Chapter Three
Florida Medicaid Appendix

Welcome

Thank you for your participation with Humana Family, where our goal is to provide quality services to Medicaid enrollees.

This provider manual highlights the key points related to Humana Family Medicaid policies and procedures and is an extension to your contract. It is intended to be a guideline to facilitate and inform you and your staff of what the Florida Medicaid program is about, what we need from you, and what you can expect from Humana Family. The guidelines outlined in this provider manual are designed to assist you in providing caring, responsive service to our Humana Family Medicaid enrollees.

We look forward to a long and productive relationship with you and your staff. Should you need further assistance, please contact your provider contracting representative.

Sincerely,

Susan C. Lempicki
Vice President, MSO Network Operations
Humana Family

Humana®

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SECTION 1

Program Description

Florida has offered Medicaid services since 1970. Medicaid provides health care coverage for income-eligible children, seniors, disabled adults and pregnant women. It is funded by both the state and federal governments and includes both capitated health plans as well as fee-for-service coverage. The Agency for Health Care Administration (AHCA) is responsible for administering the Medicaid program and will administer contracts, monitor Health Plan performance and provide oversight in all aspects of Health Plan operations. The state has sole authority for determining eligibility for Medicaid and whether Medicaid recipients are required to enroll in, may volunteer to enroll in, may not enroll in a Medicaid health plan or are subject to annual enrollment.

The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services. This program is referred to as statewide Medicaid managed care (SMMC).

In entering into a Contract with AHCA to provide services to Medicaid beneficiaries, Humana has agreed to comply with the provisions of the Medicaid Contract (the "Contract") as well as with all applicable Agency rules relating to the Contract and the applicable provisions in the Florida Medicaid Handbooks ("Handbooks").

Humana's obligations under the Contract include, but are not limited to:

- Maintaining a quality improvement program aimed at improving the quality of member outcomes.
- Maintaining quality management and utilization management programs.
- Furnishing AHCA with data as required under the Contract and as may be required in additional ad hoc requests.
- Collecting and submitting encounter data in the format and in the time frames specified by AHCA.

In signing this contract, Humana has been authorized to take whatever steps are necessary to ensure that providers are recognized by the State Medicaid program, including its Choice Counseling/ Enrollment Broker contractor(s) as a participating provider of Humana. In addition, Humana has the responsibility to ensure providers' submission of encounter data is accepted by the Florida Medicaid Management Information System (MMIS) and/or the State's encounter data warehouse.

The Florida Medicaid program is implementing a new system through which Medicaid enrollees will receive services. This program is called the Statewide Medicaid Managed Care Managed Medical Assistance program. The Managed Medical Assistance (MMA) program is comprised of several types of managed care plans:

- Health Maintenance Organizations
- Provider Service Networks
- Children's Medical Services Network
- Most Medicaid recipients must enroll in the MMA program

The following individuals are NOT required to enroll, although they may enroll if they choose to:

- Medicaid recipients who have other creditable health care coverage, excluding Medicare
- Persons eligible for refugee assistance
- Medicaid recipients who are residents of a developmental disability center
- Medicaid recipients enrolled in the developmental disabilities home- and community-based services
- Waiver or Medicaid recipients waiting for waiver services

To be a Humana Family Provider, you must be a Medicaid-registered provider who provides services in one of the following regions:

- Region 1: Escambia, Okaloosa, Santa Rosa and Walton counties
- Region 6: Hardee, Highlands, Hillsborough, Manatee and Polk counties
- Region 9: Indian River, Martin, Okeechobee, Palm Beach and St. Lucie counties
- Region 10: Broward County
- Region 11: Miami-Dade and Monroe counties

Florida's Managed Medical Assistance (MMA) program is designed to implement a new statewide managed care delivery system that will improve outcomes, improve consumer satisfaction and reduce and control costs.

The Florida MMA program will focus on four key objectives in order to support successful implementation:

1. Preserving continuity of care.
2. Requiring sufficient and accurate networks under contract and taking patients, allowing for an informed choice of plans for recipients and the ability to make appointments.
3. Paying providers fully and promptly to preclude provider cash flow or payroll issues, and to give providers ample opportunity to learn and understand the plan's prior authorization procedures.
4. Coordinating with the Choice Counseling Call Center and website operated by the Agency's contracted enrollment broker.

1.1. Definitions

The following are definitions that are specific to this Appendix:

Abuse (for program integrity functions) — Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care; or recipient practices that result in unnecessary cost to the Medicaid program.

Abuse, Neglect and Exploitation — In accordance with Chapter 415, F.S., and Chapter 39, F.S.:

"Abuse" means any willful act or threatened act by a caregiver that causes or is likely to cause significant impairment to an enrollee's physical, mental or emotional health. Abuse includes acts and omissions.

"Exploitation" of a vulnerable adult means a person who:

1. Stands in a position of trust and confidence with a vulnerable adult and knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use, a vulnerable adult's funds, assets or property for the benefit of someone other than the vulnerable adult.
2. Knows or should know that the vulnerable adult lacks the capacity to consent, and obtains or uses, or endeavors to obtain or use, the vulnerable adult's funds, assets or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit or possession of the funds, assets or property for the benefit of someone other than the vulnerable adult.

"Neglect" of an adult means the failure or omission on the part of the caregiver to provide the care, supervision, and services necessary to maintain the physical and behavioral health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision and medical services, that a prudent person would consider essential for the well-being of the vulnerable adult. The term "neglect" also means the failure of a caregiver to make a reasonable effort to protect a vulnerable adult from abuse, neglect or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness that produces, or could reasonably be expected to result in, serious physical or psychological injury or a substantial risk of death.

"Neglect" of a child occurs when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment, or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, behavioral or emotional health to be significantly impaired or to be in danger of being significantly impaired.

Action — The denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b). The reduction, suspension or termination of a previously authorized service. The denial, in whole or in part, of payment for a service. The failure to provide services in a timely manner, as defined by the state. The failure of the Managed Care Plan to act within ninety (90) days from the date the Managed Care Plan receives a grievance, or forty-five (45) days from the date the Managed Care Plan receives an appeal. For a resident of a rural area with only one (1) managed care entity, the denial of an enrollee's request to exercise the right to obtain services outside the network.

Acute Care Services — Short-term medical treatment that may include, but is not limited to, community behavioral health, dental, hearing, home health, independent laboratory and X-ray, inpatient hospital, outpatient hospital/emergency medical, practitioner, prescribed drug, vision or hospice services.

Adjudicated Claim — A claim for which a determination has been made to pay or deny the claim.

Advance Directive — A written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.

Advanced Registered Nurse Practitioner (ARNP) — A licensed advanced practice registered nurse who works in collaboration with a practitioner according to Chapter 464, F.S., according to protocol, to provide diagnostic and clinical interventions. An ARNP must be authorized to provide these services by Chapter 464, F.S., and protocols filed with the Board of Medicine.

Adverse Incident — Critical events that negatively impact the health, safety or welfare of enrollees. Adverse incidents may include events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing or major medication incidents.

After Hours — The hours between 5 p.m. and 8 a.m. local time, Monday through Friday inclusive, and all day Saturday and Sunday. State holidays are included.

Agency — State of Florida, Agency for Health Care Administration or its designee.

Aging and Disability Resource Center (ADRC) — An agency designated by the DOEA to develop and administer a plan for a comprehensive and coordinated system of services for older and disabled persons.

Ancillary Provider — A provider of ancillary medical services who has contracted with a Managed Care Plan to serve the Managed Care Plan's enrollees.

Appeal — A request for review of an action, pursuant to 42 CFR 438.400(b).

Area Agency on Aging — An agency designated by the DOEA to develop and administer a plan for a comprehensive and coordinated system of services for older persons.

Behavioral Health Care Provider — A licensed or certified behavioral health professional, such as a clinical psychologist under Chapter 490, F.S., clinical social worker, mental health professional under Chapter 491, F.S.; certified addictions professional; or registered nurse qualified due to training or competency in behavioral health care, who is responsible for the provision of behavioral health care to patients, or a physician licensed under Chapters 458 or 459, F.S., who is under contract to provide behavioral health services to enrollees.

Behavioral Health Services — Services listed in the Community Behavioral Health Services Handbook and the Mental Health Targeted Case Management Coverage and Limitations Handbook as specified in Section V, Covered Services and the MMA Exhibit.

Beneficiary Assistance Program — A state external conflict resolution program authorized under s. 409.91211(3)(q), F.S., available to Medicaid participants, that provides an additional level of appeal if the Managed Care Plan's process does not resolve the conflict.

Benefits — A schedule of health care services to be delivered to enrollee covered by the Health Plan as set forth in Section V of the MMA contract and Section Two (2) of this Appendix.

Business Days — Traditional workdays, which are Monday, Tuesday, Wednesday, Thursday and Friday. State holidays are excluded.

Calendar Days — All seven days of the week. Unless otherwise specified, the term "days" in this attachment refers to calendar days.

Care Coordination/Case Management — A process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an enrollee's health needs using communication and all available resources to promote quality outcomes. Proper care coordination/case management occurs across a continuum of care, addressing the ongoing individual needs of an enrollee rather than being restricted to a single practice setting.

Case Record — A record that includes information regarding the management of services for an enrollee including the plan of care and documentation of care coordination/case management activities.

Cause — Special reasons that allow mandatory enrollees to change their Managed Care Plan choice outside their open enrollment period. May also be referred to as "good cause." (See 59G-8.600, F.A.C.)

Centers for Medicare & Medicaid Services (CMS) — The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act.

Certification — The process of determining that a facility, equipment or an individual meets the requirements of federal or state law, or whether Medicaid payments are appropriate or shall be made in certain situations.

Child Health Checkup Program (CHCUP) — Comprehensive and preventive health examinations provided on a periodic basis that are aimed at identifying and correcting medical conditions in children/adolescents. Policies and procedures are described in the Child Health Checkup Services Coverage and Limitations Handbook.

Children/Adolescents — Enrollees under the age of 21.

Children's Medical Services Network — A primary care case management program for children from birth through age 21 with special health care needs, administered by the Department of Health for physical health services and the Department of Children and Families for behavioral health.

Children's Medical Services (CMS) Plan — A Medicaid specialty plan for children with chronic conditions operated by the Florida Department of Health's Children's Medical Services Network as specified in s. 409.974(4), F.S., through a single, statewide contract with the agency that is not subject to the SMMC procurement requirements, or regional plan limits, but must meet all other plan requirements for the MMA program.

Claim — (1) A bill for services, (2) a line item of service, or (3) all services for one (1) recipient within a bill, pursuant to 42 CFR 447.45, in a format prescribed by the Agency through its Medicaid provider handbooks.

Clean Claim — A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, pursuant to 42 CFR 447.45.

Commission for the Transportation Disadvantaged (CTD) — An independent commission housed administratively within the Florida Department of Transportation. The CTD's mission is to ensure the availability of efficient, cost-effective, and quality transportation services for transportation-disadvantaged persons.

Community Care for the Elderly Lead Agency — An entity designated by an Area Agency on Aging and given the authority and responsibility to coordinate services for functionally impaired elderly persons.

Community Outreach — The provision of health or nutritional information or information for the benefit and education of, or assistance to, a community in regard to health-related matters or public awareness that promotes healthy lifestyles. Community outreach also includes the provision of information about health care services, preventive techniques and other health care projects and the provision of information related to health, welfare and social services or social assistance programs offered by the state of Florida or local communities.

Community Outreach Materials — Materials regarding health or nutritional information or information for the benefit and education of, or assistance to, a community on health-related matters or public awareness that promotes healthy lifestyles. Such materials are meant specifically for the community at large and may also include information about health care services, preventive techniques, and other health care projects and the provision of information related to health, welfare and social services or social assistance programs offered by the State of Florida or local communities. Community outreach materials are limited to brochures, fact sheets, billboards, posters and ad copy for radio, television, print or the Internet.

Community Outreach Representative — A person who provides health information, information that promotes healthy lifestyles, information that provides guidance about social assistance programs, and information that provides culturally and linguistically appropriate health or nutritional education. Such representatives must be appropriately trained, certified and/or licensed, including but not limited to, social workers, nutritionists, physical therapists and other health care professionals.

Complaint — Any oral or written expression of dissatisfaction by an enrollee submitted to the Health Plan or to a state agency and resolved by close of business the following business day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships, such as rudeness of a provider or Health Plan employee, failure to respect the enrollee's rights, Health Plan administration, claims practices or provision of services that relates to the quality of care rendered by a provider pursuant to the Health Plan's Contract. A complaint is an informal component of the grievance system.

Continuous Quality Improvement — A management philosophy that mandates continually pursuing efforts to improve the quality of products and services produced by an organization.

Contract, Medical Assistance — As a result of receiving a regional award from the Agency pursuant to s. 409.966(2), F.S., and/or s. 409.974, F.S., and successfully meeting all plan readiness requirements, the agreement between the Managed Care Plan and the Agency where the Managed Care Plan will provide Medicaid-covered services to enrollees, comprising the Contract and any addenda, appendices, attachments, or amendments thereto, and be paid by the Agency as described in the terms of the agreement. Also referred to as the "Contract."

County Health Departments (CHD) — CHDs are organizations administered by the Department of Health for the purpose of providing health services as defined in Chapter 154, F.S., which include the promotion of the public's health, the control and eradication of preventable diseases and the provision of primary health care for special populations

Coverage and Limitations Handbook and/or Provider General Handbook (Handbook) — A Florida Medicaid document that provides information to a Medicaid provider about enrollee eligibility; claims submission and processing; provider participation; covered care, goods and services; limitations; procedure codes and fees; and other matters related to participation in the Medicaid program.

Covered Services — Those services provided by the Health Plan in accordance with the Health Plan's Medicaid Contract, and as outlined in Section V of the MMA contract and in Section Two (2) Covered Services of this Appendix.

Crisis Support — Services for persons initially perceived to need emergency behavioral health services, but upon assessment, do not meet the criteria for such emergency care. These are acute care services available twenty-four hours a day, seven days a week (24/7) for intervention. Examples include: mobile crisis, crisis/emergency screening, crisis hotline and emergency walk-in.

Department of Children and Families (DCF) — The state agency responsible for overseeing programs involving behavioral health, childcare, family safety, domestic violence, economic self-sufficiency, refugee services, homelessness and programs that identify and protect abused and neglected children and adults.

Department of Elder Affairs (DOEA) — The primary state agency responsible for administering human services programs to benefit Florida's elders and developing policy recommendations for long-term care in addition to overseeing the implementation of federally funded and state-funded programs and services for the state's elderly population.

Department of Health — The state agency responsible for public health, public primary care and personal health, disease control, and licensing of health professionals.

Direct Secure Messaging (DSM) — Enables Managed Care Organizations and providers to securely send patient health information to many types of organizations.

Direct Service Behavioral Health Care Provider — An individual qualified by training or experience to provide direct behavioral health services.

Disease Management — A system of coordinated health care intervention and communication for populations with conditions in which patient self-care efforts are significant. Disease management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Disenrollment — The Agency-approved discontinuance of an enrollee's participation in a Managed Care Plan.

