:**

- Humana’s contract with the Florida Agency for Health Care Administration (AHCA)
- Humana’s policies and procedures
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1. About Humana

- Insurance products
- Health and wellness services
- $39 billion in annual revenues
- 50,000 employees
- Plans for employer groups, individuals and government agencies
- Commercial, Medicare and Medicaid (in select markets)
- Plans include health, dental, vision and behavioral health
- 14.3 million medical members
- 7 million specialty members
2. Humana’s Florida Medicaid Plan

• Humana awarded a comprehensive plan for Florida’s Statewide Medical Managed Care Program (SMMC).

• Comprehensive plans are awarded to managed care plans that are eligible to provide Managed Medical Assistance (MMA) and long-term-care (LTC) services to eligible recipients.

• Humana’s Florida Medicaid Plan is available to eligible recipients in all regions, statewide.
2. Statewide Medical Managed Care Program (SMMC) – Purpose and Eligibility

SMMC is designed to care for all eligible individuals by providing access to:

**LTC**
- Adults with disabilities and elders who meet nursing-home level of care

**Eligibility requirements:**
- 18 years of age or older
- Resides in Florida
- Meets physical and financial requirements as determined by the Agency for Health Care Administration (AHCA)

**MMA**
- Managed Medical Assistance (MMA)

**Eligibility requirements:**
- Beneficiary ages – birth to 21 and 21 and older
- Resides in Florida
- Meets the eligibility requirements as established by the AHCA

**Comprehensive**
- Includes MMA and LTC
2. Humana’s Florida Medicaid Plan

The SMMC Program has three components:

- **Long-Term Care (LTC)**
  Medicaid recipients who qualify and enroll in the Florida Long-Term Care Managed Care (LTCMC) program receive LTC services through an LTC-managed care plan.

- **Managed Medical Assistance (MMA)**
  Medicaid recipients who qualify and enroll in the Florida MMA program receive all healthcare services other than long-term care though a managed care plan.

- **Comprehensive Plan**
  Medicaid recipients who qualify for both LTC and MMA can enroll in Humana’s comprehensive plan.
3. Florida’s MMA Program

• Florida’s MMA program is designed to provide a statewide managed care delivery system that improves outcomes, improves consumer satisfaction and reduces and controls costs.

• The Florida MMA program focuses on four key objectives to support successful implementation:

  1. Preserve continuity of care (COC).
  2. Require sufficient and accurate provider networks with scheduling room to onboard patients; allow for an informed choice of plans for recipients and the ability to make appointments.
  3. Pay providers fully and promptly to preclude provider cash flow or payroll issues and give providers ample opportunity to learn and understand the plan’s prior-authorization procedures.
  4. Coordinate with the Choice Counseling call center and website operated by the agency’s contracted enrollment broker.
3. Humana’s foundation for Florida Medicaid

- Our focus on member well-being through a coordinated care and engagement strategy and strong support infrastructure simultaneously benefits each of our members on his or her journey to better health.

**MEMBER ENGAGEMENT**
- Continuity of care
- Member outreach
- Healthy behavior incentives
- Case management
- Disease management
- Care coordination (LTC)
- Interdisciplinary care team (LTC)

**PROVIDER ENGAGEMENT**
- Initial and ongoing training
- Town halls for each region
- Monthly primary care provider (PCP) staff visits
- Quality bonuses
- Preferred PCP network

**COMMUNITY ENGAGEMENT**
- Advisory panels
- Healthy Start collaboration
- Community outreach

**SUPPORT INFRASTRUCTURE**
- Member and provider services
- Quality management and improvement
- Compliance
- Administrative services
- Collaboration and alignment with AHCA

**STRATEGY & IMPLEMENTATION APPROACH**
How Humana will provide a seamless transition and continuity of care for Florida members:
- Organizational structure
- Clinical staffing support
- Florida training program
- Transition/continuity of care
- Leveraging behavioral health expertise
Keys to success

- Humana has a proven track record in providing high-quality care to Florida members.
  - Florida-based market support team
  - Experience with Florida and its unique populations
  - Seamless and scalable network
  - Community integration and outreach
  - Dedication to lifelong well-being
  - Focus on measurable outcomes
5. Covered services
## Covered services

Humana, through its contracted healthcare providers, is required to arrange for the following medically necessary services for each patient:

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<td>Emergency behavioral health services</td>
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<td>Assistive care services</td>
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<td>Durable medical equipment (DME) and medical supplies</td>
<td>Laboratory services</td>
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<td>Dialysis services</td>
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<td>Emergency services</td>
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<td>Covered services (cont’d)</td>
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<td>Optometric and vision services</td>
<td>Rural health clinic services</td>
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<td>Physician assistant services</td>
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<td>Renal dialysis services</td>
<td>X-ray services, including portable X-rays</td>
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<td>Adult companion care</td>
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<td>Assisted living</td>
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<td>Caregiver training</td>
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<td>Home accessibility adaptation services</td>
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<td>Homemaker services</td>
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<td>Early intervention services (EIS)</td>
<td>Medical foster care</td>
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Early Intervention Services (EIS)
• EIS is an early identification and treatment program for Medicaid recipients younger than 3 with developmental delays or related conditions.

Child Health Services Targeted Case Management (TCM)
• Case management services are activities performed by the provider to assist accessing needed medical, social, educational and other services for Medicaid-eligible individuals. Examples of “other services” may include assistance accessing housing or transportation needs.

Medical Foster Care (MFC)
• Services provide care to recipients with complex medical needs to enable them to live in a foster care home.

Nursing Facility Services for MMA
• MMA benefits must pay for all medically necessary Medicaid skilled nursing facility (SNF) stays, up to 120 days from date of admission, when the enrollee is not also eligible for long-term care (LTC) benefits. SNF services are provided in accordance with statewide Medicaid managed care (SMMC)-contracted provisions and all state and federal rules and regulations.

• If the affected member is younger than 21, a Children’s Multidisciplinary Assessment Team (CMAT) must assess the case to determine service eligibility to meet the member’s needs.
6. Humana’s expanded services
Expanded services

• Expanded services are services or benefits offered by Humana that are not otherwise covered or that exceed limits outlined in the Medicaid State Plan, Florida Medicaid Coverage and Limitations Handbooks and the Florida Medicaid Fee Schedules.

• Expanded services descriptions and details can be found in the member handbook.

• All expanded services have waived copayments, therefore, providers must not charge enrollees copayments. However, there are some expanded benefits that, if a member requests them, are paid out of pocket first and subsequently are reimbursed when Humana receives proper documentation.
Existing expanded benefits

Many of the expanded benefits below have been increased:

- Hearing service expansion
- Over-the-counter (OTC) drugs and supplies
- Vision service expansion
- Day trip – meal reimbursement/allowance
- Non-emergency transportation increase for LTC
- Nutritional counseling for adults
- TDAP vaccine for adults – unlimited
- Flu vaccine for adults – unlimited
- Shingles vaccine for adults – unlimited
- Pneumonia vaccine for adults – unlimited
- Behavioral health (BH) assessment services – unlimited
- BH day services/day treatment – unlimited
- BH screening services – unlimited
- BH medical services: medication management – unlimited
- BH medical services: verbal interaction – unlimited
- BH medical services: drug screening – unlimited
- Crisis intervention services – unlimited
- Medication-assisted treatment – unlimited
- Self help/peer support services – unlimited
- Substance abuse treatment or detox services (outpatient) – unlimited
- Individual/Family therapy – unlimited
- Disaster relief meals
- Group therapy – unlimited
- Therapeutic behavioral on-site services – unlimited
- Targeted case management – unlimited
- Chiropractic services – unlimited
- Assisted living facility (ALF) bed-hold increase (30 days)
- Increased transition assistance (nursing facility to community – $5,000)
- Crisis stabilization units
- Prenatal/Perinatal visits and breast pump rental – unlimited
- Newborn circumcisions
- Post-discharge meals
- Home health nursing/aide services – unlimited
- No financial caps on outpatient hospital services
- Art therapy
- Pet therapy
- Waived copayments
- Primary care visits – unlimited
- Physician home visits – unlimited
- CPAP and oxygen supplies
- Glucose pads -- unlimited
- Monitoring supplies for continuous glucose monitoring – unlimited
- Nebulizer supplies – unlimited
- Day trip meal reimbursement/allowance
Expanded benefits – What’s new?

Member self-referral through customer service (*member qualification may be required*):

- Cellular phone service expansion (members under case management)
- Disaster preparedness/relief meals
- Doula services for pregnant women
- Home care/homemaker services (e.g., carpet cleaning for members under case management for asthma)
- Home-delivered meals
- Housing assistance (MMA members)
- Swimming lessons

Services through Tivity (vendor):

- Acupuncture services (unlimited) – member may self refer
- Massage therapy (unlimited) – treating physician (e.g., PCP, pain management provider or chiropractor) must refer

Services that require prior authorization from the member’s PCP:

- Therapy services (OT, PT, RT, SP) – applies to adult MMA members

Additional expanded benefit:

- CVS pharmacy discount program – savings card delivered following member enrollment
Member self-referral through behavioral health vendor

Member self-referral through customer service (*member qualification may be required*):

**Member self-referral through behavioral health vendor:**
- Computerized cognitive behavioral analysis (unlimited)
- Equine therapy
- Home visits by a clinical social worker
- Individual therapy sessions to caregivers (unlimited)
- Psychosocial rehabilitation (unlimited)
7. Contracting and credentialing
Contracting process

**Humana MMA**
Visit:
www.humana.com/provider/medical-providers/network/learn-more/
1. Review important information prior to completing the online form.
2. Click on “Complete our online form,” complete and submit.
3. Review frequently asked questions regarding what to expect during and after the online process.

