Hospice Value-Based Insurance Design (VBID) Model Operational Guidelines for Out-of-Network Providers*

**In order to be contracted with Humana for an In-Network status for Hospice VBID CY2024, a provider must have an executed contract with Humana and undergone required credentialing for contracted status for the program. All other providers servicing Humana eligible plan members in the demonstration footprint will have an Out-of-Network status at this time for CY2024.*

Purpose

This document serves to provide guidance to Hospice providers serving Humana participating members in the Hospice VBID model. The aims of Hospice Value-Based Insurance Design (VBID) Model Demonstration:

- Ease care transitions and ensure that hospice-eligible enrollees do not need to choose between curative or hospice care when considering hospice election
- Improve quality and timely access to the Medicare hospice benefit
- Provide the full scope of hospice benefits, as defined in the Social Security Act (Act) at §1861 dd)
- Improve hospice utilization patterns and costs of care related and unrelated to the terminal condition, based on improving the coordination and quality of care and service delivery
- Enable enrollees and their families and caregivers to experience the benefits of hospice care over a more appropriate period of time as aligned with their wishes and the member's needs
- Create an opportunity to provide additional support and value to hospice enrollees through the use of supplemental benefits with in-network hospice provider election
- Encourage use of voluntary consultation by palliative providers upstream of hospice election
- Provide access to palliative care for all eligible members

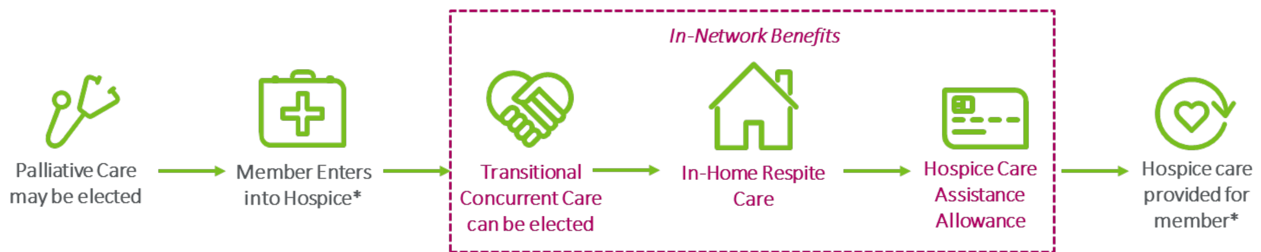
Table of Contents

Section	Page
Definitions	3
Humana Hospice VBID Model Overview	3
Palliative Care and Voluntary Consultation	4
Member Eligibility Verification and Benefit Eligibility	9
Provider Notification Process	11
Humana Hospice Centralized Team	12
Transitional Concurrent Care	13
Supplemental Benefits:	13
Care Assistance Allowance	13
In-Home Respite Care	13
DispatchHealth Partnership	13
Billing and Claims	14
Grievance and Appeals	17
Contracting and Credentialling	17
Advancing Health Equity	17
Frequently Asked Questions	18

Definitions

- Availity – Online portal where providers can register for access to information on a variety of topics such as eligibility, benefits, referrals, authorizations, claims, and electronic remittances
- EOB – Election of Benefits
- Humana Hospice Centralized Team (HHCT) – The team who will be handling the day-to-day operations of the Hospice VBID Demonstration
- INN – Provider participating in Humana's network (IN-Network)
- MAC – Medicare Administrative Contractor
- NOE – Notice of Election
- NOTR – Notice of Termination/Revocation
- NTUC – Not Taken Under Care
- OON – Provider not participating in Humana's network (Out-Of-Network)
- TCC – Transitional Concurrent Care
- VBID – Value Based Insurance Design

Humana Hospice VBID Model Overview



Humana's Hospice VBID model focuses on creating better continuity for our members between their MA experience and end-of-life care receiving Hospice.

Humana's Hospice VBID model encompasses a VBID-specific Palliative Care providers that will partner with Humana to proactively identify and outreach to members who may benefit from the support of a Palliative Care Program simultaneous to their MA plan coverage.

Palliative Care providers will support voluntary consultation with our members surrounding hospice readiness and assist in understanding of the benefits available on VBID CY2024 plans.

When a member elects hospice with an in-network provider, they will have access to Transitional Concurrent Care as required by CMS/CMMI and two additional supplemental benefits that are unique to Humana's model: In-home Respite Care, and a $500 Hospice Care Assistance Allowance. All three of these unique and differentiated services will be coordinated by the Hospice team that continues to oversee patient care with the same four levels of hospice care as prescribed by the current Medicare Policy Manual.

Palliative Care

Palliative care is available to members with advanced illness who have begun a process of progressive and significant decline in their health, to help bridge gaps for those who that are not ready or clinically appropriate for Hospice but need more hands-on assistance than provided by traditional Care Management. The multi-disciplinary palliative care team coordinates directly with the member's Primary Care Physician (PCP) and specialists to manage pain, symptom relief, and clinical interventions. Unlike the Medicare hospice benefit, palliative care does not have a prognosis restriction and may be provided together with curative treatment at any state of a serious illness.