Downward Substitution — The use of less restrictive, lower cost services than otherwise might have been provided, that are considered clinically acceptable and necessary to meet specified objectives outlined in an enrollee's plan of treatment, provided as an alternative to higher cost services.

Dual Eligible — An enrollee who is eligible for both Medicaid (Title XIX) and Medicare (Title XVIII) programs.

Durable Medical Equipment (DME) — Medical equipment that can withstand repeated use, is customarily used to serve a medical purpose, is generally not useful in the absence of illness or injury and is appropriate for use in the enrollee's home.

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) — As defined by 42 CFR 440.40(b) (2012) or its successive regulation, means: (1) Screening and diagnostic services to determine physical or mental defects in recipients under age 21; and (2) Health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered. Pursuant to s. 42 CFR 441.56 (2012) or its successive regulation, this is a program about which all eligible individuals and their families must be informed. EPSDT includes screening (periodic comprehensive child health assessments) consisting of regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. As a minimum, these screenings must include, but are not limited to: (a) comprehensive health and developmental history, (b) comprehensive unclothed physical examination, (c) appropriate vision testing, (d) appropriate hearing testing, (e) appropriate laboratory tests, (f) dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age. Screening services must be provided in accordance with reasonable standards of medical and dental practice determined by the Agency after consultation with recognized medical and dental organizations involved in child health care. Requirements for screenings are contained in the Medicaid Child Health Checkup Coverage and Limitations handbook. Diagnosis and treatment include: (a) diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids; (b) dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health; and (c) appropriate immunizations. (If it is determined at the time of screening that immunization is needed and appropriate to provide at the time of screening, then immunization treatment must be provided at that time.) (See definition of Child Health Check-up program.)

Early Intervention Services (EIS) — A Medicaid program designed for children receiving services through the Department of Health's Early Steps program. Early Steps serves eligible infants and toddlers from birth to thirty-six (36) months who have development delays or a condition likely to result in a developmental delay. EIS services are authorized in the child's Early Steps Individualized Family Support Plan and are delivered by Medicaid-enrolled EIS providers throughout the state.

Emergency Behavioral Health Services — Those services required to meet the needs of an individual who is experiencing an acute crisis, resulting from a mental illness, which is a level of severity that would meet the requirements for an involuntary examination (see s. 394.463, F.S.), and in the absence of a suitable alternative or psychiatric medication, would require hospitalization.

Emergency Medical Condition — A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following:
Serious jeopardy to the health of a patient, including a pregnant woman or fetus;

- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.
- With respect to a pregnant woman:
  - That there is inadequate time to affect safe transfer to another hospital prior to delivery;
  - That a transfer may pose a threat to the health and safety of the patient or fetus;
  - That there is evidence of the onset and persistence of uterine contractions or rupture of other membranes, Section 395.002.F.S.

Emergency Services and Care — Medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists. If an emergency medical condition exists, emergency services and care includes the care or treatment that is necessary to relieve or eliminate the emergency medical condition within the service capability of the facility.

Emergency Transportation — The provision of emergency transportation services in accordance with s. 409.908 (13)(c)4., F.S.

Encounter Data — A record of diagnostic or treatment procedures or other medical, allied, or long-term care provided to the Managed Care Plan's Medicaid enrollees, excluding services paid by the Agency on a fee-for-service basis.

Enrollee — A Medicaid recipient currently enrolled in the Health Plan.

Enrollees with Special Health Care Needs — Enrollees who face physical, behavioral or environmental challenges daily that place at risk their health and ability to fully function in society. This includes individuals with mental retardation or related conditions; individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care; and all enrollees in LTC Managed Care Plans.

Enrollment — The process by which an eligible Medicaid recipient signs up to participate in a Managed Care Plan.

Enrollment Broker — The state's contracted or designated entity that performs functions related to outreach, education, enrollment, and disenrollment of potential enrollees into a Managed Care Plan.

Enrollment Specialists — Individuals, authorized through an Agency-approved process, who provide one-on-one information to Medicaid recipients to help them choose the Managed Care Plan that best meets the health care needs of them and their families.

Expanded Benefit — A benefit offered to all enrollees in specific population groups, covered by the Managed Care Plan for which the Managed Care Plan receives no direct payment from the Agency. These specific population groups are as follows: TANF; SSI No Medicare, non-LTC eligible; SSI with Medicare, non-LTC eligible; Dual Eligible, LTC eligible; Medicaid Only, LTC eligible; HIV/AIDS Specialty Population, with Medicare; HIV/AIDS Specialty Population, No Medicare; and Child Welfare Specialty Population.

Expedited Appeal Process — The process by which the appeal of an action is accelerated because the standard time frame for resolution of the appeal could seriously jeopardize the enrollee's life, health or ability to obtain, maintain or regain maximum function.

External Quality Review (EQR) — The analysis and evaluation by an External Quality Review Organization (EQRO) of aggregated information on quality, timeliness and access to the health care services that are furnished to Medicaid recipients by a Health Plan.

External Quality Review Organization (EQRO) — An organization that meets the competence and independence requirements set forth in federal regulation 42 CFR 438.354, and performs external quality review (EQR), other related activities as set forth in federal regulations or both.

Facility-based— As the term relates to services, services the enrollee receives from a residential facility in which the enrollee lives. Under this Contract, assisted living facility services, assistive care services, adult family care homes and nursing facility care are facility-based services.

Federally Qualified Health Center (FQHC) — An entity that is receiving a grant under section 330 of the Public Health Service Act, as amended. (Also see s. 1905(l)(2)(B) of the Social Security Act.) FQHCs provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.

Fee-for-Service (FFS) — A method of making payment by which the Agency sets prices for defined medical or allied care, goods or services.

Fee Schedule – A list of medical, dental or mental health services or products covered by the Florida Medicaid program, which provide the associated reimbursement rates for each covered service or product and are promulgated into rule.

Florida Mental Health Act — Includes the Baker Act that covers admissions for persons who are considered to have an emergency mental health condition (a threat to themselves or others) as specified in ss. 394.451 through 394.47891, F.S.

Fraud — An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to that person or another person. The term includes any act that constitutes fraud under applicable federal or state law.

Full Benefit Dual Eligible — An enrollee who is eligible for full Medicaid benefits under Medicaid (Title XIX) and Medicare (Title XVIII) programs.

Functional Status — The ability of an individual to perform self-care, self-maintenance and physical activities in order to carry on typical daily activities.

Grievance — An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships, such as rudeness of a provider or employee or failure to respect the enrollee's rights.

Grievance Process — The procedures for addressing enrollees' grievances.

Grievance System — The system for reviewing and resolving enrollee complaints, grievances and appeals. Components must include a complaint process, a grievance process, an appeal process, access to an applicable review outside the Managed Care Plan (Beneficiary Assistance Program) and access to a Medicaid Fair Hearing through the Department of Children and Families.

Health Assessment — A complete health evaluation combining health history, physical assessment and the monitoring of physical and psychological growth and development.

Health Care-Acquired Condition (HCAC) — A condition, occurring in any inpatient hospital or inpatient psychiatric hospital setting, including crisis stabilization units (CSUs), identified as a hospital-acquired condition (HAC) by the Secretary of Health and Human Services under section 1886(d)(4)(D)(iv) of the Social Security Act for purposes of the Medicare program as specified in the Florida Medicaid State Plan. By federal law, Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE), as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients, are not reportable PPCs/HCACs. HCACs also include never events.

Health Care Professional — A physician or any of the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), a licensed clinical social worker, registered respiratory therapist and certified respiratory therapy technician.

Healthcare Effectiveness Data and Information Set (HEDIS®) — The data and information set developed and published by the National Committee for Quality Assurance. HEDIS includes technical specifications for the calculation of performance measures.

Health Information Exchange (HIE) — The secure, electronic exchange of health information among authorized stakeholders in the health care community – such as care providers, patients, and public health agencies – to drive timely, efficient, high-quality, preventive and patient-centered care.

Health Information Technology for Economic and Clinical Health (HITECH) Act — The Health Information Technology Act, found in Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-005.

Healthy Behaviors (MMA Managed Care Plans Only) — A program offered by Managed Care Plans that encourages and rewards behaviors designed to improve the enrollee's overall health.

Health Fair — An event conducted in a setting that is open to the public or segment of the public (such as the "elderly" or "schoolchildren") during which information about health care services, facilities, research, preventive techniques or other health care subjects is disseminated. At least one (1) community organization or two (2) health-related organizations that are not affiliated under common ownership must actively participate in the health fair.

Hospital — A facility licensed in accordance with the provisions of Chapter 395, F.S., or the applicable laws of the state in which the service is furnished.

Licensed — A facility, equipment or an individual that has formally met state, county and local requirements, and has been granted a license by a local, state or federal government entity.

Licensed Practitioner of the Healing Arts — A psychiatric nurse, registered nurse, advanced registered nurse practitioner, physician assistant, clinical social worker, mental health counselor, marriage and family therapist, or psychologist.

List of Excluded Individuals and Entities (LEIE) — A database maintained by the Department of Health & Human Services, Office of the Inspector General. The LEIE provides information to the public, health care providers, patients and others relating to parties excluded from participation in Medicare, Medicaid and all other federal health care programs.

Managed Behavioral Health Organization (MBHO) — A behavioral health care delivery system managing quality, utilization and cost of services. Additionally, an MBHO measures performance in the area of mental disorders.

Managed Care Plan — An eligible plan under Contract with the Agency to provide services in the MMA Statewide Medicaid Managed Care Program.

Mandatory Assignment — The process the Agency uses to assign enrollees to a Managed Care Plan. The Agency automatically assigns those enrollees required to be in a Managed Care Plan who did not voluntarily choose one.

Mandatory Enrollee — The categories of eligible Medicaid recipients who must be enrolled in a Managed Care Plan.

Mandatory Potential Enrollee — A Medicaid recipient who is required to enroll in a Managed Care Plan but has not yet made a choice.

Marketing — Any activity or communication conducted by or on behalf of any Managed Care Plan with a Medicaid recipient who is not enrolled with the Managed Care Plan or an individual potentially eligible for Medicaid that can reasonably be interpreted as intended to influence such individual to enroll in the particular Managed Care Plan.

Medicaid — The medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., and regulations thereunder, as administered in the state of Florida by the Agency under 409.901 et seq., F.S.

Medicaid Fair Hearing — An administrative hearing conducted by DCF to review an action taken by a Managed Care Plan that limits, denies, or stops a requested service.

Medicaid Program Integrity (MPI) — The unit of the Agency responsible for preventing and identifying fraud and abuse in the Medicaid program.

Medicaid Recipient — Any individual whom the DCF, or the Social Security Administration on behalf of the DCF, determines is eligible, pursuant to federal and state law, to receive medical or allied care, goods or services for which the Agency may make payments under the Medicaid program, and who is enrolled in the Medicaid program.

Medicaid State Plan — A written plan between a state and the federal government that outlines the state's Medicaid eligibility standards, provider requirements, payment methods, and health benefit packages. A Medicaid State Plan is submitted by each state and approved by the Centers for Medicare & Medicaid Services (CMS).

Managed Medical Assistance (MMA) Plan — A Managed Care Plan that provides the services described in s. 409.973, F.S., for the MMA Statewide Medicaid Managed Care (SMMC) program.

Medical/Case Record — Documents corresponding to medical or allied care, goods or services furnished in any place of business. The records may be on paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media.

Medically Complex — An individual who is medically fragile who may have multiple comorbidities or be technologically dependent on medical apparatus or procedures to sustain life.

Medically Necessary or Medical Necessity — Services that include medical or allied care, goods or services furnished or ordered to:

1. Meet the following conditions:

a. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
b. Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs;
c. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational;
d. Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
e. Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee's caretaker or the provider.

2. Medically Necessary or Medical Necessity for those services furnished in a hospital on an inpatient basis cannot, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
3. The fact that a provider has prescribed, recommended or approved medical or allied goods or a service does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

Medicare — The medical assistance program authorized by Title XVIII of the Social Security Act.

Medicare Advantage Plan — A Medicare-approved health plan offered by a private company that covers both hospital and medical services, often includes prescription drug coverage, and may offer extra coverage such as vision, hearing, dental and/or wellness programs. Each plan can charge different out-of-pocket costs and have different rules for how to get services. Such plans can be organized as health maintenance organizations, preferred provider organizations, coordinated care plans, and special needs plans.

Mental Health Targeted Case Manager — An individual who provides mental health targeted case management services directly to or on behalf of an enrollee on an individual basis in accordance with 65E-15, F.A.C., and the Florida Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook.

National Provider Identifier (NPI) — An identification number assigned through the National Plan and Provider Enumerator System of the federal Department of Health & Human Services.
NPIs can be obtained online at **https://nppes.cms.hhs.gov.**

Never Event (NE) — As defined by the National Quality Forum (NQF), an error in medical care that is of concern to both the public and health care professionals and providers, clearly identifiable and measurable (and thus feasible to include in a reporting system), and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the health care organization. Currently, in Florida Medicaid, never event health care settings are limited to inpatient hospitals and inpatient psychiatric hospitals, including CSUs.

Newborn — A live child born to an enrollee, who is an enrollee of the Health Plan.

Noncovered Service — A service that is not a covered service/benefit.

Nonparticipating Provider — A person or entity eligible to provide Medicaid services that does not have a contractual agreement with the Managed Care Plan to provide services. In order to receive payment for covered services, non-participating providers must be eligible for a Medicaid provider agreement and recognized in the Medicaid system (Florida MMIS) as either actively enrolled Medicaid providers or as Managed Care Plan registered providers.

Normal Business Hours — The hours between 8 a.m. and 5 p.m. local time, Monday - Friday inclusive. State holidays are excluded.

Nursing Facility — An institutional care facility that furnishes medical or allied inpatient care and services to individuals needing such services.

Other Provider-preventable Condition (OPPC) — A condition occurring in any health care setting that:

- Is identified in the Florida Medicaid State Plan;
- Is reasonably preventable through the application of procedures supported by evidence-based guidelines;
- Has a negative consequence for the beneficiary;
- Is auditable; and
- Includes, at a minimum, the following:
    - Wrong surgical or other invasive procedure performed on a patient;
    - Surgical or other invasive procedure performed on the wrong body part; and
    - Surgical or other invasive procedure performed on the wrong patient.

Outpatient — A patient of an organized medical facility, or distinct part of that facility, who is expected by the facility to receive, and who does receive, professional services for less than a 24–hour period, regardless of the hours of admission, whether or not a bed is used and/or whether or not the patient remains in the facility past midnight.

Overpayment — Overpayment defined in accordance with s. 409.913, F.S., includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.

Participating Provider — A health care practitioner or entity authorized to do business in Florida and contracted with the Managed Care Plan to provide services to the Managed Care Plan's enrollees.

Participating Specialist — A physician, licensed to practice medicine in the State of Florida, who contracts with the Health Plan to provide specialized medical services to the Health Plan's enrollees.

