Network Participating Provider Manual

CY2025

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Quick Reference

Website - www.valorhealthplan.com

Medical Claims Submissions *(Electronic and Paper Submissions) – Page 23*

Valor Health Plan
PO Box 3398
Little Rock, AR 72202-3398

Provider Services for Claims *(Reimbursement Options) - Page 23*

- Claim Status – Request portal access utilizing the portal request form. It is found on the providers tab of our website https://valorhealthplan.com/providers. Email the completed request to ppmanagement@accesshealthservices.com.
- Phone - 1-866-225-8501 - (8:00 am to 4:00 pm - Central Time)

Credentialing – providerservices@valorhealthplan.com

Expedited Appeals Address, Fax #, and Email Inquiry

Valor Health Plan Attn: Appeals
PO Box 3630
Little Rock, AR 72202-3630
Fax 1-866-820-0690
Email Status Inquiry - claims@accesshealthservices.com

Pharmacy Management

1-833-459-4423

Part D Appeals

MedImpact
ATTN: Coverage Decisions
10181 Scripps Gateway Ct
San Diego, CA 92131

Valor Mailing Address

Valor Health Plan
PO Box 527
Green, Ohio 44232-0527

Valor Health Plan - Medicare Compliance Officer – *Pages 35 and 36*

(For FWA, compliance, privacy or civil rights questions)

Compliance Hotline Phone Number

1-844-223-2371

Mailing Address

PO Box 527
Green, Ohio 44232-0527

Introducing Valor Health Plan (HMO SNP)

Welcome to the Valor Health Plan (Valor) Institutional Special Needs Plan (HMO SNP). We are pleased to have you as a participating provider. Valor is an Ohio-based Health Maintenance Organization (HMO) dedicated to Medicare Advantage product offerings. Valor serves individuals with Medicare and living in a residential healthcare facility.

A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan that exclusively enrolls a disproportionate percentage of special needs individuals as set forth in §422.4(a)(1) (iv) of the MA regulations and provides Part D benefits under 42 CFR Part 423. A SNP is also an MA plan that has been approved by the Centers for Medicare & Medicaid Services (CMS) meeting the MA SNP requirements, on a plan-by-plan basis using criteria that includes the appropriateness of the target population, the existence of clinical programs or special expertise to serve the target population.

Members must reside in the approved service area in order to enroll in the plan. The current Ohio service area includes the following counties:

Valor Health Plan County Service Area

Adams, Allen, Ashland, Ashtabula, Auglaize, Brown, Butler, Carroll, Champaign, Clark, Clermont, Clinton, Columbiana, Coshocton, Crawford, Cuyahoga, Darke, Defiance, Erie, Fairfield, Fayette, Fulton, Geauga, Greene, Guernsey, Hamilton, Hancock, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Knox, Lake, Licking, Logan, Lorain, Lucas, Madison, Mahoning, Medina, Mercer, Miami, Monroe, Montgomery, Morgan, Morrow, Muskingum, Noble, Ottawa, Paulding, Perry, Pike, Portage, Preble, Putnam, Sandusky, Seneca, Shelby, Stark, Summit, Trumbull, Tuscarawas, Van Wert, Vinton, Warren, Washington, Wayne, Wood, and Wyandot.

Model of Care

Our model of care ensures early diagnosis and intervention by the Nurse Practitioner (NP) and/or Primary Care Physician (PCP), to encourage improved communication between providers and Members (and family, if desired), and the delivery of the appropriate services. Care coordination is central to our model of care. This approach is centered in the belief that an individualized, closely monitored and highly coordinated level of care can enhance patient well-being.

As a result, Valor's model of care is grounded in the following core principles:

Nurse Practitioners (NPs) will coordinate and provide care for members residing in a network residential care facility, with an emphasis on a Member's well-being and maintaining an optimal level of wellness.

Case Managers will coordinate care for those members residing in the community through telephonic contact and face-to-face intervention with the NP when necessary.

Clinicians will monitor the complete picture of a Member's physical, social and psychological needs.

Plan providers will have experience or additional education in geriatric medicine, with a specific interest in caring for the frail, elderly and disabled.

The model will minimize Member transfers of care and provide a greater amount of care within the nursing home or other least restrictive setting by bringing providers to the Member, when possible.

Clinicians will place a strong focus on disease prevention, working with nursing home staff and other clinicians to

help ensure regular assessments and early detection of health conditions.

Care teams advocate for patients and assist with maximizing care benefits available to them.

Families will be encouraged to be more involved in a Member's care, with stronger and more consistent communication among the family, their care team, and nursing home staff.

Each Member has a Primary Care Physician. Members are also assigned an NP who works with the Primary Care Physicians, nursing facilities staff, and families to provide intensive primary and preventive services to Members who have a long-term or advanced illness or have disabilities.

1. The Role of the Primary Care Physician

The following specialties are considered Primary Care Physicians, or PCPs:

- Family practice
- General practice
- Geriatrics
- Internal medicine

All Valor Members must select a PCP. If the Member has not selected a PCP, one will be assigned based on the Member's geographic area.

The scope of services to be provided by the PCP may include, but is not limited to, the following:
Diagnostic testing and treatment
Injections and injectable substances
Office or nursing facility visits for illness, injury and prevention

The PCP has the primary responsibility for coordinating the Member's overall healthcare among the Member's various healthcare providers. The PCP works closely with the NP, to reduce redundant or unnecessary services and provide the most cost-effective care. Valor monitors referrals to promote the use of network providers, analyze referral patterns and assess medical necessity.

PCPs, as well as all other providers, are expected to:

- Maintain high quality of care
- Provide the appropriate level of care
- Use healthcare resources efficiently

2. The Role of the Nurse Practitioner (NP)

Our model of care introduces the concept of the NP as a trusted partner in the integrated care team. Together with physicians, administrators, Members, and families, NPs treat the "whole person," rather than addressing the patient's disease or illness only.

The NP visits the nursing home setting on a regular basis, working with the nursing home staff, interdisciplinary team and physicians to closely monitor changes in health, focus on early diagnosis and intervention, and coordinate communication between all relevant practitioners and family members.

The NPs assess and help develop and manage personalized care plans for Valor Members. The NPs work closely with the nursing facility interdisciplinary staff and PCPs, the Member and his/ her family to ensure a responsive plan of care for the Member. Based on an initial Personal Health Assessment, which is done upon enrollment and at least annually unless triggered by a change in health status or condition, or admission to the hospital. The NP develops a

care plan and assures that the plan is implemented and the Member's needs are met.

The NPs review the Health Risk Assessment that is performed by the Case Manager, oversee diagnostic services and treatments to ensure medical and mental health parity, ensure access to comprehensive benefits as needed, and provide education on the health risks and care to the Member and his/her family. They coordinate multiple services; help facilitate better communication between physicians, institutions, patients and their families; and help ensure effective integration of treatments.

The NPs are available 24 hours per day, 7 days per week and are on-site for providers and Members, Monday - Friday at variable times due to patient needs during normal business hours. After-hours, weekend and holiday coverage is provided 24 hours per day, 7 days per week by a health plan staff member designated to be on-call.

3. The Role of the Case Manager

Each Member is assigned to a Case Manager. Depending on the needs of the Member, the Case Manager may make contact, generally through phone calls, as frequently as weekly for the higher need members, but at least monthly for the average member.

The case manager assures timely and appropriate delivery of services, providers' use of clinical practice guidelines developed by professional associations, seamless transitions, and timely follow-up to avoid lapses in services or care when there is transition across settings or providers, and conducts chart and/or pharmacy reviews.

The case manager completes, analyzes, and incorporates the results of the initial and annual Health Risk Assessment into the care plan and collaborates to develop and annually update an individualized care plan for each Member. The interdisciplinary team also manages the medical, cognitive, psychosocial, and functional needs of beneficiaries through the initial and annual health assessments, and communicates to coordinate care plan with the provider, Member, family and health plan, as needed.

