



2026

Provider Manual

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I. Overview of Healthy Mississippi

A. Overview

Welcome to Healthy Mississippi. Thank you for joining our network of participating physicians, hospitals, and other healthcare professionals. This Provider Manual is a reference guide for providers and their staff who provide services to members with Medicare Advantage benefits.

Purpose of this manual: Healthy Mississippi and all provider types including, but not limited to, physicians, hospitals, and ancillary healthcare providers (hereinafter collectively and/or individually, as the context requires, referred to as “provider(s)).

This manual furnishes all such participating providers and their office staff with important information concerning Healthy Mississippi policies and procedures, claims submission and adjudication requirements, and guidelines used to administer Healthy Mississippi health plans. Other policies and procedures are posted online. State-specific Medicaid provider manuals (sometimes referred to as appendices) are also available and may contain additional information. This manual replaces and supersedes any other previous versions and is located on HealthyMississippi.com. A paper copy may be obtained at any time upon written request to [HealthyMississippi](mailto:HealthyMississippi@healthyms.com). Any capitalized terms not otherwise defined herein shall have the meaning as outlined in the agreement.

Except as may otherwise be outlined in the agreement, providers are contractually required to comply with all provisions contained in this manual. However, in the event of a conflict between the obligations, terms, and conditions of the participation agreement and this manual, the obligations, terms, and conditions in the agreement shall be controlled.

Revisions to this manual constitute revisions to Healthy Mississippi’s policies and procedures.

Variations in applicable laws, regulations and governmental agency guidance including, but not limited to, state or federal laws, regulations and/or changes to such laws, regulations or guidance may create certain requirements related to the content in this manual that are not expressly outlined in this manual. Any requirements under applicable law, regulation, or guidance that are not expressly outlined in the content of this manual shall be incorporated herein by this reference and shall apply to providers and/or Healthy Mississippi where applicable. Such laws and regulations, if more stringent, take precedence over the content in this manual. Providers are responsible for complying with all laws and regulations that are applicable.

Note: State laws and/or regulations do not affect the adjudication of claims for Medicare Advantage members.

Healthy Mississippi may deny payment for any services or supplies for which a provider failed to comply with Healthy Mississippi’s policies and procedures.

Responsibility for Provision of Medical Services: Providers are independent contractors and are solely responsible to members for the provision of health services and the quality of those services. This means providers and Healthy Mississippi do not have an employer-employee, principal-agent, partnership, joint venture or similar arrangement. It also means that providers have a duty to

exercise independent medical judgment to make independent healthcare treatment decisions, regardless of whether a health service is determined to be a covered service. Nothing in the agreement or this manual is intended to create any right for Healthy Mississippi to intervene in the provider's medical decision-making regarding a member. Additionally, providers are responsible for the costs, damages, claims and liabilities that arise out of their own actions. Healthy Mississippi does not endorse, or control clinical judgments or treatment recommendations made by providers.

Healthy Mississippi requires preauthorization with respect to certain services and procedures. Healthy Mississippi's preauthorization determination relates solely to administering its plans and is not, nor should it be construed to be, a medical decision. The provider, along with the members, makes the decision whether the services or procedures are provided.

Medical Directors: Medical directors serve as the major interface between healthcare organizations and participating providers, as well as other healthcare providers in the community. The medical director is not engaged in the practice of medicine while acting in the medical director role. The role is invaluable in establishing a provider network and facilitating provider participation and cooperation. The medical director's responsibilities include, but are not limited to, the oversight of:

- Quality management programs required by federal or state law or accrediting agencies
- Healthy Mississippi health programs
- Credentialing
- Utilization management (UM)/health services

Healthy Mississippi Plan: Healthy Mississippi plan offers a Medicare Advantage Plan. For more information, contact the Provider Relations team at 1-833-218-8492

QUESTIONS OR COMMENTS: Questions or comments about this manual should be directed to the provider representative in the local Healthy Mississippi market office. Any suggestions regarding this manual or its contents should be directed to:

Healthy Mississippi, Inc.
10996 Four Seasons Place
Suite 100C
Crown Point, IN 46307

II. Contact Information

Website

Network providers may visit Healthy Mississippi's website at <https://www.healthy-ms.com> to log into the web portal for administrative and informational needs pertaining to Healthy Mississippi. Healthy Mississippi's website offers a variety of information resources, including Healthy Mississippi's drug list. The Healthy Mississippi Provider Portal (registration required) features transactional capabilities, such as member eligibility verification, claims status, preauthorization requests, referral submissions, and medical records management.

Healthy Mississippi Website <https://www.healthy-ms.com> (No Registration is Required)

- Provider Medicare Information: Provides more information about plans offered in specific areas.
- Preauthorization List: Provides a comprehensive list of services and medications outlining which services and plans require preauthorization or notification.
- Provider Appeal Process: Provides an explanation of the appeals process for physicians and other healthcare providers.
- Credentialing Services: Council for Affordable Quality Healthcare (CAQH) – Provides a link to CAQH’s Universal Credentialing Data source.
- Resources for Healthy Mississippi insured Patients: Learn more about services that may benefit patients with Healthy Mississippi plans.
- Prescription Tools and Resources: Learn more about Healthy Mississippi’s pharmacy programs by using the drug list.

Healthy Mississippi Provider Portal: <https://qualexahc.vbagateway.com/> (Registration is Required)

After going to the Healthy Mississippi website, please hover over the Provider tab and select Provider Portal. This will redirect you to <https://portal.smartdatastream.us>. Provider Portal offers online tools to help healthcare professionals to streamline administrative tasks. After registration has been completed, the following may be accessed:

- Eligibility and benefits inquiry (including out-of-pocket accumulators)
- Referral/authorization submission, modification and inquiry
- Claims status inquiry
- Remittance advice inquiry and download
- Online electronic claims submission

Contact Us

Case Management:

Refer to the Population Health Management section for more detailed information.

Fraud, Waste and Abuse:

Healthy Mississippi Hotline: 601-213-3118

Healthy Mississippi Customer Service:

Call 1-833-218-8492 or call the number listed on the back of the member’s ID card for assistance regarding:

- Benefits
- Eligibility
- Claims

- Copayments
- Grievances and/or Appeals
- Provider Directory Concerns

Member Eligibility Inquiries:

- Customer Service: 1-833-218-8492. Hours of Operation: 8:00 am – 8:00 pm CST

Note: A copy of the Medicare enrollment form may serve as verification of eligibility for Medicare members who have not received their member ID card at the time of service. Members may not be denied covered, medically necessary medical services.

Healthy Mississippi verification of eligibility does not guarantee payment. If Healthy Mississippi subsequently learns that the member was ineligible on the verification date, no payment will be made. Therefore, providers must always ask a patient for his or her most recent insurance status.

Preauthorization:

Access the Provider Portal at <https://qualexahc.vbgateway.com/> where you can complete the preauthorization process for many services online or call Customer Service for assistance.

- Customer Service: 1-833-218-8492

Provider Relations:

Telephone 1-833-218-8492. Hours of Operation: 8:00 am – 8:00 pm CST

Seva Care of MS

Provider Relations Department

Telephone Number: 1-833-218-8492

Referrals:

Telephone: 1-833-218-8492. Referrals also may be submitted electronically via the Healthy Mississippi Provider Portal at <https://qualexahc.vbgateway.com/>

III. Claims Procedures

Checking Member Eligibility

To check eligibility via the web: If the provider is registered for the Healthy Mississippi Provider Portal, a specific member's eligibility can be checked online by entering the subscriber's identification (ID) number and date of birth.

If a provider is not yet registered on the Healthy Mississippi Provider Portal, go to <https://www.healthy-ms.com>, please hover over the Provider tab, and select Provider Portal to register. Follow the prompts to complete the online registration process.

To check eligibility via the phone:

- Call Healthy Mississippi Customer Service at 1-833-218-8492 or the number listed on the back of the member’s ID card.
- Provide the subscriber’s identification number and other authentication information.

Seva Care of MS is a provider network, **not an insurance company, health plan administrator, or other payer, and**, therefore, does not verify member eligibility and benefits. The member ID card bears the name and logo of the insurance company or plan administrator to contact to verify member benefits and eligibility. The verification phone number and/or Website address also can be found on the member ID card.

Member Identification (ID) Card

The member identification (ID) card is issued to members upon enrollment and contains information regarding telephone numbers for questions regarding benefits. Members have been issued unique member identification (UMID) numbers that are assigned by Healthy Mississippi.

Note: To avoid potential problems with identity theft or fraud, ask the member for a separate form of identification, Such as his/her driver’s license, along with the member ID card.



When applicable, a copayment is collected from the member at the time of service. Providers should have a timely process in place to refund members any difference between their copayment and the allowable amount for the office visit (in instances when the allowed amount is less than the copay collected) when Healthy Mississippi processes the claim. For assistance with questions, please contact Healthy Mississippi Customer Service at the number listed on the back of the member’s ID card.

Medical Coverage Policies, Clinical Trials

Healthy Mississippi's medical coverage policies are available on the Provider Portal (See "Utilization Management, Clinical Review Guidelines" for further information about Healthy Mississippi's medical coverage policies. The medical coverage policy specific to clinical trials contains the details on the codes that are to be billed when services are provided as part of a clinical trial. For claims to be paid properly, a provider must include these codes on the claim's submission.

Claims Submission and Processing

Claims Submission: Unless applicable law provides that submissions may be in paper format, providers must submit all claims, encounters, and clinical data to Healthy Mississippi by electronic means. Those electronic means accepted as industry standards may include claims clearinghouses or electronic data interface companies used by Healthy Mississippi. Providers using electronic submission must submit all claims to Healthy Mississippi or its designee, as applicable, using the HIPAA-compliant 837 electronic format. When the 837 standard electronic format requires the submission of a taxonomy code from one or more providers, a taxonomy code must be submitted for each provider, and the taxonomy code must be the code most appropriate for that provider and the services provided.

The provider acknowledges that Healthy Mississippi may market certain programs and/or products that will require electronic submission of claims and clinical data in order for the provider to participate. Providers must notify Healthy Mississippi when they have completed their transition to electronic medical records and agree to provide information on the status to Healthy Mississippi upon request. Unless applicable law mandates that submission may be in paper format, provider must submit to Healthy Mississippi all Healthy Mississippi required clinical data (including, but not limited to, laboratory data) by available electronic means within 30 days of the date of service or within the time specified by applicable law.

When submission of a paper format is permissible, providers must submit claims using an original CMS-1500 and/or an original UB-04 form, or their successors.

Healthy Mississippi expects that all services resulting in the generation of a lab result require the provider to submit the corresponding lab results data electronically to Healthy Mississippi within 30 days of the member's date of service. The lab results data must be submitted electronically in Healthy Mississippi standard layout that is located on the Provider Portal (Healthy Mississippi) and include the correct Logical Observation Identifiers Names and Codes (LONIC) and other values associated with the result in the correct data format as outlined in Healthy Mississippi standard layout. Submission must be made through one of Healthy Mississippi approved methods as outlined on the Healthy Mississippi provider website. Provider's failure to comply with claims, encounters and lab results data submission guidelines may result in a reduction of the amount, if any, which otherwise would be due under this agreement for the service.

This data will be used within the guidelines allowed by HIPAA and the Genetic Information Nondiscrimination Act (GINA) and applicable state laws, if any. This data allows Healthy

Mississippi to comply with accreditation and regulatory requirements established by CMS, the National Committee for Quality Assurance (NCQA) and/or other regulatory agencies. This data also may be used to establish member clinical profiles, to more easily and quickly predict disease progression and reduce acuity, as well as to calculate Healthcare Effectiveness Data and Information Set (HEDIS) qualitative scores and other member-related initiatives.

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:

Healthy Mississippi Medical Claims and Encounters
Healthy Mississippi Claims Office
P O Box 21069
Eagan, MN 55121

Electronic Payer ID: 99914

Note: No claim is complete for a covered service and/or no reimbursement is due for a covered service unless provider's performance of that covered service is fully and accurately documented in the member's medical record prior to the initial submission of the claim.

Prompt Payment of Claims: A claim is deemed to have been adjudicated promptly if it has been paid, pended for review (when applicable under state guidelines), or denied within the time established by the applicable state or federal prompt payment statutes and/or regulations. To assure that a claim is processed promptly and within a timely manner, the following criteria must be satisfied upon the claim's submission to Healthy Mississippi:

- The claim must be submitted either electronically or by paper if permitted by applicable law.
- The claim must be "complete" and must qualify as a "clean claim."
- Complete – the information provided in the claim must be sufficient to substantiate the services rendered to the Healthy Mississippi member.
- Clean claim – the claim must satisfy the description set forth in state or federal law, as applicable, based upon the type of plan.
- A member's original signature, or a "signature on file" or "assignment on file" stamp is required for payments made directly to the provider.

Note: The provider must maintain a valid written assignment of benefits from the member on file. This will serve as evidence that the provider is entitled to all payments for service. Healthy Mississippi reserves the right to review the original signed assignment document at any time.

- Separate charges must be itemized on separate lines. Medical record documentation must validate the scope of services provided and billed.

The time frame for submitting claims is listed below, if not otherwise specified by the agreement or applicable state or federal law:

- Medicare lines of business: one (1) calendar year from date of service

Specialist Providers: Reimbursement for specialist services is dependent upon referral authorization and corresponding documentation. All specialist claims must include a referral authorization number, when applicable, or an inpatient authorization number. The referral authorization or inpatient authorization number must be shown in Box 23 of the CMS-1500 Claim Form or Box 64 of the UB04 Claim Form or loop 2300/REF02 segment which is the equivalent electronic submission field. For additional information, see the Referrals heading of this manual.

Note: If the referral authorization number is not on the claim, the claim may be rejected. The member may not be balance billed for this type of rejected claim.

Inpatient Specialty Services: Depending on the type of plan, claims for inpatient treatment may require an inpatient authorization number. If the physician is not the admitting physician, the authorization number is obtained from the member's chart, member's primary care office, IPA, delegated entity or Healthy Mississippi Customer Service.

Note: If the inpatient authorization number is not on the claim, the claim may be rejected. The member may not be balance billed for this type of rejected claim.

Requests for Review of Denied Claims: Providers may request a review of claim payment denials by the plan(s). To obtain a review, providers must call Healthy Mississippi Customer Service at the number listed on the back of the member's ID card or send a written request to the appropriate Healthy Mississippi claims address. For additional information, see the Provider Claims Dispute Process section of this manual.

Claims Processing Procedures: Healthy Mississippi will process accurate and complete provider claims in accordance with Healthy Mississippi normal claims processing procedures, including, but not limited to, claims processing edits and claims payment policies, and applicable state and/or federal laws, rules and regulations.

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

- The complexity of a service
- Whether a service is one of multiple same-day services such that the cost of the service to the provider is less than if the service had been provided on a different day. For example:
 - Two or more surgeries performed the same day
 - Two or more therapy services performed the same day
- Whether an assistant surgeon, surgical assistant or any other provider who is billing independently is involved

- When a charge includes more than one claim line, whether any service is part of or incidental to the primary service that was provided, or if these services cannot be performed together
- Whether the service is reasonably expected to be provided for the diagnosis reported
- Whether a service was performed specifically for the member
- Whether services can be billed as a complete set of services under one billing code

Healthy Mississippi develops claims processing procedures based on review of one or more of the following sources, including, but not limited to:

- Medicare laws, regulations, manuals and other related guidance
- Federal and state laws, rules and regulations, including instructions published in the Federal Register
- National Uniform Billing Committee (NUBC) guidance including the UB-04 Data Specifications Manual
- American Medical Association's (AMA) Current Procedural Terminology (CPT®) and associated AMA publications and services
- CMS' Healthcare Common Procedure Coding System (HCPCS) and associated CMS publications and services
- International Classification of Diseases (ICD)
- American Hospital Association's (AHA) Coding Clinic Guidelines
- Uniform Billing Editor
- American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services
- Food and Drug Administration (FDA) guidance
- Medical and surgical specialty societies and associations
- Industry-standard utilization management criteria and/or care guidelines
- Our medical and pharmacy coverage policies
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published peer reviewed literature

Changes to any one of the sources may or may not lead Healthy Mississippi to modify current or adopt new claims processing procedures.