**Humana LTC**
Call:
• Customer Service at **1-888-998-7735**
• Provider Relations at **1-502-301-3647** to connect with a provider service representative

**Email**: LTCProviderrelations@humana.com

After receipt and review of the request, a provider contracting representative will contact you.
Contracting process – required information

- Physician/practice/facility name
- Service address with phone, fax and email information (please provide counties served)
- Mailing address, if different than service address
- Taxpayer identification number (TIN)
- Specialty
- Medicaid provider number for both NPI types, group/billing and rendering (enrolled or limited with corresponding registered provider specialty code and provider type code)
- National Provider Identifier (NPI)
- Council for Affordable Quality Healthcare (CAQH®) number
- Indicate which lines of business are of interest (e.g., Medicaid, Medicare, etc.)
- Type of contract (e.g., individual, group, facility)
- Disclosure of Ownership
- Practitioner Office Site Evaluation Tool (POSET)
- PCP patient load attestation
- For LTC: Florida state license and proof of insurance
Credentialing

- Healthcare providers must be credentialed prior to network participation to treat Humana-covered patients.
- Provider office site evaluations must be completed for all PCP and OB-GYN provider locations prior to participation with Humana and during recredentialing.
- Recredentialing occurs at least every three years.
- Some circumstances require shorter recredentialing cycles.
- Humana participates with Council for Affordable Quality Healthcare (CAQH®) for applicable provider types.

Further details regarding Humana’s credentialing/recredentialing requirements can be found in Humana’s Provider Manual at https://www.humana.com/provider/support/publications.
Physicians and healthcare professionals need to use the CAQH ProView tool to provide credentialing information to Humana. Please note: This excludes facilities.

CAQH ProView is the trusted source and industry standard for self-reported provider data and eliminates redundant applications, including state applications, required by a healthcare professional’s contracted health plans, including Humana. Using CAQH reduces the amount of time healthcare professionals spend on credentialing and recredentialing by allowing them to submit information to the tool once and then update it via the attestation process.

How this affects you:

- **Initial applicants** must use CAQH for requests submitted **Jan. 1, 2017, and after.**
- Healthcare professionals due for **recredentialing Sept. 1, 2017, and after** need to submit their information through CAQH.
- The use of **CAQH reduces the amount of time involved with credentialing and recredentialing, as well as reducing costs.**
- Network healthcare professionals who have not used CAQH or who have outdated information are notified via fax to their credentialing point of contact.
- If you are **already registered** with CAQH, then please ensure your information is current and complete and that you have granted Humana authorization to review/receive the credentialing information.
- If you **are not registered** with CAQH, then please complete a registration form via https://proview.caqh.org/PR/Registration. Once the registration is submitted, you will receive an email from CAQH with a CAQH Provider ID. You will then need to complete the online CAQH application and grant Humana authorization to review/receive your information.
- Questions may be emailed to credentialingInquiries@humana.com
Contacts for contracting/credentialing

• **For Humana MMA:** To check the status of your credentialing or contract, please call Humana Provider Relations at 1-800-626-2741 (Monday through Friday, 9 a.m. to 6 p.m. Eastern time), email your local contracting representative or email FLMedicaidProviderRelations@humana.com.

• **For Humana LTC:** To check the status of your credentialing or contract, please contact your local contracting representative or call Humana Provider Relations at 1-502-301-3647 (Monday through Friday, 8 a.m. to 5 p.m. Eastern time) or email LTCProviderrelations@humana.com.
8. Access to care requirements
Access to care requirements

• Participating primary care physicians (PCP) and specialists are required to ensure adequate accessibility for healthcare 24 hours per day, seven days per week and may not discriminate against members. An after-hours telephone number must be available to members (voicemail is not permitted). Members should be triaged and provided appointments for care within the timeframes listed on the following slide.
• **Appointments for urgent medical or behavioral healthcare services shall be provided:**
  a) Within 48 hours of a request for medical or behavioral healthcare services that do not require prior authorization.
  b) Within 96 hours of a request for medical or behavioral healthcare services that do require prior authorization.

**Appointments for non-urgent care services shall be provided:**
  a) Within 7 days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment.
  b) Within 14 days for initial outpatient behavioral health treatment.
  c) Within 14 days of a request for ancillary services for the diagnosis or treatment of injury, illness or other health condition.
  d) Within 30 days of a request for a primary care appointment.
  e) Within 60 days of a request for a specialist appointment after the appropriate referral is received by the specialist.
9. Web resources
Provider website – public

Humana MMA
Humana.com/providers and Humana.com/FloridaMedicaid

• Health and wellness programs
• Clinical practice guidelines
• Provider publications (including Provider Manual – Florida Appendix)
• Pharmacy services
• Claim resources
• Quality resources
• What’s new

Humana LTC
Humana.com/HumanaLongTermCare

• Provider manual
• Provider directory
• Provider education
• Provider e-billing
• Updates
Provider self-service help

For help or more information regarding web-based tools:

**Humana MMA**
- For help with registration or questions about the Availity Portal, please call Availity Client Services at 1-800-AVAILITY (1-800-282-4548).

**Humana LTC**
- Call 1-502-301-3647

For training:

**Humana MMA**
Visit [www.humana.com/providerwebinars](http://www.humana.com/providerwebinars)

**Humana LTC**
Visit [www.humana.com/humanalongtermcare](http://www.humana.com/humanalongtermcare)
Working with Humana online?
Use the multipayer Availity Provider Portal

The Availity Provider Portal is Humana’s preferred method for online transactions.
✓ Use one consistent site to work with Humana and other payers
✓ Check eligibility and benefits
✓ Submit referrals and authorizations (MMA)
✓ Manage claim status
✓ Use Humana-specific tools

About Availity
• Cofounded by Humana
• Humana’s clearinghouse for electronic transactions (EDI) with providers

How to register
• Go to www.Availity.com

Join us for a training session
• Visit www.Availity.com/Humana to learn about training opportunities and reserve your space.

Questions?
• Availity help with registration and tools: Call 1-800-AVAILITY (1-800-282-4548).
10. Preauthorization and notification
Preauthorization and notification

• Humana requires preauthorization for certain services to facilitate care coordination and maximize benefits for your patients with Humana coverage, as well as to confirm that the services are being provided according to Agency for Health Care Administration (AHCA) coverage policies. For LTC, contact provider relations at 1-502-301-3647.

• Required for many services and medications.

• Physicians or other healthcare providers should review the most current Florida Medicaid Preauthorization and Notification List online at Humana.com/PAL.

• Preauthorization must be obtained prior to the date of service.
Preauthorization for medical procedures

**Humana MMA**
- Call 1-800-523-0023 (available 24 hours a day) for automated requests
- Representatives available 8 a.m. to 8 p.m. Eastern time, Monday through Friday (excluding major holidays)
- Press “0” or say “representative” for live help
- Have tax ID number available

**Humana LTC**
- Authorizations are requested by the provider or the member’s care manager
- Provider receives a faxed copy of the authorization
Drug prior authorization and notification

• Get forms at www.humana.com/pa or call 1-800-555-2546 (Monday through Friday, 8 a.m. to 6 p.m. Eastern time)

• For drugs delivered/administered in physician’s office, clinic, outpatient or home setting (fee-for-service providers only):
  • www.humana.com/medpa
  • 1-866-461-7273 (Monday through Friday, 8 a.m. to 6 p.m. Eastern time)
Online authorizations for MMA

- **Online submission**
  - Fast and easy entry of authorizations through the Availity Portal
  - Express-entry feature
  - Real-time responses
  - Ability to add attachments
  - Quick-print feature

- **Online management**
  Access to last 18 months of authorization history
  Ability to update authorizations
  Status updates on submitted authorizations

This process does not apply to Humana LTC providers.

Sign into Humana’s secure provider portal at Availity.com
11. Claims processing
Electronic claim submission

• **Claims clearinghouses:**
  - Availity Portal  www.availity.com  1-800-282-4548
  - Change Healthcare (formerly Emdeon)  www.changehealthcare.com  1-866-371-9066
  - Waystar  www.waystar.com  1-877-494-7633
  - TriZetto  www.trizettoprovider.com  1-800-969-3666
  - RelayHealth  www.relayhealth.com  1-800-388-2316
  - SSI Group  www.thessigroup.com  1-800-881-2739

*Some clearinghouses and vendors charge a service fee. Contact the clearinghouse for more information.