4. The Role of the Specialist

Members may see in-network specialists with an order from the PCP or NP. There is no official referral/authorization process through Valor Health Plan that is needed for referrals. Female Members may see network gynecologists or their PCP for a well-woman examination without any prior authorization or referral.

To maximize their benefits and reduce out-of-pocket costs, Members are encouraged to see in-network specialists. If Members see a non-network provider, the service may not be covered. Please call with questions about network participating providers or visit www.valorhealthplan.com.

Preventive Screenings and Disease Management

The NP visits each Member at least monthly. In addition, Valor requests that PCP's visit each member at least quarterly and perform an annual medical evaluation, addressing the Member's specific needs and conducting appropriate preventive screenings.

Preventive guidelines to be addressed include, but are not limited to:

- Screening for colorectal cancer
- Mammography (females)
- Influenza vaccine administration
- Pneumonia vaccine administration

Gaps in Member care require appropriate intervention to improve and meet recommended goals. Either Valor staff or the Member's PCP may provide this intervention.

The following charts list suggested guidelines for Providers to follow when ordering preventive tests and treatments for Members with chronic conditions.

Prevention Measurements Table

General Preventive Care:

	Pneumonia Vaccine	Once per lifetime = >65 years
	Influenza Vaccine	Once every 12 months
	Breast Cancer Screening	Once every 12 months
	Body Mass Index (BMI)	Once every 12 months
	Prostate Cancer Screening	Once every 12 months
	Colorectal Cancer Screening: Fecal Occult Blood Test	Once every 12 months

Chronic Conditions Measurements Table

Diabetes/Obesity:

	Eye Exam	Once every 12 months
	HgbA1C	Once every 6 months
	Microalbumin	Once every 12 months
CHF:		
	Ejection Fraction measurement	Once per lifetime
CAD:		
	LDL levels	Once every 12 months

Clinical Practice Guidelines

Valor Health Plan adopts Clinical Practice Guidelines for the purpose of improving health care and reducing unnecessary variations in care. The guidelines are evidence-based, sourced from recognized organizations, approved by the Valor Health Plan Quality Improvement Committee, disseminated to Valor Health Plan healthcare providers, reviewed annually, and updated as needed. The Clinical Practice Guidelines in this document are considered essential to healthcare for the member population we serve.

Selecting a Primary Care Physician (PCP)

All Valor Members must select a PCP from the list of participating primary care physicians in the Valor Provider directory. If a Member does not select a PCP, Valor will assign a PCP based on geographic access. A PCP is not permitted to refuse services to an eligible health plan Member.

Members may change PCPs by contacting Member Services. The change becomes effective on the first day of the following month.

Verifying Member Eligibility

Possession of an ID card is not a guarantee of eligibility. Providers should photocopy the card and check it for any change of information, such as address and eligibility date.

Providers should verify Member eligibility before each office visit using the telephone number listed on the back of the Member's health plan ID card or by calling member service at 1-866-225-8501.

Member Copayments and Coinsurance

Valor covers the same benefits as Original Medicare as well as some enhanced services.

For a list of benefits and their respective cost-sharing amounts, go to www.valorhealthplan.com for the most recent Summary of Benefits and Evidence of Coverage (EOC).

As an Institutional Special Needs Plan, some members may be eligible for the cost sharing benefits provided by Ohio Medicaid. Generally, this will provide the member with no cost sharing for covered services provided by in-network providers. Other members of the plan will have the same cost sharing expenses as with Original Medicare Part A and Part B with applicable deductibles, copayments, and co-insurance costs.

Providers are not allowed to charge copayments, co-insurance, or deductible charges that are the responsibility of Valor or Ohio Medicaid.

Benefit Exclusions

The following list indicates some, but not all, of the services not covered by Medicare or Valor. Some of these services may be covered by the State Medicaid Program. Valor staff will help coordinate benefits and services.

SERVICE	EXPLANATION AND EXCEPTIONS
Abortion	
Acupuncture	
Ambulance	Ambulance is covered only if transportation in any other vehicle would endanger the Member's life. Air ambulance is paid only in emergency situations. If land ambulance would not seriously endanger the Member's health, Medicare will reimburse land ambulance rates only.
Chiropractic services	Exception: Manual manipulation of the spine to correct subluxation.
Contraceptives	

Cosmetic surgery	Exception: Reconstructive surgery is a covered benefit, as it is primarily intended to improve bodily function, relieve symptoms or improve appearance altered by disease, trauma or previous therapeutic processes (e.g., when breast reconstruction is performed following a mastectomy), or exists because of congenital or developmental abnormality.
Custodial care or respite care	
Dental services	Exceptions include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, or services that would be covered when provided by a physician except as specifically stated in the Member's EOC. Tooth extractions for other reasons are not covered.
Foot care, routine	
Durable medical equipment and medical supplies that do not meet Medicare coverage criteria	Examples include shower chairs, safety tubs, stair lifts and blood pressure monitors.
Exercise programs	
Experimental or investigative procedures	
Eye surgery for refractive defects	Exception: Veterans Affairs hospitals and military treatment facilities are considered for payment according to current legislation.
Government treatment	Same as above.
Homemaker services	
Naturopath services	
Obesity treatment	Exception: This exclusion does not apply to surgical obesity treatment if treatment is necessary to treat another life-threatening condition involving obesity or if providers document that non-surgical obesity treatments have failed.
Orthodontia	
Orthopedic shoes, unless part of a leg brace	
Personal comfort items	
Private duty nursing	Exception: If Valor determines that such services are medically necessary before service is rendered
Sex transformation	
Work-related conditions	

Quality Improvement

Valor's approach to quality improvement is built on a model that involves the entire organization and related operational processes. The Quality Improvement program incorporates information from all of Valor departments and encourages providers to participate in quality improvement initiatives.

The Quality Improvement model employs a cycle of continuous improvement methodology. Opportunities for improvement are identified through qualitative and quantitative reviews of member care and services.

Quality improvement is a shared responsibility between Valor and its contracted networks and other delegated entities. The Quality Improvement department oversees and assists with many of the activities that support

continuous quality improvement, including:

- Reviewing processes to identify quality improvement needs
- Organizing work groups and committees, such as the Clinical Quality Improvement Committee
- Identifying best practices
- Developing and implementing improvement initiatives
- Collecting data to evaluate the results of the activities and initiatives

Member satisfaction and quality of care/quality of service issues evaluated and reviewed on a regular basis. The CMS Star program results and the Quality Reporting Metrics serve as ongoing indicators for the Quality Improvement Work Plan.

Participation in the collection, review, and submission of CMS Star quality rating system performance data is one means by which Valor evaluates the quality of Member Services, care and satisfaction.

In addition, Valor is a full participant in CMS-required activities, including but not limited to the Chronic Care Improvement Program (CCIP) that targets the improvement of care for Members with a chronic condition as outlined by CMS. Program development is underway to meet this standard and improve the care and health outcomes for our Members.

Advance Directives

All healthcare providers who participate in the Medicare Advantage program must offer Members written information about their right to make their own healthcare decisions, including the right to accept or refuse medical treatment and the right to execute advance directives.

An Advance Directive generally is a written statement that an individual has established – in advance of serious illness – regarding a medical decision. The Advance Directive must be in accordance with the Member's state regulatory guidelines in order for it to be considered valid. All adults have the right to create and initiate an Advance Directive.

The two most common forms of advance directives are a living will and a healthcare durable power of attorney.

Living Will – A living will take effect while the individual is still living. It is a written document concerning the kind of medical care a person wants or does not want if he or she is physically or mentally unable to make a decision.
Healthcare Durable Power of Attorney – A healthcare durable power of attorney is a signed, witnessed written statement by an individual naming another person as an agent to make medical decisions if he or she is physically or mentally unable to do so. A healthcare durable power of attorney can include instructions about any treatment the individual desires to undergo or avoid.

Neither document becomes effective unless the individual is unable to make decisions (generally as certified by a treating physician). The individual can change or revoke either document at any time. Otherwise, it should remain effective throughout the person's life.