Members are proactively identified by a claims-based algorithm or by direct physician referral.

A requirement of the Hospice VBID Demonstration Model is to ensure that all members on a participating plan, and within the selected model geographies, have access to a Palliative Care provider. For the 2024 plan year, Humana has partnered with select palliative care providers to serve model-participating members.

Palliative Model of Care

- Multidisciplinary team providing in-home and virtual support (MD, NP, RN, Social Worker and Chaplain)
- Plan of care and treatment based upon patient preferences
- Allows for curative treatment
- Managed relief from symptoms, pain and stress
- Collaboration with patient's physician/provider team
- Guidance through complex treatment choices
- Advance Care Planning
- Emotional and spiritual support
- 24/7 MD & NP availability
- Voluntary Consultation as appropriate

Palliative Care Coordination

Palliative care offers specialized care to patients facing a serious illness. Palliative Care coordinates closely with a patients existing PCP and specialists. Patients continue to see their PCP and specialists while on service and receiving active treatment. The patient's designated PCP receives a palliative care summary after every palliative care visit.

Top Clinical Interventions during Palliative Care

Advance Care Planning

- Facilitate conversations surrounding complex treatment choices and completion of advance care planning documentation to enable future health decisions

Hospice Orders

- Write orders for patients to enter hospice
- Coordinate hospice orders with PCP and/or specialists
- Communicate the supplemental benefits available with the election of an in-network hospice

- Facilitate hospice transition per the members wishes

Medication and Non-medication Orders

- Write prescriptions for medications to treat acute symptoms and exacerbations in order to avoid unnecessary ER visits and/or hospitalizations
  - Most frequent prescriptions for Humana-covered members
    Steroids, opiates, antibiotics, diuretic, anti-nausea, inhalers for COPD, oxygen
  - Most frequent non-medication orders
    Mobile X-ray, durable medical equipment, skilled home health
- Coordinate medication orders with primary care physician (PCP) and/or specialists

Expected Outcomes of Palliative Care

- Significantly reduce risk of hospitalization
- Achieve greater patient and caregiver satisfaction
- Facilitate Advance Care Planning discussions
- Identify member's goals of care and end of life wishes
- Increase quality hospice transitions
- Increase Hospice length of stay

Referral to Palliative Care

Palliative Care services are provided at no extra cost to eligible Humana-covered patients with advanced illnesses. Hospice Providers, PCPs, and Humana medical directors may refer members, including revocations and NTUCs.

*For VBID plan members in **Georgia, Ohio, Colorado and Virginia:***

- Physician sends referral and member's demographic information to **Aspire** via email at referrals@aspirehealthcare.com, by phoning 1-844-232-0500, or by faxing to 1-888-972-4927.

*For VBID plan members in **Colorado:***

- Physician sends referral and member's demographic information to Care Synergy via email at humanapalintake@caresynergynetwork.org, by phoning 1-303-336-1267 or by faxing 1-303-398-2377

*For VBID plan members in **Florida**:*

- Physician sends referral and member's demographic information to Harbor Palliative Care Services via email at PalliativeCareConsult@trustbridge.com, by phoning 1-866-640-6804 or by faxing 1-561-863-2806

*For VBID plan members in **Wisconsin***:

- [For all VBID PBPs in the following counties only: Brown, Calumet, Door, Fond Du Lac, Green Lake, Kewaunee, Manitowoc, Marathon, Marinette, Marquette, Oconto, Outagamie, Shawano, Waupaca, Waushara, Winnebago]
  Physician sends referral and member's demographic information to **Unity Support Care Management** via email at referrals@unityhospice.org, or by phoning 1-920-338-1111.
- [For VBID PBPs in all other counties] Physician sends referral and member's demographic information to **Aspire** via email at referrals@aspirehealthcare.com, by phoning 1-844-232-0500, or by faxing to 1-888-972-4927.

*For VBID plan members in **Kentucky***:

- [For PBP H5216-019-000 in the following Kentucky counties only: Anderson, Bourbon, Clark, Fayette, Franklin, Jessamine, Madison, Scott, Woodford]
  Physician sends referral and member's demographic information to **Bluegrass Palliative Care** via email at deptofmedicine@bgcarenav.org, by phoning 1-859-278-4869, or by faxing to 1-859-278-7690
- [For all VBID PBPs in the following counties only: Indiana--Clark, Floyd, Harrison; Kentucky—Bullitt, Hardin, Henry, Jefferson, Larue Meade, Nelson, Oldham, Shelby, Spencer]
  Physician sends referral and member's demographic information to **Pallitus Health Partners** via email at referrals@pallitus.org, or by phoning 1-502-719-8910.
- [For all other VBID PBPs and Counties] Physician sends referral and member's demographic information to **Aspire** via email at referrals@aspirehealthcare.com, by phoning 1-844-232-0500, or by faxing to 1-888-972-4927.