Patient Responsibility — The cost of Medicaid long-term care services not paid for by the Medicaid program, for which the enrollee is responsible. Patient responsibility is the amount enrollees must contribute toward the cost of their care. This is determined by the DCF's Economic Self Sufficiency only and is based on income and type of placement.

Peer Review — An evaluation of the professional practices of a provider by the provider's peers. The evaluator assesses the necessity, appropriateness and quality of care furnished by comparing the care to that customarily furnished by the provider's peers and to recognized health care standards.

Person (entity) — Any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care.

Physician Assistant (PA) — A person who is a graduate of an approved program or its equivalent or meets standards approved by the Board of Medicine or the Board of Osteopathic Medicine, and is certified to perform medical services delegated by the supervising physician in accordance with Chapter 458, F.S.

Physicians' Current Procedural Terminology (CPT®) — A systematic listing and coding of procedures and services published annually by the American Medical Association.

Portable X-ray Equipment — X-ray equipment transported to a setting other than a hospital, clinic or office of a physician or other licensed practitioner of the healing arts.

Post-stabilization Care Services — Covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain, improve or resolve the enrollee's condition pursuant to 42 CFR 422.113.

Potential Enrollee — Pursuant to 42 CFR 438.10(a), an eligible Medicaid recipient who is subject to mandatory assignment or who may voluntarily elect to enroll in a given Managed Care Plan, but is not yet an enrollee of a specific Managed Care Plan.

Pre-enrollment — The provision of marketing materials to a Medicaid recipient.

Preferred Drug List — A listing of prescription products selected by a pharmaceutical and therapeutics committee as cost-effective choices for clinician consideration when prescribing for Medicaid recipients.

Prescribed Pediatric Extended Care (PPEC) — A nonresidential health care center for children who are medically complex or technologically dependent and require continuous therapeutic intervention or skilled nursing services.

Primary Care — Comprehensive, coordinated and readily accessible medical care including: health promotion and maintenance; treatment of illness and injury; early detection of disease; and referral to specialists when appropriate.

Primary Care Case Management — The provision or arrangement of enrollees' primary care and the referral of enrollees for other necessary medical services on a twenty-four (24) hour basis.

Primary Care Provider (PCP) — A Health Plan staff or contracted physician practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, advanced registered nurse practitioner, physician assistant or other specialty approved by the Agency, who furnishes primary care and patient management services to an enrollee.

Primary Dental Provider (PDP) — A Managed Care Plan staff or subcontracted dentist practicing as a general dentist or pediatric dentist who furnishes primary dental care and patient management services to an enrollee.

Prior Authorization — The act of authorizing specific services before they are rendered.

Protected Health Information (PHI) — For purposes of this attachment, protected health information shall have the same meaning and effect as defined in 45 CFR 160 and 164, limited to the information created, received, maintained or transmitted by the Managed Care Plan from, or on behalf of, the Agency.

Protocols — Written guidelines or documentation outlining steps to be followed for handling a particular situation, resolving a problem or implementing a plan of medical, nursing, psychosocial, developmental and educational services.

Provider — A person or entity that has a Medicaid provider agreement in effect with the Agency, and a contractual agreement with the Health Plan.

Provider-preventable Condition (PPC) — A condition that meets the definition of a health care-acquired condition or other provider-preventable condition as defined in 42 CFR 447.26(b). PPCs include health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs) in inpatient hospital and inpatient psychiatric hospital settings, including crisis stabilization units (CSUs).

Provider Contract — An agreement between the Health Plan and a health care provider as described above.

Public Event — An event that is organized or sponsored by an organization for the benefit and education of or assistance to a community in regard to health-related matters or public awareness. A Managed Care Plan may sponsor a public event if the event includes active participation of at least one (1) community organization or two (2) health-related organizations not affiliated with the Managed Care Plan.

Quality — The degree to which a Health Plan increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality Enhancements — Certain health-related, community-based services that the Managed Care Plan must offer and coordinate access to its enrollees. Managed Care Plans are not reimbursed by the Agency/Medicaid for these types of services.

Quality Improvement (QI) — The process of monitoring and ensuring that the delivery of health care services are available, accessible, timely, medically necessary, and provided in sufficient quantity, of acceptable quality, within established standards of excellence and appropriate for meeting the needs of the enrollees.

Region — The designated geographical area within which the Managed Care Plan is authorized by the Contract to furnish covered services to enrollees. The Managed Care Plan must serve all counties in the Region(s) for which it is contracted. The 67 Florida counties are divided into 11 regions pursuant to s. 409.966(2), F.S. May also be referred to as “service area.”

Registered Nurse (RN) — An individual who is licensed to practice professional nursing in accordance with Chapter 464, F.S.

Registered Provider — A provider that is registered with FMMIS via the Managed Care Plan. Such providers cannot bill Medicaid through fee-for-service claims submissions. Registered providers are assigned a Medicaid provider identification number for encounter data purposes only.

Remediation — The act or process of correcting a fault or deficiency.

Risk Adjustment (also Risk-adjusted) — In a managed health care setting, risk adjustment of capitation payments is the process used to distribute capitation payments across Managed Care Plans based on the expected health risk of the members enrolled in each Managed Care Plan.

Risk Assessment — The process of collecting information from a person about hereditary, lifestyle and environmental factors to determine specific diseases or conditions for which the person is at risk.

Rural — An area with a population density of less than one hundred (100) individuals per square mile, or an area defined by the most recent United States Census as rural, i.e., lacking a metropolitan statistical area (MSA).

Rural Health Clinic (RHC) — A clinic that is located in an area that has a health care provider shortage. An RHC provides primary health care and related diagnostic services and may provide optometric, podiatry, chiropractic and behavioral health services. An RHC employs, contracts or obtains volunteer services from licensed health care practitioners to provide services.

Sanctions — In relation to Section VIII.F: Any monetary or non-monetary penalty imposed upon a provider, entity or person (e.g., a provider entity or person being suspended from the Medicaid program). A monetary sanction under Rule 59G-9.070, F.A.C. may be referred to as a "fine." A sanction may also be referred to as a disincentive.

Screen or Screening — A brief process, using standardized health screening instruments, used to make judgments about an enrollee's health risks in order to determine if a referral for further assessment and evaluation is necessary.

Serious Injury — Any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

Service Authorization — The Managed Care Plan's approval for services to be rendered. The process of authorization must at least include an enrollee's or a provider's request for the provision of a service.

Service Delivery Systems — Mechanisms that enable provision of certain health care benefits and related services for Medicaid recipients as provided in s. 409.973, F.S., which include, but are not limited to, the Medicaid fee-for-service program and the Medicaid Managed Medical Assistance Program.

Sick Care — Non-urgent problems that do not substantially restrict normal activity, but could develop complications if left untreated (e.g., chronic disease).

Special Supplemental Nutrition Program for Women, Infants and Children (WIC) — Program administered by the Department of Health that provides nutritional counseling, nutritional education, breast-feeding promotion and nutritious foods to pregnant, postpartum and breast-feeding women, infants and children up to the age of 5 who are determined to be at nutritional risk and who have a low-to-moderate income. An individual who is eligible for Medicaid is automatically income-eligible for WIC benefits. Additionally, WIC income eligibility is automatically provided to an enrollee's family that includes a pregnant woman or infant certified eligible to receive Medicaid.

Spoken Script – Standardized text used by Managed Care Plan staff in verbal interactions with enrollees and/or potential enrollees designed to provide information and/or to respond to questions and requests. Spoken scripts also include interactive voice recognition (IVR) and on-hold messages. Marketing scripts are intended to influence such individuals to enroll in the particular Managed Care Plan.

State — State of Florida.

Statewide Inpatient Psychiatric Program (SIPP) — A twenty-four (24) hour inpatient residential treatment program funded by Medicaid that provides mental health services to children under twenty-one (21) years of age.

Subcontract — An agreement entered into by the Health Plan for provision of some of its functions, services or responsibilities for providing services under this Contract.

Subcontractor — Any person or entity with which the Health Plan has contracted or delegated some of its functions, services or responsibilities for providing services under this Contract.

Temporary Assistance to Needy Families (TANF) — Public financial assistance provided to low-income families through DCF.

Temporary Loss Period — Period in which an enrollee loses eligibility and regains it, allowing the recipient to be re-enrolled in the Managed Care Plan in which the recipient was enrolled prior to the eligibility loss.

Transportation — An appropriate means of conveyance furnished to an enrollee to obtain Medicaid authorized/ covered services.

Unborn Activation — The process by which an unborn child, who has been assigned a Medicaid ID number, is made Medicaid eligible upon birth.

Urban — An area with a population density of greater than 100 individuals per square mile or an area defined by the most recent United States Census as urban, i.e., as having a metropolitan statistical area (MSA).

Urgent Behavioral Health Care — Those situations that require immediate attention and assessment within 23 hours even though the enrollee is not in immediate danger to self or others and is able to cooperate in treatment.

Urgent Care — Services for conditions, which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain, etc.) or could substantially restrict an enrollee's activity (e.g., infectious illnesses, flu, respiratory ailments, etc.).

Validation — The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

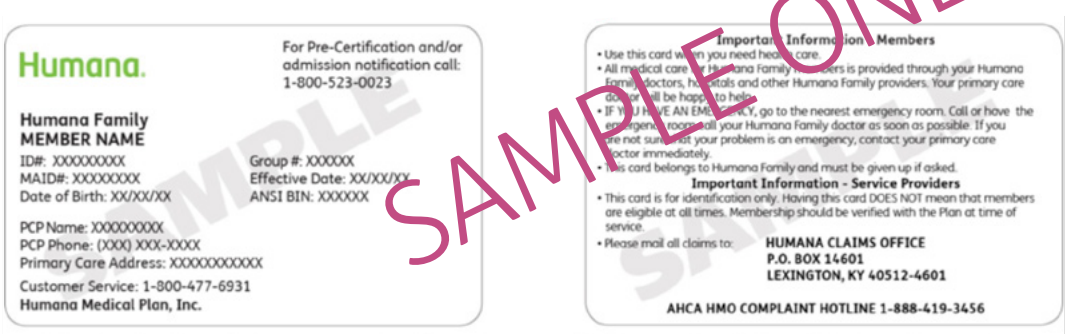
Voluntary Enrollee — A Medicaid recipient who is not mandated to enroll in a Managed Care Plan, but chooses to do so.

Voluntary Potential Enrollee — A Medicaid recipient who is not mandated to enroll in a Managed Care Plan, has expressed a desire to do so, but is not yet enrolled in a Managed Care Plan.

Well Care Visit — A routine medical visit for one of the following: CHCUP visit, family planning, routine follow-up for a previously treated condition or illness, adult physicals or any other routine visit for other than the treatment of an illness.

1.2. Enrollee Identification (ID) Card

Each enrollee will receive an ID card from Humana Family. If they lose their card, they may call Customer Service at 1-800-477-6931 to obtain a new one.



SECTION 2

Covered Services

2.1 General Services

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

Advanced Registered Nurse Practitioner Services
Ambulatory Surgical Centers
Assistive Care Services
Behavioral Health Services — Inpatient and Outpatient
Birth Center Services
Child Health Checkup Services
Chiropractic Services
Community Mental Health Services
County Health Department Services
Dental Services
Durable Medical Equipment and Medical Supplies
Dialysis Services
Emergency Services
Emergency Behavioral Health Services
Family Planning Services and Supplies
Federally Qualified Health Center Services
Free-standing Dialysis Centers
Healthy Start Services
Hearing Services
Home Health Services and Nursing Care
Hospice
Hospital Services — Inpatient/ Outpatient
Imaging Services
Immunizations
Laboratory Services
Licensed Midwife Services
Optometry
Physician Assistant Services
Podiatric Services
Primary Care Services
Primary Care Case Management Services
Prescribed Drug Services
Prostheses and Orthoses
Renal Dialysis Services
Rural Health Clinic Services
Specialty Provider Services
Targeted Case Management
Therapy Services
Transplant Services
Transportation Services
Vision Services
X-ray Services, Including Portable X-rays

In providing covered services to Medicaid enrollees, the provider is required to adhere to applicable provisions in the Florida Medicaid Coverage and Limitations Handbook, as well all state and federal laws pertaining to the provision of such services.

2.2. Out-of-Network Care for Services Not Available

Humana Family will arrange for out-of-network care if it is unable to provide members with necessary covered services or a second opinion, if a network health care provider is not available. Humana Family will coordinate payment with the out-of-network provider to confirm that any cost to the member is not greater than it would be if the service were provided in-network.

2.3. Expanded Services

Expanded services are those services offered by Humana Family and approved in writing by the Agency.

Such expanded benefits are those services or benefits not otherwise covered or that exceed limits outlined in the in the Medicaid State Plan and the Florida Medicaid Coverage and Limitations Handbooks and the Florida Medicaid Fee Schedules. These services are in excess of the amount, duration and scope of those services listed above. In instances where an expanded benefit is also a Medicaid covered service, the Managed Care Plan shall administer the benefit in accordance with any applicable service standards pursuant to this Contract, the Florida Medicaid State Plan and any Medicaid Coverage and Limitations Handbooks.

If copayments are waived as an expanded benefit, the provider must not charge enrollees copayments for covered services; and if copayments are not waived as an expanded benefit, that the amount paid to providers shall be the contracted amount or for FFS Managed Care Plans, the Medicaid fee schedule amount, less any applicable copayments.

SECTION 3

Emergency Service Responsibilities

Participating providers are required to ensure adequate accessibility for health care 24 hours per day, seven days per week. Enrollees should call their PCP first if they have an emergency, but go to the closest emergency room or any other emergency setting if they have an emergency like any of the following:

- Heavy blood loss
- Heart attack
- Severe cuts requiring stitches
- Loss of consciousness
- Poisoning
- Severe chest pains
- Loss of breath
- Broken bones

Enrollees are instructed to call their PCP as soon as possible when they are in a hospital or have received emergency care.

When an enrollee presents at a hospital seeking emergency services and care, the determination that an emergency medical condition exists shall be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a hospital physician. See ss. 409.9128, 409.901, F.S. and 641.513, F.S.

If the emergency room doctor treating the enrollee tells the enrollee that the visit is not an emergency, the enrollee will be given the choice to stay and get medical treatment or follow up with his/her primary care physician. If the enrollee decides to stay and receive treatment, then the services rendered will not be a covered benefit.

If the enrollee's PCP responds to the hospital's notification, and the hospital physician and the PCP discuss the appropriate care and treatment of the enrollee, the Managed Care Plan may have a member of the hospital staff with whom it has a participating provider contract participate in the treatment of the enrollee within the scope of the physician's hospital staff privileges.

If the enrollee is treated for an emergency and the treating doctor recommends treatment after the enrollee is stabilized, the enrollee is instructed to call his/her Humana Family PCP.

Enrollees who are away from home and have an emergency are instructed to go to the nearest emergency room or any emergency setting of their choice. In such situations, enrollees should call their PCP as soon as possible.

3.1 Emergency Behavioral Health Services

For mental health services, enrollees should call the mental health care provider in their area. The provider can give the enrollee a list of common problems with behavior and talk to the enrollee about how to recognize the problems.