A Member who decides to execute a living will or a healthcare durable power of attorney is encouraged to notify their PCP, or treating provider, of its existence, provide a copy of the document to be included in personal medical records and discuss this decision with the PCP or treating provider. If a Member is under the care of a provider who is unable to honor the Member's Advance Directive, the Member may transfer to the care of a provider willing to do so.

Member Appeals

The Evidence of Coverage is provided to each member and states that every Member has the right to file an appeal. Members or their authorized representative must file an appeal within 60 calendar days of receiving notification of Valor's denial decision or provide "Good Cause" for the delay in filing.

Examples of Good Cause reasons include the following:

- The Member did not personally receive the adverse organization determination notice or received it late
- The Member was seriously ill, which prevented a timely appeal
- There was a death or serious illness in the Member's immediate family
- An accident caused important records to be destroyed
- Documentation was difficult to locate within the time limits
- The Member had incorrect or incomplete information concerning the reconsideration process
- The Member lacked the capacity to understand the time frame for filing a request for reconsideration

A Member may appoint an authorized representative or request that the Member's physician, ancillary practitioner or hospital represent him/her in the appeal or grievance. To be appointed, both Member and the proposed representative (including attorneys) must sign, date, and complete the Appointment of a Representative (AOR) form (CMS1696 form) or an equivalent written notice. The AOR form is available on the CMS website at: https://www.cms.gov/cmsforms/downloads/cms1696.pdf .

A Member's treating physician or non-physician provider may file an appeal on the Member's behalf without representation documentation. However, Medicare regulations require that the physician notify the Member that the appeal is being filed.

Valor must provide an expedited determination if a Member or Member's physician indicates (the physician does not have to use the exact words) that applying the standard time frame could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.

There must be potential Member liability (e.g., an actual claim for services already rendered as opposed to an advance organization determination) in order for a provider to appeal utilizing the Member appeal process.

Certain Member or provider appeals (pre-service and payment) may require that Valor obtain additional medical records from the treating provider to adequately perform a fair and independent review. A plan representative, generally an Appeals Specialist, will request medical records. The Appeals Medical Director may also request a peer-to-peer review to address treatment or patient-specific information to assist in the plan's appeal determination.

A provider has the right to an appeal when a denial of a service rendered occurs, or upon receipt of an initial claim or Revised Payment Determination that results in a zero payment to the provider.

Expedited appeals should be faxed to 1-866-820-0690. Standard appeals may be faxed to the same number or mailed to:

Valor Health Plan
Attn: Appeals
PO Box 3630
Little Rock, AR 72202

CMS Timeliness Standards Regarding Member Appeals

CMS regulations require that Valor respond to pre-service standard appeals within 30 calendar days and within 60 calendar days for post-service appeals. Therefore, providers must respond to requests for information from Valor within five calendar days so that Valor is able to obtain all appropriate and complete information to make a timely and fully-informed decision. The deadline for pre-service standard appeals may be extended by 14 calendar days if doing so is in the interest of the Member.

Valor must make a determination for expedited appeal requests within 72 hours of receipt. Providers must respond to Valor's requests for information regarding expedited pre-service appeals within 24 hours to ensure timely resolution. The deadline for pre-service expedited appeals may be extended by 14 calendar days if doing so is in the interest of the Member. (Post- service (payment) appeals cannot be processed as expedited.)

Expedited appeals should be faxed to 1-866-820-0690.

Clinical Services – Overview

Valor strives to deliver a coordinated care approach to providing care for our Members. This coordination is led by the Nurse Practitioner or facility members working in conjunction with the PCP and the Member's Interdisciplinary Care Team which may include community-based providers, facility-based providers and the facility staff.

It is through this coordinated approach that services are delivered in the most effective and efficient manner. Therefore, Valor has incorporated certain authorization processes.

Valor urges all providers to use the services of a network hospital. This will assure the most appropriate cost sharing for the Members. The model of care emphasizes appropriate care at the most clinically appropriate setting. Whenever appropriate, unnecessary hospitalization should be avoided to minimize Member disruption and the risk of infections.

Transition of Care

If a facility-based Member must be hospitalized, the NP discusses the Member's typical functioning level with the hospital staff. This communication can often result in avoiding unnecessary therapy or care, preventing redundant X-ray or lab tests, and reducing the length of stay.

The Valor NP and Case Manager are the central resource in coordinating transitions of care and ensuring that Members are appropriately and successfully transferred from one care setting to another. The majority of transitions are from the nursing facility to the hospital, and back again to the nursing facility.

The goal is to help reduce re-hospitalizations and avoid adverse events during the periods of transition. Valor staff is on call 24 hours a day, 7 days a week and are notified immediately when a facility transition of care is underway.

The NP or PCP reviews the appropriateness of the transfer and ensures all necessary Member information is transferred via the facility transfer face sheet, medication list, and Do Not Resuscitate (DNR) orders. The NP may also visit the Member in the hospital within one day of the transition to monitor the Member's status and communicate any issues or concerns.

Authorizations

Valor requires authorization for all outpatient and inpatient procedures. Providers are required to utilize the authorization request form obtained on the Valor Health Plan website under the *providers tab* at https://valorhealthplan.com/providers. **Completed authorization requests are faxed to 1-844-798-4357**. Valor will review all requests and will respond promptly. Please call 1-844-228-1070 if you have any questions.

Medicare criteria, as well as a contracted healthcare guidelines service or other geriatric focused criteria, are used when reviewing authorization requests. If additional information is needed, Valor staff will contact the requesting provider in order to obtain such documentation. **The approved authorization is valid for the dates listed on the authorization.**

Authorizations Questions - Contact the Utilization Management team directly at 1-844-228-1070 from 8:00 am – 4:00 pm EST.

The requested provider should use the Valor authorization number, indicated in the confirmation letter, in the authorization field of the claim form. The CMS-1500 claim form can be found at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf

An initial notification of pending denial will be faxed to the requesting provider before the denial decision. The requesting provider may discuss the decision with a physician reviewer or request a copy of the criteria used to make the determination by calling Provider Services at **1-866-225-8501.**

If a denial decision is made, the denial letter will contain all information necessary for an appeal. A copy of the denial letter and appeal information is also sent to the Member.

Elective Admissions

To admit a Member for an elective admission, the admitting provider must receive prior authorization from Valor at least three business days before the admission.

The admitting provider must work with the NP / case manager and the hospital to schedule the admission and any pre-admission testing.

Pre-Admission Diagnostic Testing

Pre-admission diagnostic testing includes:
Laboratory diagnostic tests
Radiological diagnostic tests
Other diagnostic tests, including electrocardiogram, pulmonary function and neurological function

All preadmission diagnostic testing conducted before a Member's medically necessary surgery or admission to the hospital is covered when performed at an approved facility. **All outpatient and inpatient procedures require a prior authorization.**

Emergency Admissions

Valor will cover care for an emergency medical condition with symptoms of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part

Upon admitting a Member from the emergency department, the hospital should collect the following information:

- The name of the Member's PCP
- The name of the Member's referring Provider (PCP, NP or the nursing facility), if applicable
- The name of the admitting Provider if different from the referring Provider or PCP
- Nursing Facility Residence

The hospital or facility should notify Valor at 1-844-228-1070 within 48 hours or on the next business day following the emergency admission.

Observation Status

Observation status applies to Members for whom inpatient hospital admission is being considered but is not certain. Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether the Member will require further treatment as hospital inpatients or if he/she is able to be discharged from the hospital. Observation services are commonly ordered for Members who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning his/her admission or discharge.

Observation status should be used when:

- The Member's condition is expected to be evaluated and/or treated within 24 hours, with follow-up care provided on an outpatient basis.

The Member's condition or diagnosis is not sufficiently clear to allow the Member to leave the hospital.

Authorization is not required for an observation status. There is no time limit on an observation status.