Information required for referral:

- Patient's name and date of birth
- Patient's Humana ID number
- Patient's address and phone number
- PCP's name
- Diagnosis
- Referring physician's name and phone number

A patient's participation with palliative care *does not affect* the PCP's billing for any services (if applicable).

Frequently Asked Questions

- **Who is offered palliative care?**
  - Patients within a VBID plan that are proactively identified by a claims-based algorithm OR referred directly by a provider who have advanced illness and are deemed to need additional support. Common diagnoses examples (but not limited to): Advanced Cancer, Advanced CHF (class III-IV), Advanced COPD (stage III-IV), Advanced Dementia, and Geriatric Frailty.
- **If patient is not ready for Hospice care, can they enroll with Palliative care upstream?**
  - A referral can be made to the Palliative Care provider in your market pending a clinic review for appropriateness. Palliative Care can help the member understand their clinical trajectory and illness as they consider electing hospice.
- **Which palliative providers are serving VBID plans in my area?**
  - Please refer to the information above under the "Referral" section to find the appropriate Palliative Care provider in your area and with the appropriate PBP.

- **How will a Hospice agency hear from the Palliative Provider?**
    - If a member receiving palliative care is ready to transition to hospice, the palliative Nurse Practitioner or MD will reach out to the local hospice provider selected by the member to initiate the transition. The palliative provider or PCP will write the official order for hospice. The palliative team will communicate to the hospice provider if the member is a VBID participant.
- **Will hospice agencies know if palliative care was provided to the VBID member prior to transitioning to hospice?**
    - Any member transitioning to hospice from palliative care will be identified as a VBID member. If the PCP is the ordering physician, VBID identification will need to be validated. However, there may be scenarios where the member received palliative care earlier in their health care journey but are not transitioning directly from an active palliative care episode and therefore palliative care experience would be unknown to the hospice provider at the time of hospice transition. Any questions specific to palliative care utilization can be directed to palliative@humana.com.
- **Will palliative care educate patient on Transitional Concurrent Care?**
    - Palliative care facilitates advance care planning discussions at every visit and as part of education on the hospice benefit. The palliative provider will inform the member of supplemental benefits available through election of an in- network provider including Transitional Concurrent Care as well as ensuring the member is aware of out-of-network providers.
- **What patient information or medical records can hospice expect if palliative care was provided to the member prior to entering hospice?**
    - Documentation is dependent upon the ordering provider. If hospice order is coming from the palliative provider, documentation would include hospice qualifying condition, any open gaps in care, current care plan, and recent MD summary. Regardless of whether the palliative provider writes the hospice order, or the PCP/specialist prefers to do it, the interdisciplinary palliative team is involved in the transition to ensure it is seamless for the patient/family. This often includes a joint visit with the hospice admission RN to support continuity of care.
    - If a patient has elected an in-network provider with the intention to receive Transitional Concurrent Care, the palliative provider will include specifics around current care plan goals and advance care planning discussions to the hospice provider as part of the transition.
    - All VBID plan members transitioning to hospice from palliative care include VBID identification as required documentation.
- **How will palliative providers be educated on Humana's In- and Out-Of-Network Providers?**

    - Palliative providers will receive a list of hospice providers participating in Humana's network by region and are educated on the in- and out-of-network options available to members when electing a hospice provider.

- **Who should providers contact with additional questions specific to palliative care?**
    - To contact the Humana Palliative Team, email palliative@humana.com.

Voluntary Consultation

A voluntary consultation is an optional outreach to the patient that is a part of the CMMI Hospice VBID model with a purpose of ensuring the member understands the hospice benefit and their coverage options under the Hospice VBID demonstration.

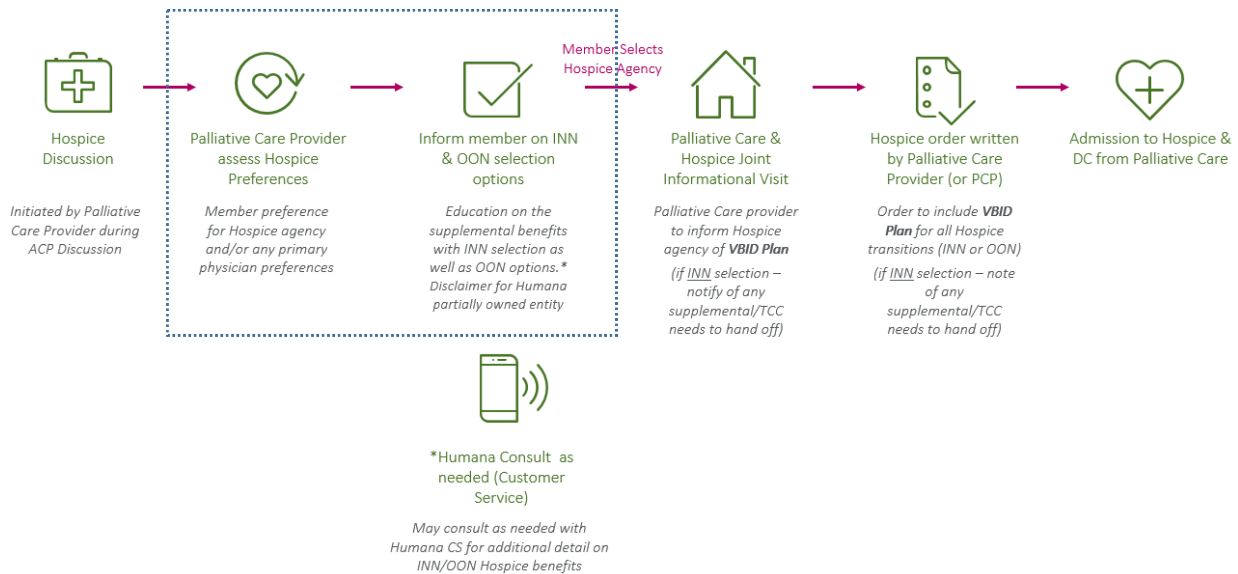
This process recommendation is outlined by CMMI in the RFA and Technical and Operational Guidelines Documents for Hospice VBID Component CY2024, and can be found at innovation.cms.gov/innovation-models/vbid.