Members in Miami-Dade, Monroe, Broward, Palm Beach, Indian River, Martin, Okeechobee, St. Lucie, Hardee, Highlands, Hillsborough, Manatee and Polk counties may call PsychCare at 1-800-221-5487.

Members in Escambia, Okaloosa, Santa Rosa and Walton counties may call Lake View/ Access Behavioral Health at **1-866-477-6725.**

Treatment for psychiatric and emotional disorders includes the following services:

- Counseling
- Evaluation and testing services
- Therapy and treatment services
- Pet Therapy
- Art Therapy
- Rehabilitation services
- Children's behavioral health care services
- Day treatment services

For emergency mental health care within or outside the service area, please instruct enrollees to go to the closest hospital emergency room or any other recommended emergency setting. They should contact you first if they are not sure the problem is an emergency.

Emergency mental health conditions include:

- Danger to themselves or others
- Unable to carry out actions of daily life due to so much functional harm
- Serious harm to the body that may cause death

In addition, the Plan and the mental health provider shall ensure:

1. The enrollee has a follow-up appointment within seven (7) days after discharge; and
2. All required prescriptions are authorized at the time of discharge.

It is agreed that the Humana Family Health Plan provider will do the following:

1. Provide a health screening evaluation that should consist of comprehensive health and developmental history, including assessment of past medical history, developmental history and behavioral health status; comprehensive unclothed physical examination; developmental assessment; nutritional assessment; appropriate immunizations according to the appropriate Recommended Childhood Immunization Schedule for the United States; laboratory testing (including blood lead testing); health education (including anticipatory guidance); dental screening (including a direct referral to a dentist for enrollees beginning at 3 years of age or earlier as indicated); vision screening, including objective testing as required; hearing screening, including objective testing as required; diagnosis and treatment; and referral and follow-up as appropriate.

2. For children/adolescents who the primary care provider identifies through blood lead screenings as having abnormal levels of lead, the primary care provider should provide case management follow-up services as required in chapter two (2) of the Child Health Checkup Services Coverage and Limitations Handbook. Screening for lead poisoning is a required component of health screening. Humana requires all providers to screen all enrolled children for lead poisoning at 12 and 24 months of age. In addition, children between the ages of 12 months and 72 months of age must receive a blood screening lead test if there is no record of a previous test. The primary care provider should provide additional diagnostic and treatment services determined to be medically necessary to a child diagnosed with an elevated blood lead level. The primary care provider should recommend, but not require, the use of paper filter tests as part of the lead screening requirement.

3. The primary care provider should inform enrollees of all testing/screenings due in accordance with the periodicity schedule specified in the Medicaid Child Health Checkup Services Coverage and Limitations Handbook. The primary care provider should contact enrollees to encourage them to obtain health assessment and preventive care.

4. The primary care provider should refer enrollees to appropriate service providers within four weeks of the examination for further assessment and treatment of conditions found during the examination.

5. The primary care provider shall cover fluoride treatment for children/adolescents even if the Health Plan does not provide dental coverage. Fluoride varnish application in a physician's office is limited to children up to 3 ½ years (42 months) of age.

6. The primary care provider should offer scheduling assistance and transportation to enrollees in order to assist them to keep, and travel to, medical appointments.

7. The CHCUP program includes the maintenance of a coordinated system to follow the enrollee through the entire range of screening and treatment, as well as supplying CHCUP training to medical care providers.

8. Pursuant to s. 409.975(5), F.S., Humana shall achieve a CHCUP screening rate of at least eighty percent (80%) for those enrollees who are continuously enrolled for at least eight (8) months during the federal fiscal year (October 1-September 30). This screening compliance rate is based on the CHCUP screening data reported by the primary care provider and due to the Agency by January 15 following the end of each federal fiscal year. The data should be monitored by the Agency for accuracy, and, if the primary care provider does not achieve the 60 percent screening rate for the federal fiscal year reported, the primary care provider should file a corrective action plan (CAP) with the Agency no later than February 15, following the fiscal year reported. Any datum reported by the primary care provider found to be inaccurate should be disallowed by the Agency, and the Agency should consider such findings as being in violation of the Contract and may sanction the primary care provider accordingly.
9. Humana Family will adopt annual screening and participation goals to achieve at least an 80 percent CHCUP screening and participation rate. For each federal fiscal year that the Humana Family Provider Network does not meet the 80 percent screening and participation rate, Humana must file a CAP with the Agency no later than February 15, following the federal fiscal year being reported.

SECTION 4

Child Health Check Up

4.1 Prescribing Psychotropic Medication to a Child

Florida statute requires that providers have express and informed consent from a child's parent or legal guardian for the prescription of a psychotropic (psychotherapeutic) medication to a child in the Medicaid program. The provider needs to document the consent in the child's medical record and provide the pharmacy with a signed attestation of this documentation with the prescription. A "child" means a person from birth until the person's 13th birthday.

The attestation must be completed and presented to the pharmacy with every new prescription. The word "new" refers to every time a new prescription number is assigned, and includes all new prescriptions, including same drug/same dose prescriptions for continuing therapy. It does not replace prior authorization requirements for medications not included on the preferred drug list (PDL) or prior authorized antipsychotics for the children and adolescents birth through 17 years of age.

Prescriptions may be phoned in or emailed for these medications when the child is younger than 13. The pharmacist should obtain a completed consent form from the prescriber via fax, mail or from the guardian prior to dispensing.

Psychotropic medications include antipsychotics, antidepressants, antianxiety medications and mood stabilizers. Anticonvulsants and attention-deficit hyperactivity disorder (ADHD) medications (stimulants and nonstimulants) are not included at this time.

For additional information, including a list of generic names of medications subject to the informed consent and a link to a variety of consent forms allowed, please visit http://ahca.myflorida.com/medicaid/Prescribed_Drug/banners.shtml.

SECTION 5

Provider Complaints

For all inquiries, including complaints, please contact Humana customer service at **(1-800-477-6931)** or your provider contracting representative. Based on the type of issue or complaint, your inquiry will be reviewed by a Humana associate with the designated authority to resolve your issue or complaint.

SECTION 6

Grievance System

The section below is taken from Humana Family's Enrollee Grievance and Appeal procedure as set forth in the Humana Family Member Handbook. This information is provided to you so that you may assist the Humana Family enrollees in this process should they request your assistance. Please contact your provider contracting representative should you have questions about this process.

Humana Family has representatives who handle all enrollee grievances and appeals. A special set of records is kept with the reason, date and results. Humana Family keeps these records in the central office.

Filing a Grievance or an Appeal

If an enrollee has questions or an issue, he or she may call Humana Family Customer Service at **1-800-477-6931** between 8 a.m. – 8 p.m.

If an enrollee is not happy with the answer he or she receives from customer service, an enrollee can file a grievance/appeal.

An enrollee can call customer service to file a complaint, grievance or an appeal. If an enrollee calls about a complaint and we are unable to resolve the complaint by the close of business the following day, then we will automatically send it to our grievance process. If an enrollee would like to file a complaint, grievance or appeal in writing, the enrollee may send us a letter or he or she can get a form from our website or by calling customer service. If an enrollee asks for a form from Humana Family, it will be mailed within three working days. An enrollee can also request help from Humana Family to fill out the form.

All grievance/appeals will be considered. The enrollee can have someone help during the process, whether it is a provider or someone he or she chooses.

The enrollee has the right to continue services during the grievance/appeal process. If the enrollee would like his/her services to continue, the enrollee must to submit an appeal within 10 business days after the notice of action is mailed; or within 10 business days after the intended effective date of action, whichever is later. However, if the decision of the Grievance/Appeal Committee is not in the enrollee's favor, the enrollee may have to pay for those services.

The grievance/appeal must have the following:

- Name, address, telephone number and ID number
- Facts and details of what actions were taken to correct the issue
- What action would resolve the grievance/appeal
- Signature
- Date

Grievance: The enrollee has the right to make a written or verbal grievance within one year of the incident. The grievance process may take up to 90 days. However, Humana Family will resolve the enrollee's grievance as quickly as his or her health condition requires. A letter telling the enrollee the outcome of the grievance will go out within 90 days from the date Humana Family receives the request. The enrollee can request a 14 day extension if needed. We can also request an extension if additional information is needed and is in the enrollee's best interest. Humana Family will send the enrollee a letter telling him or her about the extra time, what additional information is needed and why it is in the enrollee's best interest.

Appeal: An enrollee must file the appeal either verbally or in writing within 30 calendar days of the receipt of the notice of action, and except when expedited resolution is required, must be followed with a written notice within ten (10) calendar days of the oral filing. The date of the oral notice will be considered the date of receipt. An enrollee has up to one year to file an appeal if the denial is not in writing. The appeal process may take up to 45 days. However, Humana Family will resolve the appeal as quickly as the health condition requires. A letter telling the enrollee the outcome of the appeal will go out within 45 days from the date Humana Family receives the request. The enrollee can request a 14-day extension if needed. We can also request an extension if additional information is needed and is in the enrollee's best interest. Humana Family will inform the enrollee by mail of any extra time needed to make a decision, what additional information is needed and why it is in the enrollee's best interest.

Expedited Process: The enrollee has the right to make an expedited verbal or written grievance or appeal. If there is a problem that is putting the enrollees life or health in danger, they or their legal spokesperson can file an "urgent" or "expedited" appeal. These appeals are handled within 72 hours. Let the person you are talking to know that this is an "urgent" or "expedited" appeal. You may request an expedited appeal by calling Humana Family at 1-888-259-6779. If it is determined that it is not an expedited process, it will go through the normal process.

Medicaid Fair Hearing: If an enrollee is not happy with Humana Family's grievance or appeal decision, they can ask for a Medicaid Fair Hearing.

An enrollee may seek a Medicaid Fair Hearing without having first exhausted the Humana's grievance and appeal process.

An enrollee who chooses to exhaust the Humana's grievance and appeal process may still file for a Medicaid Fair Hearing within ninety (90) calendar days of receipt of the Humana's notice of resolution.

An enrollee who chooses to seek a Medicaid Fair Hearing without pursuing the Humana's process must do so within ninety (90) days of receipt of the notice of action. Parties to the Medicaid Fair Hearing include the Plan as well as the enrollee, or that person's authorized representative.

The addresses and phone numbers for Medicaid Fair Hearings at the local Medicaid Area Offices can be found at:

https://portal.flmmis.com/FLPublic/Provider_ContactUs/tabId/38/Default.aspx
and is as follows:

Department of Children and Families

Office of Appeal Hearings
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

850-488-1429

850-487-0662 (fax)

Appeal_Hearings@dcf.state.fl.us (email)

http://www.myflfamilies.com/about-us/office-inspector-general/investigation-reports/appeal-hearings

The enrollee has the right to continue to receive benefits during a Medicaid Fair Hearing. He or she can request to continue to receive benefits by calling our customer service department at **1-800-477-6931** between 8 a.m. – 8 p.m. If the decision is not in the enrollee's favor, he or she may have to pay for those benefits. The enrollee has the right to review his or her case before and during the appeal process.

Beneficiary Assistance Program: If the enrollee is not satisfied with Humana Family's appeal or grievance decision, he or she can ask for a review by the Beneficiary Assistance Program (BAP). The enrollee has one year from receipt of the decision letter to request this review. If the member has already had a review completed by the Medicaid Fair Hearing, the BAP will not consider the appeal.

To request this review, the enrollee may contact: Agency for Health Care Administration, Beneficiary Assistance Program, Building 3, MS 26, 2727 Mahan Drive, Tallahassee, Florida 32308, or cal**l 850-412-4502**, or toll free **1-888-419-3456**.

To send the grievance or appeal request in writing, the enrollee may mail it to the following address:

South Florida Humana Family
Humana Medical Plan, Inc
P.O. Box 14546
Lexington, KY 40512-4546
Attn: Medicaid Grievance & Appeal Analyst

Office hours for the grievance and appeals review department are from 8 a.m. – 8 p.m. Eastern time, Monday – Friday. If the enrollee cannot hear or has trouble talking, he or she may call 711.

If the enrollee wishes to walk in and file a grievance and appeal, the enrollee may do so at the following address:

Humana Medical Plan, Inc.
3501 SW 160th Avenue
Miramar, FL 33027

Office hours are Monday – Friday from 9 a.m. – 5 p.m. Eastern time.
If the enrollee wishes to contact our customer service department by phone, he or she may call 1-800-477-6931.
If the enrollee cannot hear or has trouble talking, he or she may call 1-800-833-3301.
Customer service department hours are Monday – Friday, 8 a.m. – 8 p.m. Eastern time.

If the enrollee is calling after-hours, weekends or holidays for an urgent/expedited grievance or appeal, he or she will be asked to leave a voicemail and he or she will receive a callback by the end of the following day by a specialized team to address the expedited grievance or appeal.

SECTION 7

Chronic and Complex Conditions

7.1. Comprehensive Diabetes Care: Diabetic Retinal Examinations: Humana Family is committed to reducing the incidence of diabetes-induced blindness in Humana Family enrollees. Early intervention and continual monitoring of diabetic eye disease could reduce the incidence of diabetes-related blindness. Based on guidelines proposed by the American College of Physicians, the American Diabetic Association and the American Academy of Ophthalmology, the Humana Family primary care provider will provide or manage services such that recipients with a history of diabetes will receive at least one fundoscopic exam every 12 months.

Glycohemoglobin Levels: Humana Family acknowledges that tight control of blood glucose levels can delay the onset and slow the progression of many of the side effects from diabetes. Glycohemoglobin is one laboratory indicator of how well an enrollee's blood sugar is controlled. Consistent with the American Diabetic Association recommendations, the Humana Family primary care provider will provide or manage services such that enrollees with a history of diabetes will receive glycohemoglobin determinations at least twice a year.

Lipid Levels: Humana Family recognizes the direct link between hyperlipidemia, secondary hyperlipoproteinemias and diabetes mellitus. By closely monitoring lipids and lipoprotein levels in diabetics, better control and maintenance of diabetes is possible. Consistent with the recommendations of the American Diabetes Association, the Humana Family primary care provider will provide or manage services such that enrollees with a history of diabetes will receive lipid and lipoprotein determination annually. If anomalies are found in the annual baseline, additional studies should be conducted as medically necessary.

7.2. Nephropathy: The Humana Family primary care provider screening for nephropathy is to delay or prevent loss of renal function through early detection and initiation of effective therapies, and to manage complications in those identified with a renal disease. The primary care provider will manage the enrollee by identifying evidence of a positive test for protein in the urine (microalbuminuria testing). Enrollee is to be monitored for the disease, including end stage renal, chronic renal failure, renal insufficiency or acute renal failure, and referred to a nephrologist as deemed medically appropriate.

7.3. Congestive Heart Failure: Humana Family is aware there are effective options for treating heart failure and its symptoms. Humana Family recognizes that with early detection symptoms can be reduced, and many heart failure patients are able to resume normal active lives. To further these goals, the Humana Family primary care provider will provide or manage care of the CHF enrollee by prescribing and monitoring an ace inhibitor, angiotensin II receptor blockers (ARB) and diuretic and reviewing the contraindications of those medications prescribed. An echocardiogram should be performed annually, and the enrollee should be instructed on nutrition and education ongoing of his or her disease.

