Humana
Healthy Horizons®
in Florida

Provider Orientation and Training 2025

Information for Florida Medicaid healthcare providers and administrators

Humana Healthy Horizons in Florida is a Medicaid product of Humana Medical Plan, Inc.
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Welcome to Humana Healthy Horizons in Florida

About Humana Healthy Horizons in Florida

Welcome and thank you for becoming a participating provider with Humana Healthy Horizons® in Florida. We are a community-based health plan that serves Medicaid consumers throughout Florida.

- In 2024, Humana was awarded a statewide contract for all 9 regions in Florida by the Agency for Health Care Administration (AHCA) to serve as a comprehensive long-term care (LTC) plus plan for the Florida Statewide Medicaid Managed Care (SMMC) program.
- Comprehensive LTC plus plans are awarded to managed care plans qualified to provide managed medical assistance (MMA) and LTC services to eligible recipients, as well as one or more MMA specialty products to Medicaid recipients who meet specified criteria based on age, medical condition or diagnosis.
  - To qualify, health plans are required to meet high standards in network, member quality and clinical performance metrics.
- Humana Healthy Horizons is available to all eligible Medicaid recipients in the state of Florida.

Find more information by visiting our Humana Healthy Horizons in Florida provider webpage or by calling MMA/Comprehensive/Specialty Provider Services at 800-477-6931, Monday – Friday, 8 a.m. – 8 p.m., Eastern time, or LTC Provider Services at 888-998-7735, Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

The foundation for Humana Healthy Horizons

Our focus is on member well-being achieved through coordinated care via community and provider partnerships. Humana Healthy Horizons offers a strong support infrastructure to engage both members and providers with the goal of improving member outcomes and overall health.

Member engagement

- Continuity of care
- Member outreach
- Healthy behavior incentives
- Case management
- Disease management
- Care coordination (LTC)
- Interdisciplinary care team (LTC)
- HumanaBeginnings®

Support infrastructure

- Member and provider contact centers
- Quality management and improvement
- Compliance
- Collaboration and alignment with AHCA
- Availity Essentials™ provider portal
- Claims inquiry and resolution support

Provider engagement

- Initial and ongoing training
- Town halls for each region
- Quarterly primary care provider (PCP) staff visits
- Quality bonuses and value-based programs
- Preferred PCP network
- Obstetrician incentive program
- Quality performance review and support

Community engagement

- Advisory panels
- Healthy Start collaboration
- Community outreach

Strategy and implementation approach

Humana Healthy Horizons will provide a seamless transition and continuity of care for Florida members with:

- Organizational structure
- Clinical staffing support
- Florida training program
- Transition/continuity of care
- Behavioral health expertise

Florida SMMC program purpose and eligibility

The Florida SMMC cares for all eligible individuals by providing access to different components of the program:

MMA

MMA is a Florida Medicaid program that provides members with services other than LTC services.

Medicaid recipients who qualify and enroll in the Florida MMA program receive all healthcare services other than LTC though a managed care plan.

Eligibility requirements:

- Meets income and medical need requirements
- Resides in Florida
- Meets physical (nursing home level of care) and financial requirements as determined by the AHCA

LTC

Medicaid recipients who qualify and enroll in the Florida long-term care managed care (LTCMC) program receive LTC services through an LTCMC.

This program component applies to adults with disabilities and members who meet nursing home level of care.

Eligibility requirements:

- 18 or older
- Resides in Florida
- Meets physical (nursing home level of care) and financial requirements as determined by the AHCA

Comprehensive

Medicaid recipients who qualify for both LTC and MMA can enroll in Humana's Comprehensive plan.

Specialty

Included with the MMA or Comprehensive plans, Humana Healthy Horizons offers 2 specialty product plans:

- Severe mental illness (SMI) plan
- HIV/AIDS plan

Humana Healthy Horizons' new specialty plans

Included with the MMA or Comprehensive plans, Humana Healthy Horizons offers 2 specialty product plans:

- SMI plan
  - For those members in 1 or more of the following diagnostic categories:
    - Psychotic disorders
    - Bipolar disorder
    - Major depression
    - Schizophrenia
    - Delusional disorder
    - Obsessive-compulsive disorders
  - Individuals enrolling in the SMI specialty plan must be at least 6 years of age.
- HIV/AIDS plan
  - Individuals enrolled in the HIV/AIDS specialty plan must be diagnosed with HIV or AIDS.