For purposes of this demonstration, Humana will leverage existing palliative care providers and processes to offer, when appropriate, patients on palliative care service a voluntary consultation as part of their facilitated advance care planning discussions.

To assist in supporting patients on the end-of-life continuum, Humana has also created a separate option for the consultation process aimed at counseling the individual (and/or caregiver(s)) and representatives regarding hospice and other care options.

If counseling beyond benefit and provider information is needed, the Humana Hospice Centralized Team may answer questions and counsel on options for care. The consultation is voluntary and not a requirement for members in year three of the demonstration.

Voluntary Consult Process



Member Eligibility Verification

If the member is in a Humana MA plan and the hospice election date is on or after the date listed in the table below, identify the MA contract number and plan benefit package identification information on the MA enrollment card. It will look like this: H#######. For example, H1234-001. Please refer to the Participating Plans section of this guidance.

Market	Plan Benefit Packages	Benefit Eligibility Date
Louisville, KY / Lexington, KY	HumanaChoice H5216-019-000 (PPO)	1/1/2022 – 12/31/2023
Louisville, KY	Humana Community H1036-236-000 (HMO)	1/1/2023- 12/31/2024
Kentucky	Humana Gold Plus H5619-071-000 (HMO)	1/1/2023- 12/31/2024
Atlanta, GA	Humana Gold Plus H4141-015-000 (HMO)	1/1/2021- 12/31/2024
Atlanta, GA	HumanaChoice H5216-073-000 (PPO)	1/1/2021- 12/31/2024
Atlanta, GA	Humana Care Extra H5216-239-000 (PPO)	1/1/2022 – 12/31/2023
Georgia	HumanaChoice H5216-203-001 (PPO)	1/1/2023- 12/31/2024
Macon and Albany, GA	HumanaChoice H5216-203-002 (PPO)	1/1/2023- 12/31/2024
Georgia	Humana Gold Plus H4141-017-003 (HMO)	1/1/2024
Macon and Albany, GA	Humana Gold Plus H4141-017-005 (HMO)	1/1/2024
Richmond/Tidewater, VA	Humana Gold Plus H6622-004-000 (HMO)	1/1/2021- 12/31/2024

Richmond/Tidewater, VA	Humana Gold Plus H6622-005-000 (HMO)	1/1/2021 – 12/31/2023
Richmond/Tidewater, VA	HumanaChoice H5216-144-000 (PPO)	1/1/2022- 12/31/2024
Richmond/Tidewater, VA	HumanaChoice H5216-266-000 (PPO)	1/1/2022 – 12/31/2022
Richmond/Tidewater, VA	Humana Gold Plus H5619-139-001 (HMO)	1/1/2022 – 12/31/2023
Richmond/Tidewater, VA	Humana Gold Plus H5619-139-002 (HMO)	1/1/2022 – 12/31/2023
Richmond/Tidewater, VA	Humana Gold Plus H5619-140-001 (HMO)	1/1/2022 – 12/31/2023
Richmond/Tidewater, VA	Humana Gold Plus H5619-140-002 (HMO)	1/1/2022 – 12/31/2023
Richmond/Tidewater, VA	Humana Gold Plus H5619-157-000 (HMO)	1/1/2024- 12/31/2024
Cleveland, OH	Humana Cleveland Clinic Preferred H6622-023-000 (HMO)	1/1/2021- 12/31/2024
Denver, CO	Humana Gold Plus H0028-025-001 (HMO)	1/1/2021- 12/31/2024
Denver, CO	Humana Gold Plus H0028-025-002 (HMO)	1/1/2021- 12/31/2024
Denver, CO	Humana Gold Plus H0028-047-000 (HMO)	1/1/2021- 12/31/2024
Green Bay, WI	Humana Gold Plus H6622-001-000 (HMO)	1/1/2022- 12/31/2024
Milwaukee/Green Bay, WI	HumanaChoice H5216-252-000 (PPO)	1/1/2023- 12/31/2024
Milwaukee/Green Bay, WI	HumanaChoice H5216-253-000 (PPO)	1/1/2023- 12/31/2024
Milwaukee/Madison, WI	Humana Gold Plus H6622-034-000 (HMO)	1/1/2023- 12/31/2023
Green Bay, WI	HumanaChoice H5216-001-000 (PPO)	1/1/2024
South Florida, FL	HumanaChoice Florida H5216-068-000 (PPO)	1/1/2023- 12/31/2024