Admission Review

The Member and attending physician are notified immediately and the case is referred to the Valor Medical Director if:

- An admission request does not appear to meet guidelines upon initial review and/or
- A Member's condition no longer meets criteria for an extended length of stay/level of care

The admitting provider will have the opportunity to discuss the treatment plan and/or medical guidelines with the Valor Medical Director. If a request results in a denial or adverse determination, Valor will send a letter of non-authorization the same day by messenger, fax or mail. This letter includes the appeals process.

Valor Members have the right to an immediate Peer Review Organization (PRO) review of a denial. The Member or authorized representative must make such a request in writing or by telephone by calling **Utilization Management at 844-228-1070 by noon on the next business day following receipt of the notice of non-coverage.**

If the Member or authorized representative does not choose to initiate an immediate PRO, the Member retains the right to appeal through the regular appeal process and should contact Member Services.

Notices of Non-Coverage/Denial

If a provider makes a recommendation for care and the Member does not agree, the Member must be given his/her appeals rights, which requires the Member to call Valor and dispute the recommended services. Once the Member has filed a grievance, Valor will process the request for services accordingly. If the decision results in a denial, Valor will send out the appropriate form.

Those updated forms include:

- Integrated Denial Notice: Notice of Denial of Medical Coverage/Notice of Denial of Payment (CMS 100003–NDMCP) – When denying a request for medical service, in whole or in part, or when denying a Member's request for payment of a service already received.

- Notice of Medicare Non-Coverage (CMS 10095-NOMNC) – When informing Members receiving skilled nursing, home health (including psychiatric home health), or comprehensive outpatient rehabilitation facility services of the termination of services. (Valor must provide the service termination date to the provider no later than two days before the termination of services.)

Concurrent Review

Concurrent review is performed to assess the appropriateness of continued inpatient care in a hospital or skilled nursing facility.

Concurrent review includes:

- Review of medical necessity
- Determination of the next review date
- Discharge planning
- Research/coordination of alternatives to inpatient care, such as home healthcare

The review is conducted on Members in acute, rehabilitation, skilled nursing, and psychiatric facilities.

Medicare criteria, as well as an evidenced-based clinical decision support solution of healthcare guidelines, are used when coordinating inpatient care. Valor obtains clinical information on inpatient Members by coordinating with the utilization review staff at the facility. This may involve reviewing the medical record and/or interviewing attending physicians.

Transfers

The Member's NP or case manager will help coordinate the transfer of any Valor Member from a network hospital to another facility. Every effort should be made to maintain the use of contracted facilities. This helps to ensure a coordinated approach to the management of the Member and minimizes Member disruption.

Discharge Planning

The Valor NP and Case Manager work with hospital staff, attending physicians, PCP, and facility staff to coordinate discharge planning. A Valor clinical team member helps coordinate follow-up care, ancillary services and other appropriate services.

The Valor clinical team member will place a post-discharge call or visit to Members. The call/visit may include:

- Confirmation that follow-up appointments are made
- Verification that prescriptions are filled
- Confirmation that discharge services are completed
- Identification of symptoms of complications that may require readmission

Transplant Management

The Valor care management team helps providers interpret transplant benefits for Members and choose a facility from the national transplant network. Each transplant facility is selected based upon its level of expertise and standards of care using an established set of criteria.

Transplant coverage includes pre-transplant, transplant and post-discharge services, as well as the treatment of complications after transplantation. Providers should contact Health and Wellness Services as soon as they feel transplant services may be necessary and before evaluation for transplant services.

A claim for a transplant may be reviewed for medical necessity to ensure coverage for qualified Medicare benefits.

Provider, Member and Member's Family Satisfaction Surveys

Satisfaction surveys provide Valor with feedback on performance relating to:

- Access to care and/or services
- Overall satisfaction with Valor
- Provider availability
- Quality of care received
- Responsiveness to administrative processes
- Responsiveness to inquiries

Member ID Cards

All Valor members are provided a Member ID Card which should be presented at the time of medical services. Refer to the Valor website at www.valorhealthplan.com for information about specific benefits, and Member cost-sharing.

Claims and Reimbursements - Billing Guidelines

Providers should bill Valor rather than Medicare or a Medicare Supplement carrier. Providers should bill all Medicare-covered services in accordance with Medicare and CMS rules, standards and guidelines applicable to Parts A and B. In addition, providers should use applicable CMS billing forms (i.e., UB-04/CMS1450, CMS1500, or such successor forms) and follow the same coding rules and billing guidelines as Original Medicare, including Medicare CPT Codes, HCPCS codes and defined modifiers.

Diagnosis codes should be billed to the highest level of specificity. The following information should be included on claims:

- National Provider Identifier (NPI)
- The Member's identification number
- Date(s) of service
- Required CMS modifiers
- Diagnosis
- All other required CMS fields (e.g., number of service units, service location, etc.)

Providers who are paid based on interim rates should include with the claim a copy of the current interim rate letter if the interim rate has changed since the previous claim submission.

Billing questions and/or problems should be directed to Provider Services at **1-866-225-8501**.

Claim Submission Guidance

- Do not bill the Medicare carrier or fiscal intermediary. Doing so will delay payment and Medicare will not process the claim.
- Providers must include their NPI number on all claims.
- Durable medical equipment suppliers must use a 10-digit DME Medicare supplier number.
- Laboratories must use their 10-digit Clinical Laboratory Improvement Amendments (CLIA) number.
- Providers should submit claims to Valor as soon as possible after the service is rendered.
- Submit claims using the same coding rules as original Medicare and use only Medicare- approved CPT codes and defined modifiers.
- Bill diagnosis codes to the highest specificity.

5. Clean vs. Unclean Claims

Valor processes and pays all error-free claims, known as clean claims, for covered services provided to a Member within 30 calendar days of receipt by the plan, or as required by applicable federal law. If a clean claim is not paid within the 30-day time frame, Valor will pay interest on the claim according to Medicare guidelines.

Under CMS guidelines, a "clean" claim is a claim with no defects or improprieties. An "unclean" claim may include:

- Lack of required substantiating documentation
- A particular circumstance requiring special treatment that prevents timely payment from being made on the claim
- Any required fields where information is missing or incomplete
- Invalid, incorrect or expired codes (e.g., the use of single-digit instead of double-digit place-of- service codes)

- A missing Explanation of Benefits (EOB) for a Member with other coverage

Valor will process all unclean claims and notify providers of the determination within 60 days of receiving such claims.

6. National Provider Identifier

All healthcare Providers should have a NPI. The NPI replaces Legacy identifiers such as the Unique Physician Identification Number or UPIN.

The purpose of the NPI is to uniquely identify a healthcare Provider in standard transactions, such as healthcare claims. The NPI may also be used to identify healthcare Providers on prescriptions, in internal files to link proprietary Provider identification numbers, in coordination of benefits between health plans, inpatient medical record systems and in program integrity files.

The NPI is the only healthcare Provider identifier that can be used for identification purposes in such transactions.

7. Reimbursements

Valor complies with Medicare's prompt payment of claims requirements for all clean claims. Claims must be submitted within the time frame specified in the provider's contracts. Valor processes all error-free claims (known as clean claims) for covered services provided to a Member within 30 calendar days of receipt by the plan.

8. Special Circumstances

For certain Medicare-approved providers, Valor pays as follows:

- Eligible hospitals are reimbursed according to CMS IPPS DRG reimbursement methodology, including Capital Indirect Medical Education Expense (IME) payments. Hospitals receive the same IPPS DRG reimbursements, including add-on payments, that they would receive under original Medicare based on rates published on the CMS website (www.CMS.gov). The payment is added to the Inpatient Prospective Payment System (IPPS). However, because Fiscal Intermediaries are responsible for operating IME and DGME, Valor does not reimburse those components of the DRG.

- Valor reimburses qualifying Disproportionate Share Hospitals the same capital exception payments and add-on payments for operating DSH that they would have received under original Medicare. The payment is added to the Prospective Payment System (PPS) rate. Valor reimburses DSH payments on a claim-by-claim basis in the same manner as CMS.