7.4. Asthma: Humana Family recognizes that asthma is a common chronic condition that affects children and adults. The primary care provider will be expected to measure the enrollee's lung function and assess the severity of asthma and to monitor the course of therapy based on the following:

1. Educate the enrollee about the contributing environmental control measures to avoid or eliminate factors that precipitate asthma symptoms or exacerbations.
2. Introduce comprehensive pharmacologic therapy for long-term management designed to reverse and prevent the airway inflammation characteristic of asthma as well as pharmacologic therapy to manage asthma exacerbations.
3. Facilitate education that fosters a partnership among the enrollee, his or her family and clinicians.

7.5. Hypertension: Humana Family recognizes that primary care providers can assist the enrollees by checking blood pressure at every opportunity and by counseling enrollees and their families about preventing hypertension. Enrollees would benefit from general advice on healthy lifestyle habits, in particular healthy body weight, moderate consumption of alcohol and regular exercise. The primary care provider is expected to document in each enrollee's medical record the confirmation of hypertension and identify if the enrollee is at risk for hypertension.

7.6. HIV/AIDS: Humana Family requires that primary care providers assist enrollees in obtaining necessary care in coordination with Humana Family Health Services staff. Please contact health services at 305-626-5119 or your provider contract representative for more details.

7.7. Tuberculosis: Humana shall be responsible for the care for enrollees who have been diagnosed with Tuberculosis disease, or show symptoms of having Tuberculosis and have been designated a threat to the public health by the Florida Department of Health (FDOH) Tuberculosis Program and shall observe the following:

1. Said enrollees shall be hospitalized and treated in a hospital licensed under Chapter 395 F.S. and under contract with the FDOH pursuant to 392.62, Florida Statutes;
2. Treatment plans and discharge determinations shall be made solely by FDOH and the treating hospital;
3. For enrollees determined to be a threat to public health and receiving Tuberculosis treatment at an FDOH contracted hospital, the Managed Care Plan shall pay the Medicaid per diem rate for hospitalization and treatment as negotiated between Florida Medicaid and FDOH, and shall also pay any wrap-around costs not included in the per diem rate; and
4. Reimbursement shall not be denied for failure to prior authorize admission, or for services rendered pursuant to 392.62 F.S.

7.8. Humana provides a Telephonic Medicaid Disease Management Program:

The goals of the Medicaid disease management program:

- Improve members' understanding and assist self-management of their disease with education and support while following their doctor's plan of care.
- Help members maintain optimal disease management and mitigate potential comorbidities using interventions to influence behavioral changes.

- Increase member compliance and disease-specific knowledge with plan of care via mailed materials, recommended websites and newsletters.
- Ensure timely medical/psychological visits and appropriate utilization of access to care to include the use of home health care services.
- Find and obtain community-based resources that meet the member's medical, psychological and social needs.
- Develop routine reporting and feedback loops that may include communications with patients, physicians, health plan and ancillary providers via telephonic contact and secure fax progress notes.
- Provide proactive health promotion education to increase awareness of the health risks associated with certain personal behaviors and lifestyles.
- Evaluate clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall population health of disease management program members.

Disease management case managers with a nursing license are selected based on demonstrated skills in classifying, assessing, monitoring, evaluating, instructing, intervening and documenting goals and outcomes of members with:

- Diabetes
- Congestive Heart Failure
- Hypertension
- HIV+/AIDS
- Adult/Pediatric Asthma

Member eligibility is based on a member having one or more of the above diagnoses.

The disease management program provides services that include, but are not limited to:

- Evaluating member needs that can affect control of their disease such as physical limitations, mental health effects, transportation difficulties and environmental needs.
- Developing self-management goals and plan of care considering members' health history, psychosocial assessment, providers' plan of care and members' needs.
- Educating on diagnosis and potential treatment modalities.
- Referring to internal and external programs
- Supporting members and providers regarding diagnosis, plan of care and other health-related concerns.
- Educating and assisting members on reaching disease-specific diet and exercise goals.
- Educating members on recommended health checks.

The member may contact the primary care physician to request a Disease Management program referral or may call Humana at 1-800-322-2758 for a self-referral.

Referrals are also generated by claims data, on-site and telephonic nurses after discharge, PCPs, internal and external programs and community partners.

To obtain more information about the program, refer a member, provide feedback or file a complaint for disease management, please call 1-800-322-2758. Hours of operation are Monday – Friday, 8:30 a.m. – 5 p.m. Eastern time, or navigate to **Humana.com**. Enrollment or disenrollment from this program is voluntary.

Complex Case Management: Complex case management is a service provided to Medicaid members by Humana nurses specially trained in case management. Their specialized focus is on members with complex medical needs. Management is designed to meet the medical and psychosocial needs of the member and varies depending on situation and severity. A multidisciplinary team approach is utilized to ensure the member's needs are met and all efforts are made to improve and optimize his/her overall health and well-being. A team of Physicians, Social Workers, and Community Services Partners are on hand to help make sure members' needs are met and all efforts are made to improve and optimize their overall health and well-being. The case management program is optional. To refer Medicaid members and verify program eligibility, please call the health services department at 1-800-322-2758.

Quality Improvement (QI) Program: Humana's quality improvement program includes clinical care, preventive care and member services. View Humana's Quality Improvement Progress Report for information about our quality improvement program and progress toward our goals on the provider website: **http://www.humana.com/providers/clinical/quality_resources.aspx**. Health care providers may also obtain a written quality improvement (QI) program description by calling 1-800-4-HUMANA (1-800-448-6262).

We welcome health care providers' input regarding our QI Program. Feedback can be provided in writing to the following address:

Humana Quality Management Department
321 West Main, WFP 20
Louisville, KY 40202

Utilization Management (UM): Humana Family wants to ensure its members receive the right medical care from the right provider at the right time. Humana Family works with practitioners and providers to deliver services that are correct and medically needed for a member's medical condition.

- UM decision making at Humana is based only on appropriateness of care and service and existence of coverage.
- Humana does not specifically reward practitioners or other individuals for issuing denials of coverage.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

If you have questions or concerns related to utilization management, staff is available Monday – Friday from 8:30 a.m. – 5:00 p.m. Eastern time, by calling 1-800-322-2758.

Humana Family has people and free language interpreter services available to answer questions related to utilization management from non-English speaking members. TTY users should call 711.

SECTION 8

PCP and Other Provider/Subcontractor Responsibilities

8.1. Access to Care

Participating primary care providers are required to ensure adequate accessibility for health care 24 hours per day, seven days per week. An after-hours telephone number must be available to members (voice mail is not permitted). The enrollee should have access to care for PCP services and referrals to specialists for medical and behavioral health services available on a timely basis, as follows:

- Urgent Care: Enrollee must be seen within one (1) day of the request.
- Sick Care: Enrollee must be seen within one (1) week of requesting an appointment.
- Well-care Visit: Enrollee must be seen within one (1) month of requesting an appointment.

8.2. Transition/Coordination of Care of New Enrollees

There will be coordination of care for new enrollees transitioning into the Managed Care Plan. In the event a new enrollee is receiving prior authorized ongoing course of treatment with any provider, the Managed Care Plan shall be responsible for the costs of continuation of such course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or nonparticipating providers. Providers shall be reimbursed at the rate they received for services immediately prior to the enrollee transitioning for a minimum of thirty (30) days.

Humana shall provide continuation of MMA services until the enrollee's PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the enrollee's treatment plan, which shall be no more than sixty (60) calendar days after the effective date of enrollment. Providers should continue providing services to enrollees during the 60 day continuity of care period for any services that were previously authorized or prescheduled prior to the implementation, regardless of whether the provider is participating in Humana's network.

Providers should keep previously scheduled appointments with new enrollees during the transition.

The following services may extend beyond the continuity of care period with the enrollee's current provider:

- Prenatal and postpartum care
- Transplant services (through the first year post-transplant)
- Radiation and/or chemotherapy services (for the current round of treatment)

If the services were prearranged prior to enrollment with the plan, written documentation includes the following:

- Prior existing orders;
- Provider appointments (e.g., dental appointments, surgeries, etc);
- Prescriptions (including prescriptions at nonparticipating pharmacies); and
- Behavioral health services.

Although no additional authorization is needed for any ongoing treatment, written documentation for the provision of continued services may be needed for proper payment of the provided services.

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

- Continue Care Plan as is for up to 60 days
- Ensure there are no care disruptions
- Emphasize the member's comfort and safety while addressing unmet needs
- Contract with nonparticipating providers
- Reassess and update the personalized plan of care
- Identify members who desire to transition/continuity of care
- Determine unmet needs and put necessary services in place
- Coordinate and build relationships with providers
- Put the enrollee with a new case manager
- Identify members who desire to transition/continuity of care
- Determine unmet needs and put necessary services in place
- Coordinate and build relationships with providers

8.3. Family Planning Services

Any Medicaid provider can provide family planning services to a Medicaid enrollee without receiving preauthorization for such services. In addition, Medicaid providers should make available and encourage all pregnant women and mothers with infants to receive postpartum visits for the purpose of voluntary family planning, which may include a discussion of all appropriate methods of contraception, counseling and services for family planning. Providers furnishing such family planning services to enrollees must document the offering and provision of family planning services in the enrollee's medical records. This provision should not prevent a health care provider from refusing to furnish any contraceptive or family planning service, supplies or information for medical or religious reasons.

8.4. Immunizations

Immunizations should be provided in accordance with the Recommended Childhood Immunization Schedule for the United States or when medically necessary for the Enrollee's health, as determined by the physician. Providers should participate in the Vaccines for Children program (VFC) as described in Section 1905(c)(1) of the Social Security Act and administered by the department of Health, Bureau of Immunizations. The VFC provides vaccines at no charge to physicians and eliminates the need to refer children to County

Health Departments (CHDs) for immunizations. Title XXI MediKids enrollees do not qualify for the VFC program and must be billed through Medicaid fee-for-service directly for immunizations provided to Title XXI MediKids participants.

8.5. Adult Health Screening

Adult Preventive Health Exam – Beginning at age 21 Years

Elements:	Guidelines
1. Risk Screening	Screening to identify high-risk individuals, assessing family medical and social history is required. Screening for the following risks are to be included as a minimum: cardiovascular disease, hepatitis, HIV/AIDS, STDs and TB.
2. Interval History	Interval histories are required with preventive health care. Changes in medical, emotional and social status are to be documented.
3. Immunizations	Immunizations are to be documented and current. If immunization status is not current, this is to be documented with a catch-up plan. Immunizations are required as follows: Influenza, annually beginning at age 65 years, Td booster every 10 years; pneumococcal vaccine beginning at age 65. When an individual has received a pneumococcal vaccination prior to the age of 65 years and it has been five years since the vaccination, the individual should be revaccinated.
4. Height and Weight	Documented height and weight is required for all preventive health care visits and at least: – every five years for ages 21-40 – every two years beginning at age 41
5. Vital Signs	Pulse and blood pressure are required for all preventive health care visits and at least: – every five years for ages 21-40 – every two years beginning at age 41
6. Physical Exam	Appropriate evaluation for inclusion in the baseline physical examination of an asymptomatic adult are: – general appearance – skin – gums/dental/oral

	– eyes/ears/nose/throat – neck/thyroid – chest/lungs – cardiovascular – breasts – abdomen/GI – genital/urinary – musculoskeletal – neurological – lymphatic If noncompliance or refusal is documented, the risk associated with the noncompliance must be documented.
7. Cholesterol Screening	Screening required every five years for: – Men, beginning age 35 – Women, beginning age 45 (Earlier if there is any risk factor evident for cardiovascular disease)
8. Visual Acuity Testing	Visual acuity testing, at a minimum, is to document the patient's ability to see at 20 feet. Referrals for testing must be documented.
9. Hearing Screening	Test or inquire about hearing periodically/once a year.
10. Electrocardiogram	Periodically after age 40 to 50 (or as primary care deems medically appropriate)
11. Colorectal Cancer Screening	Colorectal cancer screening must be documented beginning at age 50. **Risk Factors:** First-degree relatives or personal history of colorectal cancer, personal history of female genital or breast cancer, familial adenomatous polyposis, Gardner's syndrome, hereditary nonpolyposis colon cancer, chronic inflammatory bowel disease.
12. Pap Smear	Baseline pap smears are required annually for three consecutive years until three consecutive normal exams are obtained; then every two to three years. May stop at age 65 if patient had regularly normal smears up to that age

13. Mammography	Required as appropriate between ages 35 and 40 – Every one to two years for women age 40 or older. – Earlier and/or more frequent for women at high risk.
14. Prostate Exam/Screening	U.S. Preventive Services Task Force December 2002 Evidence is insufficient to recommend for or against routine screening for prostate cancer using PSA testing or digital rectal examination. The USPSTF found evidence that PSA can detect early-stage prostate cancer but mixed and inconclusive evidence that would suggest early detection improves health outcomes. There was insufficient evidence to determine whether the benefits outweigh the harms (of biopsies, complications and anxiety), especially in a cancer that may have never affected the patient's health. American College of Physicians 2004 Recommendations are for selected testing in 50 to 69-year-olds provided that the risks, benefits and uncertainties are understood. Current available evidence suggests it is difficult to justify routine screening of men 70 and older.
15. Education/Anticipatory Guidance	Health education and guidance must be documented. Educational needs are based on risk factors identified through personal and family medical history and social and cultural history and current practices.
16. Osteoporosis	Screening for women age 65 and older is required; begin at age 60 if at increased risk for osteoporotic fractures. Perform DEXA scan for serial monitoring every two years; special conditions may need more frequent monitoring. All perimenopausal women should have a DEXA scan after a fracture, if test has not been performed recently.

8.6. Hysterectomies, Sterilizations and Abortions

Participating providers must maintain a log of all hysterectomy, sterilization and abortion procedures performed on enrollees. The log must include, at a minimum, the enrollee's name and identifying information, date of procedure and type of procedure. The participating provider should provide abortions only in the following situations:

- If the pregnancy is a result of an act of rape or incest; or
- The physician certifies that the woman is in danger of death unless an abortion is performed.

8.7. Healthy Start Services

Providers treating enrollees who are pregnant should offer Florida's Health Start prenatal risk screening to each pregnant enrollee as part of her first prenatal visit. Providers conducting such screening must use the Department of Health (DOH) prenatal risk form (DH Form 3134), which can be obtained from the local county health department (CHD). One copy of the completed screening form should be kept in the enrollee's medical record, and another copy should be provided to the enrollee. Within 10 business days from completion, the provider must submit the screening form to the CHD in the county in which the prenatal screen was completed.

Providers should also complete the Florida Healthy Start Infant Postnatal Risk Screening Instrument (DH Form 3135) with the Certificate of Live Birth and transmit both documents to the CHD in the county in which the infant was born within five business days from completion. Copies of Form 3135 should be maintained by the provider, included in the enrollee's medical record and furnished to the enrollee.

The provider shall notify the health plan immediately of an enrollee's pregnancy, which can be identified through medical history, examination, testing, claims or otherwise.