Member eligibility for the Value Based Insurance Design can be verified by calling Humana Customer Service at 1-800-457-4708 (TTY:711) or electronically via Availity to confirm member is enrolled in one of the qualified Plan Benefit Packages and in one of the selected market geographies. Please refer to the Availity Registration and Authentication material located in the Provider Portal (humana.com/hospice) for additional information.

Hospice providers can confirm a member's Medicare eligibility and check for Medicare Advantage (MA) enrollment by using any of the following online tools or services:

- MAC Portal
- MAC Interactive Voice Response (IVR) System
- Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS)
- Billing agencies, clearinghouses, or software vendors

Additionally, if a member is receiving care from a partnered palliative care vendor and receives a referral to your hospice, that member and/or palliative care team should communicate that he or she is a VBID participant.

If a member or provider has questions about implications to VBID benefits due to enrollment or election changes, they may contact the Humana Hospice Centralized Team at 1-800-950-1071 or HHCT_Support@humana.com.

Benefit Eligibility

Hospice providers should conduct regular and ongoing coverage checks for awareness of member's benefit plan. If a member has a plan change while enrolled in hospice, Humana will continue providing payment for all services including both hospice and non-hospice care, until the enrollee's coverage with. a VBID qualifying plan ends. Please refer to the document on Enrollment Plan Changes located on the website.

Provider Notification Process

Providers must submit copies of the Signed Election and Consent statements and NOTR for live discharge or transfer. Verbal or written communication must be submitted to the Humana Hospice Centralized Team for member's who expire. Below is an overview of the process for submission.

Please refer to the Availity Submission Guidelines document in the Provider Portal (humana.com/hospice) for additional step-by-step information regarding notifications to Humana within Availity.

- Hospice providers must notify Humana of member's hospice election by providing Humana with a notification flag in the form of an "authorization" with copies of the Signed Election and Consent Statement documentation attached with the submission.
    - Authorization should be built through Availity as an outpatient authorization with a service type of hospice, **regardless of member's setting for hospice care**. Please do NOT submit an inpatient Hospice authorization to Humana to designate member on-service status for hospice.
    - There will be **no** utilization management review of member's election in hospice and all submissions will receive an automated "approved" status with the submission.
    - The provider will include the member's Signed Election and Consent Statement as an attachment in the notification process.
    - Providers are required to submit the authorization and attached documentation within 5 days of member election, consistent with the MAC submission deadlines. Failure to submit notification to Humana timely may result in payment delays as well as provider responsibility for cost of care for days in arrears.
    - Please refer to the Availity Submission Guidelines document in the Provider Portal (humana.com/hospice) for more detailed steps and screenshots of submission requirements.

- Hospices do not need to notify Humana of any changes in level of care. There is no authorization required for level of care changes.
- Hospice providers must also submit a copy of the NOTR to Humana for live discharge or transfer. Verbal or written notification is required to the Humana Hospice Centralized Team if the member expires.
    - A Humana Care Manager will collect key information including the discharge disposition and advise of any outstanding services for unrelated care or supplemental benefits
        - Member revokes
        - Member chooses to transfer to another hospice
        - Member does not meet recertification criteria
        - Member is discharged due to cause
        - Member passes away
    - Please refer to the Availity Submission Guidelines document in the Provider Portal (humana.com/hospice) for additional information regarding NOTR submission requirements.

Please note, hospice providers continue current notifications to MAC for both Notice of Election and claims submission through existing processes and are reminded to complete the signed Medicare Election and Consent Statement and NOTR within the CMS-identified time frames.

Humana Hospice Centralized Team

To ensure that providers and members have a smooth and seamless experience with the Hospice VBID Model, a team of Humana clinicians is available to support the hospice experience for our members and providers. The Humana Hospice Centralized Team (HHCT) is a dedicated team of RNs, LSW, and an Administration Coordinator who support the daily operations of the VBID Demonstration.

Upon receiving the signed Medicare Election and Consent Statement, Humana will assign each member receiving care with a Hospice Care Manager. The Hospice Care Manager will outreach to the provider to establish their relationship.

The primary role of the Care Manager will be to support our members' care experience and needs through coordination with the Hospice interdisciplinary team. Humana will not establish a separate care plan or goals for members during their Hospice election.