These claims processing procedures may result in an adjustment or denial of reimbursement, a request for the submission of relevant medical records, prior to payment, or the financial recovery of a previous reimbursement.

Providers may submit a dispute request of any adjustment produced by these claims processing procedures by submitting a timely request to Healthy Mississippi. For additional information, see the Provider Claims Dispute Process section of this manual.

Pass-through Billing: Healthy Mississippi prohibits pass-through billing. Pass-through billing occurs when a provider bills for a service for which neither that provider nor any individual under that provider's direct employment performed that service. Provider agrees that pass-through billing services will not be eligible for reimbursement from Healthy Mississippi and provider shall not bill, charge, seek payment or have any recourse against Healthy Mississippi or members for any amounts related to the pass-through billing provision.

Discarded Drugs

Healthy Mississippi requires the following JW/JZ Modifier supporting documents for Part B Claims:

Supporting Document / Information Required for JW Modifier:

- Name of the specific drug and total amount in the single-use container
- The amount of the drug administered to patient
- The discarded amount identifying the exact amount of the drug that was wasted.
- The date and time of the administration and wastage of drug
- Reason for wastage

Supporting Document / Information Required for JZ Modifier:

- Name of the specific drug and total amount in the single-use container
- Record of the administered dose confirming the entire amount of drug was administered.

General Documentation:

- Patient Information: All pages of the records must include the patient's identification details such as full name and date(s) of service.
- Records must include legible signatures of the physician or other non-physician provider responsible for the patient's care.
- Medical Necessity documentation to support services provided including clinical notes and/or prior authorization
- ICD codes selected in the claim
- HCPCS code accurately describing the service performed

Additional Documentation:

- Detailed invoice or receipt showing drug cost

Reimbursement

Payment terms are defined in the agreement. Additionally, the amount of payment for services provided may be affected by one or more of the following factors including, but not limited to:

- Member's eligibility at the time of service

- Whether services provided are covered by the member's plan
- Whether services provided are medically necessary, as required by the member's plan
- Whether services provided require prior approval by the member's plan
- Amount of the provider's billed charges
- Member copayments, coinsurance, deductibles and other cost-share amounts due from the member
- Coordination of benefits with third-party payers as applicable
- Adjustments of payments based on claims processing procedures described in the "Claims Processing Procedures" subheading in this manual
- Adjustments of payments based on provider payment integrity policies which can be found on the Healthy Mississippi website, providers' section

Healthy Mississippi applies site-of-service payment differentials, based on applicable contract, to the reimbursement of physician or other healthcare professional services. Additionally, Healthy Mississippi does not reimburse a physician or other healthcare professional for the technical component of a service provided to a member registered as an inpatient or outpatient at a hospital or other facility.

A provider who receives reimbursement for services rendered to a Healthy Mississippi Medicare Advantage member must comply with all federal laws, rules and regulations applicable to individuals and entities receiving federal funds, including without limitation Title VI of the Civil

Rights Act of 1964, Rehabilitation Act of 1973, Age Discrimination Act of 1975 and the Americans with Disabilities Act of 1990.

Nothing contained in the agreement, or this manual is intended by Healthy Mississippi to be a financial incentive or payment which directly or indirectly acts as an inducement for providers to limit medically necessary services.

Note: Additional information may justify additional payment for some claims submitted by physicians and other healthcare professionals. For example, a provider's clinical notes may establish that a procedure initially determined as incidental to another procedure involved distinct and significant provider efforts during provider's encounter with the member.

Request for Claims Dispute: If a provider disagrees with how Healthy Mississippi has adjudicated a claim, the provider should follow the procedures set forth in the "Claims Processing Procedures" subheading in the manual regarding provider claims dispute or any applicable state laws.

Balance Billing: Providers must accept payment in full from Healthy Mississippi payment for covered services provided to health plan members in accordance with the reimbursement terms outlined in the agreement. Members are responsible for applicable copayment, coinsurance and deductible amounts. For covered services, providers may not balance bill members for an amount other than their applicable copayment, coinsurance and/or deductible responsibilities. Subject to the limitation for services provided to a Medicare Advantage plan member, discussed below, a provider is not prohibited by the agreement from collecting from health plan members for a service not covered under the terms of the applicable member plan. A reduction in payment because of claims processing procedures is not an indication that the service provided is a non-covered service.

Note: For a Medicare Advantage plan member, a provider may only collect for a service not covered under the terms of the applicable member plan if the provider followed the procedures outlined in the Utilization Management/ Preauthorization (Prior Authorization) section of this manual.

Services Which Are Not Medically Necessary: Provider agrees that, when Healthy Mississippi determines that rendered services covered under the terms of the applicable member plan were not medically necessary, provider shall not bill, charge, seek payment or have any recourse against member for such services.

Overpayments: Healthy Mississippi Provider Payment Integrity

1. Overview

Healthy Mississippi strives to offer our members high-quality healthcare at affordable rates. To facilitate this objective, Healthy Mississippi Provider Payment Integrity (PPI)

reviews Healthy Mississippi claims payments for accuracy and requests refunds if claims are overpaid or paid in error.

2. Contacts, General Inquiries and Escalations:

For more information on how to resolve recoupment concerns, such as overpayments, financial recovery reviews, disputes and medical record requests, please call Healthy Mississippi Customer Service at 1-833-218-8492.

3. Healthy Mississippi operates a review program to detect, prevent and correct fraud, waste and abuse and to facilitate accurate claim payment

IV. Utilization Management

The Utilization Management program involves implementing utilization review processes to ensure the quality, appropriateness, and efficiency of care and resources. Utilization Management encompasses prior authorization, concurrent review, retrospective review, and discharge planning. Healthy Mississippi implements and administers the program in accordance with the regulatory requirements of the Centers for Medicare and Medicaid Services (CMS).

The goal is to improve the member experience, enhance the quality of care, reduce healthcare costs, and enhance the provider experience.

Preauthorization (Prior Authorization)

“Preauthorization” is defined as a process through which the physician or other healthcare provider is required to obtain advance approval from the plan for any covered item or service. Preauthorization applies to all elective and/or scheduled services on Healthy Mississippi’s preauthorization list and must be obtained before the services are rendered.

Preauthorization or notification is requested for certain medications and medical services under most Healthy Mississippi plans. Requests should be made as soon as possible but at least ten days prior to the proposed service date. Services that require preauthorization can be found on our website. Providers should review the Healthy Mississippi preauthorization and notification list on our website or call Customer Service at 1-833-201-6413 to obtain a copy of the preauthorization and notification list.

Healthy Mississippi’s preauthorization and notification list is subject to change. New-to-market drugs may be added to the list of medications which require review. Healthy Mississippi also reviews and may update the preauthorization and notification list at least biannually. Changes to the preauthorization list outside of the new-to-market drugs are communicated through notices to providers in accordance with provider agreements.

Emergent/Urgent care services do not require preauthorization. However, providers should notify Healthy Mississippi within one calendar day of the initiation of these services.

If a healthcare provider does not obtain preauthorization for a service, it could result in financial penalties/payment denials for the practice and reduced benefits for the patient, based on the healthcare provider's contract and the patient's certificate of coverage.

Services or medications provided without preauthorization may be subject to retrospective medical necessity review – a written summary of medical necessity and services provided stating why proper authorization was not obtained must be submitted by the provider.

We recommend that an individual practitioner making a specific request for services or medications verify benefits and preauthorization requirements with Healthy Mississippi prior to providing services.

Notification

“Notification” refers to the process in which the physician or other healthcare provider notifies Healthy Mississippi of the intent to provide an item or service. Healthy Mississippi requests notification as it helps coordinate care for your Healthy Mississippi covered patients. This process differs from preauthorization as Healthy Mississippi does not issue an approval or denial related to a notification.

How to Request a Preauthorization

To initiate a preauthorization or notification request, a provider may:

- Visit Healthy Mississippi UM Portal at <https://qualexma.cgt.us/>
- Call the number for precertification on the back of the member's ID card
- Fax the request to 1-662-350-0412

When a member's life, health or ability to regain maximum function is in serious jeopardy, you should immediately submit an expedited authorization request by calling 1-833-218-8492 for assistance.

Information Required

Information required for a preauthorization request or notification may include but is not limited to:

- Member's ID number, name and date of birth
- Date of actual service or hospital admission
- Procedure codes, up to a maximum of 10 per authorization request
- Date of proposed procedure, if applicable
- Diagnosis codes (primary and secondary), up to a maximum of six per authorization request
- Service location – inpatient or outpatient
- Tax ID number of treatment facility where service is being rendered
- Tax ID number of the provider performing the service
- Applicable ICD diagnosis code

- Caller's telephone number
- Attending physician's telephone number
- Relevant clinical information
- Discharge plans

Submitting all relevant clinical information at the time of the request will facilitate a more expeditious determination. If additional clinical information is required, a Healthy Mississippi representative will request the specific information needed to complete the authorization process.

For Medicare Advantage (MA) plans: Advanced Coverage Determinations (ACD)/Predeterminations and Advanced Beneficiary Notice (ABNs)

CMS does not permit providers to use the Advanced Beneficiary Notice (ABN) for a Medicare Advantage plan enrollee. However, as with Original Medicare, if a provider believes that a specific service might not be covered, CMS expects the provider to share that information with the member before providing the service. CMS mandates that providers contracted with a Medicare Advantage plan are not permitted to hold a Medicare Advantage member financially responsible for payment of a service not covered under the member's Medicare Advantage plan unless that member has received an Advanced Coverage determination notice of denial

Before providing a service that might not be covered, you should call Healthy Mississippi to request an ACD/predetermination, unless the member's plan certificate clearly indicates that the service is one that is never covered.

For procedures or services that are investigational, experimental or may have limited benefit coverage, or for questions regarding whether Healthy Mississippi will pay for any service, you may request an ACD on behalf of the patient prior to providing the service. You may be contacted if additional information is needed.

ACDs for medical services may be initiated by submitting a written request, fax or telephone request:

Send written requests to the following:

Healthy Mississippi, Inc.
Correspondence
P.O. Box 240359
Apple Valley, MN 55124

Submit by fax: 1-888-710-8090
Submit by telephone: 1-833-218-8492

ACDs for medications on the list may be initiated by submitting a fax or telephone request:

Submit by fax: 1-888-710-8090
Submit by telephone: 1-833-218-8492

Emergency Services

Emergency Services are covered inpatient and outpatient services that are:

- Furnished by a Provider qualified to furnish emergency services
- Needed to evaluate or stabilize an Emergency Medical Condition

It is Healthy Mississippi's policy that emergency services are covered:

- Regardless of whether services are obtained within or outside the network of available Providers.
- Regardless of whether there is prior authorization for the services. In addition:
 - No materials furnished to Members (including wallet card instructions) may contain instructions to seek prior authorization for emergency services. As noted in the Member Handbook, Members have a right to call **911** at their discretion.
 - No materials furnished to Providers, including contracts, may contain instructions to Providers to seek prior authorization before the Member has been stabilized.
- In accordance with a prudent layperson's definition of "emergency medical condition" regardless of the final medical diagnosis.

Referrals

If a member requires specialized treatment beyond the scope of a primary care physician (PCP), the member may be referred to a specialist for consultation and/or treatment, Healthy Mississippi contracts with specialists in the plan's service area.

The PCP initiates the referral by submitting a referral request through the Provider Portal at <https://qualexahc.vbgateway.com/>

Methods for submitting referral requests are outlined in the "Preauthorization" section above. The primary care physician (PCP) will receive a referral number from Healthy Mississippi if the referral request is: 1) Completed and Healthy Mississippi determines the services are covered under the provider agreement; 2) Provided by an approved provider/facility; and 3) Medically necessary.

An approved referral number does not override member eligibility, provider agreement exclusions, etc. Prior to the specialist rendering services, preauthorization must also be obtained by the specialist for any additional medications or medical services on the preauthorization and notification list.

The status of a referral can be verified by accessing the Provider Portal at <https://qualexahc.vbgateway.com/> or by calling Customer Service at 1-833-218-8492. After the member has been treated, the specialist's findings, diagnosis and recommendation for treatment should be sent to the member's PCP. The specialist must also submit claim/encounter data to Healthy Mississippi.

Preauthorization for medications and medical services on the preauthorization and notification list is required.

Note: Original Medicare does not cover some services or supplies when they are ordered/referred unless certain requirements (e.g., qualifications of the ordering/referring provider, billing requirements) are satisfied. For Medicare Advantage members, Healthy Mississippi follows Original Medicare billing and enrollment requirements for services and supplies covered under Original Medicare.

Inpatient Coordination of Care/Concurrent Review

Concurrent review is the process that determines coverage during the inpatient stay, including, but not limited to, acute inpatient facility, skilled nursing facility (SNF), long-term acute care hospital (LTAC), inpatient rehabilitation facility, and behavioral health partial hospital/residential treatment facilities. Each admission will be reviewed for medical necessity and compliance with contractual requirements. Healthy Mississippi will contact the provider if additional clinical review is required. In addition to the information provided for the initial admission, providers should indicate any complicating factors that prevent discharge. Providers must also contact Healthy Mississippi with the discharge date and discharge disposition upon member discharge.

If coverage guidelines for an inpatient stay are not met and/or the member's certificate does not provide the benefit, a licensed medical professional from Healthy Mississippi will consult with the PCP and/or facility utilization management and discharge planning staff. If necessary, the licensed medical professional will refer the case to a Health plan medical director for review and possible consultation with the attending physician. Should the medical director determine that coverage guidelines for continued hospitalization are no longer validated, the member, attending physician, hospital, and the member's primary care office, as appropriate, will be notified in writing that benefits will not be payable if the member remains in the hospital on and after the effective date of the non-approval.

Discharge Planning

The Healthy Mississippi UM team collaborates with the member/member's family or guardian, the hospital's UM and discharge planning departments and the member's attending physician/PCP to facilitate the member's discharge plan, including identifying the most appropriate post-discharge level of care.

Discharge planning begins upon notification of the Member's inpatient status to facilitate continuity of care, post-hospitalization services, referrals to a SNF or rehabilitation facility, evaluating for a lower level of care and maximizing services in a cost-effective manner. As part of the UM process, Healthy Mississippi will help coordinate the transition of Member care from one level of care to another. The discharge plan will include an evaluation of the Member's health needs and identification of the services and supplies required to facilitate appropriate care following discharge.

Some of the services involved in the discharge plan include, but are not limited, to:

- DME

- Transfers to an appropriate level of care, such as a long-term acute care facility (LTAC) or SNF
- Home healthcare
- Medications
- Physical, occupational, or speech therapy (PT, OT, ST)

Special Requirements for Hospitals – Medicare Advantage (MA) Plan Members

Hospital Discharge Rights for Medicare Advantage Members

The Centers for Medicare & Medicaid Services (CMS) requires that hospitals deliver the Important Message from Medicare (IM), CMS-R-193, to all Medicare beneficiaries, including Medicare Advantage (MA) plan members who are hospital inpatients. Hospitals are required to provide the IM to the MA member upon admission and at least two days prior to the anticipated last covered date. The notice must be given on the standardized CMS IM form. The form and instructions regarding the IM may be found on the CMS website at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>.