Pregnant enrollees or infants who do not score high enough to be eligible for Healthy Start care coordination may be referred for services, regardless of their score on the Healthy Start risk screen, in the following ways:

1. If the referral is to be made at the same time the Healthy Start risk screen is administered, the provider may indicate on the risk screening form that the enrollee or infant is invited to participate based on factors other than score; or
2. If the determination is made subsequent to risk screening, the provider may refer the enrollee or infant directly to the Healthy Start care coordinator based on assessment of actual or potential factors associated with high risk, such as HIV, hepatitis, hepatitis B, substance abuse or domestic violence.

Humana Family should refer all pregnant women, breast-feeding and postpartum women, infants and children up to age 5 to the local WIC office:

1. The participating provider of Humana Family should provide:
    I. A completed Florida WIC program medical referral form with the current height or length and weight (taken within 60 calendar days of the WIC appointment);
    II. Hemoglobin or hematocrit test results; and
    III. Documentation of any identified medical/nutritional problem.
2. For subsequent WIC certifications, providers should coordinate with the local WIC office to provide the above referral data from the most recent CHCUP.
3. Each time the participating provider completes a WIC referral form, the provider should give a copy of the WIC referral form to the enrollee and retain a copy in the enrollee's medical record.

Providers must provide all women of childbearing age HIV counseling and offer them HIV testing. (14)

1. In accordance with Florida law, providers should offer all pregnant women counseling and HIV testing at the initial prenatal care visit and again at 28 and 32 weeks.
2. Providers must attempt to obtain a signed objection if a pregnant woman declines an HIV test. (16)
3. All pregnant women who are infected with HIV should be counseled about and offered the latest antiretroviral regimen recommended by the U.S. Department of Health & Human Services. (17)

(14) Chapters 381, F.S., 2004.

(16) Sections 384.31, F.S., 2004 and 64D-3.019, F.A.C., 2004.

(17) U.S. Department of Health & Human Services, Public Health Service Task Force report entitled "Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States."

Providers must screen all pregnant enrollees receiving prenatal care for the Hepatitis B surface antigen (HBsAg) during the first prenatal visit.

1. Providers must perform a second HBsAg test between 28 and 32 weeks of pregnancy for all pregnant enrollees who tested negative at the first prenatal visit and are considered high-risk for Hepatitis B infection. This test should be performed at the same time that other routine prenatal screening is ordered.
2. All HBsAg-positive women should be reported to the local CHD and to Healthy Start, regardless of their Healthy Start screening score.

Participating providers should ensure that infants born to HBsAg-positive enrollees should receive Hepatitis B Immune Globulin (HBIG) and the Hepatitis B vaccine once they are physiologically stable, preferably within 12 hours of birth, and should complete the Hepatitis B vaccine series according to the recommended vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States.

1. Providers should test infants born to HBsAg-positive enrollees for HBsAg and Hepatitis B surface antibodies (anti-HBs) six months after the completion of the vaccine series to monitor the success or failure of the therapy.
2. Providers must report to the local CHD a positive HBsAg result in any child age 24 months or less within 24 hours of receipt of the positive test results.
3. Participating providers should ensure that infants born to enrollees who are HBsAg-positive are referred to Healthy Start, regardless of their Healthy Start screening score.

Participating providers should report to the Perinatal Hepatitis B prevention coordinator at the local CHD all prenatal or postpartum enrollees who test HBsAg-positive. Participating providers should also report said enrollees' infants and contacts to the Perinatal Hepatitis B prevention coordinator at the local CHD.

1. The participating provider should report the following information: name, date of birth, race, ethnicity, address, infants, contacts, laboratory test performed, date the sample was collected, thedue date or estimated date of conception (EDC), whether or not the enrollee received prenatal careand immunization dates for infants and contacts.
2. The participating provider should use the Perinatal Hepatitis B Case and Contact Report (DH Form2136) for reporting purposes.

PCPs must maintain all documentation of Healthy Start screenings, assessments, findings and referrals in the enrollees' medical records.

Participating providers should provide the most appropriate and highest level of quality care for pregnant enrollees, including, but not limited to, the following:

1. Prenatal Care — Participating providers of Humana Family, are expected to:
    I. Require a pregnancy test and a nursing assessment with referrals to a physician, physician assistant (PA) or advanced registered nurse practitioner (ARNP) for comprehensive evaluation;
    II. Require case management through the gestational period according to the needs of the enrollee;
    III. Require necessary referrals and follow-up;
    IV. Schedule return prenatal visits at least every four weeks until the 32nd week, every two weeks until the 36th week, and every week thereafter until delivery unless the enrollee's condition requires more frequent visits;
    V. Contact those enrollees who fail to keep their prenatal appointments as soon as possible, and arrange for their continued prenatal care;
    VI. Assist enrollees in making delivery arrangements, if necessary; and
    VII. Ensure that all pregnant enrollees are screened for tobacco use and make available to the pregnant enrollees smoking cessation counseling and appropriate treatment as needed.
2. Nutritional Assessment/Counseling — Participating providers should supply nutritional assessment and counseling to all pregnant enrollees. In addition, participating providers of Humana Family are expected to:
    I. Ensure the provision of safe and adequate nutrition for infants by promoting breastfeeding and the use of breast milk substitutes;
    II. Offer a mid-level nutrition assessment;
    III. Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse or physician following the nutrition assessment; and
    IV. Document the nutrition care plan in the medical record by the person providing counseling.

Providers are required to immediately notify Humana Family of an enrollee‘s pregnancy by calling **1-800-897-9823**, whether identified through medical history, examination, testing, claims or otherwise.

If a member becomes pregnant while on the plan, she is requested to call Humana Family's obstetrics case manager at **1-800-322-2758.** She should choose a Humana Family obstetrician or midwife for her care, and make an appointment to see this doctor as soon as possible. She must also notify the Department of Children and Family (DCF) of the pregnancy by calling **1-866-762-2237**.

Before the last trimester, the member must choose a PCP for the baby. If the baby is enrolled with Humana Family and she does not choose a PCP for the baby, Humana Family will select one for her. If Humana Family selects the PCP and she does not want the one selected, she can change the child to another doctor. To select or change the baby's health plan, the member is instructed to call Choice Counseling at 1-877-711-3662 as soon as possible. She must also notify the Department of Children and Family (DCF) of the birth of the baby by calling 1-866-762-2237.

8.8. Domestic Violence, Alcohol and Substance Abuse and Smoking Cessation

PCPs should screen enrollees for signs of domestic violence and should offer referral services to applicable domestic violence prevention community agencies. See "Quality Enhancement" section 8.9 below.

PCPs should screen enrollees for signs of tobacco, alcohol and substance abuse as a part of prevention evaluation at the following times:

a) Upon initial contact with enrollee;

b) During routine physical examinations;

c) During initial prenatal contact;

d) When the enrollee shows evidence of serious overutilization of medical, surgical, trauma or emergency services; and

e) When documentation of emergency room visits suggests the need.

PCPs should screen and educate enrollees regarding smoking cessation by:

a) Making enrollees aware of and recognizing dangers of smoking.

b) Teaching enrollees how to anticipate and avoid temptation.

c) Providing basic information to the enrollee about smoking and successfully quitting.

d) Encouraging the enrollee to quit.

e) Encouraging the enrollee to talk about the quitting process.

8.9. Quality Enhancements

Quality Enhancements are defined as certain health-related, community-based services to which Humana and its providers must offer and coordinate access for members. These include children's programs, domestic violence classes, pregnancy prevention, smoking cessation and substance abuse programs. These programs are not reimbursable. In addition to the covered services specified in this section, Humana and its providers should offer quality enhancements (QE) in community settings accessible to enrollees.

Humana may co-sponsor an annual training to providers, provided that the training meets the provider training requirements for the following programs. Services can be offered in collaboration with agencies like Early Intervention Programs, Healthy Start Coalitions and local school districts.

The provider shall ensure documentation of the member's medical record of referrals to the community program and follow up on the enrollee's receipt of services from the community program.

QE programs shall include, but not be limited to, the following:

1. **Children's Programs** — Humana and its providers are required to provide regular general wellness programs targeted specifically toward members from birth to age 5, or make a good faith effort to involve enrollees in existing community children's programs.
    a) Children's programs should promote increased use of prevention and early intervention services for at-risk members. Humana will approve claims for services recommended by the Early Intervention Program when they are covered services and medically necessary.
    b) Humana is required to offer annual training to providers that promotes proper nutrition, breast-feeding, immunizations, CHCUP, wellness, prevention and early intervention services.

2. **Domestic Violence** — Providers must screen members for signs of domestic violence and offer referral services to applicable domestic violence prevention community agencies.
3. **Pregnancy Prevention** — Humana and its providers are required to conduct regularly scheduled pregnancy prevention programs or make a good faith effort to involve members in existing community pregnancy prevention programs, such as the Abstinence Education program. The programs should be targeted toward teen members, but should be open to all members, regardless of age, gender, pregnancy status or parental consent.
4. **Prenatal/Postpartum Pregnancy programs** — Humana is required to provide regular home visits conducted by a home health nurse or aide, counseling and educational materials to pregnant and postpartum enrollees who are not in compliance with the Health Plan's prenatal and postpartum programs.
5. **Smoking Cessation** — Humana and its providers are required to conduct regularly scheduled smoking cessation programs as an option for all members or make a good faith effort to involve members in existing community smoking cessation programs. Smoking cessation counseling must be available to all members. Providers should use the Quick Reference Guide to assist in identifying tobacco users and supporting and delivering effective smoking cessation interventions. Copies of the guide may be obtained by contacting:
   DHHS, Agency for Health Care Research & Quality (AHR) Publications Clearinghouse
   P.O. Box 8547
   Silver Spring, MD 20907-8547
   1-800-358-9295
6. **Substance Abuse** — Humana is required to offer substance abuse screening training to providers.
   - Humana and its providers are required to offer targeted members either community- or plan-sponsored substance abuse programs.

8.10. Quality Improvement Requirements

Humana should monitor and evaluate the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to enrollees through:

- **Performance improvement projects (PIPs)** — Ongoing measurements and interventions, significant improvement to the quality of care and service delivery, sustained over time, in both clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.
- **Medical record audits** — Annual medical record reviews conducted by external quality review organizations (EQRO) to evaluate the quality outcomes concerning timeliness of, and enrollee access to, covered services.

- **Performance measures** — Data on patient outcomes as defined by the Health Plan Employee Data and Information Set (HEDIS®) or otherwise defined by the Agency.
- **Surveys** — Consumer Assessment of Health Plans Survey (CAHPS®) and Provider Satisfaction Survey.
- **Peer Review** — Conducted by the Plan to review a provider's practice methods and patterns and appropriateness of care.

8.11. Community Outreach and Provider-based Marketing Activities

Providers need to be aware of and comply with the following requirements:

1. Health care providers may display health-plan-specific materials in their own offices. Providers are permitted to make available and/or distribute Humana marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all Managed Care Plans with which the provider participates. If a provider agrees to make available and/or distribute Humana's marketing materials it should do so knowing it must accept future requests from other Managed Care Plans with which it participates. Providers are also permitted to display posters or other materials in common areas such as the provider's waiting room. Additionally, long-term care facilities are permitted to provide materials in admission packets announcing all Managed Care Plan contractual relationships.
2. Health care providers cannot orally or in writing compare benefits or provider networks among health plans, other than to confirm whether they participate in a health plan's network. If a provider can assist a recipient in an objective assessment of his/her needs and potential options to meet those needs, the provider may do so. Providers may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.
3. Health care providers may announce a new affiliation with a health plan through general advertising (e.g., radio, television, websites). Providers may give their patients a list of health plans with which they contract.
4. Health care providers may co-sponsor events, such as health fairs and advertise with the health plan in indirect ways; such as television, radio, posters, fliers and print advertisement.
5. Health care providers shall not furnish lists of their Medicaid patients to the health plan with which they contract, or any other entity, nor can providers furnish other health plans' membership lists to the health plan; nor can providers assist with health plan enrollment.
6. For the health plan, health care providers may distribute information about non-health-plan specific health care services and the provision of health, welfare and social services by the State of Florida or local communities as long as inquiries from prospective enrollees are referred to the member services section of the health plan or the Agency's choice counselor/enrollment broker. Providers may refer their patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office. They may also share information with patients from the Agency's website or CMS' website.

Providers may not:

- Offer marketing/appointment forms.
- Make phone calls or direct, urge or attempt to persuade recipients 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 induce recipients/enrollees to select them as their provider.
- Offer inducements to persuade recipients to enroll in the Managed Care Plan.
- Conduct health screening as a marketing activity.
- Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.
- Distribute marketing materials within an exam room setting.
- Furnish to the Managed Care Plan lists of their Medicaid patients or the membership of any Managed Care Plan.

8.12. Florida Medicaid Provider Number

All providers must be eligible for participation in the Medicaid program.

If a provider is currently suspended or involuntarily terminated from the Florida Medicaid program whether by contract or sanction, other than for purposes of inactivity, that provider is not considered an eligible Medicaid provider.

All providers are required to have a unique Florida Medicaid provider number in accordance with the guidelines of the Agency for Health Care Administration (AHCA). Each provider is required to have a National Provider Identifier (NPI) in accordance with Section 1173 (b) of the Social Security Act, as enacted by Section 4707 (a) of the Balanced Budget Act of 1997.

Humana is authorized to take whatever steps are necessary to ensure all providers are recognized by the Agency and its agent(s) as a participating provider of the plan and that the provider's submission of encounter data is accepted by the Agency.

8.13. Provider Contracts, Credentialing and Recredentialing

If providers wish to become part of the Humana Family network, they may:

• Visit **Humana.com/providers**

• Choose "Join Our Network"

• Choose "Contracting with Humana"

• Complete online form

They may also contact their local Provider Contract office.

The following information will be needed for the contracting process:

• Physician/practice/facility name

• Service address with phone, fax and email information

• Mailing address, if different than service address

• Taxpayer identification number (TIN)

• Specialty

• Medicaid provider number

• National Provider Identifier (NPI)

• CAQH® number

• Lines of business (e.g., Medicaid, Medicare, etc.) of interest

• Type of contract (e.g., individual, group, facility)

Health care providers must be credentialed prior to network participation in order to treat Humana members.

Recredentialing occurs at least every three years. Some circumstances require shorter recredentialing cycles.

Humana participates with CAQH® (Council for Affordable Quality Healthcare).

Humana Network Operations/Credentialing will collect Florida Medicaid numbers for all Medicaid contracted providers at initial credentialing. The Medicaid numbers will be loaded into the credentialing system.

Network operations, or an agent thereof, will perform periodic office site reviews on all Medicaid contracted Primary Care Physicians (PCPs) and OBGYNs. The Humana Site Visit Tool will be used. Verification will include ensuring the statewide consumer call center telephone number, summary of Florida Patients' Bill of Rights and Responsibilities and consumer assistance notice are posted in the office.

Network operations/credentialing will collect a signed Medicaid attestation from all Medicaid contracted PCPs.