Humana Healthy Horizons offers specialty plans to Medicaid recipients who meet specific criteria based on age, medical condition or diagnosis. Each specialty plan offers additional benefits to eligible recipients.

Provider resources and support

Helpful contact information

Contact name	Contact(s)	Hours of operation
Behavior Analysis (BA) inquiries	Email address: FLBA@humana.com	N/A
Access Behavioral Health (Region A)	Phone: 866-477-6725 **Mailing address for claims:** Access Behavioral Health Attn: Claims Dept. 1221 W. Lakeview Ave. Pensacola, FL 32501 **Case management staff email:** abhreferral@lifeviewgroup.org	24 hours a day, 7 days a week
Availity Essentials™	**Phone:** 800-282-4548	Monday – Friday, 8 a.m. – 8 p.m., Eastern time
Carelon Behavioral Health (Regions B through I)	Phone: 844-265-7590 **Mailing address for claims:** Carelon Behavioral Health P.O. Box 1870 Hicksville, NY 11802-1870	Monday – Friday, 8:30 a.m. – 6 p.m., Eastern time
CenterWell Pharmacy®	Phone: 800-526-1490	Monday – Friday, 8 a.m. – 6 p.m., Eastern time
Central abuse hotline	Phone: 800-96-ABUSE (800-962-2873)	24 hours a day, 7 days a week
Clinical intake team	Phone: 800-523-0023 Fax: 813-321-7220	Monday – Friday, 8 a.m. – 8 p.m., Eastern time
Credentialing inquiries	Email: CredentialingInquiries@humana.com	N/A

Helpful contact information (continued)

Contact name	Contact(s)	Hours of operation
Credentialing reconsideration requests	**Mailing address:** Humana Attn: <Dr. Shoba Srikantan, M.D. Regional Medical Director> 101 E. Main St. Louisville, KY 40202	N/A
Discharge planning	Phone: 877-329-0413 Fax: 833-996-2187	After hours (after Monday – Friday, 8 a.m. – 8 p.m., Eastern time) and weekends
Early intervention services (EIS) inquiries	Email address: eisprovidernetworkfl@humana.com	N/A
Encounter submission	**Mailing address:** Humana Claims Office P.O. Box 14605 Lexington, KY 40512-4605	N/A
Ethics Help Line	Phone: 877-5 THE KEY (877-584-3539)	24 hours a day, 7 days a week
Go365 for Humana Healthy Horizons®	Phone: 888-225-4669 (TTY: 711)	Monday – Friday, 8 a.m. – 8 p.m., Eastern time
Humana Clinical Pharmacy Review (HCPR)	Phone: 800-555-CLIN (800-555-2546) Fax: 877-486-2621	Monday – Friday, 8 a.m. – 8 p.m., Eastern time
Humana Concierge Service for Accessibility	Phone: 877-320-2233	24 hours a day, 7 days a week
Humana Healthy Horizons ethics	Email: ethics@humana.com	N/A
Humana Healthy Horizons MMA case management	Phone: 800-229-9880 (TTY: 711) Email: fl_mma_cm_referrals@humana.com	Monday – Friday, 8:30 a.m. – 5 p.m., Eastern time

Helpful contact information (continued)

Contact name	Contact(s)	Hours of operation
Humana Healthy Horizons in Florida coaching line (tobacco cessation program and weight management program)	Phone: 855-330-8053 (TTY: 711)	Monday – Friday, 8 a.m. – 6 p.m., Eastern time
CenterWell Pharmacy Medicaid intake team	Phone: 866-461-7273 Fax: 888-447-3430	Monday – Friday, 8 a.m. – 8 p.m., Eastern time
Medicare and Medicaid health services phone line	Phone: 800-322-2758, ext. 1394119 for HumanaBeginnings Email: FL_MMA_OB_Referrals@humana.com	Monday – Friday, 8:30 a.m. – 5 p.m., Eastern time
LTC case management	Phone: 888-998-7735	Monday – Friday, 8 a.m. – 5 p.m., Eastern time
LTC contracting	Email address: LTCNetworkRequests@humana.com	N/A
LTC Member Services	Phone: 888-998-7732	Monday – Friday, 8 a.m. – 5 p.m., Eastern time
LTC Provider Services	Phone: 888-998-7735	Monday – Friday, 8 a.m. – 5 p.m., Eastern time
LTC/comprehensive claims submission	**Mailing address:** Humana LTC C/O Humana Inc. P.O. Box 14732 Lexington, KY 40512	N/A