- Valor does not reimburse facilities for bad debt incurred as a result of Members not paying their cost-sharing amounts (if any), unless specified in a provider's contract.

- Valor does not enter into the annual cost settlement process with providers, contracted or non-contracted. Providers who have treated Valor Members should contact Medicare or their Fiscal Intermediary regarding their cost settlements.

9. Billing for Non-Covered Services

Providers may not bill a Member if Valor denies payment because the service was not covered, unless:

- The provider has informed the Member in advance that the services may not be covered, and
- The Member has agreed, in writing, to pay for the services.

10. Balance Billing Provisions

A provider may collect only applicable plan cost-sharing amounts from Valor Members and may not otherwise charge or bill Members. Balance billing is prohibited by providers who furnish plan-covered services to Valor Members.

11. Provider Remittance Advice Form

Valor sends Providers a Provider Remittance Advice Form (PRAF) once it has received and paid a claim.

Remittance Advice Through our Portal - For providers that are contracted or receiving payments, to make a request to utilize Valor's portal, complete the Valor Provider Portal Request Form which is located on our website at https://www.valorhealthplan.com/providers or by calling Provider Services at 1-866-225-8501.

Remittance Advice Through Zelis - EFT Payments Enrollment – Zelis – If you are a contracted provider interested in receiving payments through electronic funds transfer (EFT) without fees, please follow the Valor EFT Request for PAR Providers process available on our website at ttps://www.valorhealthplan.com/providers. Please allow 10 days after contracting with Valor for Zelis to provision your TIN.

Questions regarding the PRAF may be addressed to Valor at 1-866-225-8501 from 8 AM to 5 PM (CST), Monday-Friday a week.

When calling, Providers should have the following information available for the representative:

- National Provider Identifier (NPI)
- Claim number in question
- Member's name
- Date of service
- Member's date of birth
- Issue requiring review
- Member's ID number
- Copy of claim (if available)

12. Coordination of Benefits

If a Member has primary coverage with another plan, providers should submit a claim for payment to that plan first. The amount payable by Valor will be governed by the amount paid by the primary plan and the coordination of benefits policies.

In order to bill the correct payer, the provider must obtain all the information that determines whether the Member is covered. The provider must include all this information on the claim form to facilitate the correct adjudication.

For a provider who accepts Medicaid and who treats a Valor Member who is a Medicaid patient, Valor will pay the Medicare portion of the claim. The provider must then submit the claim to the appropriate state Medicaid entity for the Medicaid portion of the claim.

The following types of situations, not an exhaustive list, will prevent payment by Valor as the primary payer:

- Elderly Workers Employed Group Health Plan (EGHP): These Members, who are 65 years or older, are covered by an EGHP with 20 or more employees or the spouse of a person covered by an EGHP. The spouse's age is not material to the determination of primary coverage, only the qualification of the EGHP.

- Disabled Beneficiaries Employer Group Health Plans: These Members are eligible for Medicare based on disability and are under the age of 65 years and are covered by a Large Group Health Plan (LGHP) through their own or a family member's employment. LGHP is defined by at least one of the employers having at least 100 employees.

- Federal Black Lung Program: The Black Lung Program was established under the Department of Labor to assist coal miners with pulmonary and respiratory diseases that resulted from their employment. The program is billed for all services that relate to either respiratory or pulmonary diseases. Valor is the primary payer for all other care and service needs.

- Workers' Compensation: The Workers' Compensation carrier is responsible for all injuries and illnesses that result from employment. Valor pays only when the Workers' Compensation benefits are exhausted or the services/care were not covered by the Workers' Compensation carrier but are Medicare benefits.

- Veterans Administration (VA) Coverage: Care and services authorized by the VA are payable in full by the VA. Claims from one government program cannot be reimbursed by another government program. Valor may supplement VA payment when the Member files a claim for Part B services that were not fully reimbursable by the VA.

Filing a Claim for Payment

Medicare Eligibility Checking – Valor Health Plan = TSG Guard, Inc - H Code - H1119 (001)

Electronic Submissions

Filing claims electronically reduces administrative costs, speeds claims payment and improves payment accuracy. Submissions utilize Valor's **EDI# 43259**.

Paper Submissions

Providers who prefer to submit claims by mail should send them to the following address:

Valor Health Plan
C/O Access Health Services
PO Box 3398
Little Rock, AR 72202-3398

Reimbursement Options and Changes

Virtual Credit Card to Paper Checks

For You will receive Virtual Credit Card payments with your Explanation of Payment (EOP). Your office will receive fax notifications, each containing a virtual credit card with a number unique to that payment transaction including an instruction page for processing. Normal transaction fees apply based on your merchant acquirer relationship. If you are a contracted provider for Valor and want to receive paper checks instead of a Virtual Credit Card, contact Zelis Payment Support at 877-828-8770 or email ClientServices@zelispayments.com.

EFT Payments Enrollment – Zelis – If you are a contracted provider interested in receiving payments through electronic funds transfer (EFT) without fees, please follow the Valor EFT Request for PAR Providers process available on our website at https://www.valorhealthplan.com/providers. Please allow 10 days after contracting with Valor for Zelis to provision your TIN.

EFT Payments Support – Zelis – For support with EFT payments, you can contact the Zelis E-Payment Support Center at 855-774-4392. The fee-free EFT payments for the Valor Health Plan (with Access Health as our claims processor) are sponsored by the payer and are specific to Valor payments as opposed to paying a fee for Zelis to manage all your claims payments.

Payments Support (Payment Issues, Changes, and General Inquires) – For changes to your payment method or if you encounter any payment issues (not related to claims), please contact Zelis Support at 877-828-8770 or email ClientServices@zelispayments.com.

Change of Payment Mailing Address - To request a change of a remittance address, please email your new address, TIN, Group NPI, and an updated W-9 to providerservices@valorhealthplan.com.

Portal Request Form (Check Claims Status and to Determine Eligibility)

For providers that are contracted or receiving payment, to make a request to utilize Valor's portal, complete the Valor Provider Portal Request Form which is located on our website at https://www.valorhealthplan.com/providers or by calling Provider Services at 1-866-225-8501.

Provider Payment Dispute Resolution Process - Appeals

If a provider believes a clean claim should have been paid differently, providers have the right to dispute the payment.

Appeals and Corrected Claims Timelines

The timeframe for submitting corrected claims or an appeal is based on their network status and applies to all providers.

- **In network providers** - Submit an appeal or corrected claim within 120 days of the original paid/denied date.
- **Out-of-network providers** - Submit an appeal or corrected claim within 60 days of the original paid/denied date.

Process

Providers must address disputes regarding claims payments (such as denied claims, inappropriate payments, the timing of payments or the amount of the claim) in writing. **Our fax number for appeals is 866-820-0690**. Providers may contact Provider Services at **1-866-225-8501.**

To file an official payment dispute, providers should submit a letter disputing the payment along with any supporting documentation. Providers should place this letter on company letterhead and may include a cover sheet outlining the reason for the requested review along with the claim and Provider Remittance Advice Form, or PRAF.

Please provide the following information on the written provider dispute:

- Date(s) of service
- Member name
- Member ID number and/or date of birth
- Provider name
- Provider Tax ID / TIN
- Total billed charges
- The provider's statement explaining the reason for the dispute
- Supporting documentation when necessary (e.g. proof of timely filing, medical records)

Expedited Appeals Address, Fax #, and Email Inquiry

Valor Health Plan Attn: Appeals
PO Box 3630
Little Rock, AR 72202-3630
Fax 1-866-820-0690
Email Status Inquiry - claims@accesshealthservices.com

Valor will respond to all written disputes regarding claims within 60 business days.

If Valor agrees with the reason for the payment dispute, Valor will issue a new Explanation of Payment (EOP) and pay the additional amount that is requested, including any interest due.

Valor will inform providers in writing if the decision is unfavorable and no additional amount is owed, as well as supply information regarding the provider's appeal rights.