The IM informs hospitalized MA beneficiaries about their hospital discharge appeal rights. MA members who are hospital inpatients have the statutory right to request an “immediate review” by a quality improvement organization (QIO) when Healthy Mississippi, along with the hospital and physician, determines that inpatient care is no longer necessary.

Guidelines for Important Message from Medicare (IM) notification by telephone:

If the hospital staff is unable to personally deliver the IM to the patient or his or her representative, then the hospital staff should telephone the patient or representative to advise him or her of the member’s rights as a hospital patient, including the right to appeal a discharge decision.

At a minimum, the telephone notification should include:

- The name and telephone number of a contact at the hospital
- The beneficiary’s planned discharge date and the date when the beneficiary’s liability begins
- The beneficiary’s rights as a hospital patient, including the right to appeal a discharge decision
- How to get a copy of a detailed notice describing why the hospital staff and physician believe the beneficiary is ready to be discharged

- A description of the steps for filing an appeal
- When (by what time/date) the appeal must be filed to take advantage of the liability protections
- To whom to appeal, including any applicable name, address, telephone number, fax number or other method of communication the entity requires to receive the appeal in a timely fashion

Note: The date that the hospital staff conveys this information to the representative, whether in writing or by telephone, is the date of receipt of the notice.

The hospital is required to:

- Confirm the telephone contact by written notice mailed to the member's authorized representative on that same date.
- Place a dated copy of the notice in the member's medical file and document the telephone contact with either the member or his or her representative on either the notice itself or in a separate entry in the member's file.
- Ensure that the documentation indicates that the staff person told the member or representative the planned discharge date, the date that the beneficiary's financial liability begins, the beneficiary's appeal rights and how and when to initiate an appeal.
- Ensure that the documentation includes the name of the staff person initiating the contact, the name of the member or representative contacted by phone, the date and time of telephone contact and the telephone number called.

When direct phone contact with a member or a member's representative cannot be made, the hospital must:

- Send the notice to the member or representative by certified mail, return receipt requested or via another delivery method that requires signed verification of delivery. The date of signed verification of delivery (or refusal to sign the receipt) is the date received.
- Place a copy of the notice in the member's medical file and document the attempted telephone contact to the member or representative.
- Ensure that the documentation includes:
 - The name of the staff person initiating the contact
 - The name of the member or member's representative
 - The date and time of the attempted call
 - The telephone number called

Right to Appeal a Hospital Discharge:

When members choose to appeal a discharge decision, the hospital or their Medicare health plan must provide them with the Detailed Notice of Discharge (DND). These requirements were published in a final rule, CMS-4105-F: Notification of Hospital Discharge Appeal Rights, which became effective on July 2, 2007.

When the QIO notifies the hospital and Healthy Mississippi of an appeal, Healthy Mississippi will provide the hospital with a DND. The hospital is responsible for delivering the DND as soon as possible to the member or his or her authorized representative on behalf of Healthy Mississippi, but no later than noon local time of the day after the QIO notifies Healthy Mississippi or the hospital of the appeal. The facility must fax a copy of the DND to the QIO and to Healthy Mississippi.

If the member misses the time frame to request an immediate review from the QIO and remains in the hospital, he or she may request an expedited reconsideration (appeal) through Healthy Mississippi appeals department. For more information about notification of termination requirements, practitioners may visit the CMS website at <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>.
Medicare Outpatient Observation Notice (MOON) Requirement

The Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE ACT) Public Law 114-42 was passed on Aug. 6, 2015 and amended Section 1866(a)(1) of the Social Security Act. The amendment requires hospitals and critical access hospitals (CAHs) to provide the Medicare Outpatient Observation Notice (MOON) to Original Medicare beneficiaries and Medicare Advantage (MA) plan members or their authorized representatives. This includes beneficiaries who do not have Part B coverage, beneficiaries who are subsequently admitted as an inpatient prior to the required delivery of the MOON and beneficiaries for whom Medicare is the primary or secondary payer. The MOON is intended to inform beneficiaries who receive observation services for more than 24 hours that they are outpatients, not inpatients and the reasons for their status.

Important information:

- Effective as of March 8, 2017, hospitals and CAHs are responsible to provide the written MOON and a verbal explanation of the notice to all Original Medicare and MA beneficiaries who receive outpatient observation services for more than 24 hours.
- The MOON must be provided to the beneficiary (or the beneficiary's authorized representative) no later than 36 hours after observation services begin and may be delivered before a beneficiary receives 24 hours of observation services as an outpatient.
- If the beneficiary is transferred, discharged or admitted, the MOON still must be delivered no later than 36 hours following initiation of observation services.

- The start time of observation services is measured as the clock time observation services are initiated in accordance with a physician's order.
- Hospitals and CAHs must use the Office of Management and Budget (OMB)-approved MOON (CMS-10611) and instructions available on the CMS website at <http://www.cms.gov/Medicare/Medicare-General-Information/BNI> (opens in new window).

Additional information about the MOON can be found on the CMS Medicare Learning Network site (MLN Matters Number: 9935) at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9935.pdf>

Special Requirements for Skilled Nursing Facilities (SNFs), Home Health Agencies (HHA) and Comprehensive Outpatient Rehabilitation Facilities (CORFs) – Medicare Advantage (MA) Plan Members

Notice of Medicare Non-Coverage (NOMNC):

The Centers for Medicare & Medicaid Services (CMS) requires that physicians and other healthcare providers give the Notice of Medicare Non-Coverage (NOMNC) to Medicare Advantage (MA) health plan members at least two days prior to termination of skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services. Additionally, if the member's SNF services are expected to be fewer than two calendar days, the NOMNC should be delivered at the time of admission. For HHA or CORF services, the notice needs to be given no later than the next to the last time services are furnished. The NOMNC informs members how to request an expedited determination from their quality improvement organization (QIO) if they disagree with the termination.

The form and instructions regarding the NOMNC are available on the CMS website at: <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html> Practitioners also may contact their QIO for forms or additional information. A form may also be obtained from Healthy Mississippi health services utilization management department. No modification of the text on the CMS NOMNC is allowed. For the NOMNC to be valid:

- The member must be able to comprehend and fully understand the notice contents.
- The member or his or her authorized representative must sign and date the notice as proof of receipt.
- The notice must be the standardized CMS NOMNC form.

If a member refuses to sign the NOMNC, the member's refusal to sign, the date, time, name of person who witnessed the refusal and his or her signature must be documented on the NOMNC. Valid delivery does not preclude the use of assistive devices, witnesses or interpreters for notice delivery. Any assistance used with delivery of the notice also must be documented. If a member is not able to comprehend and fully understand the NOMNC, a representative may assume responsibility for decision-making on the member's behalf; in such cases, the representative, in addition to the member, must receive all required notifications. The following specific information is required to be given when contacting a member's representative of the NOMNC by phone:

- The member's last day of covered services and the date when the beneficiary's liability is expected to begin.
- The member's right to appeal a coverage termination decision.
- A description of how to request an appeal by a QIO.
- The deadline to request a review, as well as what to do if the deadline is missed.
- The telephone number of the QIO to request the appeal.

The date when the information is verbally communicated is considered the NOMNC's receipt date. Practitioners must document the telephone contact with the member's representative on the NOMNC on the day that it is made, indicating that all of the previous information was included in the communication. The annotated NOMNC also should include:

- The name of the staff person initiating the contact
- The name of the representative contacted by phone
- The date and time of the telephone contact
- The telephone number called

A dated copy of the annotated NOMNC must be placed in the member's medical file, a copy mailed to the representative the same day as the telephone contact and a copy faxed to the practitioner's Healthy Mississippi health services utilization management department.

Right to appeal a NOMNC (Fast-track Appeal):

CMS offers fast-track appeal procedures to Medicare enrollees, including MA members, when coverage of their SNF, HHA or CORF services are about to end. CMS contracts with QIOs to conduct these fast-track appeals. When notified by Healthy Mississippi or the QIO that the member has requested a fast-track appeal, SNFs, HHAs and CORFs must:

- Provide medical records and documentation to Healthy Mississippi and the QIO, as requested, no later than close of the calendar day on which they are notified. This includes, but is not limited to, weekends and holidays.
- Deliver the Detailed Explanation Non-Coverage (DENC) form that is provided by Healthy Mississippi (or that is delegated to the practitioner to complete) to members or their authorized representatives no later than close of the calendar day on which they are

notified including on weekends and holidays. The DENC provides specific and detailed information concerning why the SNF, HHA or CORF services are ending.

If a member misses the time frame to request an appeal from the QIO, the member still can appeal through Healthy Mississippi appeals department.

For more information about notification of termination requirements, practitioners may visit the CMS website at: <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>.

Transition of Care

Transition of care benefits are available temporarily for newly eligible Members who are in active treatment or who have a previously approved procedure(s) with a provider not contracted with the plan.

To promote a transition undertaken in an orderly manner that maximizes Member safety and continuity of care, Providers shall cooperate with Healthy Mississippi for the transition of Members to other participating Providers and, when applicable, continue providing Covered Services to Members.

If a new Member has an existing relationship with a Provider who is not part of Healthy Mississippi's Provider network, Healthy Mississippi will permit the Member to continue an ongoing course of treatment by the non-participating Provider during a transitional period of:

- The lesser of the period of active treatment for a chronic or acute medical condition or up to 90 days; or
- The postpartum period for Members in their second or third trimester of pregnancy; or
- When a longer period is required by Laws or Program Requirements.

For Members transitioning to the plan, Healthy Mississippi will honor any written documentation of prior authorization of ongoing Covered Services for a period of 30 calendar days after the effective date of enrollment.

For all Members, written documentation of prior authorization of ongoing services includes the following, if the services were prearranged prior to enrollment with Healthy Mississippi:

- Prior existing orders
- Provider appointments (for example, dental appointments, surgeries, etc.)
- Prescriptions (including prescriptions at non-participating pharmacies)

Healthy Mississippi can delay service authorization if written documentation is not available in a timely manner. Providers may contact the Claims Department for claims payment or claims resolution issues and their Provider Relations representative for rate negotiations.

Members who are acute inpatients at the time of disenrollment from Healthy Mississippi will be covered by Healthy Mississippi throughout the acute inpatient stay. However, Healthy Mississippi will not be responsible for any discharge needs the Member may have.

Continuity of Care

When a Member is in active treatment with a provider who is not part of Healthy Mississippi's Provider network, Healthy Mississippi will permit the Member to continue the ongoing course of treatment with the non-participating provider until the treatment concludes, until the Member has stabilized, or until it is clinically appropriate for the Member to transition to an in-network Provider, if one is available.

Continued Care with a Terminated Provider

When a Provider terminates participation in Healthy Mississippi's network or is terminated by Healthy Mississippi without cause, Healthy Mississippi will provide coverage for Members in active treatment to continue either through the completion of their condition (up to 90 calendar days) or until the Member selects a new Provider. Care provided after termination shall continue under the same terms, conditions, and payment arrangements as in the terminated contract.

If a Provider's network participation is terminated by Healthy Mississippi for cause, Healthy Mississippi may direct the Member immediately to another participating Provider for continued services and treatment, and may deny coverage for further services received from the terminated provider.

Clinical Review Guidelines

Healthy Mississippi applies the Centers for Medicare & Medicaid Services National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and Medicare Benefit Policy Manual. It also uses nationally accepted clinical guidelines to determine the medical necessity of services. The review guidelines are a screening guide for approving services during utilization management.

A licensed and board-certified medical director reviews all available clinical documentation and records to evaluate potential medical necessity denials. The medical director renders a decision in accordance with clinical review guidelines and currently accepted medical standards of care, considering the individual circumstances of each case. Providers may obtain the guidelines used to make a specific adverse determination by contacting Healthy Mississippi.

Peer-to-Peer Review

Peer-to-peer discussion must be completed prior to the adverse determination being rendered. For prior authorization requests, Healthy Mississippi provides an opportunity for the attending physician or ordering Provider to request a physician discussion prior to issuance of an Adverse Determination. The requesting Provider or facility will have the opportunity to discuss the

decision with the peer clinical reviewer within the turnaround time of the prior authorization request. Healthy Mississippi will provide notification of determination to Providers verbally or via facsimile and notification will include the Utilization Management Department's contact information for requesting a peer-to-peer discussion.

Second Medical Opinions

A member has the right to a second medical opinion in any instance in which the member questions the reasonableness, necessity, or lack of necessity for the following:

- Surgical procedures
- Treatment for a serious injury or illness
- Other situations in which the member feels that he/she is not responding to the current treatment plan in a satisfactory manner

Members may obtain a second opinion by another participating physician, but the PCP must issue a referral. The final treatment plan is determined by the member's PCP. Follow-up services must be obtained through or arranged by the member's PCP.

V. Office Procedures

This section provides policies and procedures that pertain to the daily operations of a provider's office.

All Providers must adhere to standards of timeliness for appointments and in-office waiting times. These standards take into consideration the Member's immediate needs. Healthy Mississippi will monitor Providers against the standards below to help Members obtain needed health services within acceptable appointment times, in-office waiting times, and after-hours standards. Providers not in compliance with these standards will be required to implement corrective actions.

Office Appointment and Wait Times:

In part to coincide with providers' commitment to assist Healthy Mississippi with its performance and quality management, providers shall implement procedures and make reasonable efforts to ensure that:

- Members are seen by a clinician within 15 minutes of the member's appointment time.
- Routine and follow-up appointments are made within 30 calendar days.
- Urgent appointments are made within 24 hours, seven days per week.
- Urgently needed services must be provided immediately for Medicare members.

- Emergent appointments are made immediately (arrange for on-call or after-hours coverage), 24 hours per day, seven days per week.
- The standards should consider the enrollee's need and common waiting times for comparable services in the community. Examples of reasonable standards for primary care services are: (1) urgently needed services or emergency – immediately; (2) services that are not emergency or urgently needed, but in need of medical attention – within one week; and (3) routine and preventive care – within 30 days.

Address Change or Other Practice Information

For Healthy Mississippi to maintain accurate participating provider directories and for reimbursement purposes, providers are contractually required to report all changes of address or other practice information to Healthy Mississippi in writing as soon as possible. Notices of any changes must adhere to the time frames outlined in the agreement.

Changes that require notice to Healthy Mississippi may include, but are not limited to, the following:

- Provider demographic information
- Tax identification number*
- National Provider Indicator (NPI)
- Address
- Office hours
- Phone number / Fax Number
- Practice name
- Adding a provider – provider joining practice/group**
- Provider deletions – provider no longer participating with the practice/group
- Patient restrictions (age, gender, etc.)
- Accepting new patients
- Medicare numbers
- Hospital privileges

*Changes in practice name, legal entity or Tax ID numbers may require an amendment, assignment or new agreement, depending on the reason for the change. Check with the provider representative at Healthy Mississippi-for specific information.

**If adding a provider, the new provider must first be credentialed before rendering treatment to any plan member.

Healthy Mississippi requires that changes such as those outlined above be submitted at least 30 days prior to the effective date of the change to facilitate accurate directory information and claims payment.

VI. Medical Records

Medical Records: Healthy Mississippi Provider Representatives must be permitted access to the provider's office records and operations. This access allows Healthy Mississippi to monitor compliance with regulatory requirements. Providers must maintain all medical records, supporting documentation, and other information related to services provided under this Medicare Advantage plan for a minimum of 10 years from the last date of service or from the completion date of any audit, whichever is later. These records must be made available to the plan, CMS, or their designees upon request. Each provider office will maintain complete and accurate medical records for all Healthy Mississippi members receiving medical services in a format as required by the following:

- Applicable state and federal laws
- Licensing, accreditation and reimbursement rules and regulations to which Healthy Mississippi is subject
- Accepted medical practices and standards
- Healthy Mississippi policies and procedures

Note: Healthy Mississippi has adopted guidelines based on federal and state medical record documentation requirements.