Helpful contact information (continued)

Contact name	Contact(s)	Hours of operation
Medicaid fair hearing requests	Phone: 877-254-1055 Fax: 239-338-2642 **Mailing address:** Agency for Health Care Administration Medicaid Hearing Unit P.O. Box 7237 Tallahassee, FL 32314-7237 Email address: MedicaidHearingUnit@ahca.myflorida.com	Monday – Friday, 8 a.m. – 5 p.m., Eastern time
Member grievance and appeal requests	**Mailing address:** Humana Healthy Horizons P.O. Box 14546 Lexington, KY 40512-4546	N/A
Member Health Risk Assessment (HRA) completion	Phone: 800-611-1467	Monday – Friday, 8:30 a.m. – 5 p.m., Eastern time
Member urgent or expedited appeals	Phone: 888-259-6779	Monday – Friday, 8 a.m. - 8 p.m., Eastern time
MMA/Comprehensive/Specialty Member Services	Phone: 800-477-6931 (TTY: 711)	Monday – Friday, 8 a.m. – 8 p.m., Eastern time
MMA/Comprehensive/Specialty Provider Services	Phone: 800-477-6931 (TTY: 711)	Monday – Friday, 8 a.m. – 8 p.m., Eastern time
MMA contracting	Email address: Humana_FL_Centralized_Provider_Relations@humana.com	N/A

Helpful contact information (continued)

Contact name	Contact(s)	Hours of operation
MMA/Specialty claim submission	**Mailing address:** Humana Healthy Horizons MMA Plan Attn: Claims Department P.O. Box 14601 Lexington, KY 40512-4601	N/A
Modivcare	Phone: 866-779-0565	Monday – Friday, 8 a.m. – 5 p.m., Central time
Neonatal intensive care unit (NICU) admissions	Phone: 855-391-8655 Email address: NICU@humana.com	Monday – Friday, 8:30 a.m. – 5 p.m., Eastern time
Patient-centered medical home (PCMH) program	Email address: FL_Medicaid_PCMH@humana.com	N/A
Provider complaint submission	**Mailing address:** Humana Healthy Horizons Provider Correspondence P.O. Box 14601 Lexington, KY 40512-4601	N/A
Provider Relations	Email address: FLMedicaidPR@humana.com	N/A
Referrals	Email address: FL_MMA_CM_Referrals@humana.com	N/A
Special Investigations Unit (SIU)	Phone: 800-614-4126 Email: siureferrals@humana.com	24 hours a day, 7 days a week

Provider website

Additional details on all topics within this orientation can be found within the Humana Healthy Horizons in Florida Provider Handbook. The provider handbook is updated annually and is an extension of your provider agreement. The handbook and other resources can be found on our Humana Healthy Horizons in Florida provider webpage.

Medical resources for Humana Healthy Horizons providers—Humana Healthcare for Providers main webpage.

- Claims and payment policies
- Credentialing
- Prior authorization (PA)/referrals
- Clinical practice guidelines
- Drug PA
- News and provider publications (including provider handbook)
- Network participation information
- Reconsideration and appeals
- Health and wellness programs
- Pharmacy services
- Quality resources
- Self-service portal
- Electronic funds transfer(EFT)/electronic remittance advice (ERA) resources
- Provider newsletter
- General updates

Humana Healthy Horizons in Florida—Humana Healthy Horizons in Florida provider webpage.

- Provider handbook
- Provider directory
- Provider education
- Pharmacy, quality and training materials

Specialty product for members with HIV/AIDS or SMI

Humana Healthy Horizons provides additional education and training on our Education and training provider webpage and through our continuing education program for medical and nonmedical network providers through Relias®—a web-based continuing education (CE) library. With more than 300 modules to choose from and over 500 hours of CE credits available, Relias' training modules provide integrated information to support comprehensive care and address unique patient needs. Relias offers courses designed to help you succeed in the emerging value-based healthcare delivery system.