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**Humana MMA providers**
- Go to [Humana.com/ClaimResources](http://Humana.com/ClaimResources)
- Choose “Claims and encounter submission”

**Humana LTC providers**
- Go to [www.availity.com](http://www.availity.com)
Payer IDs

When filing an electronic claim, you will need to utilize one of the following payer IDs:

**Humana MMA**
- 61101 for fee-for-service claims
- 61102 for encounter claims

Questions
www.availity.com

**Humana LTC**
- 61115 for all claims
- 61105 for delegated providers

Questions
LTCProviderrelations@humana.com
Paper claims submission

Paper claims should be submitted to the address listed on the back of the member’s ID card or to the appropriate address listed below:

**Medical claims**
Humana Claims Office  
P.O. Box 14601  
Lexington, KY 40512-4601

**Encounters**
Humana Claims Office  
P.O. Box 14605  
Lexington, KY 40512-4605

**Behavioral health claims**
**Regions 1 and 2**
Access Behavioral Health  
1221 W. Lakeview Ave.  
Pensacola, FL 32501

**Behavioral health claims**
**Regions 3 — 11**
Beacon Health Options  
P.O. Box 1869  
Hicksville, NY 11802-1869

**Humana LTC claims**
Humana Long-Term Care Plan  
P.O. Box 14732  
Lexington, KY 40512-4732
Importance of encounter submissions in Medicaid

**AHCA requires 100% encounter submissions.**

- **Goal:** 95% pass rate through state system
- Three key items for compliance:
  1. Capitated providers must submit encounter/claims with billed charges versus zero dollars.
  2. Encounter provider information must match provider information filed with AHCA.
  3. Billing and rendering providers must be actively enrolled/registered with AHCA.

**Consequences for noncompliance**

- Fines
- Enrollment freezes

**Encounters identify members who have received services**

- Decrease the need for medical record review during Healthcare Effectiveness Data and Information Set (HEDIS) surveys
- Are critical for future world of Medicaid Risk Adjustment
- Helps identify members receiving preventive screenings and decreases members listed in GAP reports
Encounter submission errors and how to avoid them

Common reasons for rejection or denial:

• Providers submitting an incorrect NPI/ZIP code/taxonomy code (Note: NPI, taxonomy code and ZIP + 4 are referred to as the NPI Crosswalk.)
• Encounters missing NPI/ZIP code/taxonomy code.
• Providers submitting with a billing and/or rendering NPI that is not enrolled/registered for Medicaid with AHCA.
• Providers submitting encounters with zero-dollar billed charges.

How to avoid these errors:

• Confirm that the provider information submitted matches exactly the provider information registered with AHCA and in accordance with the services provided (e.g., NPI, Medicaid number, taxonomy code, ZIP + 4, provider specialty code, provider type code).
• Ensure that the billing and rendering NPIs on the claim are correct and are enrolled/registered for Medicaid with AHCA.
• Ensure billed amounts are not zero dollars. (Providers must submit billed charges).
Claims submission errors and how to avoid them

Common rejection or denial reasons:

- Patient not found.
- Insured subscriber not found.
- Invalid Healthcare Common Procedure Coding System (HCPCS) code submitted.
- No authorization or referral found.
- Billed amount missing.
- National Drug Code (NDC) not covered or invalid.
- Billing/rendering NPIs not enrolled/registered for Medicaid with AHCA

How to avoid these errors:

- Confirm that patient information received and submitted is accurate and correct.
- Ensure that all required claim form fields are complete and accurate.
- Obtain proper authorizations and/or referrals for services rendered.
- Ensure billed amounts are not zero-dollar.
- Ensure you have a valid Medicaid ID for the billing/rendering NPIs submitted on the claims.
Timely filing

- **MMA**: Fee-for-service claims should be filed as soon as possible, but no later than six months, per state guidelines.
- **LTC**: Claims should be filed as soon as possible, but no later than six months after the date of service, per state guidelines.
- **MMA and LTC crossover**: Questions regarding specifics around timely filing should be directed to customer service.
- **Encounter** claims should be filed within 30 days of the date of service.
- **Claims timely filing and HEDIS**:  
  - Providers are required to timely file their claims/encounters for all services rendered to members. Timely filing is an essential component reflected in Humana’s HEDIS reporting and can ultimately affect how a plan and its providers are measured in member preventive care and screening compliance.
Claim escalation

• **Step 1:** Call the number on the back of the member’s ID card.
  • Have reference number handy.
  • Ask for front-line leader.

• **Step 2:** Submit claim dispute to the following address:
  • **MMA:** Humana Provider Correspondence
    P.O. Box 14601
    Lexington, KY 40512-4601
  • **LTC:** Humana LTC
    Attention Grievance and Appeals Dept.
    P.O. Box 14546
    Lexington, KY 40512-4546

• **Step 3:** If there is a factual disagreement with the response, send an email with the reference number to:
  • **MMA:** humanaproducerservices@humana.com
  • **LTC:** LTCPricipalrelations@humana.com
Claims payment: Electronic funds transfer (EFT) and electronic remittance advice (ERA)

- Receive Humana payments via direct deposit into the bank account of your choice.
- Get paid up to seven days faster than via mail.
- Reduce the risk of lost or stolen checks.
- Receive HIPAA-compliant ERA transactions.
- Have remittances sent to your clearinghouse, or view them online.
- Reduce paper mail and time spent on manual processes.
eBusiness resources

Contact us if your organization needs:

Payments deposited in **more than one bank account.**

Separate remittance information for different providers or facilities.

ERA/EFT setup for **multiple provider groups, facilities and/or individuals.**

To set up ERA/EFT, please visit availity.com (registration required) or call 1-800-626-2741 for MMA providers or 1-502-301-3647 for LTC providers.
Balance billing

• Per Humana’s provider manual:
  
  • **Services that are not medically necessary:** The provider agrees that in the event of a denial of payment for services rendered to members determined not to be medically necessary by Humana, the provider shall not bill, charge, seek payment nor have any recourse against the member for such services.
Crossover claims

Effective Oct. 1, 2016, with the exception of LTC nursing facility crossover claims, providers no longer need to send Medicare crossover claims for dually eligible recipients directly to Humana. Under this initiative, providers only need to submit their claims once to the Centers for Medicare & Medicaid Services (CMS) for processing and are no longer required to submit secondary claims to Humana. This means CMS will automatically forward claims to Humana for members who are dually eligible for both Medicare and Medicaid coverage.

• **Please note:** If a provider submits a claim for a dually eligible member that CMS already forwarded to Humana, Humana will deny the provider-submitted claim as a duplicate claim.
12. Continuity of care (COC)
Transition/continuity of care: Enrollee services/care coordination/utilization management

Through the following process, we will ensure that transitioning members will still receive care even if Humana does not have a contract with their current provider:

**Transitioning process**

- Ensure no care disruptions
- Emphasize maintaining member’s well-being and safety while addressing unmet needs
- Contract with nonparticipating providers

- Identify members to transition
- Determine unmet needs and put necessary services in place
- Coordinate and build relationships with providers

**Florida-based case managers**

- Based on location to ensure familiarity with local resources
- Assign PCP Center to facilitate coordinated care with PCP
- Consider cultural and language needs
Transition/continuity of care: Enrollee services/care coordination/utilization management

The following services may continue past 60 days from the members transition to Humana:

- Prenatal/postpartum care up to six weeks after birth
- Transplant services up to one year post-transplant
- Current round of oncology treatment
- Full course of hepatitis C treatment drugs

- Authorization isn’t required for COC of transitioning members.
Coordination with carved-out service contractors

- Humana’s referral processes, whether Humana services, Medicaid fee-for-service (FFS) delivery system or prepaid dental plan, support the best possible quality outcomes for enrollees throughout the healthcare system.
- Humana’s proactive approach enables identification of services needed that are covered by Medicaid FFS or prepaid dental plan, and coordinates a referral.
- The process identifies enrollees who may qualify for Medicaid FFS or prepaid dental plan services through a variety of resources, including the following:
  - Outbound and inbound calls with enrollees
  - Case management program, supports, and assessments
  - Disease management
- Providers can call Humana to coordinate a Medicaid FFS or dental referral:
  - MMA member/provider services – 1-800-477-6931
Humana will coordinate a referral for the following services that are not provided by the managed care plan, but are available to eligible Medicaid recipients through the Medicaid FFS delivery system:

- County health department (CHD)-certified match program services
- Developmental disabilities individual budgeting (iBudget) HCBS waiver services
- Familial dysautonomia HCBS waiver services
- Hemophilia factor-related drugs distributed through the comprehensive hemophilia disease management program services
- Intermediate care facilities for individuals with an intellectual disability or related conditions (ICF/IID) services
- School-based services provided through the Medicaid-certified school match program
- Model HCBS waiver services
- Newborn hearing services
- Prescribed pediatric extended care services (PPEC)
- Program for all-inclusive care for children services
- Behavior analysis services
- Substance abuse county match program services
- Programs of All-inclusive Care for the Elderly (PACE) services
Coordination with carved-out service contractors – dental

Under the new SMMC contract, eligible adults and children can select a prepaid dental plan offered by the following contractors:

- Managed Care of North America – www.mcnafl.net/

Humana will assist members with the prepaid dental plan enrollment process and coordinate services and referrals.
# Dental plan or health plan: Who covers what?