The provider's medical records must be available for utilization, risk management, peer review studies, customer service inquiries, grievances and appeals processing, claims disputes and other initiatives Healthy Mississippi may be required to conduct. To comply with accreditation and regulatory requirements, Healthy Mississippi may periodically perform a documentation audit of some provider medical records. The provider must meet 85 percent of the requirements for medical record keeping with a goal of 90 percent, or per applicable state and federal requirements if more stringent.

The participating provider must respond to the Healthy Mississippi member grievance and appeal unit expeditiously with submission of the required medical records to comply with time frames established by CMS and/or the state department of insurance for the processing of grievances and appeals. Only those records for the time period designated on the request should be sent. A copy of the request letter should be submitted with the copy of the record. The submission should include test results, office notes, referrals, telephone logs and consultation reports. Medical records should not be faxed to Healthy Mississippi market office unless provider can ensure confidentiality of those medical records.

To be compliant with HIPAA, providers should make reasonable efforts to restrict access and limit routine disclosure of protected health information (PHI) to the minimum necessary to accomplish the intended purpose of the disclosure of member information.

If a plan member changes his/her PCP for any reason, the provider must transfer a copy of the member's medical record to the member's new PCP at the request of the plan or the member.

The agreement states whether the original or a copy of the medical record must be sent. If a provider terminates, the provider is responsible for transferring the members' medical records.

Charges for copying medical records are considered a part of office overhead and are to be provided at no cost to members and Healthy Mississippi, unless state regulations or the agreement stipulate otherwise.

- **Medical Record Standards**
 - HMI's medical record standards reflect the importance of confidentiality and accessibility by authorized users only
 - Audits of records will be conducted periodically throughout the year to ensure the standards are met; corrective actions may be required based on findings
- We require providers and practitioners to:
 - Keep an individual record for each patient
 - Establish an organized record-keeping system to ensure that medical records are easily retrievable for review and available for use when needed, including at each patient visit
 - Store and maintain medical records in a centralized and secured location accessible only to authorized personnel and provide equivalent security for electronic medical record
 - If there is a paper medical record, ensure that documents are fastened securely within a paper medical record
 - CMS requires Medicare-managed program providers to retain medical records for 10 years; HMI follows CMS standards for medical records retention requirements.
- Documentation standards
 - Member identifiers appear on every piece of documentation
 - Entries are legible to others and are recorded in black or blue ink if on paper
 - Entries are dated and authenticated by the author
 - Documentation is made at the time service is provided
 - Documentation must support all codes submitted
 - Only standard medical abbreviations should be used in documentation
 - All patient encounters, including telephone, fax, and electronic message exchanges are documented
 - Documentation of any advance directives is in a prominent part of a member's medical record and includes whether a member has executed an advance directive, as well as documentation of any information about advance directives that was made available to the member
- Documentation must include the following content:
 - Problem list, including significant illnesses and medical conditions

- Medications
- Adverse drug reactions
- Allergies
- Smoking status
- Any history of alcohol use or substance abuse
- Biographical or personal data
- Pertinent history
- Physical exams
- Documentation of clinical findings and evaluation for each visit
- Laboratory and other studies that signify review by the ordering provider

Diagnoses list consistent with findings and test results

- Treatment plans consistent with diagnoses
- A date for return visits or a follow-up plan for each encounter
- Previous problems addressed in follow-up visits
- A current immunization record
- Preventive services and risk screening
- Authorship and authentication of dictated reports
 - All entries are to show authorship and be authenticated
 - Only authorized individuals may enter documentation in the medical record
 - All entries must indicate author and be authenticated
 - An entry may not be made or signed by someone other than the author
 - Dictated and transcribed authentication shall be completed no longer than five calendar days post transcription
 - Authors of documentation are required to clearly authenticate entries using signature or electronic identification
- Protected health information
 - Patient privacy is a top priority at HMI. Any information about a patient is confidential regardless of the medium upon which it is stored. Contracted providers must have documented policies and procedures for safeguarding patient privacy.

VII. Provider Claims Dispute Process, Member Grievance/Appeal Process, and Provider Termination Appeal Process

Provider Claims Dispute Process

For All Products:

If, upon receipt of an initial claim determination from Healthy Mississippi via Explanation of Remittance, Automated Remittance Advice, or Remittance Advice, the provider disagrees with the determination made by Healthy Mississippi and would like to request a dispute/reopening of the issue, the providers may do so by contacting Healthy Mississippi in one of two ways. The first is by telephone and the second is via written correspondence. Members can have specific addresses or telephone numbers associated with their membership, so it is best to utilize the contact information located directly on the back of the ID card of the member in question. If the provider does not have this information, he or she may contact Healthy Mississippi via the general phone number or mailing address:

Phone: [1-833-218-8492](tel:1-833-218-8492)

Address: Healthy Mississippi Inc.

Correspondence

PO Box 21069

Eagan, MN 55121

When sending in a written request for dispute/reopening, a provider may contest the payment denial or nonpayment of a claim with a minimum of the following information:

- Provider name
- Tax ID
- Member name and identification number
- Date of service
- Relationship of the member to the patient
- Claim number
- Charge amount
- Payment amount
- Proposed correct payment
- Difference between the amount paid and the proposed correct payment amount
- Brief description of the basis for the contestation.

In addition, be sure to include any relevant supporting documentation (medical records, copy of invoice, etc.).

All provider requests for claims disputes must be received by Healthy Mississippi within 120 days of the date of the denial/EOP unless state or federal law or the agreement requires another time period or the claim will not be reopened. Providers would request reconsideration for:

1. Provider Claims payment dispute: Provider disagrees with payment after claim is finalized

2. Administrative dispute: Claim final but an administrative denial was put into place if the provider did not obtain prior auth.

Note that lack of Medical Necessity disputes would follow the appeals process as outlined in this document.

If the provider is unsatisfied with the determination made on the phone call, or upon receipt of the determination made by Healthy Mississippi Claims Research Unit or Correspondence Team that completed the review, they may submit a request for a second dispute/reopening to <https://www.healthy-ms.com>. The Healthy Mississippi Provider Services Team reviews escalated issues when providers are unable to obtain resolution to disputes/re-openings via normal submission methods. Providers will need to include the member's information, claim information, the reference ID numbers provided on previous contacts with Healthy Mississippi and any other relevant information to the review (medical records, copy of invoice, etc.). Within 48 hours of email submission, the provider will receive a reference ID number that they may use to contact Customer Service to receive status of the review at any time.

Note: The above provisions of this section are to be considered as separate and distinct from the arbitration provisions set forth in the provider's agreement.

Member Grievance/Appeal Process

The grievance/appeal processes apply to members who are dissatisfied with the healthcare services received, or any aspect of the plan, or who have received an adverse determination.

Grievances

Grievances can be filed verbally or in writing as follows:

- Call Healthy Mississippi Member Services at **833-201-6413** and we will document the information collected over the phone. (TTY users should call 711). Member Services hours are 8:00 am – 8:00 pm CST. This call is free.
- Go to our website 24 hours a day, 7 days a week to fill in the form and submit. The website is <https://www.healthy-ms.com/Complaints>,
- Send the information by fax to (601) 427-0760 with "Attention Complaint" in the subject line.
- Mail the information to
Healthy Mississippi, Inc.
Attention: Complaints
10 Canebrake Boulevard, Suite 110
Flowood, MS 39232

Grievance also known as a complaint is an expression of dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare Advantage Plan or its delegated entity in the

provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A Grievance does not include and is distinct from, an Appeal. Examples of a Grievance include but are not limited to the quality of care, aspects of interpersonal relationships such as rudeness of a Provider or Plan employee, waiting times for an appointment, cleanliness of contracted Provider facilities, failure of the Plan or a contracted Provider to respect the Member's rights under the Plan, involuntary disenrollment, Plan benefit design, the coverage decision or Appeals process, the Plan formulary, or the availability of contracted Providers. Grievances should be filed within 60 days of the incident/ event that caused the dissatisfaction.

A Quality-of-Care (QOC) Grievance is a grievance related to a member's concern that the care received did not meet professionally recognized standards. May also refer to concerns about health care services have been provided in appropriate settings. A QOC Grievance may be reported through the plan's grievance procedures, the enrollee's Beneficiary Family Centered Care - Quality Improvement Organization (BFCC-QIO), or both. For any grievance submitted to the BFCC-QIO, plans must cooperate with the BFCC-QIO in resolving the grievance, including directing providers to respond to BFCC-QIO requests for information, within 14 days. Plans should provide any records and requested information as quickly as possible and within 14 days.

QOC grievances are reviewed by a qualified physician who will classify the outcome using the adapted framework from the Institute of Health (2018).

1. No harm
2. No harm, incident mitigated
3. Mild Harm
4. Moderate Harm
5. Severe Harm
6. Death

These cases may also be reviewed by the Health Plan's Quality Improvement Committee (QIC) or the Credentialing Committee. And the Plan may refer the case to the BFCC-QIO for assistance as appropriate.

All grievances are typically responded to by the Plan within thirty (30) days. The Plan may also be allowed to take an extension under certain circumstances. Medicare allows an expedited grievance only if the Plan diverts an expedited request for a coverage decision or Appeal to the standard timeframe or if the Plan takes an extension in making a coverage decision or deciding an Appeal (when allowed). These expedited grievances are decided within twenty-four (24) hours.

Medicare Appeals

Appeals can be filed verbally or in writing following these directions:

- Call Healthy Mississippi Member Services at **833-201-6413** and we will document the information over the phone. (TTY users should call 711). Member Services hours are 8:00 am – 8:00 pm CST. This call is free.
- Go to our website 24 hours a day, 7 days a week to fill in the form and submit. The website is <https://www.healthy-ms.com/Appeals>,

- Send the information by fax to (601) 427-0760 with “Attention Appeals” in the subject line.
- Mail the information to
Healthy Mississippi, Inc.
Attention: Appeals
10 Canebrake Boulevard, Suite 110
Flowood, MS 39232

Appeal definition: Medicare defines an appeal as the procedures that deal with the review of adverse initial determinations made by the Plan on health care items, services, or benefits under Part C or Part D that the Member believes they are entitled to receive, including a delay in providing, arranging for, or approving health care services or drug coverage (when a delay would adversely affect the Member’s health), or on any amounts the Member must pay for a service or drug. These appeals procedures include a Plan reconsideration (Part C) or redetermination (Part D) (also referred to as a **Level 1 appeal**), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.

A Medicare Advantage plan member, representative, or physician acting on behalf of the member may appeal **preservice denials** as long as the member is notified. **Contracted providers** may not appeal claims payments but will follow the payment dispute process described in this document.

A **nonparticipating provider** may only appeal claim denials with a waiver of liability form for the following:

- Full claim denials
- Claims paying zero dollars
- Claims denied for medical necessity
- Claims denied for non-covered benefits

A Medicare Prescription Drug plan (PDP) member, representative, the prescribing physician, or other prescriber may request an appeal. The member’s prescribing physician and other prescribers have the right to file a standard redetermination request on behalf of the member as long as the member is notified. An Appointment of Representative (AOR) is not required.

Medicare Appeals – Definition of Terms:

Authorized Representative: an individual either appointed by a member or authorized under state or other applicable law to act on behalf of the member in obtaining an organization/coverage determination, or grievance or appeal determination.

Expedited/Urgent Appeal: A verbal or written request for a fast appeal review of a preservice denial, termination of care, or a reduction in the level of care if the time frame for a standard appeal could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function, or care or treatment that if not rendered could subject the member to severe pain that cannot be adequately managed, based on the opinion of a

practitioner with knowledge of the member's medical condition. Expedited appeals exclude requests for payments for services already provided.

Independent Review Entity (IRE): an independent entity contracted by CMS to provide an independent review of a plan's appeal decision.

Reconsideration (MA appeal): the first step in the appeal process after an adverse organization determination; a Medicare health plan or independent review entity may reevaluate an adverse organization determination, the findings upon which it was based and any other evidence submitted or obtained. Note Part B drugs are considered medical appeals and are not processed under the Part D appeals process.

Redetermination (PDP appeal): the first level of the appeal process which involves a Part D plan reevaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.

Healthy Mississippi will accept and process any PDP or Medicare Advantage appeal from a member or an authorized representative expressing dissatisfaction with Healthy Mississippi adverse determination. In addition, Healthy Mississippi will accept and process any additional evidence or allegations of law and fact related to the disputed issue.

Healthy Mississippi will identify and remove any communication barriers that may impede members or representatives from effectively making appeals. Healthy Mississippi will facilitate the request to file an appeal for a member who has a communication challenge affecting his/her ability to communicate or read through the following means:

- The TTY line is available for the hearing impaired
 - A translation service or in-house translator will be used for members unable to speak English; and
 - Additional accommodations will be made for any member with special needs who is unable to follow the standard process

Healthy Mississippi will provide a full and fair review of the appeal including specialty review for clinical appeals. Appeals must be submitted within 60 calendar days from the date of the adverse determination notice, unless the member can demonstrate good cause.

Medicare Advantage plans: Notification of the decision will be issued within the following time frames from the date of receipt of the request:

- Expedited – As expeditiously as the member's health condition requires, but no later than 72 hours
- Preservice – As expeditiously as required based on the member's health, but no later than 30 calendar days
- Post Service – 60 calendar days from the receipt of the request

Time frames for decisions may be extended for expedited and preservice appeals up to 14 calendar days if the:

- Member requests the extension

- Healthy Mississippi justifies the necessity for additional information and documents that it is in the best interest of the member

The extension notification to the member must occur prior to the expiration of the decision time frame and must include the right to file an expedited grievance if the member disagrees with the extension.

Medicare Prescription Drug plans: Notification of the decision will be issued within the following time frames from the date of receipt of the request:

- Expedited – As expeditiously as the member’s health condition requires, but no later than 72 hours
- Standard – Seven calendar days

If the initial determination is upheld during the appeal process, the resolution letter from Healthy Mississippi will provide additional information on next-level appeals.

All **Level 1 appeals that are denied** will be automatically forwarded to the IRE for review.

VIII. Covered Services

A service must be medically necessary and covered by the member’s contract to be paid for by the plan. The plan determines whether services are medically necessary as defined by either the member’s summary plan description, certificate of insurance or evidence of coverage. To verify covered or excluded services, call Healthy Mississippi Customer Service at the number listed on the back of the member’s ID card, or verify benefits on the Smartdata Stream Provider Portal. All services may be subject to applicable copayments, deductibles and coinsurance.

Healthy Mississippi uses the current, nationally approved criteria for any medical necessity reviews required.

Healthy Mississippi makes coverage determinations, including medical necessity determinations, based upon its member’s summary plan description, certificate of insurance or evidence of coverage. However, Healthy Mississippi is not a provider of medical services and it does not control the clinical judgment or treatment recommendations made by the providers in its networks or otherwise be selected by members. Providers make independent healthcare treatment decisions.

IX. Compliance / Ethics

Liability Insurance

Upon request, all providers must provide Healthy Mississippi with evidence of insurance coverage in accordance with their agreement’s requirements.

Compliance and Fraud, Waste and Abuse Requirements

Contracted providers and those they employ and/or contract to support a contract with Healthy Mississippi are responsible for complying with all applicable laws, regulations and Healthy Mississippi's policies and procedures. Those who provide services for Healthy Mississippi Medicare eligible members, as well as those they employ or contract, also must comply with requirements outlined in Healthy Mississippi Compliance Policy and Standards of Conduct documents.

These documents incorporate requirements outlined by the government:

- CMS for all sponsors, individuals and entities that perform a function or service in support of Medicare Advantage or prescription drug plans, as detailed in Chapter 21 of the Medicare Managed Care Manual and Chapter 9 of the Prescription Drug Benefit Manual.