Humana Healthy Horizons created a resource guide to support providers, clinicians and care teams to screen and address social determinants of health (SDOH). This resource guide is available to network providers by downloading our Addressing social determinants of health (SDOH) provider quick guide and is designed to support network providers to:

- Understand the impacts of unmet health needs
- Screen patients using evidence-based screening tools
- Support the discussion of SDOH with patients and provide patient-specific resources and support
- Offer guidance for documentation and coding to monitor and follow up with patients of resource referral, ultimately leading to improved health outcomes

Additionally, Humana Healthy Horizons offers additional training to providers on the provision of language services.

Specialized provider education for treating members with HIV, AIDS and SMI

You are required to complete formal training and verify completion of training in the use of evidence-based assessment tools, instruments and techniques for identifying individuals with unmet health needs. To access the training and screening tool, please visit the Addressing social determinants of health (SDOH) provider quick guide. Additional training is available via Relias to help you treat members with HIV and SMI.

Provider self-service help

For help or more information regarding web-based tools:

Humana Healthy Horizons—MMA

For help with registration or questions about Availity Essentials, please call Availity Essentials at 800-AVAILITY (800-282-4548), Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Humana Healthy Horizons—LTC

Please call 888-998-7735, Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

For training:

Humana Healthy Horizons

Please visit our Provider compliance training webpage.

Availity Essentials

Availity Essentials is Humana's preferred method for online transactions.

- ☑ Use one consistent site to work with Humana and other payers.
- ☑ Check eligibility and benefits.
- ☑ Submit referrals and authorizations (MMA).
- ☑ Manage claim status.
- ☑ Use Humana-specific tools.

About Availity Essentials

- Cofounded by Humana
- Humana's clearinghouse for electronic transactions with providers

How to register

- Go to Availity Essentials

Join us for a training session

- Visit the Provider web-based training and resources page to learn about training opportunities and reserve your space.

Questions?

- Availity Essentials help with registration and tools: Call 800-AVAILITY (800-282-4548), Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Provider and member rights and responsibilities

Humana Healthy Horizons-contracted providers have rights and responsibilities. Members are advised of their rights and responsibilities via the Member Handbook.

Detailed information on provider rights and responsibilities can be found in the provider handbook on our Humana Healthy Horizons in Florida main provider webpage.

Required training and annual compliance

Humana Healthy Horizons offers training materials to support providers' efforts to care for patients with Medicaid coverage and to help meet state and federal compliance requirements. Visit our Humana Healthy Horizons in Florida main provider webpage and the Provider compliance training page for direct links to these training materials and information on how to complete annual training and required attestation.

Providers must complete additional compliance training on other topics, as required.

These and other training units are located on the following provider websites:

- Provider compliance training (public)
- Availity Essentials (secure, registration required)

Member eligibility and PCP assignment

Member eligibility and enrollment

Determination

AHCA determines a member's eligibility and will provide eligibility information to Humana Healthy Horizons.

Newborn coverage

Newborn coverage starts on the date of birth when the newborn's mother is a member of a Humana Healthy Horizons plan.

Eligibility

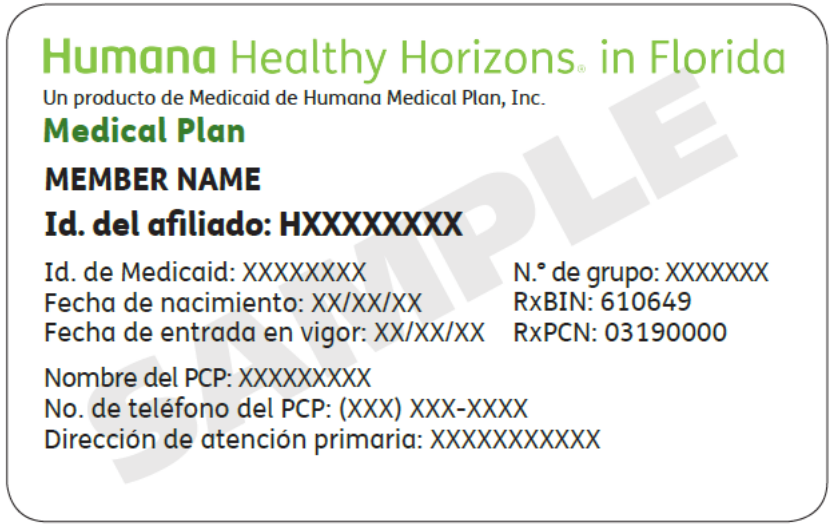
If Humana Healthy Horizons members lose Medicaid eligibility but become eligible again within 180 calendar days, they are automatically reenrolled in Humana Healthy Horizons and assigned to the same PCP, if possible.