Credentialing will perform a satisfactory Level II background check pursuant to s.409.907, F.S., for all treating providers not currently enrolled in Medicaid's Fee For Service program. Credentialing may verify the provider's Medicaid eligibility through the Agency for Health Care Administration electronic background screening clearinghouse at http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/

Humana Medical Plan will not contract with any provider who has a record of illegal conduct as identified in Section 435.04, F.S.

Credentialing will report providers suspended or terminated from the Humana Medical Plan to the appropriate authorities (e.g., National Practitioner Data Bank (NPDB), Office of Inspector General (OIG), General Services Administration (GSA) and state licensing board).

Credentialing will conduct regular license monitoring for all Medicaid contracted providers to verify active licensure.

Credentialing will review sanction information for any individual/entity identified above:

- List of Excluded Individuals and Entities (maintained by Office of the Inspector General (OIG)): http://exclusions.oig.hhs.gov/
- State Medicaid Agency Sanctions: http://apps.ahca.myflorida.com/dm_web/(S(yhjinjtwnu1wjnr1c3tsmwxf))/default.aspx
- General Services Administration (GSA) Exclusions: https://www.sam.gov/portal/public/SAM/

8.14. Advanced Registered Nurse and Physician Assistant Services

Humana provides services rendered by advanced registered nurse practitioners (ARNP) and physician assistants (PA). Services may be rendered in the physician's practitioner's office, the patient's home, a hospital, a nursing facility or other approved place of service as necessary to treat a particular injury, illness or disease.

ARNPs are licensed and work in collaboration with practitioners pursuant to Chapter 464, F.S., according to protocol, to provide diagnostic and interventional patient care.

PAs are certified to provide diagnostic and therapeutic patient care and be fully licensed as a PA as defined in Chapter 458 or 459. F.S. The services must be provided in collaboration with a practitioner licensed pursuant to Chapter 458 or 459, Florida Statutes.

Humana complies with provisions of the Medicaid Physician Practitioner Services Coverage and Limitations Handbook. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Physician Practitioner Services Coverage and Limitations Handbook.

8.15. Medicaid Preferred Drug List

The Humana Family (Medicaid) Preferred Drug List (PDL) includes many of the restrictions currently in place with our other lines of business. These include prior authorization requirements, step therapy requirements and dispensing limits. Since the Humana Family Preferred Drug List (PDL) is a closed formulary, some drugs are considered nonpreferred and are not covered by the plan. Please consider the alternative drugs available for your Humana Family (Medicaid)-covered patients. Prior authorization, step-edit therapy protocols for PDL drugs may not be more restrictive than those posted on the Agency website.

Physicians can request an exception to the four restricted categories: not normally covered, step therapy medicines, medicines with prior authorization or medicines needing a quantity over the limits in place; by calling Humana Pharmacy Clinical Review (HCPR) at 1-800-555-CLIN (1-800-555-2546) or by fax at 1-877-486-2621. The call center is available Monday – Friday, 8 a.m. – 6 p.m. Eastern time. Please have patient demographic and medical information ready to answer questions.

You may also obtain forms and information at **Humana.com/pa**.

For drugs delivered/administered in physician's office, clinic, outpatient or home setting (fee-for-service providers only) you may contact us at:

- **Humana.com/medpa**
- 1-866-461-7273 (Monday – Friday, 8 a.m. – 6 p.m. Eastern time)

The Plan shall not cover barbiturates and benzodiazepines for dual eligible Medicare and Medicaid enrollees.

For the first 60 days after the regional implementation of the MMA program, Humana must refill prescriptions even if the pharmacy is not in the plan's network. After the regional implementation of the MMA program, Humana will continue to refill prescriptions during the continuity of care period. During the continuity of care period, Humana and it's Providers will educate new enrollees on how to access their prescription drug benefit through Humana's participating provider network.

Humana Family has an over-the-counter (OTC) program through PrescribeIT (1-800-526-1490). The benefit gives each household up to a $25 a month allowance of over-the-counter products. Orders will be shipped to the enrollee's home by UPS or the U.S. Postal Service. There is no charge for shipping. Please allow 10 to 14 working days from when the order is received.

8.16. Healthy Behaviors Program

Healthy Behaviors is a program offered by Humana Family that encourages and rewards behaviors designed to improve the enrollee's overall health. Programs administered by Humana must comply with all applicable laws, including fraud and abuse laws that fall within the purview of the United States Department of Health and Human Services, Office of Inspector General (OIG).

Included in the program is a medically approved smoking cessation program, a medically directed weight loss program and a medically approved alcohol or substance abuse recovery program.

Humana Family identifies enrollees who smoke, are morbidly obese, or are diagnosed with alcohol or substance abuse in order to establish written agreements to secure the enrollees' commitment to participate in these programs.

Once the enrollee is identified and enrolled in the program, Humana Family may inform them about the healthy behavior programs, including incentives and rewards.

As part of its smoking cessation program, the Managed Care Plan shall provide participating PCPs with the Quick Reference Guide to assist in identifying tobacco users and supporting and delivering effective smoking cessation interventions.

As part of its medically approved alcohol or substance abuse recovery program, Humana Family shall offer annual alcohol or substance abuse screening training to its providers. PCPs shall screen enrollees for signs of alcohol or substance abuse as part of prevention evaluation at the following times:

1) Initial contact with a new enrollee;
2) Routine physical examinations;
3) Initial prenatal contact;
4) When the enrollee evidences serious overutilization of medical, surgical, trauma or emergency services; and
5) When documentation of emergency room visits suggests the need.

8.17 Emergency and nonemergency transportation

- For emergency transportation services, call 911.
- If a member needs a ride to a health care appointment that is not an emergency or to the pharmacy right after a doctor's visit, the member may call LogistiCare at 1-866-779-0565. The member must call at least 24 hours before the appointment time.

8.18. Inpatient Hospital Services:

For members up to age 21 and pregnant adults, the plan shall provide up to 365 days of health-related inpatient care, including behavioral health each year. Prior authorization may apply.

Physical and Behavioral Health

- The plan will cover up to 45 days of inpatient coverage and up to 365 days of emergency inpatient care, including behavioral health.
- Prior authorization and other limits may apply.

Substance Abuse Treatment Program

- The plan will cover up to 28 days of inpatient coverage for pregnant adults.
- Prior authorization and other limits may apply.

Transplant Services

- The plan will cover medically necessary transplants and related services.
- Prior authorization and other limits may apply.

SECTION 9

Preauthorization and Referral Procedures

Providers must determine whether preauthorization or notification is required with respect to medical services rendered to any Humana members. To make this determination, providers must review Humana's preauthorization and notification lists (available on **Humana.com**, in the Provider Tools and Resources section or call Customer Service for assistance in locating the lists) which provide a list of medical services that require preauthorization or notification. (Note: Precertification, preadmission, preauthorization and notification requirements all refer to the same process of preauthorization.)

Humana will update the lists periodically and notify providers of revisions in accordance with the time frame specified in the provider agreement. In addition to **Humana.com**, preauthorization or notification requirements for a service may be obtained by contacting Humana Customer Service.

Referrals for service can be submitted and viewed by participating and registered providers on www.Availty.com and **Humana.com**.

For hospital admission, the provider must access **Humana.com**, Availity.com or call the number listed on the back of the member's ID card. The following information is required for each hospital admission:

- Subscriber's name
- Member's ID number, name and date of birth
- Date of actual or proposed admission
- Date of proposed procedure
- Bed type: inpatient or outpatient
- Federal tax ID number of treatment facility or hospital
- Applicable ICD diagnosis code
- Caller's telephone number
- Attending physician's telephone number

For urgent authorizations or notifications, call clinical intake (available 24 hours a day) at 1-800-523-0023. Representatives are also available 8 a.m. – 8 p.m. Eastern time, Monday – Friday (excluding major holidays). Press "0" or say "representative" for live help. Have your tax ID number available.

SECTION 10

Medical Records Requirements

For each Medicaid enrollee, the provider should maintain detailed and legible medical records that include the following:

- Include the enrollee's identifying information, including name, enrollee identification number, date of birth, sex and legal guardianship (if any);
- Include a summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications;
- Include all services provided. Such services must include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases;
- Document referral services in enrollees' medical/case records;
- Each record shall be legible and maintained in detail;
- All records shall contain an immunization history;
- All records shall contain information relating to the enrollee's use of tobacco, alcohol and drugs/substances;
- All records shall contain summaries of all emergency services and care and hospital discharges with appropriate, medically indicated follow-up;
- All records shall reflect the primary language spoken by the enrollee and any translation needs of the enrollee;
- All records shall identify enrollees needing communication assistance in the delivery of health care services;
- All entries shall be dated and signed by the appropriate party;
- All entries shall indicate the chief complaint or purpose of the visit, the objective, diagnoses, medical findings or impression of the provider;
- All entries shall indicate studies ordered (e.g., laboratory, X-ray, EKG) and referral reports;
- All entries shall indicate therapies administered and prescribed;
- All entries shall include the name and profession of the provider rendering services (e.g., MD, DO, OD), including the signature or initials of the provider;
- All entries shall include the disposition, recommendations, instructions to the enrollee, evidence of whether there was follow-up and outcome of services; and
- Include copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child under the age of 13.

Humana shall maintain written policies and procedures for enrollee advance directives that address how the Plan will access copies of any advance directives executed by the enrollee. All medical/case records shall contain documentation that the enrollee was provided with written information concerning the enrollee's rights regarding advance directives (written instructions for living will or power of attorney) and whether or not the enrollee has executed an advance directive. Neither the Managed Care Plan, nor any of its providers shall, as a condition of treatment, require the enrollee to execute or waive an advance directive.

Humana has a form called "5 Wishes" that an enrollee can use to make his or her health care wishes known. This form can serve as advance directives. The member may call Humana Health Services at 1-800-322-2758 for a copy of this form.

Humana and providers shall be responsible for coordination of care for new enrollees transitioning to Humana or another plan or delivery system and shall assist with obtaining the enrollee's medical/case records. This should be done within 30 days.

10.1. Confidentiality of Medical Records

For each medical record, the provider shall have a policy to ensure the confidentiality of medical records, including confidentiality of a minor's consultation, examination and treatment for a sexually transmissible disease.

The enrollee or authorized representative shall sign and date a release form before any clinical/medical case records can be released to another party. Clinical/medical case record release shall occur consistent with state and federal law.

Providers will ensure compliance with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR, Part 431, Subpart F.

SECTION 11

Claims and Encounter Submission Protocols and Standards

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

Behavioral Health Claims:
Region 1 only
Access Behavioral Health
1221 West Lakeview Ave

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

Behavioral Health Claims:
Regions 6, 9, 10, and 11
PsychCare, LLC
Attn: Claims Dept.
10200 Sunset Drive
Miami, FL 33173-3033

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

- 61101 for fee-for-service claims
- 61102 for encounter claims

For claim payment inquiries or complaints, please contact Humana customer service at 1-800-448-6262 (1–800–4HUMANA) or your provider contracting representative. You may also email questions to: **ebusiness@humana.com**. Submit claim disputes to:

Humana Provider Correspondence, P.O. Box 14601, Lexington, KY 40512–4601.

If there is a factual disagreement with response, send email with the reference number to **Humanaproviderservices@humana.com**.

For information regarding electronic claim submission, contact your local provider contracting representative or visit **Humana.com/providers** and choose "Claims Resources" then "Electronic Claims & Encounter Submissions" or www.Availity.com.

In addition to the claim payment provisions outlined in the Medicaid Addendum to your Provider Agreement, Humana should reimburse providers for Medicare deductibles and coinsurance payments for Medicare dual-eligible enrollees according to the lesser of the following:

a) Rate negotiated with the provider; or

b) Reimbursement amount as stipulated in Section 409.908 F.S.

Following is a list of some of the commonly used claims clearinghouses and phone numbers:

Availity®	http://www.availity.com	1-800-282-4548
ZirMed®	http://www.zirmed.com	1-877-494-7633
Trizetto	http://www.trizetto.com	1-800-556-2231
McKesson	http://www.mckesson.com	1-800-782-1334
Caparioˢᴹ	http://www.capario.com	1-800-792-5256
SSI Group	http://www.thessigroup.com	1-800-881-2739

AHCA requires 100 percent encounter submissions:

- 95 percent must pass through state system.
- Necessitates appropriate provider registration and documentation.
- Fee-for-service and capitated providers included.

Encounters and claims identify members who have received services

- Decreases the need for medical record review during HEDIS.
- Will be critical for future world of Medicaid Risk Adjustment.
- Helps identify members receiving preventive screenings – decreasing members appearing in GAP reports.

Sanctions for noncompliance can include liquidated damages and even enrollment freezes.

11.1. Common Submission Errors and How to Avoid Them

Common rejection or denial reasons:

1. Patient not found
2. Insured subscriber not found
3. Patient birthdate on the claim does not match that found in our database
4. Missing or wrong information
5. Invalid HCPCS code submitted
6. No authorization or referral found

How to avoid these errors:

1. Confirm that patient information received and submitted is accurate and correct.
2. Ensure that all required claim form fields are complete and accurate.
3. Obtain proper authorizations and/or referrals for services rendered.

11.2. Timely Filing

Providers are required to file timely claims/encounters for all services rendered to Medicaid members. Timely filing is an essential component of Humana's HEDIS reporting and can ultimately affect how a plan and its providers are measured in member preventive care and screening compliance.

Fee-for-service claims should be filed as soon as possible but no later than 12 months per state guidelines.

Encounter claims should be filed within 30 days.

Humana shall not deny claims for services delivered by providers solely based on the period between the date of service and the date of clean claims submission, unless that period exceeds three hundred sixty-five (365) calendar days.

The encounter data submission standards required to support encounter data collection and submission are defined by the Agency in the Medicaid Companion Guides, Pharmacy Payer Specifications and this section. In addition, the Agency will post encounter data reporting requirements on the following websites:

- http://portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_CompanionGuides/tabId/62/Default.aspx
- http://portal.flmmis.com/FLPublic/Provider_Pharmacy/tabId/52/Default.aspx

11.3 ERAs and EFTs

Providers may register to receive their Humana electronic remittance advice (ERA) and payments/electronic funds transfer (EFT) and get paid up to 7 days faster. The enrollment process is quick and easy:

- Sign into the secure provider website at **Humana.com/providers**
- Select the "ERA/EFT Setup-Change Request"
- Complete the form

You may also access the registration form from the public portal from the **Humana.com/providers** page:

- Select "ERA/EFT"
- Choose the "ERA/EFT Setup-Change Request" link
- Requires two check numbers from claims paid by Humana for validation

Email questions to: **ebusiness@humana.com**

SECTION 12

Cultural Competency Plan

Participating providers are expected to provide services in a culturally competent manner which includes, but is not limited to, removing all language barriers to service and accommodating the special needs of the ethnic, cultural and social circumstances of the patient.

Participating providers must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care including, but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973.

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

A report by the Institute of Medicine in 2002 confirmed the existence of racial and ethnic disparities in health care. Unequal Treatment found racial differences in the type of care delivered across a wide range of health care settings and disease conditions, even when controlling for socioeconomic status factors such as income and insurance coverage. Annual National Healthcare Disparities Reports from the Agency for Healthcare Research and Quality (AHRQ) confirm that these gaps persist in the American health care system.