Filing Deadlines

Providers that have a Participation Agreement with Valor Health Plan should consult the agreement for applicable filing deadlines.

For all non-contracted providers, Valor Health Plan follows Medicare's timely filing guidelines.

For institutions or providers billing with span dates exceeding a month in duration, the date of service is considered the discharge date, or when the service is completed, not the date treatment begins or the patient is admitted for care.

Provider Contracting, Credentialing, and Providing Updates

Contracting

To contract with Valor, email providerservices@valorhealthplan.com or call 330-498-8231. Request an **Individual Agreement** for a solo practice and a **Group Agreement** for practices with more than one provider.

Credentialing - Provider/Facility Additions, Terms, Changes

Provider Additions: If adding a new provider, please include the practice Tax ID, Group NPI, CAQH number, location address, provider NPI, provider degree, and specialty types. Include the remit address if it is a new address along with the W-9. Email providerservices@valorhealthplan.com or call 330-498-8231. Our address is Network Operations, Valor Health Plan, PO Box 527, Green, Ohio 44232-0527

Provider Terms and changes: Please include the TIN, provider NPI, and the effective date. For location changes, include the TIN, provider NPI, address, and phone numbers that are being added or removed as well as the effective date. Email providerservices@valorhealthplan.com or call 330-498-8231. Our address is Network Operations, Valor Health Plan, PO Box 527, Green, Ohio 44232-0527

Credentialing of providers may be conducted internally by Valor staff or delegated to an external entity. If delegated, Valor will conduct both pre-delegation and annual audits to ensure credentialing standards are maintained throughout the network. The standards outlined below summarize Valor's approach to credentialing. **If you have any questions or would like to request our complete credentialing policies, please contact Valor's Network Operations Director at 330-498-8231 or via email at providerservices@valorhealthplan.com.**

The provider credentialing process involves several steps: application, primary source verification, credentialing committee review, and notification. Once contracted, Valor will utilize the provider's CAQH (Council for Affordable Quality Healthcare) number and submit it our CVO to begin the review process.

Once all the credentialing information has been obtained, including primary source verification, the credentialing process includes reviewing all the criteria per our policy. If Valor notes any discrepancies, it notifies the provider in writing and gives the provider two weeks to forward the correct information to Network Operations Department.

In addition, a physician has the right to review the information submitted in support of the application. If the physician discovers erroneous information on the application, he or she has an opportunity to correct this information before the Valor Credentialing Committee or the external vendor reviews it. The physician must initial and date the corrected information or update their CAQH profile.

Credentialing Process

13. Provider Credentialing

- CMS requires provider credentialing and recredentialing as directed by 42 CFR §422.204, under the Social Security Act, Section 1852, and the Medicare Managed Care Manual, Chapter 6 (Relationships with Providers, §§ 20.2, 30, 50, 60.1-4, and 70). Credentialing is mandatory for all physicians who provide services to Medicare Advantage Organizations (MAOs) members. Additionally, other types of health care professionals who offer services to enrollees and are permitted to practice independently under state law must also undergo credentialing. Credentialing verifies that providers have the required medical training and ensures compliance with Medicare regulations.

- Initial credentialing - Must be completed prior to inclusion in the provider directory. If either party terminates the contract or there is a break in service of more than 30 calendar days, Valor must credential the provider before the provider may rejoin the network.

- Re-credentialing will be completed every 3 years unless the provider is on active military assignment, maternity leave or a sabbatical, but the contract between Valor and the provider remains in place, Valor may re-credential the provider upon his/her return. At a minimum, Valor must verify that a provider who returns has a valid license to practice before he or she resumes seeing patients. Within 60 calendar days of when the provider resumes practice, Valor must complete the recredentialing process.

14. Credentialing Committee

- Valor Health Plan established the Credentialing Committee as a governing body to oversee the credentialing and recredentialing process for provider participation in the health plan network and as required by CMS. The committee members evaluate provider credentialing reports as completed by credentialing staff and approved for review by the Network Operations Director. The Medical Director of the and the Credentialing Committee will approve or disapprove providers for participation in the network.
- Credentialing Committee members include the health plan Medical Director, who serves as Chairman of the Committee (voting member), Medical Practitioners (voting members), Network Operations Director (non-voting member) and others as deemed necessary by the Medical Director. Two voting members are necessary for approvals of the Level 2 category report.
- The Credentialing Committee meets as necessary, but not less than four times annually.

15. Provider Eligibility Requirements and Rights

- Providers applying for initial participation or requesting continued participation in the Valor provider network must have a completed application with current attestation and submitted to a reputable CVO (i.e. CAQH).
- Approval or disapproval notice for participation in the network will be sent timely to the provider.
- If a provider is not approved for participation in the network, the provider may appeal the decision.

16. Provider Terminations

Valor Health Plan reserves the right to implement immediate termination where there is reason to suspect that a provider's continued participation in the provider network could pose imminent risk to members and/or for reasons related to regulatory compliance with Medicare.

17. Site Visits

- Site visits will be conducted for Providers or Facilities who have received 4 or more member grievances within a calendar year.
- Valor will perform the onsite review of a Provider or Facility to assess compliance with Medicare requirements.
- If the MA organization becomes aware of conditions at a site that suggest compromised safety or other concerns related to the delivery of care, the MA organization will be expected to perform a site visit as soon as possible or no less than 60 days from notification of issue, to assess the facility and identify corrective actions.

18. Delegated Credentialing

- CMS requires provider credentialing and recredentialing as directed by 42 CFR §422.204, under the Social Security Act, Section 1852, and the Medicare Managed Care Manual, Chapter 6 (Relationships with Providers, §§ 20.2, 30, 50, 60.1-4, and 70). Credentialing may be conducted by a contracted health organization when Valor has delegated these activities to said organization.
- Providers that have been credentialed through a delegated entity are considered credentialed by Valor Health Plan at all provider practices.
- The credentialing staff will maintain a file on each delegated arrangement, including a copy of the fully executed delegation agreement, completed assessment tools, corrective action plans, and monitoring of corrective action plans for the contracted health organization.

19. Organization Credentialing

- CMS requires credentialing and recredentialing as directed by 42 CFR §422.204, under the Social Security Act, Section 1852, and the Medicare Managed Care Manual, Chapter 6 (Relationships with Providers, §§ 20.2, 30, 50, 60.1-4, and 70). Credentialing is mandatory for all who provide services to Medicare Advantage (MAOs) members. Additionally, other types of health care professionals who offer services to enrollees and are permitted to practice independently under state law must also undergo credentialing.
- Valor will confirm that the Facilities are in good standing with regulatory bodies and have been reviewed by an accrediting body, if required. Valor may conduct an onsite quality assessment if necessary, if the Facility is not accredited.
- Initial credentialing
- Must be completed prior to inclusion in the provider directory. If either party terminates the contract or there is a break in service of more than 30 calendar days, Valor must credential the Facility before the Facility may rejoin the network.
- Re-credentialing will be completed every 3 years. Pharmacy.

More details can be obtained by contacting providerservices@valorhealthplan.com

Medicare Part D

Overview

The Valor Pharmacy Management Department helps manage healthcare dollars spent on prescription medications. In addition, the department works with Health Services to coordinate Member care regarding medications.

Valor partners with MedImpact, a Prescription Benefit Manager (PBM), to administer the prescription programs for Valor Members.

The Valor formulary may be viewed and downloaded by going online to https://valorhealthplan.com/documents/2020/09/2021-comprehensive-formulary.pdf/

Formulary Key Points

- Physicians and clinical pharmacists on the Pharmacy and Therapeutics Committee develop and maintain the formulary for Valor.
- A staff clinical pharmacist is available to assist with the following:
  - Answer medication-related questions from providers and network pharmacies
  - Assist in educating providers and network pharmacies about pharmacy changes
  - Serve as a clinical resource for contracted providers and their staffs

20. The Prior Authorization Department:

PHONE	1-833-459-4423 (TTY users call 711) 8:00 am to 8:00 pm Monday through Friday
FAX	1-877-503-7231
MAIL	MedImpact ATTN: Coverage Decisions 10181 Scripps Gateway Ct San Diego, CA 92131
WEBSITE	www.valorhealthplan.com

Coverage Determination

Valor has several processes that help ensure the effective and efficient use of medications under the prescription benefit offered to Members. Valor refers to these processes collectively as “coverage determination.”