Open enrollment

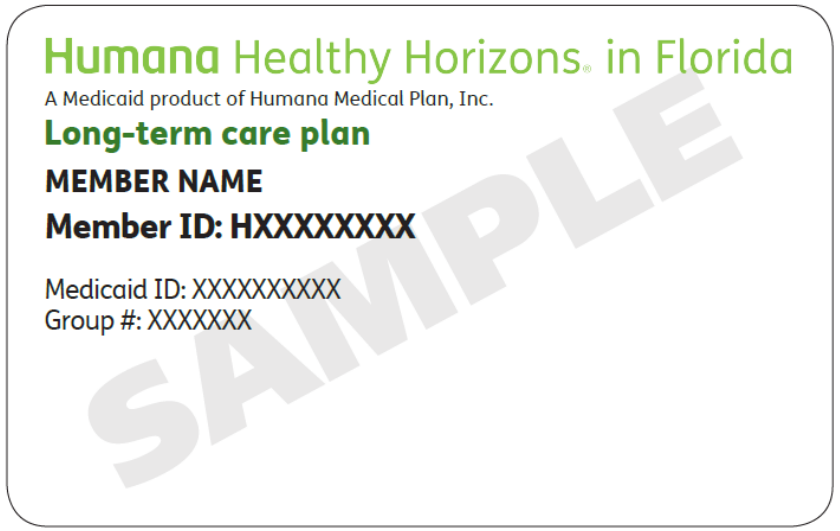
Open enrollment takes place yearly. If a member does not select a managed care organization (MCO) during this period, they will remain with their current MCO. Members have 60 calendar days after open enrollment to change MCOs if they wish.

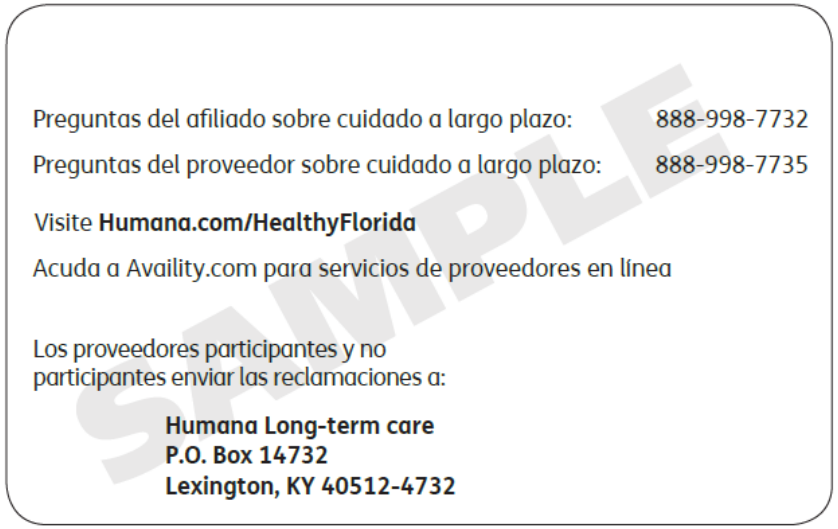
You can verify member eligibility by signing into Availity Essentials and navigating to Patient Registration, then selecting Eligibility and Benefits Inquiry.