Communication is paramount in delivering effective care. Mutual understanding may be difficult during cross-cultural interaction between patients and providers. Some disparities may be attributed to miscommunication between providers and patients, language barriers, cultural norms and beliefs and attitudes that determine health-care-seeking behaviors. Providers can address racial and ethnic gaps in health care with an awareness of cultural needs and improving communication with a growing number of diverse patients.

Humana offers a number of initiatives to deliver services to all members regardless of ethnicity, socioeconomic status, culture and primary language. These include language assistance services, race and ethnicity data collection and analysis, internal staff training and Spanish resources. Other initiatives give providers resources and materials, including tools from health-related organizations that support awareness of gaps in care and information on culturally competent care.

You may view a complete copy of Humana's Cultural Competency Plan on Humana's website at **Humana.com/providers/clinical/resources.aspx**. To request a paper copy of Humana's Cultural Competency Plan, please contact Humana customer service at 1-800-4HUMANA (1-800-448-6262) or call your provider contracting representative. The copy of Humana's Cultural Competency Plan will be provided at no charge to the provider.

SECTION 13

Member Rights and Responsibilities

13.1. Member Rights

1. A member has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need for privacy.
2. A member has the right to a prompt and reasonable response to questions and requests.
3. A member has the right to know who is providing medical services and who is responsible for his or her care.
4. A member has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
5. A member has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
6. A member has the right to know what rules and regulations apply to his or her conduct.
7. A member has privacy rights under the Health Insurance Portability and Accountability Act (HIPAA). This is a federal law that protects your health information. These rights are important for you to know. You can exercise these rights, ask questions about them, and file a complaint if you think your rights are being denied or your health information isn't being protected.
8. A member has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

9. A member has the right to participate in decisions regarding his or her health care, including the right to refuse treatment except as otherwise provided by law.
10. A member has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
11. A member who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
12. A member has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
13. A member has the right to receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have the charges explained.
14. A member has the right to request and receive a copy of his or her medical records, and request that they be amended or corrected.
15. A member has the right to be furnished health care services in accordance with federal and state regulations.
16. A member has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
17. A member has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
18. A member has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
19. A member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
20. The state must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the state Agency treat the enrollee.
21. A member has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

13.2. Member Responsibilities

1. A member is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his or her health.
2. A member is responsible for reporting unexpected changes in his or her condition to the health care provider.
3. A member is responsible for reporting to the health care provider whether he or she understands a possible course of action and what is expected of him or her.
4. A member is responsible for following the treatment plan recommended by the health care provider.

5. A member is responsible for keeping appointments, and when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
6. A member is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
7. A member is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
8. A member is responsible for following health care facility rules and regulations affecting patient care and conduct.

SECTION 14

Fraud and Abuse Policy

Provider must incorporate a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse.

Humana and AHCA should be notified immediately if a physician/provider or their office staff:

- Is aware of any physician/provider that may be billing inappropriately, e.g., falsifying diagnosis codes and/or CPT codes, or billing for services not rendered;
- Is aware of a member intentionally permitting others to use his/her member ID card to obtain services or supplies from the plan or any authorized plan provider;
- Is suspicious that someone is using another member's ID card;
- Has evidence that a member knowingly provided fraudulent information on his/her enrollment form that materially affects the member's eligibility in the plan.

Providers may provide the above information via an anonymous phone call to Humana's Fraud Hotline 1-800-614-4126. All information will be kept confidential. Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Humana ensures no retaliation against callers because Humana has a zero tolerance policy for retaliation or retribution against any person who reports suspected misconduct.

Providers may also contact Humana at 1-800-4HUMANA (1-800-448-6262) and AHCA at 1-888-419-3456, option 5.

In addition, providers may use the following contacts:

Telephonic:

- Special Investigations Unit (SIU) Direct Line: 1-800-558-4444 extension 8187 (Monday – Friday, 8 a.m. – 5:30 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: **Ethicshelpline.com**

SECTION 15

Health, Safety and Welfare

Suspected cases of abuse, neglect and/or exploitation must be reported to the state's Adult Protective Services Unit. The Florida Adult Protective Services has the responsibility for investigating allegations of abuse and neglect of elders and individuals with disabilities. This includes, but is not limited to:

- **Abuse** — Non-accidental infliction of physical and/or emotional harm.
- **Physical Abuse** — Causing the infliction of physical pain or injury to an older person.
- **Sexual Abuse** — Unwanted touching, fondling, sexual threats, sexually inappropriate remarks, or other sexual activity with an adult with disabilities; touching, fondling, sexual threats, sexually inappropriate remarks or any 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 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** — Repeated conduct or a single incident of carelessness that results or could reasonably be expected to result in serious physical or psychological/emotional injury or substantial risk of death (this includes self-neglect and passive neglect).
- **Exploitation** — Illegal use of assets or resources of an adult with disabilities. 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 any manner contrary to law.

Indicators of abuse, neglect and exploitation

Physical indicators

1. **Unexplained bruises or welts**:
    - On face, lips, mouth, torso, back, buttocks, thigh in various stages of healing
    - Reflecting shape of article used to inflict (electric cord or belt buckle) in several different surface areas
2. **Unexplained fractures**:
    - To skull, nose, facial structure, in various stages of healing
    - Multiple or spiral fractures

3. **Unexplained burns:**
   - Cigar, cigarette burns, especially on palms, legs, arms, back or soles of feet
   - Immersion burns (sock-like, glove-like, doughnut shaped on buttocks)
   - Patterned like objects (electric burner, etc.)
4. **Unexplained lacerations:**
   - Mouth, lips, gu ms, eye or to external genitalia
5. **Sexual abuse:**
   - Difficulty in walking/sitting
   - Torn, shredded or bloody undergarments
   - Bruises or bleeding in external genitalia, vaginal or anal areas
   - Venereal disease
   - Pregnancy
6. **Other:**
   - Severe or constant pain
   - Obvious illness that requires medical or dental attention
   - Emaciated (so that individual can hardly move or so thin bones protrude)
   - Unusual lumps, bumps or protrusions under the skin
   - Hair thin as though pulled out, bald spots
   - Scars
   - Lack of clothing
   - Same clothing all of the time
   - Fleas, lice on individual
   - Rash, impetigo, eczema
   - Unkempt, dirty
   - Hair matted, tangled or uncombed

Behavioral indicators

1. **Destructive behavior of victim**:
   - Assaults others
   - Destroys belongings of others or themselves
   - Threatens self-harm or suicide
   - Inappropriately displays rage in public
   - Steals without an apparent need for the things stolen
   - Recent or sudden changes in behavior or attitudes
2. **Other behavior of victim:**
   - Afraid of being alone
   - Suspicious of other people and extremely afraid others will harm them
   - Shows symptoms of withdrawal, severe hopelessness, helplessness
   - Constantly moves from place to place
   - Frightened of caregiver
   - Overly quiet, passive, timid
   - Denial of problems
3. **Behavior of family or caregive**r
   - Marital or family discord
   - Striking, shoving, beating, name-calling, scapegoating
   - Hostile, secretive, frustrated, shows little concern, poor self-control, blames adult, impatient, irresponsible

- Denial of problems
- Recent family crisis
- Inability to handle stress
- Recent loss of spouse, family member or close friend
- Alcohol abuse or drug use by family
- Withholds food, medication
- Isolates individual from others in the household
- Lack of physical, facial, eye contact with individual
- Changes doctor frequently without specific cause
- Past history of similar incidents
- Resentment, jealousy
- Unrealistic expectations of individual

Providers are required to report adverse incidents to the agency immediately but not more than 24 hours of the incident. Reporting will include information including the enrollee's identity, description of the incident and outcomes including current status of the enrollee. It is your responsibility as the provider to ensure that abuse, neglect and exploitation training occurs and to maintain necessary documentation of this training for the employees that have contact with the plan (managed care organization) enrollees. You may be requested to make such documentation available.
You may use the "adult abuse, neglect and exploitation guide for professionals" as a training tool.

It is available at
http://www.Dcf.State.Fl.Us/programs/aps/docs/guideforprofessionalsrevisedjune2009.Pdf

Suspected elder abuse, neglect, or exploitation may be reported 24 hours a day seven days a week to the central abuse hotline at 1-800-96-abuse (1-800-962-2873). You may also make a report online at: http://www.Dcf.State.Fl.Us/abuse/report/index.Asp.
When reporting suspected or confirmed abuse, neglect, or exploitation, please report the following information (if available):

- Victim's name, address or location, approximate age, race and sex;
- Physical, mental or behavioral indications that the person is infirmed or disabled;
- Signs or indication of harm or injury or potential harm or injury (physical description or behavioral changes);
- Relationship of the alleged person responsible to the victim, if possible. If the relationship is unknown, a report will still be taken if other reporting criteria are met.
- Medicaid managed care organizations may be required to ensure that all direct care providers have knowledge of and attest they will maintain compliance with staff training relative to abuse, neglect and exploitation.

15.1. Critical Incident Reporting
Humana's Risk Management Program includes critical and adverse incident reporting and management system for critical events that negatively impact the health, safety or welfare of members.

Participating providers should:

- Identify a critical and/or adverse incident: Some examples are major medication errors; death, major illness or injury; wrong surgical procedure, wrong site or wrong patient; surgical procedure to remove foreign objects remaining from a surgical procedure; involvement with law enforcement; altercations requiring surgical intervention and/or elopement/missing patient.
- Report the critical and/or adverse incident to the appropriate entity (police, adult protective services, etc.).
- Call 911 if the member is in immediate danger.
- Report the critical and/or adverse incident to the health plan and Department of Children and Family Services (DCFS) within 24 hours of identifying the incident.
- Report suspected abuse, neglect and exploitation of a member immediately in accordance with s.39-201 and Chapter 415, F.S.
- Complete a Humana's Risk Management Critical Incident Report. Submit to Humana's Risk Management Team at: **RiskManagementAdministration@humana.com**.

SECTION 16

Patient-Centered Medical Home (PCMH)

Patient- centered Medical Home (PCMH) is a transformative model of care that strengthens the physician-patient relationship by replacing episodic care with coordinated care and fosters greater accountability for both patient and physician.

PCMHs are expected to provide evidence- based services to patients and integrate care with specialty and subspecialty practices. The medical home is required to adhere to the following tenets:

Enhance Access and Continuity — Accommodate patient's needs with access and advice during and after regular office hours, give patients and their families information about their medical home and provide patients with team-based care.

Identify and Manage Patient Populations — Collect and use data for population management.

Plan and Manage Care — Use evidence-based guidelines for preventive, acute and chronic care management, including medication and mental health management.

Provide Self-care Support and Community Resources — Assist patients and their families in self-care management with information, tools and resources.

Track and Coordinate Care — Track and coordinate tests, referrals and transitions of care.

Measure and Improve Performance — Use performance and patient experience data for continuous quality improvement.

Humana offers financial incentives to providers to promote NCQA certification, dependent on the size of the practice. Practices achieving Level 2 or 3 NCQA PCMH certification will be considered a preferred provider for mandatory assignments. Practices with Level 2 or 3 NCQA PCMH certification will be designated as PCMH-certified in Humana's online provider directory.

SECTION 17

Medicaid Advisory Panel

Humana recognizes that our Medicaid plan is but one spoke in a wheel of health care providers, community organizations, health plans and other programs that provide essential services, programs and resources to enable Medicaid-qualified members to maintain quality of life and optimal well-being.

To ensure that the needs of members are being addressed and opportunities for improvement are being identified, Humana has developed a Medicaid Advisory Panel.

The panel includes community providers, such as medical service organizations and hospital corporations, nonprofit organizations, community agencies that serve the Medicaid population, a member advocate and various Humana leaders.

SECTION 18

Provider Rewards and Incentives

Provider Quality Bonus — Program aims to promote improvement and quality by providing additional financial compensation to PCP centers that demonstrate high levels of performance for select quality factors.

Eligibility:

- PCP must have an open panel for Medicaid line of business.
- PCP serves more than 49 Medicaid enrollees.

Implementation:

- No later than third quarter 2014.
- Letters outlining criteria to be released April/May 2014.
- Quarterly incentives.

Platinum Provider Program — Annual award and recognition program for PCPs who achieve high levels of performance.

Potential criteria:

- EHR usage, HEDIS scores, encounter submissions, appointment accessibility, financial performance, etc.

Implementation:

- No later than fourth quarter 2014.
- Letters outlining eligibility and criteria to be released May/June 2014.

Criteria and eligibility for all rewards and incentives programs are subject to change at Humana's discretion.

SECTION 19

Provider Resource Website

Providers may obtain plan information from **Humana.com/providers**.

This information includes, but is not limited to, the following:

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

Why register for **Humana.com**?

- Make fewer phone calls
- Save time and costs
- Get secure, real-time access to patient information:
    - Eligibility and benefits
    - View member ID cards
    - Care alerts and member summary
    - Preauthorization and referrals submissions and management
    - Send attachments
    - Claims status and remittance info
    - Medical records management

Humana created a website specific to Florida Medicaid containing resources and updates for providers, viewable at **Humana.com/providers/clinical/medicaid_materials.aspx**

For help or more information regarding Web-based tools:

Email: **ebusiness@humana.com**

SECTION 20

Provider Training

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

As part of the training requirements, providers must complete annual compliance training on the following topics:

- Compliance and Fraud, Waste and Abuse
- Cultural Competency
- Health, Safety and Welfare (Abuse, Neglect and Exploitation)

All new providers will also receive Humana's Medicaid Provider Orientation.

Providers must also complete annual required training on compliance and fraud, waste and abuse to ensure specific controls are in place for the prevention and detection of potential or suspected fraud and abuse as required by s. 6032 of the federal Deficit Reduction Act of 2005.

Providers and members of their office staff can access these online training modules seven days a week, 24 hours a day at **Humana.com/providers.** Sign in with your existing user ID and password. If your organization is not yet registered, registration can be completed immediately. Choose "Resources," locate the "Compliance" section and then choose "Required Compliance Events."

Additional provider training:

Visit **Humana.com/providers**, choose "Web-based Training Schedule" under "Critical Topics."

SECTION 21

Availity

Humana has partnered with Availity to allow providers to reference member and claim data for multiple payers using one login. Availity provides the following benefits:

- Health information network (available in 26 states)
- Eligibility and benefits
- Referrals and authorizations
- Claim status
- Claim submission
- Remittance advice

To learn more, call 1-800-282-4548 or visit http://www.Availity.com.

SECTION 22

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 – Friday, 8 a.m. – 8 p.m. Eastern time

Prior Authorization for medication billed as medical claim: 1-866-461-7273
Monday – Friday, 8 a.m. - 6 p.m. Eastern time

Prior Authorization for pharmacy drugs: 1-800-555-2546
Monday – Friday, 8 a.m. – 6 p.m. local time

Medicare/Medicaid case management: 1-800-322-2758

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

Ethics and compliance concerns: 1-877-5 THE KEY (1-877-584-3539)