How can I reach Humana's Hospice Centralized Team?
The centralized team can be reached at 1-800-950-1071 from the hours of 8:00 AM EST – 5:00 PM EST Monday-Friday. Voicemails left after working hours will be returned the next business day. During weekends and national holidays, voicemails will be monitored, and calls will be returned based on urgency.

What type of support does Humana's Hospice Centralized Team provide?

- Support Palliative Providers as needed when discussing hospice election with members/caregivers.
- Provide voluntary consultation on inbound calls from members and their approved representatives inquiring about the hospice benefit.

- Case conferences with Hospice Care provider to discuss member's benefits/utilization of benefits, Plan of Care, and any potential barriers.
- An initial case conference will be conducted by the assigned HHCT Care Manager once the hospice authorization has been submitted and received by Humana.

Transitional Concurrent Care

Transitional Concurrent Care (TCC) allows a member access to curative care or services for up to 31 days after hospice election with the intention of tapering off curative services as a member begins to receive hospice care. This is a benefit offered only to members who elect an in-network hospice. If a member has any questions regarding this benefit, please direct them to the 24/7 1-800-457-4708 (TTY:711) line.

Supplemental Benefits

Supplemental benefits are benefits that are covered by Humana at a plan level beyond what is included in the standard plan coverage. Humana created two Hospice-specific supplemental benefits to fulfill the option presented by CMMI as a part of the Hospice VBID Model Component. These supplemental benefits include a $500 Hospice Care Assistance allowance and 40 hours of In-home Respite Care per plan year. All Humana plans participating in the Hospice VBID Model have access to both benefits, however, to be eligible, the member must have elected and be in the process of receiving hospice care from an in-network hospice provider.

Hospice Care Assistance

The Hospice Care Assistance Allowance is a $500 non-primary, health-related allowance provided to members receiving Hospice from an in-network hospice, designed to address the needs based on the individual's unique situation. This is a benefit offered only to members who select an in-network hospice. If a member has any questions regarding this benefit, please direct them to Humana Customer Service 24/7 at 1-800-457-4708 (TTY:711)

In-Home Respite Care

In-home Respite Care is defined as the provision of a nursing assistant/hospice aide to support a participating member in their place of residence in lieu of their caregiver. In-Home Respite Care is a supplemental benefit available to the member upon election with an in-network hospice provider.

This is a benefit offered only to members who select an in-network hospice. If a member has any questions regarding this benefit, please direct them to Humana Customer Service 24/7 at 1-800-457-4708 (TTY:711).

DispatchHealth Hospice Partnership - Acute Injury/Illness In-Home Treatment (Select Markets Only)

Understanding the Partnership and Program Aims
Humana and DispatchHealth have created a partnership to bring same-day-in-home medical care to hospice patients for urgent illnesses and injuries that do not require an emergency department visit. This partnership creates a safe alternative to the ED when an acute medical need arises for the member in home, avoiding burdensome transitions to facility for treatment. Additional program aims are as follows: reduce the utilization of ambulance transport, reduce potential inpatient utilization and/or revocation of the hospice benefit and increase the patient's final days spent in-home.

2024 Partnership Markets

- Denver, Colorado
- Atlanta, Georgia
- Richmond, Virginia *(Not Available in Tidewater, Virginia)*
- Cleveland, Ohio
- Louisville, Kentucky
- South Florida, Florida

Conditions that DispatchHealth Treats

- Bronchitis
- Cellulitis
- CHF exacerbation
- COPD exacerbation
- COVID-19 symptoms
- Falls
- Headache / Migraine
- Influenza
- Nosebleeds
- Pneumonia
- Respiratory distress
- Strains, sprains, and minor fractures
- Urinary infections
- Vertigo
- **And more**

Advanced In-Home Treatment Capabilities
DispatchHealth is able to provide services above the usual scope of hospice agencies in-home. Advanced capabilities they are able to provide to support hospice members in the home are as follows:

- Administering IV fluids and medications
- 12 lead EKG
- Laceration repair (simple to complex) sutures or staples
- Incision and drainage of skin lesions
- Advanced blood laboratory testing on-site

- Catheter insertion (Coude, suprapubic)
- Rapid infectious disease testing (flu, COVID-19, strep, mono)
- **And more**

Is there a Member Co-Pay to Utilize Services?
The co-pay for DispatchHealth services will not be collected for purposes of this partnership. **There is a possibility that the member may receive a co-pay if DispatchHealth uses a Humana-approved 3rd party vendor to provide select in-home treatments (i.e. Imaging or labs).*

How do Members and Hospice Agencies Utilize Services?
For purposes of this enhanced partnership, all hospice members are to reach out to their hospice agency to discuss the acute illness/injury prior to engaging DispatchHealth. Hospices are to triage and to attend the member's needs in a timely manner if the acute illness/injury lies within scope of treatment responsibility and the hospice agency is able to provide services. If the hospice agency is not able to provide timely care or the illness/injury requires advanced capabilities, then hospice agency is to instruct member to reach out to DispatchHealth or call DispatchHealth on behalf of the member to initiate services.