<table>
<thead>
<tr>
<th>Type of dental service(s)</th>
<th>Dental plan covers:</th>
<th>Health plan covers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency dental services in a facility</td>
<td>___</td>
<td>All emergency dental services and reimbursement to the facility</td>
</tr>
<tr>
<td>Non-emergency (scheduled dental services in a facility</td>
<td>Dental services by a dental provider</td>
<td>Reimbursement to the facility, anesthesiologist and ancillary services</td>
</tr>
<tr>
<td>Dental services with sedation in an office setting</td>
<td>Dental services by a dental provider with a required sedation permit D-codes when rendered by the dental provider</td>
<td>Anesthesiologist (M.D. or ARNP) when required for sedation</td>
</tr>
<tr>
<td>Dental services (general or specialty) without sedation in an office setting, county health department or federally qualified health center</td>
<td>Dental services by a dental provider</td>
<td>Dental services provided by a nondental provider</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>___</td>
<td>Drugs prescribed by a healthcare provider or a dental provider within scope of practice</td>
</tr>
<tr>
<td>Transportation</td>
<td>___</td>
<td>Transportation to all dental services provided by the dental or health plan, including expanded dental benefits</td>
</tr>
</tbody>
</table>
13. Member special needs consideration
Member special needs consideration

• Providers must make efforts to understand the special needs required by members. The member may have challenges that include physical compromises as well as cognitive, behavioral, social and financial issues. Multiple comorbidities, complex conditions, frailty, disability, end-of-life issues, end-stage renal disease (ESRD), isolation, depression and polypharmacy are some of the challenges facing these members each day.

• Recognizing the significant needs of members, Humana incorporates person-centered care planning, coordination and treatment in our care coordination program.
Member special needs consideration (cont’d)

- Care management is delivered within a multidisciplinary team (MDT) structure and holistically addresses the needs of each member.
- The member and/or his/her authorized caregiver are maintained at the core of the model of care, ensuring person-centered care and supported self-care.
- The Humana case manager leads the member’s MDT and links closely to the member’s PCP to support him/her in ensuring the member gets the care needed across the full spectrum of medical, behavioral health and other services. PCP participation in the MDT is a critical component in the success of the member’s care.
- Humana’s predictive model, based on claims history and analytics, is used to determine each member’s risk level and level of intervention required in order to channel the member to the required level of coordination.
- A comprehensive assessment is completed for each member to evaluate his or her medical, behavioral and psychosocial status to determine the plan of care.
14. Member screening for alcohol or substance abuse
Member screening for alcohol or substance abuse

- Participating PCPs must screen members for signs of alcohol or substance abuse as part of prevention evaluations during the following times:
  - Initial contact with a new enrollee
  - Routine physical examinations
  - Initial prenatal contact
  - When the enrollee shows evidence of serious overutilization of medical, surgical, trauma or emergency services
  - When documentation of emergency room visits suggests the need

- Members who are determined to have met one of the above indicators may be referred to an appropriate participating behavioral health provider.
15. Clinical management programs
Clinical management programs

• Clinical management programs are designed to:
  • Reinforce medical provider’s plan of care
  • Promote healthy living
  • Provide guidance to members with complex conditions

• To learn more, visit Humana.com/HealthWellness
Health services and utilization management

- Provide on-site and telephonic concurrent review and discharge planning.
- Promote effective level of care based on member’s individual needs.
- Provide disease-specific education.
- Refer to appropriate Humana programs.
Utilization management

Front-end Review Nurse responsibilities:
• Reviews inpatient admissions for medical necessity during preauthorization or on notification of admission.

Concurrent Nurse responsibilities:
• Completes comprehensive discharge planning assessments on members with inpatient admission.
• Conducts medical necessity reviews on members with continued inpatient stays.
• Collaborates daily with member’s healthcare team to maximize member’s benefits and resources and identifies member’s anticipated discharge planning needs.
• Conducts medical necessity reviews for post-acute level of care requests in collaboration with medical director.
• Identifies and refer members to internal Humana CM/DM programs.
• Refers member to community resources or Humana social worker, when social issues place member at risk for readmission.
Health services and case management

Case management:
There is collaboration on cases where there are discharge needs identified when an MMA, LTC or MMA/LTC member is an inpatient. When the member has both MMA and LTC benefits, LTC case management is primary.

- Receives referrals from on-site/telephonic UM nurses following discharge, PCPs, specialists, self-referral, internal/external programs, community partners, etc.
- Educates members on disease process, self care, and value-added benefits such as unlimited medical transportation, vision and dental coverage.
- Completes post-discharge or post-ER visit telephonic outreach within three days of discharge (when applicable).
- Identifies gaps in care, addresses post-discharge needs and assists in making follow-up appointment with PCP and specialists.
- Stratifies members into various acuities utilizing some of the following criteria:
  - Readmission Predictive Model Score
  - Admission history
  - Metric reports (e.g., high-cost members, etc.)
Complex case management

• Complex case management responsibilities:
  • Manages and coordinates care for members requiring ongoing case management based on assigned acuity (with varying contact expectations and required time in program for each).
  • Identifies triggers for ER visit/admission and partners with member and their healthcare providers to prevent/reduce ER visits and unplanned inpatient admissions.
  • Completes a comprehensive assessment of the member’s current health status.
  • Creates an individualized care plan with the member and works toward identified goals.
  • Addresses HEDIS measures for members’ gap reports or alerts on file.
  • Refers to internal and external programs and community resources as needed (e.g., Village Health, RxMentor, behavioral health, bariatric, transplant, etc.).
  • Participates in interdisciplinary case conferences for complex members to identify the best course of action for improved outcomes.
  • Complex case management does not replace or interfere with the care members receive from their physicians.
  • Complex-case manager will reinforce the physician’s plan of care and facilitate the utilization of services that promote wellness and prevent unnecessary hospital admissions.
Health services and case management

MMA Programs
- Diabetes
- Asthma
- COPD
- CHF
- Hypertension
- HIV/AIDS
- Cancer
- Sickle Cell

LTC Disease Management Programs
- Dementia and Alzheimer’s issues
- Cancer
- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- End-of-life issues/advanced directives

Goal
- Help our members and family members become empowered through education and the development of self-management skills that foster treatment plan compliance and better health outcomes.

Overview
- Participation is voluntary.
- Referrals received from claims data, on-site/telephonic nurses after discharge, PCPs, self-referral, internal/external programs, community partners, etc.
- Telephonic outreach.
- Assessment includes health history, cognitive/psychological/depression screening, medication review, diet compliance.
- Collaborative team approach.
- Members stratified into various acuities utilizing some of the following criteria:
  - Admission history
  - Stability of symptoms
  - Understanding/compliance of disease/plan of care
Case management

Case management programs responsibilities:
• Complete a comprehensive assessment of the member’s current health status.
• Create an individualized care plan with the member and works toward identified goals.
• Address HEDIS measures for members on gap reports or with alerts on file.
• Refer to internal and external programs and community resources as needed (e.g., Village Health, RxMentor, Beacon Health Options, etc.).

Please note:
• Case manager does not replace or interfere with care that members receive from their physicians.
• Case management nurses will reinforce the physician’s plan of care and facilitate utilization of services that promote wellness and prevent unnecessary hospital admissions.
Case management (cont’d)

Additional features for LTC members in a disease management program:

- Education based on the enrollee assessment of health risks and chronic conditions
- Symptom management, including addressing needs such as working with the member on health goals
- Emotional issues of the caregiver
- Behavioral management issues of the member
- Communicating effectively with providers
- Medication management, including the review of medications that an member is currently taking to ensure that the enrollee does not suffer adverse effects or interactions from contra-indicated medications.
Other health services programs

- **Moms First**
  - Manages prenatal and postpartum members from onset of pregnancy through the 42nd post-partum day.
  - Facilitates care coordination with WIC, Healthy Start and other internal/external programs.
  - Ensures provision of Healthy Behavior Reward for program participation and visit compliance.
  - Works with member and provider to ensure compliance with prenatal and postpartum appointments.

- **Social worker**
  - Assists members with social needs including transportation and community resources.
  - Receives referrals from CM, DM and on-site NL.

- **Pediatric case management and pediatric utilization management**
  - Provides telephonic case and disease management for pediatric members.
  - Manages all pediatric inpatient utilization.
Real-time ER initiative

- Receives referrals while member is in the ER or within 24 hours.
- Includes all hospitals participating in Health Information Exchange Event Notification System (HIE ENS).
- Completes post-ER telephonic outreach within 24 to 48 hours of ER visit.
- Identifies reason for ER visit, assesses gaps in care, addresses needs and assists in making follow-up appointments with PCP.
- Educates members on disease process, proper utilization of ER and Humana’s 24-hour nurse phone line.
- Refers to other clinical programs when applicable.
Real-time ER initiative

• Case management nurses identify triggers for ER visit
  o Completes an ER assessment of member’s current health status
  o Provides members with the following:
    • Education related to alternatives to ER and importance of maintaining physician/patient relationships
    • Help with setting up appointments
    • Assistance with medication issues
  o Refers to internal and external programs and community resources as needed (e.g., SCM, DM, Village Health, Beacon Health Options, etc.)
• Case management nurses reinforce the need to utilize physicians’ offices for continuum of care for nonemergent needs.
• Case management nurses contact the PCP to notify of a member’s visit to the ER and provide a discharge summary.
Member reward programs

Healthy behavior programs designed to help members live a healthier lifestyle and maintain health.