Compliance and FWA requirements include, but are not limited to those outlined in these seven elements of an effective compliance program:

- I: Written Policies, Procedures and Standards of Conduct
- II: Compliance Officer, Compliance Committee and High Level Oversight
- III: Effective Training and Education

Note: In addition to compliance and FWA training, your organization must conduct for those supporting Medicare administered by Healthy Mississippi. Therefore, a corresponding Healthy Mississippi government contract may require training on one or more of the following topics:

- Cultural competency
- Health, safety and welfare of plan members
- Medicaid provider processes

Effective Lines of Communication

A notable example of this is prior approval must be obtained from Healthy Mississippi for any new contract or changes to an existing agreement involving any relationships with downstream entities, within or outside of the United States, for support of a Healthy Mississippi administered plan for beneficiaries eligible for Medicare. In addition, note that Healthy Mississippi must notify CMS of any location outside of the United States or a United States territory that receives, processes, transfers, stores, or accesses Medicare member-protected health information in oral, written or electronic form. Therefore, timely engagement of Healthy Mississippi is necessary to assure compliance with this CMS requirement.

- V. Well-publicized Disciplinary Standards
- VI. Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks

VII. Procedures and System for Prompt Response to Compliance Issues

Reporting Methods for Suspected or Detected Noncompliance or Fraud, Waste and Abuse (FWA)

Contracted providers, their employees and related entities are required to notify Healthy Mississippi of suspected or detected FWA or noncompliance.

Providers, their employees and downstream entities may report concerns and information related to FWA and noncompliance with this manual, Healthy Mississippi's Standards of Conduct and/or Compliance Policy to Healthy Mississippi via a number of confidential and anonymous options:

- Healthy Mississippi Phone Hotline: English 1-833-218-8492
- SIU Fax: 1-888-710-8090
- Website: <https://www.healthy-ms.com>
- Mail: Healthy Mississippi, Inc.
10996 Seasons Place, Suite 100B
Crown Point, IN 46307

Individuals and entities reporting suspected or detected false claims violations are protected from retaliation under 31 U.S.C. 3730(h) for False Claims Act complaints. Healthy Mississippi also has a policy of non-retaliation against those who in good faith report suspected or detected violations of Healthy Mississippi policies and has zero tolerance for retaliation or retribution against any person who reports suspected misconduct or participates in a corresponding investigation.

Note: An individual with knowledge of fraud against the government may file a lawsuit (plaintiff) on behalf of the government against the person or business that committed the fraud (defendant). The filer of the lawsuit is also known as a "whistle blower."

- Retaliation against individuals for investigating, filing or participating in a whistle blower action is prohibited.
- If the action is successful, the plaintiff is rewarded with a percentage of the recovery.
-

Healthy Mississippi Compliance Office performs an initial investigation of suspected fraud and, if applicable, may refer the case to the appropriate law enforcement and/or regulatory agencies (including, but not limited to, the appropriate CMS regional office) as the Compliance Office deems appropriate.

Disciplinary Standards

Confirmed FWA and/or violations of Healthy Mississippi Compliance Policy or Standards of Conduct documents or government law or regulations by healthcare providers and/or Healthy Mississippi's downstream entities could result in any or all of the following:

- Oral or written warnings or reprimands;
- Termination of an agreement;
- Other measures which may be outlined in the agreement;
- Mandatory retraining;
- Corrective action plan(s); and/or
- Reporting of the conduct to the appropriate external entity(s), such as CMS, a CMS designee and/or law enforcement agencies.

Reporting Occurrences

An occurrence is defined as any unforeseen complication or unusual event in which a member of a Healthy Mississippi health plan is involved. Examples of an occurrence include:

- Unexpected death of a member at the member's home, office or public place, particularly after a recent visit to the provider's office or facilities;
- Any complication related to a drug, treatment or service prescribed;
- Dissatisfaction angrily expressed by a member or their representative with threats related to medical care rendered by the provider;
- Breach of confidentiality and/or inappropriate release of protected health information (as defined under the Health Insurance Portability and Accountability Act);
- Requests for medical records by an attorney if the request is related to a potential medical negligence claim (Note: This does not cover medical records requests for workers' compensation and/or motor vehicle accidents); and/or
- Adverse outcomes to a member because of:
 - Surgery (such as brain or spinal damage)
 - Delayed scheduling or completing of a diagnostic test or procedure
 - Delay in diagnosis or referral process
 - Delay in reporting abnormal results
 - Diagnostic procedure
 - Prescribed medications (e.g., wrong drugs dispensed)
 - Any drug, treatment, or service prescribed
 - Surgical error and/or surgical procedure being performed on the wrong patient
 - Surgical procedure unrelated to the patient's diagnosis
 - Transplant management

Providers are expected to report any occurrence that happens to a plan member when visiting their offices, except for occurrences that take place in acute care, skilled nursing or rehabilitation facilities. Reporting occurrences inside acute care, skilled nursing and rehabilitation facilities is dictated by the operational procedures of each facility.

Report all occurrences to Healthy Mississippi as soon as possible, preferably within three business days of the occurrence. Occurrence reports for Healthy Mississippi health plan members can be reported to: **Healthy Mississippi's Provider Relations** at 1-833-218-8492.

Conflicts of Interest

A conflict of interest is a personal, familial or business relationship that could amount to, but is not limited to:

- Competing with any of Healthy Mississippi’s product offerings
- Providing services to a competitor of Healthy Mississippi
 - Interfering with the performance of work duties Therefore, healthcare providers are expected to:
 - Have a policy to internally disclose any conflicts of interest annually and upon any change or addition to this status
 - Communicate the above-mentioned policy to your employees and downstream entities
 - Review potential conflicts of interest and either remove the conflicts or, if appropriate, grant approval to continue work despite the conflicts
 - Comply with the following, if requested by Healthy Mississippi:
 - Provide information on conflicts of interest; and
 - Remove conflicts, up to removal of the person or entity that was performing any function(s) to meet contractual obligations to Healthy Mississippi

Medicare

Medicare Marketing Literature and Provider-sponsored Activities: For purposes of this manual, the term “Medicare Marketing” includes any information, whether oral or in writing, that is intended to promote or educate prospective or current Healthy Mississippi Medicare Advantage or prescription drug plan members about Healthy Mississippi or its Medicare plans, products or services. This includes, but is not limited to, any and all promotional materials used at provider-sponsored activities, such as open houses, health fairs and grand openings. Examples of promotional materials include letters, advertisements, invitations and announcements which use Healthy Mississippi name.

Medicare marketing must be approved through the Healthy Mississippi corporate review process prior to a provider conducting any Medicare marketing activity. The Healthy Mississippi corporate review process includes review by legal and regulatory compliance and filing through Healthy Mississippi’s Medicare product compliance department and CMS (as applicable), in accordance with CMS guidelines.

To obtain approved Medicare marketing materials or to arrange for a provider-sponsored activity, contact the Medicare sales director in Healthy Mississippi market office, sales and marketing support executive or physician marketing contact. Any misrepresentation of a Healthy Mississippi Medicare product or service, intentional or not, is a serious violation of Healthy Mississippi’s agreements with CMS.

Provider Affiliations: Providers may announce new or continuing affiliations for specific sponsors of Medicare Advantage or prescription drug plans through direct mail, email, telephone, or advertisement. New affiliation announcements are for those providers who have entered into a new contractual relationship with the sponsor of a Medicare Advantage or prescription drug plan. Providers may make new affiliation announcements within the first

30 days of the new contract agreement. The announcement must clearly state that the provider also may contract with other plans/Part D sponsors. Any affiliation communication materials that describe plan benefits, premiums or cost sharing must be approved by Healthy Mississippi and CMS prior to use.

Medicare Coverage/Liability: If a Medicare member disenrolls from a Medicare Advantage plan while in a SNF, costs for SNF services are covered by a new health plan or Medicare as of the effective date of the disenrollment. If a Healthy Mississippi Medicare Advantage member's effective date of disenrollment occurs while the member is hospitalized (including, but not limited to, hospitalization in a rehabilitation hospital and long-term care facility), Healthy Mississippi is responsible for paying the contracted rate through the date of discharge, unless otherwise specified in the agreement.

As long as the Medicare Advantage member resides in the service area, he/she is covered for services until the effective date of disenrollment. When a member is temporarily out of the service area (for up to six months), coverage is limited to urgently needed, emergency care, post-stabilization services following an emergency and renal dialysis until the member returns to the service area or the effective date of disenrollment. Medicare Advantage members may receive participating benefits from any participating provider, nationwide, as well as out-of-network benefits.

Medicare Disenrollment for Cause: CMS guidelines allow a PCP to request a member's disenrollment "for cause" only if the member's behavior is disruptive, unruly, abusive, threatening or uncooperative to the extent that his/her continued membership would substantially impair the provider's ability to provide health services to that particular member or other patients. A member also may be disenrolled for other reasons including, but not limited to, if he/she fails to qualify for Medicare benefits, or fraudulently permits others to use his/her member ID card for services.

A member cannot be disenrolled based on the member's utilization (or lack of use) of services or because of mental or cognitive conditions (including mental illness and developmental disabilities), disagreement with a provider regarding treatment decisions, or as retaliation for a member's complaint, appeal or grievance. Before initiating a request to disenroll a member for cause, the provider and Healthy Mississippi must make a serious effort to resolve the problems, such as encouraging the member to change his/her behavior and must document the result of this action. If the behavioral problems are not resolved, the provider may initiate a request to disenroll the member by submitting the

Request for Disenrollment for Cause form to the local Healthy Mississippi market office. The form is available through the local Healthy Mississippi market office or by calling Healthy Mississippi Provider Relations at 1-833-218-8492. CMS requires Healthy Mississippi to notify a Medicare member that the consequences of continued disruptive behavior could include disenrollment from the plan. The health plan and provider must reasonably demonstrate that the member's behavior is not related to the use of prescribed medications, mental illness or cognitive conditions (including mental illness and developmental disabilities), treatment for a medical condition, or use (or lack of use) of the provider's medical services.

Procedure for Requesting Disenrollment: A written Request for Disenrollment for Cause letter must be sent to the local Healthy Mississippi market office, along with supporting documentation as follows:

- Description of the member's age, diagnosis, mental status, functional status and social support systems
- Complete and detailed description of the member's behavior
- Efforts taken to resolve any problems and modify behavior
- Any extenuating circumstances
- Summary of the case and reason for disenrollment
- Copy of medical records
- Statements, as applicable, from other providers, office staff, members, or law enforcement agencies describing their experiences with the member.

Upon receipt, a Letter Confirming Receipt of Disenrollment Request is sent to the PCP. The information is reviewed for completeness and compliance with the Medicare member's evidence of coverage or the commercial member's certificate of coverage. If the issues are resolved, the request may be withdrawn.

If the request is deemed to have merit, it is forwarded to a health plan medical director for review and a decision. The provider is notified of the decision and may appeal the decision by resubmitting the request along with additional supporting documentation for a subsequent review.

If the member is a Medicare member, CMS requires the plan to notify the member of its intent to request CMS permission to disenroll the member and the plan's grievance procedures. The plan then notifies CMS and CMS makes the final decision on whether to allow disenrollment for cause of the member.

Member's Right to Report a Grievance: The member may request a review of the disenrollment decision by filing a grievance in writing.

Member Disenrollment: The disenrollment is effective the first day of the calendar month after the month in which the health plan gives the member written notice of the disenrollment, or as provided by CMS. The member remains the responsibility of the PCP until the member's effective date of disenrollment.

Specific Medicare Advantage Plan Requirements:

Providers must remain neutral when assisting with enrollment decisions and may not:

- Accept/collect scope of appointment forms; accept Medicare enrollment applications
- Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider
- Mail marketing materials on behalf of plan sponsors
- Offer anything of value to induce plan enrollees to select them as their provider

- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization
- Conduct health screening as a marketing activity
- Accept compensation from the plan for any marketing or enrollment activities
- Providers may:
 - Distribute unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the “Medicare & You” handbook, or “Medicare Options Compare” (from <https://www.medicare.gov>) including in areas where care is delivered
 - Provide the names of plan sponsors with which they contract and/or participate
 - Provide information and assistance in applying for the Low-Income Subsidy
 - Answer questions or discuss the merits of a plan or plans, including cost sharing and benefits information; these discussions may occur in areas where care is delivered
 - Make available, distribute and display communication materials, including in areas where care is being delivered
 - Provide or make available plan marketing materials and enrollment forms outside of the areas where care is delivered, such as common entryways, vestibules, hospital or nursing home cafeterias, and community, recreation or conference rooms
 - Refer patients to other sources of information, such as State Health Insurance Assistance Programs (SHIPs), plan marketing representatives, their state Medicaid office, local Social Security office, and CMS’ website at <http://www.medicare.gov/> or 1-800-MEDICARE
 - Share information with patients from CMS’ website, including the “Medicare and You” handbook or “Medicare Options Compare” (from <http://www.medicare.gov>), or other documents that were written by or previously approved by CMS

Healthy Mississippi is responsible for including certain CMS Medicare Advantage related provisions in the policies and procedures distributed to the providers that constitute Healthy Mississippi’s health services delivery network. The following table summarizes these provisions, which may be accessed online by viewing the Code of Federal Regulations which is available on the U.S. Government Printing Office website (ecfr.gov):

Summary of CMS Requirements	CFR 42 (Section)
Safeguard privacy and maintain records accurately and timely	422.118
Permanent "out of area" members to receive benefits in continuation area	422.54(b)
Prohibition against discrimination based on health status	422.110(a)
Pay for emergency and urgently needed services	422.100(b)
Pay for renal dialysis for those temporarily out of a service area	422.100(b)(1)(iv)
Direct access to mammography and influenza vaccinations	422.100(g)(1)
No copay for influenza and pneumococcal vaccines	422.100(g)(2)
Agreements with providers to demonstrate "adequate" access	422.112(a)(1)
Direct access to women's specialists for routine and preventive services	422.112(a)(3)
Services available 24 hours a day, seven days a week	422.112(a)(7)
Adhere to CMS marketing provisions	422.80(a), (b), (c)
Ensure services are provided in a culturally competent manner	422.112(a)(8)
Maintain procedures to inform members of follow-up care or provide training in self-care as necessary	422.112(b)(5)
Document in a prominent place in medical record if individual has executed advance directive	422.128(b)(1)(ii)(E)
Provide services in a manner consistent with professionally recognized standards of care	422.504(a)(3)(iii)
Continuation of benefits provisions (may be met in several ways, including contract provision)	422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)
Payment and incentive arrangements specified	422.208
Subject to applicable federal laws	422.504(h)
Disclose to CMS all information necessary to (1) administer and evaluate the program (2) establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services	422.64(a); 422.504(a)(4) 422.504(f)(2)
Must make good faith effort to notify all affected members of the termination of a provider contract 30 calendar days before the termination by plan or provider	422.111(e)
Submission of data, medical records and certify completeness and truthfulness	422.310(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(l)(3)
Comply with medical policy, quality improvement and medical management	422.202(b); 422.504(a)(5)
Disclose to CMS quality and performance indicators for plan benefits re: disenrollment rates for beneficiaries enrolled in the plan for the previous two years	422.504(f)(2)(iv)(A)
Disclose to CMS quality and performance indicators for the benefits under the plan regarding enrollee satisfaction	422.504(f)(2)(iv)(B)
Disclose to CMS quality and performance indicators for the benefits under the plan regarding health outcomes	422.504(f)(2)(iv)(C)
Notify providers in writing for reason of denial, suspension and/or termination	422.202(d)(1)
Provide 60-day notice (terminating contract without cause)	422.202(d)(4)
Comply with federal laws and regulations including, but not limited to, federal criminal law, the False Claims Act (31 U.S.C. et Seq.) and the anti-kickback statute (section 1128B(b) of the act)	422.504(h)(1)
Prohibition of use of excluded practitioners	422.752(a)(8)
Adhere to appeals/grievance procedures	422.562(a)

X. Product/Plan Overview

Health Maintenance Organization (HMO)

Health Maintenance Organization (HMO) plans require members to select a PCP to coordinate their care, but non-HMO plans recommend that members select a PCP. A PCP is usually from one of three disciplines:

- Family Physician – A physician who specializes in the care of all members of a family regardless of age.
- Internist – A physician who specializes in internal medicine and gives nonsurgical treatment of medical conditions.
- Pediatrician – A physician who specializes in the development, care and diseases of children

Note 1: In some states, an OBGYN who so elects also may qualify as a PCP.