The following list includes the various types of coverage determination requests:

- Formulary exception – Coverage for a Part D medication that is not on the formulary
- Prior authorization – Coverage for certain formulary prescription drugs that require specific clinical criteria
- Step therapy – Coverage for certain formulary prescription drugs that first require the trial and failure of other formulary alternatives
- Quantity limits – Coverage for certain medications that have quantity limits to ensure compliance with FDA guidelines and appropriate use of medications

Each of these various types of coverage determinations has its own respective request form, which may be accessed in the following ways:

PHONE	1-833-459-4423 (TTY users call 711) 8:00 am to 8:00 pm Monday through Friday
FAX	1-501-372-1932
MAIL	MedImpact Coverage Decisions 10181 Scripps Gateway Ct San Diego, CA 92131
WEBSITE	www.valorhealthplan.com

Excluded Medications

Medicare has excluded certain medication classes from coverage by Part D Medicare programs. These classes include all drugs (brand and generic) and combination drugs that contain a medication within these classes:

- Medications used for erectile dysfunction
- Medications used for anorexia, weight loss or weight gain
- Medications used for cosmetic purposes or hair growth
- Medications used to promote fertility
- Medications used for the symptomatic relief of cough or colds
- Nonprescription medications – Medications that, by federal law, do not require a prescription
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

Alert – No Appeal for Excluded Medications

Medications falling into the categories listed above cannot be covered even for medical necessity. The decision of non-coverage cannot be appealed, nor can exceptions be made to allow for coverage.

Discontinuing, Changing or Reducing Coverage

Generally, if a Valor Member is taking a formulary drug that was covered at the beginning of the year, Valor will continue coverage of the drug during the coverage year except when a new, less expensive generic drug becomes available or when adverse information about the safety or effectiveness of a drug is released.

Other types of formulary changes, such as removing a drug from the formulary, will not affect Members currently taking the drug and will remain available at the same cost sharing for the remainder of the coverage year.

Notification of Formulary Changes

If Valor removes drugs from the formulary; adds coverage determinations, such as prior authorizations, quantity limits, and/or step therapy restrictions on a drug; or moves a drug to a higher cost-sharing tier, Valor must notify affected Members and providers of the change at least 60 days before it becomes effective.

If the Food and Drug Administration deems a formulary drug to be unsafe or if the drug's manufacturer removes it from the market, Valor will immediately remove the drug from the formulary and notify Members who take the drug.

Transition Policy

Valor may provide temporary coverage of medications for new Members who are taking non-formulary drugs or drugs that require coverage determination. Valor may grant a temporary 30-day supply within the enrollee's first 90 days of Membership, during which time the provider should initiate the same "coverage determination" process outlined previously.

Transition coverage also is available for residents of long-term care facilities or Members whose medications are affected by a level-of-care change (e.g., discharge from acute setting or admission to/discharge from long-term care facility).

Pharmacy Network

Members must fill all medications at network pharmacies for coverage at the lowest out-of-pocket cost. Members who use non-participating pharmacies may pay higher out-of-pocket costs and must submit receipts for reimbursement.

Participating pharmacies include community-based pharmacies, pharmacies that serve long-term care facilities, and specialty pharmacies (home infusion pharmacies)

Medicare Part B

Definition of Part B Coverage

Medicare Part B originally was designed to help people with Medicare pay for their medical costs but not for their medications.
Over the years, though, Congress added benefits to treat specific diseases, including medications used to treat those diseases. The Part B benefit does not apply to specific medications (Exceptions may apply for IPPB solutions and some diabetic supplies) but rather to the treatment of certain diseases.

Medicare Part B covers a limited number of prescription drugs. These Part B drugs generally fall into three categories:

- Drugs furnished incident to a physician's service
- Drugs used as a supply to durable medical equipment (DME)
- Certain statutorily covered drugs, including:
  - Immunosuppressive drugs for beneficiaries with a Medicare-covered organ transplant
  - Hemophilia blood clotting factor
  - Certain oral anti-cancer drugs

- Oral anti-emetic drugs
- Pneumococcal, influenza and hepatitis vaccines (for intermediate to high-risk individuals)
- Antigens
- Erythropoietin for trained home dialysis patients
- Certain other drugs separately billed by End-Stage Renal Disease (ESRD) facilities (e.g., iron dextran, vitamin D injections)
- Home infusion of intravenous immune globulin for primary immune deficiency

Medicare Part B drug coverage has not been changed by implementation of the new Medicare Part D drug program. Drugs that were covered by Medicare Part B before the Part D prescription drug program became operational continue to be covered under Medicare Part B.

Copayments for each category are as follows:

- Part A – Generally No copayment (part of the Hospital payment)
- Part B – Generally No coinsurance (varies by plan and/or product)
- Part D – Generally No Member copayment (varies by plan and/or product and/or by tier level)

Part B Medication Authorizations and Claims

Drugs furnished incident to physician's services follow the same authorization and claim procedures as other physician services.

For prescription medications dispensed by a pharmacy, the Valor pharmacy claims system is able to adjudicate Part B claims. Some prescription medications may require Part B vs. Part D coverage determination review.

Medicare Part B vs. Part D Coverage Determination for Prescription Medications Dispensed by a Pharmacy

While the use of some medications is assumed to fall under Part B coverage, others require additional clinical information before coverage can be determined. Therefore, certain prescription medications are subject to prior authorization for Part B vs. Part D coverage determination. The intent is not to establish clinical grounds for approval but to determine the circumstances of the claim for payment purposes.

Valor will allow payment as a Part D benefit only when it can establish appropriate coverage. Otherwise, coverage is redirected as a Medicare Part B claim.

In addition:

- Some medications could be covered under Part B (medical) or Part D (prescription) depending on several issues, including the diagnosis, residential status of the Member or route of administration.
- Part B and Part D drugs have different copayments, and Part B drugs do not apply to True Out-of- Pocket costs (TrOOP).
- The process to determine if the drug is to be covered as Part B or Part D is the same process outlined previously for "coverage determination."

Physician Rights, Responsibilities and Roles

Valor is committed to offering its Members access to physicians and healthcare services and facilities that provide quality care in a manner that preserves a Member's dignity, privacy and autonomy.

As such, Valor employees and contracted providers shall:

- Treat all Members with respect and courtesy.
- Not discriminate against Members in the delivery of healthcare services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, and source of payment or other protected class.
- Respond promptly to Members' questions and document communications with Members as appropriate.
- Protect Members' rights by publicizing such rights to Members, employees and network providers.
- Comply with all the legal and professional standards of care, ethics, conduct and behavior applicable to health maintenance organizations, their employees and their network providers.
- Provide Members with information concerning the benefits available to them so they may avail themselves of such benefits as appropriate.
- Make sure Members have reasonable access to the services to which they are entitled under their plans.
- Give Members (or their legal guardians, when appropriate) the opportunity to make informed decisions concerning their medical care, including information about withholding resuscitative service, forgoing or withdrawing life-sustaining treatment, or participating in investigation studies or clinical trials. Healthcare providers shall obtain informed consent as required by law.
- Inform Members of their rights to an appeal if a provider chooses not to supply a service or treatment requested by the Member.
- Preserve the integrity and independence of clinical decision making by network providers. In making such decisions concerning a Member's medical care, network providers shall not allow themselves to be influenced by financial compensation to the provider or provider network that results from such decisions or by coverage of a particular treatment or course of care by the Member's plan.
- Follow the guidance of provider marketing training as required by the Medicare Improvements for Patients and Providers Act (MIPPA).