- Members can call Humana for program specifics and to join a program.
- PCPs may be asked to provide program goals and accomplishments.
- Members can earn rewards.

Healthy behavior programs include:

- Baby well visit
- Pediatric well visit
- Humana family fit (weight management)
- Mom’s First prenatal and postpartum
- Smoking cessation
- Substance abuse
- Refer to provider manual for program details and rewards.
16. Patient-centered medical home (PCMH)
PCMH

- PCMH is a model of care that strengthens the physician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship.

- Humana implemented the PCMH program to empower patients as they interact with their PCPs and healthcare delivery teams (e.g., family, therapist, specialist, diagnostic center, hospital and laboratory). The PCMH program focuses on a team-based approach to healthcare delivery. Open communication between the healthcare team and patient allow the patient to be more involved in healthcare decisions with a potential for better health outcomes and cost-effective treatment of ongoing health conditions.
According to the Agency for Healthcare Research and Quality, a PCMH program includes the following functions that transform traditional primary care into advanced primary care:

- **Comprehensive care:** A team that includes physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators and care coordinators to guide patients through the healthcare delivery system.

- **Patient-centered care:** The patient is primary in the relationship and drives decisions that influence his or her health. Physicians provide education and establish a comprehensive plan of care.

- **Coordinated care:** The PCP communicates with the healthcare delivery team and manages coordination of care.
PCMH (cont’d)

• **Accessible services:** The patient’s access-to-care preferences are important. Shorter wait times, same-day appointments for urgent needs, after-hours and around-the-clock access, as well as openness to different types of communication besides the telephone, are taken into consideration by the physician.

• **Quality and safety:** The PCP uses evidence-based medicine and clinical decision-support tools to guide the patient and healthcare delivery.

• PCPs who are interested in the PCMH program, certification requirements and the benefits may contact:

  Latoya Powell, PCMH CCE  
  Phone: **1-954-661-9472**  
  Email: pcmh@humana.com
17. Telemedicine
Telemedicine

Telemedicine is the practice of healthcare delivery by a practitioner who is located at a location other than the patient’s for the purposes of evaluation, diagnosis or recommendation of treatment. Telephone conversations, chart review, electronic mail messages or facsimiles are not considered telemedicine and are not be reimbursed.

- Florida Medicaid reimburses the practitioner who is providing the evaluation, diagnosis or treatment recommendation located at a site other than where the recipient is located. Practitioners must include modifier GT on the CMS-1500 claim form.

- Florida Medicaid does not reimburse for equipment required to provide telemedicine services.

- The practitioner must implement telemedicine fraud and abuse protocols.

- Physicians are encouraged to contact their provider relations representative if they are offering or plan to offer these services to patients with Humana Medicaid coverage.
18. Pharmacy
Humana Medical Plan Pharmacy Benefit Summary

No Copayments
Medicaid members have a zero-dollar copay at network pharmacies.

34-Day Supply
Medications are limited to a 34-day supply. Select maintenance medications may receive a 100-day supply.

Over-the-Counter (OTC) Benefit
$25 per household per month OTC benefit allowance through PrescribeIT.

State-mandated Preferred Drug List (PDL)
All plans utilize AHCA’s formulary. Online access found at Humana.com/Medicaid/Florida/MMA
AHCA contracts with Coram and Caremark CVS to provide statewide care management and pharmacy benefits management for eligible Medicaid beneficiaries with hemophilia or Von Willebrand disease.

Pharmacy Benefit

Request an authorization

- Fast and easy electronic submission via www.CoverMyMeds.com/epa/Humana
- Fax 1-877-486-2621
- Call Humana Pharmacy Clinical Review (HCPR) at 1-800-555-CLIN (1-800-555-2546)

Psychotropic informed consent

Informed consent must accompany prescriptions for psychotropic drugs when prescribed for children younger than 13 years of age.

http://ahca.myflorida.com/medicaid/Prescribed_Drug/pdf/Fl_Consent_Form_Psychotropic_Medications.pdf

Opioids

For the treatment of opioid dependency, some Medication-Assisted Treatment (MAT) products are available on the formulary without prior authorization.

To find preferred products, please visit Humana.com/Medicaid/Florida/MMA

MIT preauthorization list

For drugs administered in the physician’s office, authorization may be obtained by:

- Calling 1-866-461-7273
- Completing the appropriate fax form at Humana.com/medpa and faxing it to Humana
Prescriber quick reference guide

Humana Clinical Pharmacy Review (HCPR)
For medication supplied by a pharmacy and billed through the pharmacy benefit: medication prior authorization (PA), step therapy, quantity limits and medication exceptions. To view Humana drug list, go to Humana.com/druglists

Authorization process
- Obtain forms at Humana.com/PA or submit your request electronically by going to www.covermymeds.com/epa/humana
- Submit request by fax to 1-877-486-2621
- Call HCPR at 1-800-555-CLIN (1-800-555-2546)

Requirements for prior authorization fax form
- National Provider Identifier (NPI)
- Address of member
- Address of prescriber
- Time period and outcome of past therapy tried/failed

NOTE: Include medical records ONLY for medical necessity or off-label-use review (not for every submission)

Questions
1-800-555-CLIN (1-800-555-2546); Monday – Friday, 8 a.m. – 6 p.m. local time

Exceptions by mail
Medicare: HCPR, Attn: Medicare Coverage Determination, P.O. Box 33008, Louisville, KY 40232
Commercial and Medicaid: HCPR, Attn: Prior Authorizations, P.O. Box 33008, Louisville, KY 40232

Humana Medication Intake Team (MIT)
For medication supplied and administered in a physician’s office and billed as a medical claim (Part B for Medicare); also considered medication preauthorization/precertification

Precertification process
- Obtain forms at Humana.com/medPA
- Submit request by fax to 1-888-447-3430
- View preauthorization and notification lists at Humana.com/PAL

Questions
1-866-461-7273; Monday – Friday, 6 a.m. – 8 p.m. Eastern time

General Humana contact information

Claims address
Located on the patient’s Humana member ID card

Pharmacy appeals
Commercial and Medicaid: Humana Appeals, P.O. Box 14546, Lexington, KY 40512-4546; Fax: 1-800-949-2961
Medicare: Humana Appeals, P.O. Box 14165, Lexington, KY 40512-4165; Fax: 1-800-949-2961
To file a Part D redetermination online: Humana.com/providers/pharmacy/exceptions_appeals.aspx

Humana Pharmacy

Humana Pharmacy® (mail-delivery pharmacy for maintenance medications and durable medical equipment)
1-800-379-0092 (Fax: 1-800-379-7617), Monday – Friday, 8 a.m. – 11 p.m. Eastern time; Saturday, 8 a.m. – 6:30 p.m. Eastern time; HumanaPharmacy.com

Humana Specialty Pharmacy® (mail-delivery pharmacy for specialty medications)
1-800-486-2668 (Fax: 1-877-405-7940), Monday – Friday, 8 a.m. – 8 p.m. Eastern time; Saturday, 8 a.m. – 6 p.m. Eastern time; HumanaPharmacy.com/Specialty

PrescribeIt RX® (mail delivery for FL Medicaid)
1-800-526-1490 (Fax: 1-800-526-1491), Monday – Friday, 8 a.m. – 5 p.m. Eastern time; prescribeitrx.com

Humana recognizes that your patients have the sole discretion to choose their pharmacy. Also, we support your independent medical judgment when advising patients about their pharmacy choices. Other pharmacies are available in our network. Humana members should check their plan documents to verify their prescription benefits.
19. Medicaid Risk Adjustment (MRA)
MRA disclaimer

The information contained in this presentation and responses to the questions asked are not intended to serve as official coding or legal advice. All coding decisions should be considered on a case-by-case basis and should be supported by medical necessity and the appropriate documentation in the medical record.
History and risk model definitions

Chronic Illness and Disability Payment System (CDPS)
- The model was developed in 1996 using Medicaid claims data on disabled beneficiaries.
- The model was modified in 2000 using additional data for both disabled and Temporary Assistance for Needy Families (TANF) beneficiaries.
- The model maps ICD-10 diagnosis codes to 72 CDPS categories in Florida within 19 major categories corresponding to major body systems (e.g., cardiovascular) or type of disease (e.g., diabetes).
- CDPS condition categories are groups of ICD-10 codes, typically identified at the three-digit level but occasionally codes are grouped at the fourth- or fifth-digit level and up to seven digits for ICD-10.

Medicaid prescription (MRx)
- A pharmacy-based risk adjustment model was developed in 2001 using CDPS prescription data.
- The model maps National Drug Code (NDC) codes to 45 Medicaid prescription categories.