Note 2: In certain circumstances, a certified nurse practitioner or physician's assistant may be designated as a "NP-PCP" or "PA-PCP" when the state regulations do not prohibit or set limitations on their scope of responsibility. In these cases, the NP-PCP or PA-PCP must be fully credentialed and contractually agree to assume the responsibilities of a PCP for assigned members and comply with the terms and conditions of the agreement and this manual.

The HMO PCP agrees to accept plan members as stipulated by the agreement. The PCP must not refuse new members until such time he/she can reasonably demonstrate to the plan that his/her panel size has reached its maximum for adding new members. Further, the closing of the PCP's practice to new members must be applicable to all third-party payers with whom the PCP contracts.

Note 3: The HMO PCP is responsible for arranging for care in his/her absence.

Note 4: The attending physician should be credentialed by Healthy Mississippi.

Access Standards: To comply with the requirements of CMS, accrediting and regulatory agencies, Healthy Mississippi has adopted certain standards for participating providers that are summarized below. The purpose of these standards is to ensure that health services are available and accessible to members.

Required for Medicare Providers and Recommended for all other Providers

Covered services must be geographically accessible and consistent with local patterns of care, ensuring that no member residing in the service area must travel an unreasonable distance to obtain covered services. The following services must be available in the plan's service area:

- Medical coverage 24 hours a day, seven days a week
- Urgent but non-emergent appointments within 24 hours, seven (7) days a week
- Urgently needed services must be provided immediately for Medicare members
- Non-urgent, but in-need-of-attention appointments within 7 business days
- Routine and preventive care or well-child appointments within 30 days

In addition, Healthy Mississippi Recommends the Following Standards for all Providers:

- Response to urgent calls within 15 minutes; response to routine calls within the same business day
- After hours, response to urgent calls in 15 minutes; non-urgent response in 30 minutes
- Specialty care within 21 business days
- In the case of an unexpected emergency, which may cause this standard to be exceeded, the member should be promptly notified and given the option of waiting or rescheduling

Note: State regulations, if more stringent, may take precedence over these time frames.

By monitoring compliance with these guidelines over time, Healthy Mississippi can take action to improve member service availability and access to medical services when necessary. Healthy Mississippi may monitor compliance with the following access standards through a variety of ways including audits during site surveys, telephone audits, member surveys and complaints.

Member/Enrollee Transfers: The following guidelines apply to the transfer of a Healthy Mississippi member upon his/her request from one primary care office to another:

- The member's decision to transfer should be strictly voluntary.
- The member or the legal guardian requesting a change in the primary care office may do one of the following:
 - Sign an Enrollment Change Form or a membership Change Authorization Form.
 - Contact Healthy Mississippi Customer Service.
 - Call the phone number on the back of the member ID card to arrange the transfer.
- The member must not have been directly recruited by telephone or in person by anyone involved with either primary care office.
- The member must not have been influenced to transfer offices due to improper or incorrect information, or for medical reasons.
- Upon a member's request, the primary care office must send his/her medical records to the newly selected primary care office.

Healthy Mississippi may review the transfer and, if any of the above guidelines have been violated, a transfer in primary care offices will not be approved

PCP Transfer of Member/Enrollee: If a PCP wants to transfer a member with his/her power of attorney/guardian to another PCP, the PCP must prepare a Physician Initiated Transfer Request Member Notice and forward it with supporting documentation to the Healthy Mississippi market medical director or market president. The form may be obtained through the Healthy Mississippi market office. The PCP will be notified of the approval/denial decision. PCPs may not coerce a member to transfer.

Any primary care office that violates guidelines for transferring members to another office is given a 30-day, noncompliance written notification requiring immediate corrective action. If the primary care office is found in violation of established policies and procedures and is, therefore, considered to be noncompliant, a termination letter including appeals rights will be sent. Members or their power of attorneys/guardians have the right to file a grievance if the transfer is approved.

Disenrollment Outside of the Service Area: A member must notify a customer service representative when he/she permanently moves out of the service area. A permanent move is an absence of more than six months.

Medicare Advantage Members: If a plan offers a continuation area, permanent out-of-area Medicare Advantage members will receive benefits in the continuation area. The primary care office must:

- a. Obtain documented acceptable evidence indicating the member has permanently moved out of the service area. Acceptable evidence includes:
 - Certified return-receipt letters, indicating an absence of more than six months.
 - Conversation documented and witnessed when a member admits to a permanent absence from the service area but does not voluntarily choose to disenroll.
 - Medical records, which indicate an absence of more than six months from the service area.
- b. Complete a Request to Disenroll form by calling Provider Relations at 1-833-218-8492 and attach any supporting documentation regarding the member's move outside the service area.
- c. Send the form and documentation to the following address:

Healthy Mississippi, Inc.
Attention: Out of State Service Area Medicare Enrollment Department
P.O. Box 21069,
Eagan, MN 55121

Medicare enrollment reviews the request and supporting documentation. If there is sufficient evidence indicating the member has left the service area, the documentation is submitted to CMS. A letter is sent to the member from the Medicare retention unit to advise him/her of the effective disenrollment date and to give the member an opportunity to request a reconsideration if he/she disagrees with the decision. If the member does not respond within six months from the date of the letter, the member will be disenrolled. If Medicare enrollment does not agree with the primary care office's request for disenrollment, the office may be asked to gather additional information in support of its case and to resubmit the request.

Healthy Mississippi is a Medicare Advantage Prescription Drug Plan (MAPD) Sponsor for the state of Mississippi. The drug plan has a \$0 deductible with a five-tier prescription coverage that includes preferred generics, generics, preferred brands, non-preferred brands, and specialty.

There are discounted as well as \$0 copays for select drug tiers when the preferred pharmacy is used, and mail order is also available.

XI. Credentialing

Credentialing refers to a process performed by Healthy Mississippi to verify and confirm that an applicant (physician and/or other provider type) meets the established policy standards and qualifications for consideration in a Healthy Mississippi provider network. Upon completion of the credentialing process, each applicant is presented to the Credentials Committee comprising physicians in various specialties for review and recommendation. Initial credentialing is performed when an application is received and re-credentialing is conducted at least every three years thereafter, or as otherwise required by state regulations and at the discretion of the health plan.

There is required supporting documentation that must be submitted with each credentialing application. Such documentation may include but is not limited to, licensure, education, training, clinical privileges, work history, accreditation, certifications, professional liability insurance, malpractice history, professional competency, and any physical or mental impairments. Documentation submitted by an applicant and/or provider's office is verified for accuracy and completeness. At the discretion of Healthy Mississippi, an applicant may be required to submit additional information.

Healthy Mississippi recognizes a provider's right to review information submitted in support of his/her credentialing application to the extent permitted by law and to correct erroneous information. At any time during the credentialing process, a provider may request the status of his/her application by contacting the Healthy Mississippi Credentialing Department.

The fact that a provider is credentialed is not intended as a guarantee or promise of any level of care or service. Healthy Mississippi does not discriminate against any healthcare professional acting within the scope of their license or certification under State law in terms of participation, reimbursement, or indemnification. A written notice of explanation will be supplied to affected providers if a decision to join the network is made.

Healthy Mississippi Credentials Committee: The Healthy Mississippi Credentials Committee is composed of a chairperson, a Medical Director, or a designee. Functions of the committee include credentialing, ongoing and periodic assessment of current policies/procedures, re-credentialing, and the establishment of policies and procedures based on current guidelines and regulations.

Providers seeking network participation or re-credentialing are presented to the Healthy Mississippi Credentials Committee for review and recommendation. The committee will render a recommendation to approve or deny network participation. The provider will be

notified of the committee's decision. If approved, an agreement is executed by the provider and Healthy Mississippi.

Recredentialing: The process of credentialing is conducted at least every three years in accordance with Healthy Mississippi's Recredentialing Policy or as otherwise required by state regulations and at the discretion of the health plan.

XII. Quality Management

Quality Management

Upon request, Healthy Mississippi will make available to providers information about its quality management and quality improvement program and a summary report on Healthy Mississippi's progress in meeting quality improvement goals. To obtain a copy, call Healthy Mississippi Provider Relations at 1-833-218-8492.

Participating providers agree to assist Healthy Mississippi with its performance of the following quality management activities:

Medical Records Reviews are conducted to meet the requirements of accrediting agencies and federal and state law requirements. Annually, Healthy Mississippi will review a sample of clinical records for Healthy Mississippi-members. Healthy Mississippi does not review all records and is not responsible for assuring the adequacy or completeness of records. The Plan will forward a list of members in which the Providers must share the records either as copies or through electronic access. Note: Mississippi Health will be conducting chart reviews throughout the year which should lessen the workload during the HEDIS Hybrid season discussed below

Additionally, yearlong data exchange encourages electronic clinical data exchange. This lessens the burden for providers and the Plan, making it easier to correctly capture all the required quality data. Healthy Mississippi will work in collaboration with providers and their staff to establish these electronic forms of data exchange.

HEDIS® – Healthcare Effectiveness Data and Information Set (HEDIS) is a set of performance measures that reflect the clinical quality outcomes. Healthy Mississippi may conduct medical record reviews to identify gaps in care for Healthy Mississippi members. HEDIS now includes care coordination measures for members transitioning from a hospital or emergency department to home for which hospitals and providers have additional responsibilities. In addition to medical record reviews, information for HEDIS is gathered administratively via claims, encounters and submitted supplemental data. There are two primary routes for supplemental data, nonstandard and standard.

Nonstandard supplemental data involves directly submitting scanned images (e.g. .pdf documents) of completed attestation forms and medical records. Nonstandard data also can be accepted electronically via a proprietary Electronic Attestation Forms (EAF) or Practitioner

Assessment Forms (PAF). Nonstandard supplemental data is subject to audit by a team of nurse reviewers prior to closing HEDIS opportunities.

Standard supplemental data flows directly from one electronic database (e.g. population health system,

EMR) to another without manual interpretation. Standard supplemental data can be accepted via HEDIS-Specific custom reports extracted directly from the provider's EMR or population health tool and is submitted to Healthy Mississippi via either secure email or FTP transmission. We also accept lab data files in the same way. Healthy Mississippi partners with various EMRs to provide member summaries and detail reports and to automatically retrieve scanned charts.

CAHPS® – The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey includes several measures that reflect member satisfaction with the care and service provided by the physician.

HOS – The Health Outcomes Survey (HOS) includes several measures that reflect member's self-reported health perception, member's discussion with practitioner and member's report of receiving treatment from practitioner. Health plans use the data from HOS for quality improvement activities. CMS also uses this report to judge a health plan's ability to maintain or improve the physical and mental health of its members, provide health plan accountability and publicly report outcomes.

Healthy Mississippi is rated on an annual basis by CMS the government on multiple measures that fall under HEDIS, CAHPS and HOS. These measures, along with others are included in the Medicare Advantage Star Ratings. The Star Rating reflects the quality of care and service members are receiving as part of the Health Plan. Each year surveys are sent to our members that ask multiple questions of how you, the physician, and Healthy Mississippi are performing. It is imperative that we partner to strive for excellence in these areas. For further information, please visit <http://www.cms.gov>

Occurrences and Adverse Events Reporting – Unexpected occurrences and adverse events involving members are reported to the Quality Management Department by providers, precertification nurses and case managers. Cases are reviewed according to Healthy Mississippi Quality Management and, as applicable, peer-review process, as required by law and accrediting agencies. Please submit occurrences and adverse events to the Quality Department:

- By fax to (601) 427-0760
- Go to our website 24 hours a day, 7 days a week to fill in the Occurrence-Adverse Events form and submit. The website is <https://www.healthy-ms.com/Adversrse Events.com>

CMS Quality Improvement Organization (QIO) – QIO oversees the Medicare Advantage Prescription Drug (MAPD) plans and collaborates with the plan for Quality Improvement activities. Their role is to ensure safety and quality improvement for all Medicare Beneficiaries.

Member Complaints – Member complaints and grievances pertaining to quality-of-care and concerns may be referred to the Quality Management Department for review. All Quality of Care

(QOC) Complaints / Grievances that are found to be of valid concern will be referred to the QIO for further investigation. Providers are required by CMS regulations to comply with all requests for records from both the Health Plan and the QIO in an investigation.

Medicare Advantage (MA) Organizations Must Comply with the Following Requirements:

Maintain a health information system that collects, integrates, analyzes and reports data necessary to implement the quality improvement program.

Have a Chronic Care Improvement Program (CCIP) that identifies enrollees with multiple or severe chronic conditions, who meet the criteria for participation and a mechanism for monitoring enrollee participation in the program.

Initiate quality improvement projects (QIP) that address those areas that have been identified as healthcare priorities for MA beneficiaries, or topics that are mandated by CMS or other regulatory bodies. The QIP currently focuses on improving the HEDIS measure around follow-up after emergency department visits for people with high-risk multiple chronic conditions (FMC).

Providers and Practitioners are required to cooperate with the organization's QI activities to improve the quality of care and services and member experience. Cooperation includes collection and evaluation of data and participation in the organization's QI programs. The organization may use practitioner performance data for QI activities but will maintain provider confidentiality and will not disseminate specific provider quality data or scores externally.

Health Equity

Healthy Mississippi is committed to reducing health disparities and improving the health of all communities. The quality of the patient-provider relationship plays an influential role on patient outcomes, especially patients with social determinants of health needs and those that fall within the CMS defined social risk factor (SRF) populations. Recent data analysis by CMS and others has shown that there are wide disparities in outcomes for members in these SRF populations and has put some new requirements in place which include:

- New quality measure to evaluate the effectiveness of the health care system in assessing for key social determinants and providing interventions to reduce the barriers for achieving equal outcomes
- Creation of a new Health Equity Index that is designed to reward health plans that do well in closing the disparity gaps in the Star Rating performance.
- New guidance requires that the Health Plan put a Quality Improvement Project (QIP) in place that focuses on improving outcomes for members in the disparity populations.

Healthy Mississippi will be working collaboratively with providers and practitioners to ensure good processes are in place and effective toward meeting the CMS requirements.

Cultural Competency

Providers contracted with Healthy Mississippi are required to make services available in a culturally competent manner to all MA plan members. This includes those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.

Cultural Competency is the measure of a person or organization's willingness and ability to learn about, understand, and provide excellent customer service across all segments of the population in ways that are meaningful and acceptable to the people served. In order to support and further develop culturally appropriate communications and behaviors, Healthy Mississippi will require contracted providers to:

- Participate in cultural competency training annually and ensure that office staff routinely interacting with members have also been given the opportunity to participate in, and have participated in, cultural competency training.
- Ensure that treatment plans are developed with consideration of the Member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, gender identity, sexual orientation, and other characteristics that may influence the Member's perspective on health care.
- Ensure an appropriate mechanism is established to fulfill the Provider's obligations under the Americans with Disabilities Act, including that all facilities providing services to Members must be accessible to persons with disabilities. Additionally, no patient with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public facility, or be subjected to discrimination by any such facility.