How to Contact DispatchHealth?
DispatchHealth Humana hospice concierge number **1-855-439-5053** (Hours of operation 8am – 10pm, 7 days a week, including holidays). This phone number is to be used for the Hospice VBID enrolled hospice members only.

What is DispatchHealth's Commitment to Members?
DispatchHealth aims to treat members within 2 hours of outreach. They will notify the member in advance of their arrival.

What if DispatchHealth is Unable to Treat?
If a member calls into DispatchHealth for an issue that they are unable to treat or that is life threatening, they will escalate via the proper channels. For a life-threatening issue, DispatchHealth will call and arrange for ambulance transport to ED. If treatment is out of scope of their services, they will communicate back to hospice agency of their inability to treat, and hospice agency will be required to coordinate needed care for the member. If DispatchHealth arrives to a member's house for treatment and need to escalate care on-scene, they will call the hospice agency to discuss, and the hospice agency will need to arrange needed services.

How long is DispatchHealth Engaged in Members Care?
DispatchHealth is only engaged to treat the acute illness/injury and member remains under the hospice agencies care the entire time.
How is the Hospice Agency Made Aware of Provision of Services?
DispatchHealth will provide all visit notes and laboratory/imaging results to the Humana Hospice Centralized Team within 24 hours of care or receipt of results. The HHCT team will then provide the documentation to the Hospice agency on record.

How is Billing for Services Handled?
Humana has an established case rate reimbursement with DispatchHealth. DispatchHealth will bill Humana directly for services. Hospice agencies will not be changed for DispatchHealth services. If

DispatchHealth coordinates the need for unrelated services beyond their case rate, the member will be charged the corresponding co-pay/cost-share.

Billing and Claims

Where do I submit claims?
Claims can be submitted through Humana.com using Humana ID 61101. Providers should submit all claims, encounters, and clinical data to Humana by electronic means. Those electronic means accepted as industry standard may include claims clearinghouses or electronic data interface companies used by Humana. Providers using electronic submission must submit all claims to Humana or its designee, as applicable, using the HIPAA-compliant 837 electronic format. Claims must also continue to be submitted to CMS via the MAC. Paper claims should be mailed to Humana Claims, P.O. Box 14601, Lexington, KY 40512-4601.

How do I sign-up/Use the Availity Web Portal?
Claims can also be submitted directly to Humana using the Availity Web portal. Please refer to the Availity Registration and Authentication material located in the Provider Portal (humana.com/hospice) for additional information.

Are there any changes to the four levels of care and regulations regarding the four levels by CMS as they currently exist?
There are no changes to the four levels of care as they are currently being administered by the Centers for Medicare & Medicaid Services (CMS). Humana does not need to be notified when there are changes in the patient's level of care.

What is the process for claims reimbursement?
After timely submission of claims, hospice providers will be reimbursed at 100% of Original Medicare rates. Hospice providers should not submit any claims to members/caregivers and should continue to submit claims through existing process with their Medicare Administrative Contractor (MAC) for these members. Please note the Remittance Advice from Medicare will reflect a Claims Adjustment Reason Code of 96 and a Remark Code MA 73 to indicate this is a MA VBID patient. Humana will pay clean claims within 30 days of receipt. Please refer to the Hospice VBID Billing Tip Sheet document in the Provider Portal (humana.com/hospice) for additional guidance on billing rules that may require a claims adjustment and resubmission.

Does Humana have any caps or limitations on hospice payments?
There are no caps or limitations that will apply on hospice payments during year four of the demonstration period.

Do copays/coinsurance still apply for medications and Inpatient Respite if they are currently part of a member's plan?
Copayments and coinsurance amounts are consistent with existing CMS benefits – 5% of the cost of the drug, but not more than $5 copayment for drugs and biologicals furnished by the hospice on an outpatient basis and 5% coinsurance per day on an inpatient respite care stay.

Does Humana require detailed line-item billing?

Line-item billing will be consistent with benefit manual guidelines. Please refer to the Medicare Claims Processing Manual, Chapter 11 for Hospice Care for additional information.

How do I contact Humana with any billing/payment issues?

Humana Provider Self Service: Benefits/Eligibility, Referrals/Authorizations, Claims, ERA/EFT. Register at www.Availity.com

Humana Claim, Provider Payment Integrity, Code Edit Resolution Process: Claim Payment Inquiry Resolution Guide

Humana Provider Contact Center: Medicare 1.800.457.4708.

Humana Provider Payment Integrity Customer Service: Clinic Audit, Refund and Recoupments, 1.800.438.7885

Humana Pre-Authorization, Referrals and Notifications: www.Availity.com, 1.800.523.0023

Grievances and Appeals

Do members and caregivers have the ability to submit grievances and appeals?

The grievance/appeal process applies to members of Medicare Advantage plans who are dissatisfied with the healthcare services received, or any aspect of the plan, or who have received an adverse determination. Throughout the course of the demonstration, members, authorized representative, and/or physicians are able to submit grievances and appeals for both palliative care and hospice care provided by either in-network or out-of-network providers. Humana will address all concerns on an expedited bases in order to ensure enrollees have timely access to needed care.