CDPS + Rx
- The model was developed in 2008 and uses both diagnostic and pharmacy data.
- The model combines CDPS and Medicaid prescription and maps NDC codes to 15 Medicaid prescription categories.
Hierarchies and comorbidities

- CDPS categories are hierarchical within each major category.
- Weights/cofactors are additive across major categories.
- Within major categories, only the most severe diagnosis counts.
- CDPS categories allow an accounting of comorbidities across medical and pharmacy.
- When it comes to coding comorbidities, for which Medicaid allows up to 12 diagnosis codes on electronic forms:
  - The diagnosis shown in the record to be chiefly responsible for the services provided should be coded first.
  - All documented conditions that coexist and that require or affect patient care, treatment or management should be coded.
Risk-adjusted populations

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<tr>
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<tbody>
<tr>
<td>• TANF</td>
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<tr>
<td>• Adult (14 years and older)</td>
</tr>
<tr>
<td>• Children (1-13 years old)</td>
</tr>
<tr>
<td>• Supplemental Security Income (SSI) (persons with disabilities)</td>
</tr>
<tr>
<td>• Severely mentally ill (SMI) members</td>
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<th>Excluded</th>
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<tbody>
<tr>
<td>• TANF children (younger than 1 year old)</td>
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<tr>
<td>• SS1 children (younger than 1 year old)</td>
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<tr>
<td>• Dual eligible (duals are risk-adjusted by Medicare HCCs)</td>
</tr>
<tr>
<td>• Stand-alone long-term care</td>
</tr>
<tr>
<td>• Members with less than six months of eligibility during the observation period</td>
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Comparing risk-adjustment models

<table>
<thead>
<tr>
<th>Medicare Advantage</th>
<th>Florida Medicaid</th>
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<tbody>
<tr>
<td>CMS HCC model</td>
<td>CDPS + prescription model</td>
</tr>
<tr>
<td>Prospective (future payments adjusted twice per year + one lump-sum reconciliation payment)</td>
<td>Prospective (future payments adjusted quarterly)</td>
</tr>
<tr>
<td>Risk score based on age, gender, diagnosis and geography</td>
<td>Risk score based on age, gender, diagnosis, geography and Medicaid population (TANF, SSI)</td>
</tr>
<tr>
<td>Individual member risk scores</td>
<td>Individual member risk scores grouped at plan level, population type and age band (e.g., rate cells)</td>
</tr>
<tr>
<td>Three annual data-submission deadlines (March, September and January)</td>
<td>Four annual data-submission deadlines (February, May, August and November)</td>
</tr>
<tr>
<td>ICD-10 codes grouped into 79 HCCs</td>
<td>ICD-10 and NDC codes grouped into 72 CDPS categories and 15 Medicaid prescription categories</td>
</tr>
<tr>
<td>Unlimited risk-adjustment payments (theoretically)</td>
<td>Zero-sum settlement/budget neutral</td>
</tr>
<tr>
<td>Managed care organization (MCO) may code and submit diagnoses</td>
<td>MCO cannot code and submit diagnoses – only providers can code and submit diagnoses when supported by medical record reviews</td>
</tr>
</tbody>
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Florida MMA risk-adjustment time line for rate years 2018 through 2020

<table>
<thead>
<tr>
<th>Florida Quarters</th>
<th>Study Period Dates of Service</th>
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<tbody>
<tr>
<td></td>
<td>CY 2017</td>
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<tr>
<td></td>
<td>2017 Q1</td>
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<tr>
<td>Payment Months</td>
<td></td>
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<td></td>
<td>1/1/2017 - 12/31/2017</td>
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<tr>
<td>Rate Year '18/'19 Q1</td>
<td>Oct 2018 – Dec 2018</td>
</tr>
<tr>
<td>Rate Year '18/'19 Q2</td>
<td>Jan 2019 – Mar 2019</td>
</tr>
<tr>
<td>Rate Year '18/'19 Q3</td>
<td>Apr 2019 – Jun 2019</td>
</tr>
<tr>
<td>Rate Year '18/'19 Q4</td>
<td>Jul 2019 – Sep 2019</td>
</tr>
<tr>
<td>Rate Year '19/'20 Q2</td>
<td>Jan 2020 – Mar 2020</td>
</tr>
<tr>
<td>Rate Year '19/'20 Q3</td>
<td>Apr 2020 – Jun 2020</td>
</tr>
<tr>
<td>Rate Year '19/'20 Q4</td>
<td>Jul 2020 – Sep 2020</td>
</tr>
</tbody>
</table>

Sources: Agency for Health Care Administration (AHCA) and Milliman
Best documentation practices for diagnosis coding

LEGIBLE
- Makes entire medical record legible to any objective reader of the record

CLEAR
- Communicates to all readers the documenter’s intent

CONCISE
- Describes each diagnosis succinctly and to the highest level of specificity
- Limits or avoids altogether the use of abbreviations

CONSISTENT
- Avoids conflicts or contradictions

COMPLETE
- Includes documentation of all conditions evaluated and treated, as well as all chronic or other conditions that affect patient care, treatment or management
- Includes date of service, patient name and date of birth on each page
- Includes healthcare provider name, credentials and timely signature
Excerpt from full medical record

History of present illness: 49-year-old homeless diabetic male presents complaining of right ankle wound. He lost his balance while coming down stairs at a facility. Unable to check blood sugars given his living situation, but told it was uncontrolled at last clinic visit a few months ago. He admits to noncompliance with his diabetic diet as he eats what’s given to him. Sometimes he feels pins and needle sensation in his feet.

Physical exam:

- General: No acute distress, ambulating without assistance.
- Head, eye, ears, nose and throat (HEENT) assessment: No abnormalities noted.
- Heart: Regular rate and rhythm with no murmurs, rubs or gallops.
- Lungs: Clear bilaterally.
- Abdomen: Soft non-tender with good bowel sounds, no masses or bruits.
- Extremities: No clubbing or cyanosis, normal range of motion, right ankle 1+ edema; pedal pulses 1+.
- Neuro: Alert and oriented, ankle and knee DTR 1+/4, positive monofilament exam on plantar and dorsal surface of right foot, negative Romberg, steady gait.
- Skin: Warm and dry, tender erythematous 1 cm superficial ulceration noted right medial malleolus, but no discharge.
Clinical coding example (cont.)

Assessment:
1. Diabetes mellitus, Type 2, uncontrolled with hyperglycemia
2. Diabetic ulcer right ankle involving skin only
3. Diabetic peripheral neuropathy

Plan:
Keep wound clean and dry
• Follow-up visit in 10 to 14 days
• Prescription given for Keflex 500 mg by mouth twice daily for 10 days
• Over-the-counter (OTC) Tylenol for pain as directed
• X-ray right ankle
• Sent to lab for CBC, CMP, TSH, HBA1c, random urine albumin, urine albumin creatinine ratio
• Diabetic teaching with nutrition consult for diabetic diet
Example coded as:

**Incomplete coding**
- **E11.9** Type 2 diabetes mellitus without complications
- **S91. ØØ1A** Unspecified open wound, right ankle, initial encounter
- **G62.9** Polyneuropathy, unspecified

**Complete coding**
- **E11.622** Type 2 diabetes with other skin ulcer
- **L97.311** Non-pressure chronic ulcer of right ankle limited to breakdown of skin
- **E11.42** Type 2 diabetes mellitus with diabetic polyneuropathy
- **E11.65** Type 2 diabetes mellitus with hyperglycemia
20. Service level agreements (SLA)
SLA

SMMC-contracted managed care organizations (MCOs) must adhere to certain service level agreements for the following categories:

• Birth outcomes
• Transportation
• Network adequacy
• Claims payment
• Service authorization
• Enrollee call center metrics
• Provider call center metrics

Find out more about these SLAs at Humana.com/FLMedicaidSLAs
Electronic health records (EHRs)

• An EHR is a digital version of a patient’s paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users. While an EHR does contain the medical and treatment histories of patients, an EHR system is built to go beyond standard clinical data collected in a provider’s office and can be inclusive of a broader view of a patient’s care.

• Florida Medicaid-eligible hospitals and professionals as defined by the Health Information Technology for Economic and Clinical Health (HITECH) Act are required to use certified EHRs in a meaningful manner.
Advantages of EHRs:

- EHRs and the ability to exchange health information electronically can help you provide higher quality and safer care for patients while creating tangible enhancements for your organization. EHRs help providers better manage care for patients and provide better healthcare by:
  - Providing **accurate, up-to-date and complete information about patients** at the point of care
  - Enabling quick access to patient records for more **coordinated, efficient care**
  - Securely **sharing electronic information** with patients and other clinicians
  - Helping providers more effectively **diagnose patients, reduce medical errors, and provide safer care**
Advantages of EHRs:

• Improving patient and provider interaction and communication, as well as **healthcare convenience**
• Enabling safer, **more reliable prescribing**
• Helping promote **legible, complete documentation** and accurate, streamlined coding and billing
• Enhancing **privacy and security** of patient data
• Helping providers **improve productivity** and **work-life balance**
EHRs (cont’d)

For assistance:

Regional extension centers

• If providers need assistance with selecting an EHR system, they can reach out to their local regional extension center (REC). RECs offer unbiased EHR implementation support throughout the implementation process. These organizations, funded by the Office of the National Coordinator for Health Information Technology (ONC), also can serve as a two-way pipeline to local and federal resources.