On the Office of Minority Health's website, you will find "A Physician's Practical Guide to Culturally Competent Care." By taking this course online, you can earn up to nine CME credits, or nine contact hours for free. The course may be found at: [Physician's Site \(hhs.gov\)](http://Physician's Site (hhs.gov)) Healthy Mississippi will also be sharing training materials on the provider website that we encourage you to utilize. You are also welcome to create / utilize materials developed by you and your organization.

XIII. Care Management

Care Management Programs

Overview

Healthy Mississippi offers comprehensive care management and social determinants of healthcare services to facilitate patient assessment, planning and advocacy to improve health outcomes for patients.

Healthy Mississippi care management is comprehensive and Member-centric, dedicated to providing coordination and support services for acute and preventive care. Care management is a multi-disciplinary program designed to respond to the needs of Healthy Mississippi Members across the patient journey and care continuum.

Program components include providing coordination through episodic care management, including:

- Management across transitions that include timely follow-up post hospitalization, Emergency Department (ED) visits or stays in other institutional settings,
- Symptom and disease management,
- Medication reconciliation and management, and
- Support for exacerbations of chronic illness.
- Assess for social determinants of health

Healthy Mississippi's Care Management teams also serve in a support capacity to the PCP and assist in actively linking the Member to Providers, medical services, social and other support services, as needed. Providers may request care management services for any Member. The care management process begins with Member identification and follows the Member until discharge from the program. Members may be identified for care management in various ways, including:

- A referral from a Member's PCP
- Self-referral
- Referral from a family member
- Referral from Healthy Mississippi's internal departments
- After completing a health risk assessment
- Data mining for Members with high utilization

Healthy Mississippi's philosophy is that the Care Management Program is an integral management tool in providing a continuum of care for Members including:

- Clinical Assessment and Evaluation – A comprehensive assessment of the Member is completed to determine where they are in the health continuum.
- Care Planning – Collaboration with the Member and/or caregiver as well as the PCP/Specialist to identify the best ways to fill any identified gaps or barriers to improve access and adherence to the Provider's plan of care. Individual Care Plans (ICPs) are shared with the Member and Provider(s) in accordance with the Model of Care.
- Service Facilitation and Coordination – Working with community resources to facilitate Member adherence with the plan of care. Activities may include arranging various services such as transportation and follow-up.
- Member Advocacy – Advocating on behalf of the Member. Care managers assist Members with seeking the services to optimize their health. Care management emphasizes continuity of care for Members through the coordination of care among physicians and other Providers.

Healthy Mississippi uses Member data to stratify and prioritize care management outreach. Based on the stratification Members are identified as having low, moderate or high risk. The case

management assignment process takes into account the risk level and scoring model that was used to assess the Members score.

Members commonly identified for Healthy Mississippi's Care Management Program may include:

- **Catastrophic Injuries** – Such as head injury, near drowning, burns
- **Members with Complex care** – the program includes members with multiple or unstable comorbidities such as diabetes, chronic obstructive pulmonary disease (COPD), and hypertension, or multiple barriers to quality healthcare (for example, Acquired Immune Deficiency Syndrome [AIDS])
- **Transplantation** – Organ failure, donor matching, post-transplant follow-up
- **Complex Discharge Needs** – Members discharged home from acute inpatient or SNFs with multiple service and coordination needs (for example, DME, PT/OT, home health), complicated, non-healing wounds, advanced illness, etc.

Care managers may work closely with the Provider regarding when to discharge the Member from the Care Management Program based on the Member's needs. A Member may be discharged from the Care Management Program if they:

- Are meeting primary care plan goals
- Declined additional care management services
- Disenrolled from Healthy Mississippi
- Are unable to be contacted by Healthy Mississippi

Members who are identified by the provider in the inpatient or outpatient setting as candidates for any of the disease management or case management programs can contact Healthy Mississippi by calling the Health Services Line at 1-833-201-6413.

Contact Us

For member eligibility, preauthorization, notification, and claims, call 1-833-218-8492 or the number provided by the member.

XIV. Rights and Responsibilities

Physicians'/Providers' Rights and Responsibilities

To comply with the requirements of accrediting and regulatory agencies, Healthy Mississippi has adopted certain responsibilities for participating providers (commercial, Medicare and Medicaid) that are summarized below. This is not a comprehensive, all-inclusive list. Additional responsibilities are presented elsewhere in this manual and the agreement. Physicians/Providers must:

- Have a professional degree and a current, unrestricted license to practice medicine in the state in which the provider's services are regularly performed.

- Provider agrees to comply with Healthy Mississippi's quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures established and revised by Healthy Mississippi
- Be credentialed by Healthy Mississippi and meet all credentialing and recredentialing criteria as required
- MA providers must not be on the CMS preclusion list.
- Provide documentation on their experience, background, training, ability, malpractice claims history, disciplinary actions or sanctions, and physical and mental health status for credentialing purposes.
- Possess a current, unrestricted Drug Enforcement Administration (DEA) certificate, if applicable and/ or a state Controlled Dangerous Substance (CDS) certificate or license, if applicable.
- Have a current Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.
- Be a medical staff member in good standing with a participating network hospital(s) if he/she makes plan member rounds and have no record of hospital privileges having been reduced, denied or limited, or if so, provide an explanation that is acceptable to the plan.
- Inform Healthy Mississippi in writing within 24 hours of any revocation or suspension of his/her Bureau of Narcotics and Dangerous Drugs number and/or of suspension, limitation or revocation of his/her license, reduction and/or denial of hospital privileges, certification, CLIA certificate or other legal credential authorizing him/her to practice in any state in which the provider is licensed.

Inform Healthy Mississippi immediately of changes in licensure status, tax identification numbers, NPI, telephone numbers, addresses, status at participating hospitals, provider status (additions or deletions from provider practice), loss or decrease in amounts of liability insurance below the required limits and any other change which would affect his/ her participation status with Healthy Mississippi.

- Not discriminate against members as a result of their participation as members, their source of payment, age, race, color, national origin, religion, sex, sexual preference, health status or disability
- Not discriminate in any manner between Healthy Mississippi members and non-Healthy Mississippi members
- Inform members regarding follow-up care or provide training in self-care

- Assure the availability of physician services to members 24 hours a day, seven days a week (required for HMO PCPs and all MA providers)
- Arrange for on-call and after-hours coverage by a participating and credentialed Healthy Mississippi physician (required for HMO PCPs and all MA providers)
- Refer Healthy Mississippi members with problems outside of the physician's normal scope of practice for consultation and/ or care to appropriate specialists contracted with Healthy Mississippi on a timely basis, except when participating providers are not reasonably available or in an emergency.
- Refer members only to participating providers, except when participating providers are not reasonably available or in an emergency.
- Admit members only to participating network hospitals, SNFs and other facilities and work with hospital-based physicians at participating hospitals or facilities in cases of need for acute hospital care, except when participating providers or facilities are not reasonably available or in an emergency.
- Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Healthy Mississippi member, subscriber, or enrollee other than for copayments, deductibles, coinsurance, other fees that are the member's responsibility under the terms of their benefit plan, or fees for non-covered services furnished on a fee-for-service basis. Non-covered services are services not covered by Medicare, or services excluded in the member's plan.
- Provide services in a culturally competent manner, (i.e., removing all language barriers, arranging and paying for interpretation services for limited English proficient [LEP] and the hearing/visually impaired) as required by state and federal law. Care and services should accommodate the special needs of ethnic, cultural and social circumstances of the patient. Additional information and resources are made available by the U.S. Department of Health and Human Services, Office of Minority Health (e.g., <http://minorityhealth.hhs.gov> and <https://thinkculturalhealth.hhs.gov/authentication/login>).
- Provide access to healthcare benefits for all plan members in a manner consistent with CMS requirements for any Healthy Mississippi Medicare Advantage members.
- For Medicare Advantage members who have end-stage renal disease (ESRD), complete Chronic Renal Disease Medical Evidence Report, which is provided by the Social Security office when provider becomes aware of the disease. The form must be completed and returned to the Social Security office and the ESRD Network. Mail or fax the form to our toll-free number:

Healthy Mississippi
Fax: 1-888-710-8090

- Provide or arrange for continued treatment to all members including, but not limited to, medication therapy, upon expiration or termination of the agreement.
- Help guarantee accessibility of services to members by maintaining a ratio of members to full-time equivalent (FTE) physicians as follows:
 - One physician FTE to 2,400 Medicare Advantage member equivalents (CMMEs). An MA member counts as three member equivalents; a commercial member counts as one member equivalent
 - A non-physician practitioner (PA, ARNP, etc.) counts as .5 physician FTE for MA and commercial members
 - One physician FTE for 1,500 Medicaid members
 - A non-physician practitioner (PA, ARNP, etc.) counts as .33 physician FTE for Medicaid and may serve no more than 500 Medicaid members

Note: Full-time equivalents may vary by markets. Contact the local Healthy Mississippi market office or call Provider Relations at 1-833-218-8492.

- Retain all agreements, books, documents, papers and medical records related to the provision of services to members as required by state and federal laws and in accordance with relevant Healthy Mississippi policies.
- Treat all member records and information confidentially and not release such information without the written consent of the member, except as indicated herein, or as allowed by state and federal law, including HIPAA regulations.
- Upon request of Healthy Mississippi, provide an electronic automated means, at no cost, for Healthy Mississippi and all Healthy Mississippi affiliated vendors acting on behalf of Healthy Mississippi, to access member clinical information including, but not limited to, medical records, for all payer responsibilities including, but not limited to case management, utilization management, claims review, and audit and claims adjudication.
- Transfer copies of medical records for the purpose of continuity of care to other Healthy Mississippi providers upon request and at no charge to Healthy Mississippi, the member, or the requesting party, unless otherwise agreed upon.
- Provide copies of, access to, and the opportunity for Healthy Mississippi or its designee to examine the provider's office books, records, and operations of any related organization or entity involving transactions related to health services provided to members. A related organization or entity is defined as having:
 - Influence, ownership, or control and:
 - Either a financial relationship or a relationship for rendering services to the primary care office.

The purpose of this access is to help guarantee compliance with all financial, operational, and quality assurance: peer review obligations, as well as any other provider obligations stated in the agreement or in this manual. Failure by any person or entity involved, including the provider, to comply with any requests for access

within 10 business days of receipt of notification, will be considered a breach of contract. For records related to Healthy Mississippi MA enrollees, this access right is for the time stipulated in the agreement or the time period since the last audit, whichever is greater.

- To the extent applicable to the physician, assume full responsibility to the extent of the law when supervising/ sponsoring, whether through a protocol, collaborative, or some other type of agreement, physician assistants (PAs) advanced practice registered nurses (APRNs), nurse practitioners (NPs) and all other healthcare professionals required to be supervised or sponsored, whether through a protocol, collaborative, or some other type of agreement under applicable federal and state law in order to treat members..
- Submit a report of an encounter for each visit when the member is seen by the provider, if the member receives a HEDIS service. Encounters should be submitted electronically or recorded on a CMS-1500 Claim Form and submitted according to the time frame listed in the agreement.
- Meet the requirements of all applicable state and federal laws and regulations including, Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act and the Rehabilitation Act of 1973.
- Physician's performance of services under the agreement shall be consistent and in compliance with Healthy Mississippi contractual obligations under its Medicare Advantage contract(s). Physician agrees to cooperate with and assist Healthy Mississippi in its efforts to comply with its Medicare Advantage contract(s) and/or Medicare Advantage rules and regulations and to assist Healthy Mississippi in complying with corrective action plans necessary for Healthy Mississippi to comply with such rules and regulations.
- Submit complete member referral information when applicable and in a timely manner to Healthy Mississippi via electronic means or telephone.
- Notify Healthy Mississippi of scheduled surgeries/procedures requiring inpatient hospitalization.
- Notify Healthy Mississippi of any material change in provider's performance of delegated functions, if applicable.

- Notify Healthy Mississippi of his/her termination 60 days prior to the effective date of termination.
- Not be excluded from participating in Medicare.
- Cooperate with an independent review organization's activities pertaining to the provision of services for commercial members, Medicare enrollees in an MA plan and Medicaid members. Respond expeditiously to Healthy Mississippi's requests for medical records or any other documents in order to comply with regulatory requirements and to provide any additional information about a case in which a member has filed a grievance or appeal.
- Abide by the rules and regulations and all other lawful standards and policies of the Healthy Mississippi Plan with which the provider is contracted, including Healthy Mississippi.
- Ethics Every Day for Contracted Healthcare Providers and Business Partners.

- Understand and agree that nothing contained in the agreement, or this manual is intended to interfere with or hinder communications between providers and members regarding a member's medical condition or available treatment options or to dictate medical judgment.
- For those providers who participate in MA networks and who participate in Original Medicare, that they abide by the guidelines set out in Healthy Mississippi's Rules of Participation for MA Networks, which are available on Healthy Mississippi.com, within the Provider Self-service section, under Resources. A paper copy may be obtained upon request.
- Providers, who have downstream agreement(s) with physicians or other providers who provide services to Healthy Mississippi members, agree to provide a copy of said agreement(s) to Healthy Mississippi upon request (financial information will not be requested).
- Abide by all state and federal laws regarding confidentiality, privacy and disclosure of medical records or other health and enrollment information.
- Provider agrees to submit a claim on behalf of the member in accordance with timely filing laws, rules, regulations and policies.
- Provider agrees to pay court costs and/or legal fees incurred by Healthy Mississippi or the member to enforce the terms of this provision.
- Providers understand and agree that provider performance data can be used by Healthy Mississippi. Healthy Mississippi prohibits providers from requiring members to select and pay for any type of "concierge medicine" program in order to receive services, items and/or benefits covered by the applicable Healthy Mississippi plan from the provider. Healthy Mississippi considers concierge medicine programs to include any practice management model under which a provider charges each patient a monthly, annual or other periodic fee in exchange for enhanced practice services over and above those services that are covered under the member's health benefit plan, or charges such a fee before agreeing to provide any medical services to a patient.

A provider may offer a concierge medicine program to members, provided that any such program meets the following requirements:

- The provider accepts Healthy Mississippi's reimbursement as payment in full for all services that are covered services under the member's health benefit plan and the provider is prohibited from holding plan members liable for the payment of such services, except for member cost-sharing authorized under the plan.
- Any fees paid by members for the provider's concierge medicine program cannot be in exchange for services that are covered services under the member's health benefit plan.
- The provider must be accessible and available to members consistent with Healthy Mississippi's participating provider requirements including, but not limited to, those requirements outlined in this manual, the provider's participation agreement with Healthy Mississippi and those requirements outlined by any applicable state or federal law, including but not limited to those requirements outlined by the Centers for Medicare & Medicaid Services under the Medicare Managed Care Manual MMCM, Ch. 4, Section 110.1.1, regardless of whether a member chooses to participate in the provider's

concierge medicine program. The provider shall ensure that quality of care will not be adversely impacted if a member chooses not to participate in the provider's concierge medicine program.

- The provider is prohibited from offering its concierge medicine program in any way that discriminates against members.
- A member's choice to participate in a provider's concierge Medicine program must be entirely voluntary. The provider is prohibited from inappropriately coercing or pressuring the member to participate in a concierge medicine program.
- Any concierge medicine program agreement with a member must: (a) inform the member that the program is optional and that he or she does not have to select and pay for the program in order to receive healthcare services from the provider that are covered services under the member's health benefit plan; (b) list the fee or fees and the added services, items and/or benefits included in the program; and (c) inform the member that the selection of and payment for the program is solely for services, items and/or benefits in addition to services that are covered services under the member's health benefit plan.
- The provider must provide a copy of its concierge medicine program agreement with members and any related materials to Healthy Mississippi immediately upon request.
- The concierge medicine program does not otherwise conflict with the terms of the provider's participation with Healthy Mississippi, including, but not limited to, those terms and/or requirements outlined in this manual, the provider's participation agreement with Healthy Mississippi and any applicable state or federal law, including but not limited to those requirements outlined by the Centers for Medicare & Medicaid Services.