Provider Role in HIPAA Privacy Regulations

Valor policies and procedures include regulatory information to make sure Valor complies with the Health Insurance Portability and Accountability Act (HIPAA) regulations and the Gramm-Leach- Bliley Act.

Hospitals and providers subject to HIPAA are trained to understand their responsibilities under these privacy regulations – as is the staff at Valor.

Throughout its business areas, Valor has incorporated measures to make sure potential, current and former Members' Protected Health Information (PHI), individually identifiable health information and personally identifiable financial information are maintained in a confidential manner, whether that information is in oral, written, or electronic format. Valor employees may use and disclose this information only for those purposes permitted by federal legislation (for treatment, payment and healthcare operations), by the Member's written request, or if required to be disclosed by law, regulation or court order.

Valor developed its referral/authorization request form in accordance with the core elements and required statements contained in the HIPAA privacy rules. To determine pre-service medical necessity, providers should complete, sign and return the referral/authorization form to Valor.

All Members receive Valor's Privacy Statement and Notice of Privacy Practices in their welcome kit materials. Members also receive a copy of the privacy information with their Annual Notice of Change (ANOC) and Evidence of Coverage (EOC). These documents clearly explain the Members' rights concerning the privacy of their individual information, including the processes established to provide them with access to their PHI and procedures to request to amend, restrict use and have accounting of disclosures. The documents further inform Members of Valor's precautions to conceal individual health information from employers.

Valor's Notice of Privacy Practices is separate and distinct from the Notice of Privacy Practices providers are required to give to their patients under HIPAA. To view the Privacy Statement and Notice of Privacy Practices, contact Provider Services at **1-800-485-3793**.

Complying with the Americans with Disabilities Act

Providers' offices are considered places of public accommodation and, therefore, must be accessible to individuals with disabilities. Offices are required to adhere to the Americans with Disabilities Act (ADA) guidelines and any of its amendments, Section 504 of the Rehabilitation Act of 1973 (Section 504), and other applicable state or federal laws.

Valor requires that network providers' offices or facilities comply with these aforementioned statutes/laws.

The ADA and Section 504 require that providers' offices have the following modifications: (i) the office or facility must be wheelchair accessible or have provisions to accommodate people in wheelchairs; (ii) patient rest rooms should be equipped with grab bars; and (ii) handicapped parking must be available near the provider's office and be clearly marked. These aforementioned requirements are not an exhaustive list of the standards or access requirements mandated by the ADA, Section 504, or any other applicable state or federal law.

Anti-Kickback Statute

Valor is committed to conducting its business activities in full compliance with applicable Federal and State laws. In support of this commitment, Valor must ensure that all Providers adhere to the Federal Anti-Kickback Statute and state equivalents (the "Anti-Kickback Policy"), which applies to all covered persons.

The Anti-Kickback Statute states that anyone who knowingly and willfully accepts or solicits any remuneration (including any kickback, hospital incentive or bribe) directly or indirectly, overtly or covertly, in cash or in kind, to influence the referral of Federal healthcare program business may face charges, including felony charges, and/or civil penalties, such as being barred from participation in federal programs.

Discounts, rebates or other reductions in price may violate the anti-kickback statute because such arrangements involve remuneration to induce the purchase of items or services payable by the Medicare Program.

In order to be permissible, an activity that implicates the anti-kickback statute must qualify for protection under a specific Safe Harbor. A complete list of Safe Harbor activities: refer to the Medicare and Medicaid Fraud and Abuse Statute (42 CFR Parts 1001 – 1005; Sections 1001.951 and 1001.952) or consult your legal counsel.

Medicare Advantage and Part D Fraud, Waste and Abuse

Scope of Fraud, Waste and Abuse on the Healthcare System

The National Health Care Anti-Fraud Association (NHCAA) website reports that healthcare loss due to fraud, waste and abuse has an impact on patients, taxpayers and the government because it leads to higher healthcare costs, insurance premiums and taxes. Healthcare fraud often hurts patients who may receive unnecessary or unsafe healthcare procedures or who may be the victims of identity theft.

Healthcare fraud is knowingly and willfully executing, or attempting to execute, a scheme to defraud any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of any healthcare benefit program.

Healthcare waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Healthcare abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary.

Medical identity thieves may use a person's name and personal information, such as their health insurance number, to make doctor's appointments, obtain prescription drugs, and file claims with Medicare Advantage Plans. This may affect the person's health and medical information and can potentially lead to misdiagnosis, unnecessary treatments, or incorrect prescription medication.

To limit the number of alleged incidents of medical identity theft involving Members, provider claim personnel should verify Member account numbers when filing medical claims for processing.

Reporting Fraud, Waste and Abuse

Compliance Program

Valor has established a comprehensive Compliance Program and is committed to ensuring that all organizational areas are, and remain, compliant with applicable State and Federal regulatory requirements. The Compliance Program is an organizational value-based system that will identify, detect, prevent, correct and report suspected non-compliance with State and Federal regulatory requirements. Valor works collaboratively with State and Federal regulatory agencies to achieve the mutual goals of providing quality healthcare and the effective elimination of fraud, waste and abuse.

The Plan designed the Compliance Program and all efforts surrounding this program to establish a culture that promotes prevention, detection and resolution of conduct that may not conform to State and Federal laws, including Federal healthcare program requirements including the Plan's ethical and legal standards of conduct. In practice, the Compliance Program and the Code of Conduct effectively articulate and demonstrate the Plan's commitment to legal and ethical conduct.

Suspected incidents of fraud, waste and abuse may be reported anonymously to Valor's Compliance Department.

Compliance Hotline Phone Number (Anonymous) - 1-844-223-2371

You may also report suspected fraud, waste and abuse by regular mail by contacting:

Valor Health Plan - Compliance Officer
PO Box 527
Green, Ohio 44232-0527
Phone: 330-498-8220

Medicare Fraud Waste & Abuse Hotline
Medicare Fraud Hotline: 1-800-447-8477
Report online: https://oig.hhs.gov/fraud/report-fraud/

Additional Information
- www.insurancefraud.org
- www.ssa.gov/oig
- www.nhcaa.org

Medicare Improvements for Patients and Providers Act (MIPPA)

Rules Related to Marketing Medicare Advantage Plans

In general:

- Doctors and office staff may not encourage patients to enroll in the plan in any way; doing so is considered "steering."
- CMS draws no distinction between exclusive and non-exclusive groups when it comes to regulations on steering.
- Providers may make available to their patients, information for all plans with which they are affiliated, including common area availability for health plan events and CMS-approved marketing materials.

Plan Affiliations

Providers may:

- Release the names of plans with which they are affiliated.
- Announce plan affiliations through general advertising. Providers must make new affiliation announcements within the first thirty (30) days of the new contract agreement. However, new affiliation announcements that name only one plan may occur only once when using direct mail and/or e-mail. Additional communications must include all plans with which the provider contracts.
- Display affiliation banners, brochures and/or posters for all plans that have provided such materials and with which the provider is affiliated.

Providers should not:

- Make phone calls, direct, urge, offer inducements or attempt to persuade any prospective Medicare member to enroll in a particular plan.
- Suggest that a particular plan is approved, endorsed or authorized by Medicare.

Federal & State Regulations

Overview

There are a number of Federal Regulations that affect Valor's day-to-day operations. These regulations set the benchmarks by which the compliance department reviews all internal operational processes as well as external business initiatives and relationships.

These regulations include, but are not limited to:

- The Health Information Portability & Accountability Act (HIPAA)
- The Medicare Improvements for Patients and Providers Act (MIPPA)
- The False Claims Act and Fraud Enforcement Recovery Act
- Physician Self-Referral Law (Stark Law)
- Anti-Kickback Statute
- Fraud, Waste and Abuse
- The HITECH Act

Health Information Portability & Accountability Act (HIPAA)

Congress introduced this act in 1996 to protect health insurance coverage for workers and their families when they change or lose their jobs. It also requires the establishment of national standards for electronic healthcare transactions and national identifiers for providers, health insurance plans and employers; and helps people keep their information private.