• RECs can help with EHR implementation and project management, vendor selection, workflow redesign, privacy and security, training, ongoing technical assistance and more. Visit www.healthit.gov/faq/where-can-i-find-local-electronic-health-record-implementation-support for more information.

Florida Health Information Exchange (Florida HIE)

• If providers need assistance in technically connecting to other providers, they can reach out to the Florida HIE or visit www.florida-hie.net. The Florida HIE enables the secure exchange of health information between healthcare providers.
21. AHCA provider-based marketing guidelines
AHCA provider-based marketing guidelines

- If the managed care plan chooses to utilize its provider network to distribute marketing materials, the managed care plan shall ensure through its provider agreements that providers shall remain neutral.

- The managed care plan may permit providers to make available and/or distribute managed care plan marketing materials as long as the provider does so for all managed care plans with which the provider participates.

- The managed care plan may permit providers to display posters or other materials in common areas, such as the provider’s waiting room.

✓ The above information was extracted directly from AHCA contractual requirements.
AHCA provider-based marketing guidelines (cont’d)

• The managed care plan may permit LTC facilities to provide materials in admission packets announcing all managed care plan contractual relationships.

✓ The above information was extracted directly from AHCA contractual requirements.
AHCA provider-based marketing guidelines (cont’d)

Providers may:

• Providers may announce new or continuing affiliations with the managed care plan through general advertising (e.g., radio, television, websites).
• Providers may make new affiliation announcements within the first 30 days of the new provider agreement.
• Providers may make one announcement to patients of a new affiliation that names only the managed care plan when such announcement is conveyed through direct mail, email or phone.*
• Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all managed care plans with which the provider has agreements.*

✓ The above information was extracted directly from AHCA contractual requirements.

* Materials must be reviewed/approved by the plan and submitted to AHCA for approval, as necessary, before distributing.
AHCA provider-based marketing guidelines (cont’d)

Materials that indicate the provider has an affiliation with certain managed care plans and that only list managed care plan names, logos, product taglines, telephone contact numbers, and/or websites do not require agency approval.

✔ The above information was extracted directly from AHCA contractual requirements.

* Materials must be reviewed/approved by the plan and submitted to AHCA for approval, as necessary, before distributing.
AHCA provider-based marketing guidelines (cont’d)

Providers may not:

• Offer marketing/appointment forms.
• Make phone calls or direct, urge, or attempt to persuade potential enrollees to enroll in the managed care plan based on financial or any other interests of the provider.
• Mail marketing materials on behalf of the managed care plan.
• Offer anything of value to persuade potential enrollees to select them as their provider or to enroll in a particular managed care plan.
• Accept compensation directly or indirectly from the managed care plan for marketing activities.

✓ The above information was extracted directly from AHCA contractual requirements.
22. Additional training requirements
Providers must complete additional annual required compliance training on the following topics:

- Fraud, waste and abuse (FWA)*
- Cultural competency
- Health, safety and welfare (abuse, neglect and exploitation)
- Others as required

These training units* are located on the following provider websites:

- [Humana.com/ProviderCompliance](http://Humana.com/ProviderCompliance) (public)
- [www.availity.com](http://www.availity.com) (secure)

Be sure to complete the Medicaid Partner Training Attestation form to assure completion is documented for this training, as well as for the cultural competency and health, safety and welfare training modules.

*Your organization may use its own content or other content to meet the FWA training requirement.
23. Fraud, waste and abuse (FWA)
FWA reporting requirement and reporting options

Anyone who suspects or detects an FWA violation is required to report it either to Humana or within his/her respective organization, which then must report it to Humana:

- **Telephone:**
  - Special Investigations Unit (SIU) Direct Line: **1-800-558-4444**
    (Monday through Friday, 8 a.m. to 4 p.m. Eastern time)
  - Special Investigations Unit Hotline: **1-800-614-4126** (24/7 access)
  - Ethics Help Line: **1-877-5-THE-KEY** (1-877-584-3539)

- **Email:** siureferrals@humana.com or ethics@humana.com

- **Web:** www.ethicshelpline.com

- **Fax:** 1-920-339-3613

All information will be kept confidential.

Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Also, Humana has a zero tolerance policy for retaliation or retribution against any person who reports suspected misconduct.
Suspected fraud, waste and abuse pertaining to Florida MMA/LTC must be reported to:

- Medicaid Program Integrity (MPI) Administrator by calling 1-850-412-4600
- Florida Agency Consumer Complaint Hotline by calling 1-888-419-3456
- Florida Attorney General by calling 1-866-966-7226
- AHCA FWA Complaint Form on the web at apps.ahca.myflorida.com/MPI-ComplaintForm.

- If the suspected fraud appears to be substantial, along with reporting as indicated above, a phone call will be made directly to AHCA immediately.
- All final resolutions of a case include a written statement that provides notice to the provider or member that the resolution in no way binds the state of Florida nor precludes the state of Florida from taking further action for the circumstances that brought rise to the matter.
False Claims Act

- The False Claims Act also permits a person with knowledge of fraud against the U.S. government to file a lawsuit (plaintiff) on behalf of the government against the person or business that committed the fraud (defendant). The state of Florida has a statute matching the Federal False Claims Act that allows for the recovery of Medicaid funds by the state of Florida.

- Individuals who file such suits are known as “whistleblowers.”
  - If the action is successful, the plaintiff is rewarded with a percentage of the recovery. Retaliation against individuals for investigating, filing or participating in a whistleblower action is prohibited.

Liability (31 U.S.C. 3729(a)(1) and (a)(3)): Liability for the foregoing acts includes:
- A civil penalty of $5,000 – $10,000; and
- Three times the amount of damages which the government sustains because of that act.
- A person or company who violates the False Claims Act is also liable to the government.
24. Health, safety and welfare
Abuse

What is abuse?

– Nonaccidental infliction of physical and/or emotional harm.
– Sexual abuse upon a disabled adult or an elderly person by a relative, caregiver, household member or any other person.
– Active encouragement of any person by a relative, caregiver or household member to commit an act that inflicts or could reasonably be expected to result in physical or psychological/emotional injury to a disabled adult or an elderly person.
Physical abuse and sexual abuse

• Physical abuse of customer
  – Nonaccidental use of force that results in bodily injury, pain or impairment, including, but not limited to, being slapped, burned, cut, bruised or improperly physically restrained.

• Physical abuse
  – Infliction of physical pain or injury to an older person.

• Sexual abuse
  – Includes unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an adult with disabilities.
  – Means touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an older person when the older person is unable to understand, unwilling to consent, threatened or physically forced to engage in sexual activity.
Psychological (verbal/emotional) abuse

• **Verbal abuse**
  – Includes, but is not limited to, name calling, intimidation, yelling and swearing. May also include ridicule, coercion and threats.

• **Emotional abuse**
  – Verbal assaults, threats of maltreatment, harassment or intimidation intended to compel the older person to engage in conduct from which he or she wishes and has a right to abstain or to refrain from conduct in which the older person wishes and has a right to engage.
Neglect

• **Neglect of customer** – The failure of another individual to provide an adult with disabilities with, or the willful withholding from an adult with disabilities of, the necessities of life including, but not limited to, food, clothing, shelter or medical care.

• **Neglect** – Repeated conduct or a single incident of carelessness that results or could reasonably be expected to result in serious physical or psychological/emotional injury or substantial risk of death.

• **Self-neglect** – Individual does not attend to his/her own basic needs, such as personal hygiene, appropriate clothing, feeding or tending appropriately to medical conditions.

• **Passive neglect** – A caregiver’s failure to provide an eligible adult with the necessities of life including, but not limited to, food, clothing, shelter or medical care. This definition does not create a new affirmative duty to provide support to eligible adults; nor shall it be construed to mean that an eligible adult is a victim of neglect because of healthcare services provided or not provided by licensed healthcare professionals.
Exploitation

• **Exploitation of customer**
  - The illegal use of assets or resources of an adult with disabilities. It includes, but is 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 a manner contrary to law.

• **Financial exploitation**
  - The misuse or withholding of an older person’s resources by another person to the disadvantage of the older person or the profit or advantage of a person other than the older person.

• **Exploitation is the act of a person who stands in a position of trust and confidence with a disabled adult or an elderly person and knowingly, by deception, intimidation or force:**
  - Obtains control over the person’s funds, assets or property
  - Deprives the person of the use, benefit or possession of funds, assets or property. This intentional action can be temporary or permanent
  - Uses the person’s funds, assets or property for the benefit of someone other than the disabled adult or elderly person
Increased risk factors or traits – member

- Likelihood of abuse, neglect or exploitation occurring increases for members in the presence of one or more risk factors. These include:
  - Dependency on others for personal care
  - Dependency on others for financial management
  - Isolation from information about own rights and health
  - Diminished mental capacity
  - Serious health problems
  - Taking medications that affect cognitive status
  - Depression, anxiety or fearfulness
  - Recent losses, including the loss of a spouse, home or friend
Increased risk factors or traits – caregiver

- Problems and contributing factors exhibited by caregivers who are at risk to abuse, neglect or exploit include:
  - Alcoholism
  - Mental illness
  - Stress
  - Chronic fatigue
  - Frequent medical consultation
  - History of marital violence and/or child abuse
  - Previous relationship difficulties
  - Conflicting demands of other family members
  - Problems with housing, finances and/or employment
  - Lack of support; lack of respite
Identifying victims of human trafficking

Typically, victims of human trafficking display the following signs*:

- Lacks identification documents and may claim to be “just visiting” a certain area.
- Has no fixed address or may be unable to specify where he or she is living.
- Appears under the control of another, possibly the person accompanying him or her. The other person may attempt to speak on behalf of the victim.
- Exhibits fear, depression, submissiveness or acute anxiety.
- Will typically not be in control of his/her own money or identification documents.
- Unable or reluctant to explain the nature of an injury.