Members' Rights and Responsibilities

Healthy Mississippi adheres to certain rules of accrediting and regulatory agencies concerning member rights. Healthy Mississippi members have certain rights and responsibilities when being treated by Healthy Mississippi contracted providers. The rights and responsibilities statement below, though not intended to be exhaustive, reminds members and providers of their complementary roles in maintaining a productive relationship.

Healthy Mississippi members have the right to:

- Be provided with information about their plan, its services and benefits, its providers and the rights and responsibilities of members.
- Choose a primary care provider from our network of affiliated providers and change to another primary care provider in the Healthy Mississippi network.
- Discuss their medical record with their physician and receive, upon request, a copy of that record.
- To participate with providers in making decisions about their healthcare.
- Have a candid discussion with their provider about appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Expect reasonable access to medically necessary healthcare services, regardless of gender, race, national origin, religion, physical abilities or source payment.

- File a formal complaint, as outlined in the plan’s grievance procedure and expect a response to that complaint within a reasonable period.
- Be treated with courtesy and respect, with appreciation for their dignity and protection of their right to privacy.
- Make recommendations regarding the plan’s “rights and responsibilities” policies.
- Expect Healthy Mississippi to adhere to all privacy and confidentiality policies and procedures.
- Have an initial health risk assessment conducted for care for MA members within the first 90 days of enrollment.
- MA members have direct access to a woman’s health specialist, within the network, for routine and preventive health services, such as mammography screening and influenza vaccinations that are provided as basic benefits for women.
- MA members have direct access to influenza vaccinations for routine and preventive health services provided as basic benefits. Certain preventive health services, such as influenza and pneumococcal vaccines, do not require a copayment.
- Receive services that are provided in a culturally competent manner.
- Receive treatment for any emergency medical condition.
- Select an in-network provider and not be balance billed for medically necessary covered services.
- Receive an EOB and discuss that EOB with the plan.
- Members have the right to file a claim or have a claim filed by a provider on their behalf.
- MA members who have a disagreement with his/her physician about a denial of service have the right to request and receive an organization determination from the plan regarding the services or treatment being requested.

Healthy Mississippi members have the responsibility to:

- Give the plan and their healthcare provider complete and accurate information needed for their care.
- Read and be aware of all material distributed by the plan explaining policies and procedures regarding services and benefits.
- Obtain and carefully consider all information they may need or desire to give informed consent for a procedure or treatment.
- Be considerate and cooperative in dealing with the plan providers and respect the rights of fellow members.
- Schedule appointments, arrive on time for scheduled visits and notify their healthcare provider if they must cancel or be late for a scheduled appointment.
- Express opinions, concerns or complaints in a constructive manner.
- Inform Healthy Mississippi of any change in their contact information, such as address or phone number, even if these changes are only temporary.
- Pay all premiums and applicable copayments, coinsurance and deductible amounts by the due date.

- Follow healthcare facility rules and regulations affecting patient care and conduct.
- Always Carry their Healthy Mississippi identification card with them and use it while enrolled in the plan.
- Follow the plans and instructions for care that they have agreed upon with their providers.

Note: In some states, providers are required by law to post members' rights and responsibilities. To be in compliance with CMS' member's rights and responsibilities, Healthy Mississippi has a process in place for both current and prospective beneficiaries to exercise choice in obtaining Medicare services.

Advance Directives: The Patient Self-Determination Act of 1990 and state law provides every adult member the right to make certain decisions concerning medical treatment. Members have the right, under certain conditions, to decide whether to accept or reject medical treatment, including whether to continue medical treatment that would prolong life artificially.

These rights may be communicated by the member through an advance directive. Two kinds of advance directives are generally recognized by law: the living will and the durable power of attorney for healthcare.

The member's primary care office is not required to have living will or durable power of attorney blank forms available. However, the primary care office must have procedures in place to help assure that the existence of completed advance directive forms is conspicuously noted in the member's medical record.

Professional Conduct during Physical Examination of Plan Members: The member or provider may request a chaperone to be present during any office examination. The chaperone may be a family member or friend of the member, or the physician's/provider's assistant. Prior to an examination of a minor, the physician should obtain a parent or guardian's consent in the manner specified by the state.

Note: Some states have regulations that may conflict with these guidelines. In those instances, state regulations, if more stringent, take precedence over the guidelines stated above.

XV. Delegation

What is Delegation?

Delegation is the formal process by which one enterprise, such as Healthy Mississippi, grants to another legal entity (delegate) the authority to perform certain functions on its behalf, such as:

- Credentialing of physicians, facilities and other healthcare providers
- Provision of clinical health services such as utilization management, disease management and complex case management

- Claims adjudication and payment
- Inquiries in the medical and managed behavioral healthcare organization (MBHO) setting
- Triage and quality management in certain MBHO settings

A function may be fully or partially delegated. Full delegation allows all activities of a function to be delegated. Partial delegation is the instance in which some of the activities associated with a particular function will to be delegated.

For example, partial delegation of Utilization Management might mean that referral management is delegated while Healthy Mississippi retains the Utilization Management of inpatient services for members. The decision of which functions may be considered for delegation is determined by the type of contract a delegate has with Healthy Mississippi, as well as the ability of the delegate to perform the function pursuant to Healthy Mississippi's policies and procedures, as well as Accreditation Organization standards and state and federal regulatory requirements and to accept the required oversight of the function by Healthy Mississippi.

Healthy Mississippi does not delegate any aspect of appeal and grievance management except in certain special circumstances.

Although a health plan can delegate the authority to perform a function, it cannot delegate the responsibility or accountability for making sure that the function is performed in an appropriate and compliant manner.

Contact the local Healthy Mississippi market office provider representative for detailed information on delegation, or call Provider Relations at 1-833-218-8492.

Note: Although Healthy Mississippi can delegate the authority to perform a function, it cannot delegate the ultimate responsibility for fulfilling the service or obligation.

Delegated providers must comply with the responsibilities outlined in the Delegated Services, Policies and Procedures, Appendix A, section of this manual. The document is available on <https://www.healthy-ms.com>, or a copy may also be obtained from the local Healthy Mississippi market office, or by calling 1-833-201-6413.

XVI. Risk Adjustment

Risk adjustment is a methodology designed by the Center for Medicare and Medicaid Services (CMS) to ensure payments to the health plans reflect the health status and demographic characteristics of enrolled beneficiaries. The goal is to provide appropriate compensation to plans that enroll patients with higher medical needs, thereby promoting equity and improving healthcare accessibility.

Hierarchical Condition Categories (HCCs): HCCs are a key component of the risk adjustment model. They are grouped into related diagnoses that are used to predict future health care costs. Each HCC is assigned a risk score, which contributes to the overall risk score of a beneficiary.

For example, diabetes with complications (HCC 18) has a higher risk score than uncomplicated diabetes (HCC 19).

Risk Adjustment Factor (RAF) Score and Calculation: The RAF score is a numerical value assigned to each beneficiary based on their HCCs and demographic factors. Valid diagnosis

codes from ICD-10-CM are used to identify conditions that contribute to the beneficiary risk score. The RAF score is the sum of individual HCC scores + demographic factors (age, gender, Medicaid status, etc.). This score is used to adjust the payment to the MA plan.

Normalization: Risk scores are normalized to ensure compatibility across different populations and adjusted factors such as frailty and institutional status.

Documentation: The Center for Medicare and Medicaid Services (CMS) mandates that beneficiaries' condition(s) must be reported at least once each calendar year. Documentation must substantiate the reported condition(s) and clearly outline the provider's assessment and/or treatment management.

CMS Risk Adjustment Data Validation Audits: The Center for Medicare and Medicaid Services (CMS) conducts annual Risk Adjustment Data Validation (RADV) audits to ensure the accuracy and compliance of risk adjustment data. Health plans and their providers selected for these audits are required to submit medical records to confirm the accuracy of previously submitted diagnosis data.

This process is essential for maintaining the integrity of the Medicare risk adjustment system by verifying that the data used reflects the true health status of the population.

Data Collection: Risk adjustment relies on data from various sources, including medical records, claims, and encounter data. Accurate and comprehensive data is needed for capturing beneficiaries' health profiles.

Submission: Diagnosis data must be submitted to the Center for Medicare and Medicaid Services (CMS) through the Risk Processing System (RAPS) and the Encounter Data System (EDS). Timely and accurate submission is required for proper risk score calculation and reimbursement.

For more information on Risk Adjustment <https://www.cms.gov>

XVII. Pharmacy Services

Pharmacy services are covered through **Healthy Mississippi**. Members can find a list of in-network pharmacies on the Healthy Mississippi website or by directly contacting the Healthy Mississippi (HM) office for assistance.

Contact Information:

- **Phone:** 1-833-218-8492
- **Part D Fax:** 1-888-710-8090

Pharmacy Program

All providers are required to adhere to Healthy Mississippi's drug formularies and prescription policies. For comprehensive details regarding drug coverage and guidelines, please refer to the

Medicare Part D section of this Provider Manual. It is essential for providers to stay informed about the latest updates to ensure compliance with the formulary.

Timeframes

Prior authorization decisions must be made as expeditiously as the Member's health condition requires and within the regulatory timeframes established by CMS (Centers for Medicare & Medicaid Services).

Medicare Organization and Coverage Determination Timeframes:

- **Expedited Part D drug requests:** Decisions will be made within **24 hours**.
- **Standard Part D drug requests:** Decisions will be made within **72 hours**.

Medicare Part D

A Part D coverage determination is a critical decision regarding the provision or payment for a Part D drug. This includes decisions concerning:

- Tiering exception requests
- Formulary exception requests
- The amount of cost sharing for a drug
- Determining whether a Member has satisfied prior authorization or other Utilization Management requirements

Any party to a coverage determination—such as a Member, a Member's representative, or a Member's prescriber—has the right to request an appeal. Only Members, their representatives, or providers may request an expedited coverage determination or redetermination. The nature of the request will dictate whether the determination is standard or expedited based on the urgency of the situation.

Appeals/Redeterminations

When a Member's request for a coverage determination is denied, they have the right to designate someone (which can include an attorney, Provider, or other authorized representative) to act on their behalf. Members have up to **60 days** from the date of the denial to request a redetermination. This is the first level of appeal for Part D adverse decisions.

- **Response Time:** The redetermination request will be responded to within **7 days**. If an expedited appeal is required due to an emergent situation, the decision will be made within **72 hours** of the request.
- Members or their representatives can submit additional comments, documents, or data related to the appeal both in person and in writing at any time during this process.

If the appeal or reconsideration is denied, Members can escalate the appeal to the **Independent Review Entity (IRE)** within **60 days** of receiving the denial. The IRE will have **7 days** to make a decision for a standard appeal/reconsideration and **72 hours** for expedited requests. The IRE will notify both Healthy Mississippi and the Member of its decision. If the IRE alters the initial decision, authorization for the service must be implemented within **72 hours** for standard appeals and within **24 hours** for expedited appeals.

Part D Prescription Drug Exception Policy

CMS defines a coverage determination as the initial decision made by a plan regarding the prescription drug benefits a Member is entitled to receive under the plan. This includes:

- Decisions not to provide or pay for a Part D drug
- Decisions concerning exception requests
- Decisions on the cost-sharing amounts for a drug

An exception request is a specific type of coverage determination request. Through the exceptions process, Members can request:

- An off-formulary drug
- An exception to the plan's tiered cost-sharing structure
- An exception to the application of a cost Utilization Management tool (such as step therapy requirements, dose restrictions, or prior authorization requirements)

Healthy Mississippi is committed to ensuring access to medically necessary prescription drugs. If a drug is prescribed that is not included in HM's formulary, the Member or their representative can file for an exception.

Contact Information for Exceptions and Appeals:

- Call HM at 1-833-201-6413
- Fax: 1-888-710-8090

Formulary

The formulary is a comprehensive list of covered pharmaceuticals that includes restrictions, preferences, and copayment information. Members are encouraged to review the formulary to understand which medications are covered and any associated requirements.

Copayments for Part D

The amount that a patient pays out-of-pocket depends on the drug tier classification and whether the Member fills the prescription at a preferred network pharmacy. Understanding the tier system is crucial for Members to anticipate their costs.

Restrictions on Healthy Mississippi's Medicare Drug Coverage

Some covered drugs may have additional requirements or limits on coverage, including:

- **Prior Authorization:** Required for certain drugs, which can include both formulary and non-formulary drugs. Without prior approval, HM may deny coverage for these drugs.
- **Quantity Limits:** For certain medications, HM may impose limits on the quantity of the drug covered within a specified timeframe.
- **Step Therapy:** In some instances, HM requires Members to try specific drugs to treat a medical condition before it will cover other drugs for that condition. For example, if both Drug A and Drug B treat the same condition, HM may require the use of Drug A before approving Drug B.
- **Part B Medications:** Certain medications listed in the formulary may also be eligible for coverage under Medicare Part B, depending on the method of administration and place of service. Newly FDA-approved drugs are considered non-formulary and are subject to specific non-formulary policies and other utilization criteria.

Non-Covered HM Medicare Part D Drugs

The following categories of drugs are excluded from coverage:

- Agents used for anorexia, weight loss, or weight gain (without evidence of medical necessity).
- Agents used to promote fertility.
- Agents used for cosmetic purposes or hair growth.
- Agents intended for symptomatic relief of cough or colds.
- Prescription vitamins and minerals, except those for prenatal care and fluoride preparations.
- Non-prescription drugs, except those included in HM's Medicare over-the-counter (OTC) benefit, as applicable depending on the plan.
- Outpatient drugs where the manufacturer requires associated tests or monitoring services to be purchased exclusively from them as a condition of sale.
- Prescriptions not used for a medically accepted indication (i.e., prescriptions must either be FDA-approved or supported by compendia for the diagnosis they are used for; the Medicare-approved compendia are American Hospital Formulary Service Drug Information (AHFS) and DRUGDEX® Information System).

Requesting a Formulary Exception: A formulary exception is a request to obtain coverage for a medication that is not included in HM's list of covered drugs (formulary). This process is necessary when a member needs a specific medication that isn't listed, and it

allows the member or their provider to request that the drug be covered despite its absence from the formulary.

1. **Who Can Request:** A Member, their appointed representative, or their prescribing provider.
2. **Process:**
 - Complete the Exception request form, which is available on the HM website.
 - Submit the form via fax, as this is the predominant method for filing.
3. **Purpose:** To request coverage for a medication not included in HM's formulary.

Requesting a Formulary Redetermination (Appeal): A formulary redetermination (or appeal) is a process used to contest an adverse decision made by HM regarding coverage. This typically happens when a member receives a notice of denial for a requested drug or claim payment. The appeal allows the member or their representative to challenge this decision and seek a review for potential coverage.

1. **Who Can Appeal:** The Member or their representative following a denial.
2. **Process:**
 - If a Notice of Denial is received, you can initiate an appeal.
 - The specific steps and form needed for the appeal can also be found on the HM website or in the Provider Manual.
3. **Purpose:** To contest a denial of a requested drug or claim payment.

Additional Steps

- Ensure that all necessary documentation and supporting information are included with your request to facilitate a smoother review process.
- Keep a copy of all submitted forms and correspondence for your records.

For detailed forms and specific guidelines, always refer to the HM website or the Medicare Advantage Provider Manual. If you have further questions or need assistance with a specific case, reaching out to HM's customer support can also be helpful.

Healthy Mississippi's pharmacy network offers limited access to pharmacies with preferred cost sharing in rural areas in Mississippi. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including pharmacies with preferred cost sharing, please call 1-833-201-6413, TTY users can call 711, or consult the online pharmacy directory at www.healthy-ms.com.