How does one submit a grievance and/or appeal?

There are two ways to submit a grievance and/or appeal. The first is by calling the telephone number associated with the member's membership plan (found on the back of their ID card), and the second is via written correspondence. Please reference the Provider Claims Dispute Process and Member Grievance/Appeal Process Document.

If the member makes the decision to appeal a hospice discharge decision and file a BFCC-QIO appeal, the hospice provider should notify the Humana Hospice Centralized Team prior to the discharge.

Contracting and Credentialling

How do I become part of the Humana hospice network?

Incorporation of the Medicare Hospice Benefit into Medicare Advantage demonstration with CMS, Humana will analyze its markets for specific considerations based on a variety of factors and will look to contract with providers who met the desired partnership selection criteria.

The credentialing process utilizes the CAQH (Council for Affordable Quality Healthcare) application service for simple and secure submission of credentialing information. Upon receipt, a thorough review and verification of documentation is completed to determine participation status with our health plan. The documentation may include, but is not limited to, the applicant’s licensure, accreditation, certifications, experience, professional liability insurance, malpractice history and professional competence. Additional reviews include the Medicare Opt-Out list, sanctions report and NPDB report. Policies and procedures can be viewed by providers on Humana.com webpage.

Advancing Health Equity

What is Health Equity?
According to CMMI Health Equity is “the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.”

How is addressing Health Equity a part of the Hospice VBID Demonstration?
The 2024 RFA has required Humana to describe a detailed strategy for advancing health equity as part of its approach to the Hospice Benefit Component. This included questions regarding identification, addressing, and monitoring inequalities that could occur in the access, outcomes, or member experience while in palliative or hospice care. Additionally, Humana outlined our engagement strategy across members, caregivers, and providers to address any potential inequities. To read more about CMMI’s vision of prioritizing health equity please refer to this article.

Who is identified as having inequalities for hospice and palliative care?
CMMI has provided numerous articles in the 2024 RFA to help identify certain underserved populations that are more at risk of inequalities in their healthcare. This population includes, but is not limited to:

- Gender-based and race-based bias in pain assessment and treatment recommendations
- Disparate use of hospice along racial lines
- Gender-based disparities in caregiver burden and their resulting negative impact on the wellbeing of women
- Disparities in the use of palliative and hospice care among the LGBTQ+ population

What is Humana’s Health Equity strategy?
Humana is committed to implementing and operationalizing policies and programs that support health equity and eliminate avoidable differences in EOL care experienced by disadvantaged/underserved members. While continuing to evolve our strategy, we plan to use social determinants of health data to identify members with inequalities in both palliative and hospice care. While in palliative care, we will work with providers upstream of potential election to ensure identified members are educated on hospice care. Once in hospice care, our Hospice Centralized team will collaborate with the member’s hospice care teams to ensure identified members are utilizing supplemental benefits unique to this demonstration to help ease any burdens during their EOL care.

Frequently Asked Questions

Do member’s and caregivers have 24/7 support line?
The 24/7 customer service line can be reached at 1-800-457-4708 (TTY: 711) and is intended to provide education to caregivers and members to help answer any questions around hospice election, providers, and benefits.

To whom at Humana can Providers (Hospice, Referring, etc.) reach out with any questions?
For questions regarding eligibility, network status or member’s benefits, please call Humana Customer Service at 1-800-457-4708 (TTY: 711).

For any clinical related questions providers can reach out directly to Humana's Hospice Centralized Team at 1-800-950-1071 from the hours of 8:00 AM EST – 5:00 PM EST Monday - Friday. Voicemails can be left after working hours and will be returned the next business day. During weekends and national holidays, voicemails will be monitored, and calls will be returned based on urgency.

Should hospices continue to submit HIS Data?
Yes. There are no changes to the current Hospice Item Set (HIS) submission process.

If a member revokes the hospice benefit, or no longer meets criteria, are they eligible to enroll in palliative care?
Humana will apply eligibility criteria to members to ensure they are appropriate for referral back to palliative care after processing termination from the hospice benefit.

What information needs to be provided to Humana during a member's enrollment in Hospice?
Hospices must submit notification to Humana of member having elected hospice care through an outpatient authorization/referral in Availity.com, along with member Signed Election and Consent Statement, NOE, and NOTR forms. Providers will also submit claims to Humana for payment of hospice care. More details can be found in the Billing Tip Sheet file on the Hospice VBID Provider Portal (humana.com/hospice).

Humana's Hospice Centralized Team may reach out for additional documentation at any point during a member's hospice election to support care needs.

How can I reach out to CMS with any questions?
Please contact VBID@cms.hhs.gov directly with questions about Hospice Value Based Insurance Design Model.

Where can I read/review Humana specific policies?
Please refer to Humana.com/provider to review guidelines and policies. Humana's Provider Manual can be found here.