If you suspect trafficking, call the National Human Trafficking Hotline at 1-888-373-7888.

* List from Florida Office of the Attorney General
Steps to take for prevention

• When a provider suspects there is a risk of abuse, neglect or exploitation, he/she should work with the Humana care manager assigned to the member via the Integrated Care Team.

• When a care manager determines that a member is at risk for abuse or neglect, but does not display signs or symptoms, the care manager will include in the plan-of-care specific interventions to reduce the member’s risk.
What is a mandated reporter?

• A mandated reporter is an individual who is required by law to report situations immediately if he/she suspects an adult may have been abused, neglected or exploited or is at risk of being abused, neglected or exploited.

Rights of mandated reporters

• **Most states allow for:**
  – Immunity from civil and criminal liability unless the report was made in bad faith or with malicious intent.
  – Identity protection. Your consent must be given to reveal your identity.
  – The court may order the identity of the reporter revealed. The court can then release confidential information without penalty.
Important reporting processes

• Provider must report any suspected abuse, neglect or exploitation to the appropriate state agency. (See appendix for state-specific information.)

• Provider also must report suspected abuse, neglect or exploitation to the Humana care manager participating on the member’s interdisciplinary care team.

• Humana care manager also will report the suspected abuse, neglect or exploitation to the appropriate state agency.

• Humana care manager will follow internal Humana associate reporting procedures as well.
General reporting requirements (including but not limited to:)

• Can you identify the person being abused? If known, provide address and/or location.
• What is the approximate age of the adult?
• Does an emergency exist?
• Can you describe the circumstances of the alleged abuse, neglect or exploitation?
• What are the names and relationships of other members of the adult household, if applicable?
• Is the adult incapacitated?
• Do you know the name and address of the caregiver – if applicable?
• Do you know the name and relationship of the alleged perpetrators?
• Are there other people who may have knowledge of the adult?
• Do you know the name of the adult’s physicians?
• What is your name, address, phone number? (You can report anonymously.)
25. Critical incident reporting
Critical incident reporting

• Humana’s Risk Management Program includes a critical and adverse incident reporting and management system for critical events that negatively impact the health, safety and welfare of our members.
Critical incident reporting (cont’d)

Participating providers should report the following events:

• Member death, brain damage, spinal damage or permanent disfigurement
• Fracture or dislocation of bones or joints
• Any condition requiring definitive or specialized medical attention that is not consistent with the routine management of the patient’s case or patient’s pre-existing physical condition
• Any condition requiring surgical intervention to correct or control
• Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing more acute level of care
• Any condition that extends the patient’s length of stay
• Any condition that results in a limitation of neurological, physical or sensory function which continues after discharge from the facility
Critical incident reporting (cont’d)

• Report the critical and/or adverse incident to the appropriate entity (e.g., police, adult protective services).

• Call 911 if the member is in immediate danger.

• Report the critical and/or adverse incident to the Agency and Humana’s Health Plan Risk Management Department at 1-855-281-6067 and/or via email to riskmanagementadministration@humana.com within 24 hours of identifying the incident.

• Report suspected abuse, neglect and exploitation of a member immediately in accordance with F.S. 39-201 and F.S. 415.

Humana has the right to take corrective action as needed to ensure its staff, participating providers and direct service providers comply with the critical incident reporting requirements.
26. Managed Medical Assistance Physician Incentive Program (MPIP)
The aim of the MPIP is to promote quality of care for our Medicaid members and recognize those physicians who demonstrate high levels of performance for selected criteria.

The MPIP provides the opportunity for designated physician types to earn enhanced payments equivalent to the appropriate Medicare Fee-for-Service Rate, as established by the Agency for Health Care Administration (AHCA) based on the achievement of key access and quality measures.

Physicians eligible and qualified to participate in the MPIP are the physician types listed below who meet plan-specific medical and/or quality criteria:

- **Pediatric primary care physicians (PCPs)** — Pediatricians, family practitioners and general practitioners who provide medical services to enrollees younger than 21. Practicing as a primary care physician with a pediatric panel size of at least 200 or more assigned Humana Family Medicaid membership and meets Medical or HEDIS criteria for the measurement period.

- **Adult PCPs** — Family practitioners, general practitioners and internal medicine practitioners who provide medical services to enrollees age 21 and older. Practicing as a primary care physician with an adult panel size of at least 200 or more assigned Humana Family Medicaid membership and meets Medical or HEDIS criteria for the measurement period.

- **OB-GYNs** — OB-GYNs who had at least 10 Medicaid deliveries for the measurement period and meet Medical and HEDIS criteria for the measurement period.
MPIP, cont’d

**Pediatric Specialists** – Physicians who provide medical services to enrollees younger than 21.

The incentive program will not be extended to the following physicians:

1. Physicians not participating in Humana’s Medicaid network
2. OB-GYNs with fewer than 10 deliveries for the measurement period
3. Primary care physicians with a pediatric panel size less than 200 Medicaid members during the measurement period
4. Primary care physicians with an adult panel size of fewer than 200 Medicaid members during the measurement period
5. Federally Qualified Health Centers (FQHCs)
6. Rural Health Clinics (RHCs)
7. County Health Departments (CHDs)
8. Medical School Faculty Plans

Complete information regarding the incentive program and timelines can be found on the AHCA website at [http://ahca.myflorida.com/medicaid/statewide_mc/mma_physician_incentive.shtml](http://ahca.myflorida.com/medicaid/statewide_mc/mma_physician_incentive.shtml).
27. Medicaid enrollment for claims payment
Medicaid enrollment for claims payment

An entity that renders Medicaid-compensable services to Medicaid recipients, or that provides services of any Medicaid provider type, must be active and enrolled as a Medicaid provider with the Agency for Health Care Administration (AHCA). To meet AHCA requirements, Humana can pay only those claims and/or encounters submitted by physicians and healthcare providers with valid Medicaid enrollment. The following are some of the criteria indicating a physician or healthcare professional is properly enrolled:

• Physicians and other healthcare professionals can verify their enrollment via the Provider Master List (PML) on the AHCA website at http://portal.fllmis.com/FLPublic/Provider_ManagedCare/Provider_ManagedCare_Registration/tabld/77/Default.aspx?linkid=pml.
  
• Listed as active on the AHCA portal on the PML

• Listed with “enrollment” or “limited” in the enrollment type column

• Listed as active (A) in the current Medicaid Enrollment Status column

• Listed with accurate billing NPI and rendering NPI (not applicable to atypical providers) affiliated with the correct Medicaid ID

• Please ensure all service locations, provider type and specialty codes associated with your NPI are affiliated with the correct Medicaid ID
28. Helpful numbers
Helpful numbers

• **Medicaid customer service:**
  - Please call the number on the back of the member’s ID card for the most efficient call routing.

• **Prior authorization (PA) assistance for medical procedures:**
  1-800-523-0023 (Monday through Friday, 8 a.m. to 8 p.m. Eastern time)

• **PA for medication billed as medical claim:** 1-866-461-7273
  (Monday through Friday, 8 a.m. to 6 p.m. Eastern time)

• **PA for pharmacy drugs:** 1-800-555-2546
  (Monday through Friday, 8 a.m. to 6 p.m. Eastern time)

• **Provider relations:**
  – **MMA:** 1-800-626-2741 (Monday through Friday, 8 a.m. to 5 p.m. Central time) for fee schedule requests, demographic changes, credentialing status.
  – **LTC:** Customer Service 1-888-998-7735, Provider Relations 1-502-301-3647.
Helpful numbers (cont’d)

• **Commercial case management:** 1-800-327-9496
• **Medicaid Case Management:** 1-800-229-9880
  - Referrals: FL_MMA_CM_Referrals@humana.com
• **Medicaid Moms First:** 1-800-322-2758 extension 1500290
  - FL_MMA_OB_Referrals@humana.com
• **Commercial concurrent review:** 1-800-545-6775
• **Medicare/Medicaid concurrent review:** 1-800-322-2758
• **Clinical management program information:** 1-800-491-4164
• **PrescribeIT:** 1-800-526-1490
• **Availity customer service/tech support:** 1-800-282-4548
Helpful numbers (cont’d)

• **Ethics and compliance concerns:** 1-877-5 THE KEY (1-877-584-3539)
• **Fraud, waste and abuse reporting:** 1-800-614-4126
• **Questions about arranging interpretation services for member appointments:** 1-877-320-1235