Sample ID cards—MMA

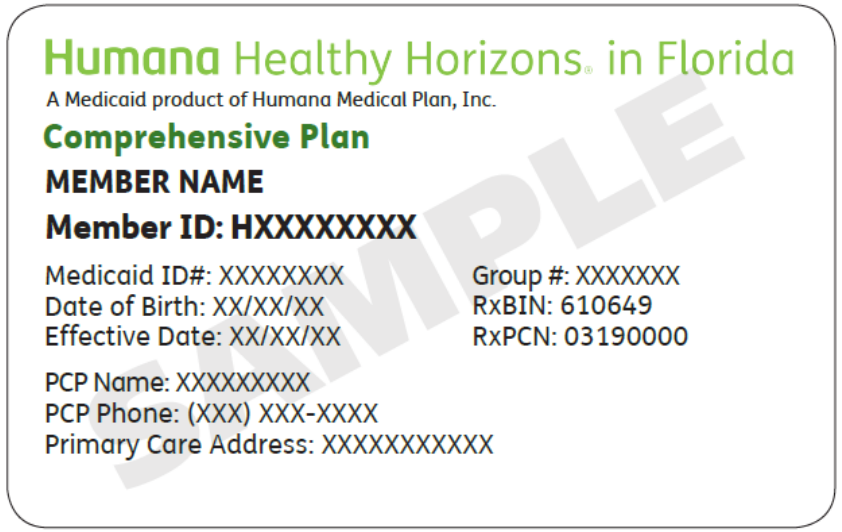


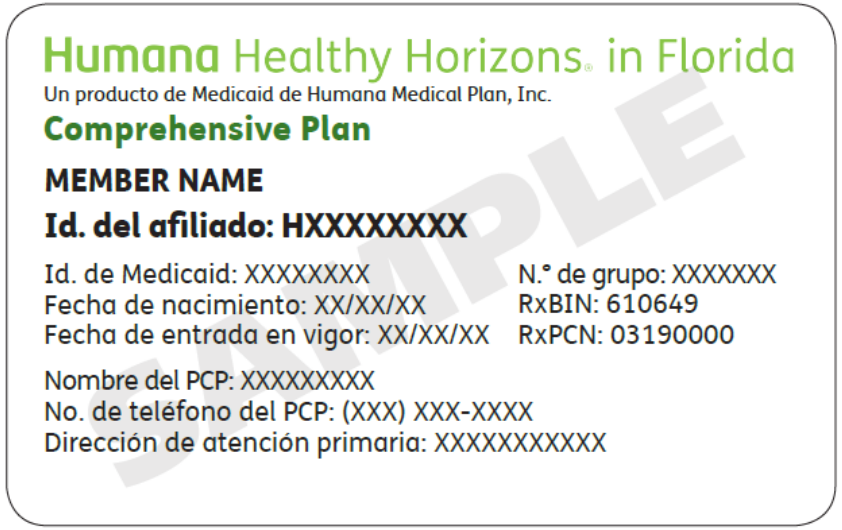
Sample ID cards—LTC



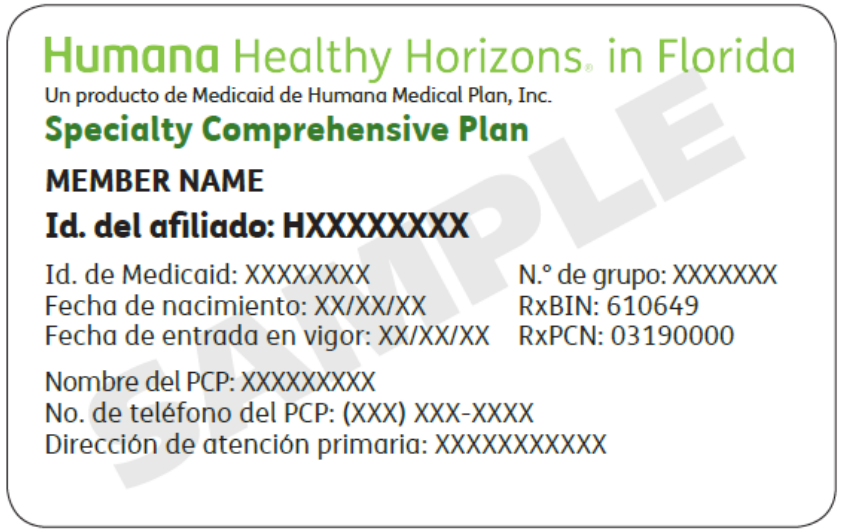


Sample ID cards—Comprehensive

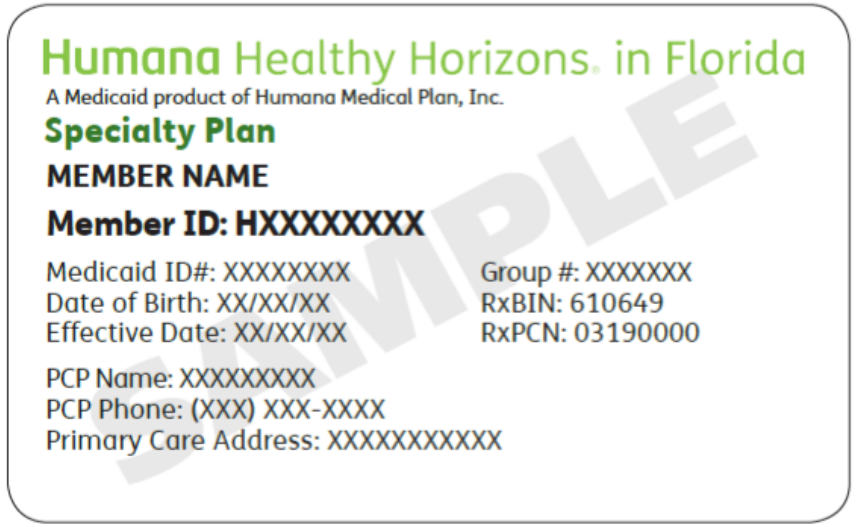


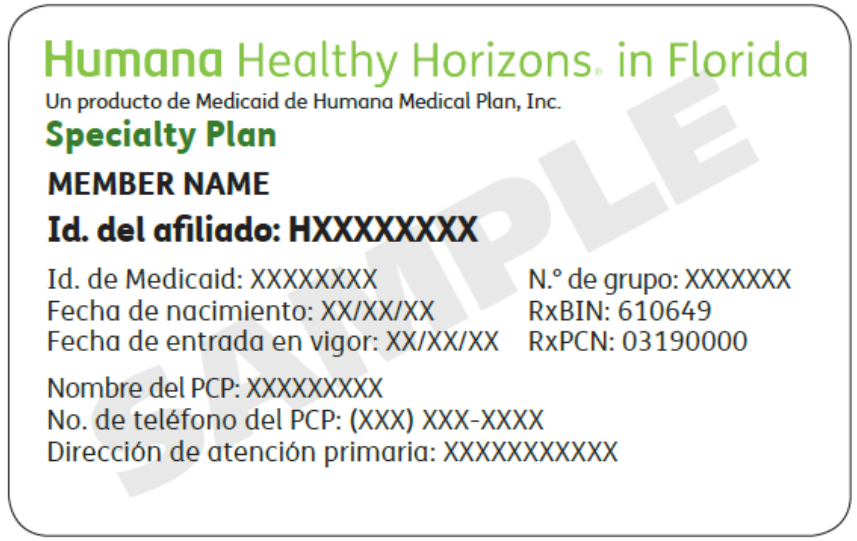


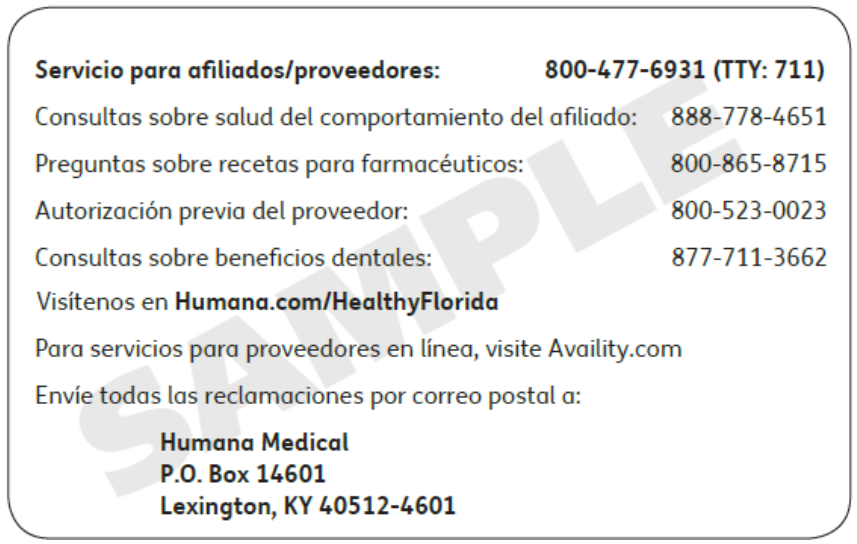
Sample ID cards—Specialty Comprehensive



Sample ID cards—Specialty







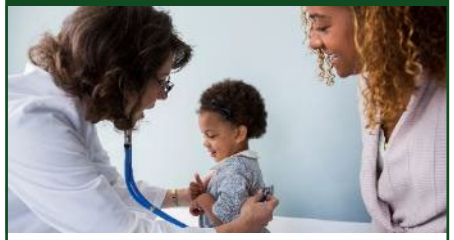
PCP auto assignment algorithm

For members who did not select a PCP during enrollment, Humana Healthy Horizons will assign one to them based on the criteria outlined below:

1. Does the member have a previous PCP with Humana Healthy Horizons?
   - If yes, assign member to that PCP—look-back period is 6 months from initial enrollment.
2. Is the member tied to a family unit (e.g., parents/siblings)?
   - If yes, assign member to the family's PCP.

If the member does not have a previous PCP or family unit, the logic will occur in this order:

1 Member age



If the member is younger than 18 the system looks for a pediatric PCP.

If the member is 18 or older, the system looks for an adult PCP.

2 Language

The system looks for a PCP who speaks the same language as the member.

Note: Member indicates language preference on 834-enrollment file.

3 PCP performance

The system assigns members to PCPs based on their performance measures.

4 Distance

The system looks for PCPs within 20 miles of the member's home address.

5 Cultural Competency

The system pairs members with PCPs who possess a degree of cultural competency relating to the member's background, including understanding the member's customs, beliefs and/or world views.

PCP reassignment: Members can change to another participating PCP by calling Humana Healthy Horizons.

Transfer-for-cause process

Provider-initiated request to transfer member off their panel for cause:

PCPs may submit member transfer-for-cause (TFC) requests to transfer a member to a different Humana Healthy Horizons PCP. PCPs may submit a member TFC request to Humana Healthy Horizons due to disruptive, unruly, abusive or uncooperative member/caregiver behavior that seriously impairs the provider's ability to furnish services.

The TFC process does not apply to members who:

- Have received a mental health diagnosis
- Are dealing with adverse health status changes
- Have diminished mental capacity
- Exhibit uncooperative or disruptive behavior due to special needs
- Have attempted to exercise the plan's grievance system

For more detailed information on the TFC process and what steps should be followed prior to initiating a request, please review the Humana Healthy Horizons in Florida Provider Handbook on our Provider education and training webpage or the Provider Transfer of Member FAQ flyer at the Provider education and training webpage.

Claims

Medicaid enrollment for claim payment

An entity that renders Medicaid-compensable services to Medicaid recipients, or that provides services of any Medicaid provider type, must be active and enrolled as a Medicaid provider with the AHCA.

- To meet AHCA requirements, Humana can pay only those claims and/or encounters submitted by healthcare providers with valid Medicaid enrollment.
- Healthcare professionals can verify their enrollment via the Provider Master List (PML) on the AHCA website on the Florida Medicaid Web Portal page.

The following are some of the criteria indicating a healthcare professional is properly enrolled:

- Listing that shows “enrollment” or “limited” in the enrollment type column
- Active (A) listing in the current Medicaid Enrollment Status column
- Accurate National Provider Identifier (NPI) listing related to attending, billing, ordering, prescribing, referring and rendering providers (not applicable to atypical providers) affiliated with the correct Medicaid ID
- Listing with all active service and/or billing locations, provider type and specialty codes associated with its respective NPI, taxonomy and Medicaid ID

Electronic claim submissions

Humana Healthy Horizons accepts electronic and paper claim submissions. Claims will not be paid if they have incomplete, incorrect or unclear information.

The following list contains some of the frequently used clearinghouses.

- Availity Essentials
- Change Healthcare® (Optum)
- TriZetto®
- McKesson
- SSI Group
- Waystar

When filing an electronic claim, use one of the following payer IDs:

Humana MMA/Specialty

- **61101** for fee-for-service (FFS) claims
- **61102** for encounter claims

Humana LTC/Comprehensive

- **61115** for all claims

Note: Availity Essentials is Humana's preferred clearinghouse, and there are no service fees when submitting Humana electronic claims. However, providers can use other clearinghouses.

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

Humana MMA/Specialty providers can find additional resources on claims submission at:
Go to the Coverage and Claims page.
Choose “Claims submission.”

Please submit questions about MMA or LTC via Availity Essentials.

Paper claim submissions

Paper claims can be submitted on the CMS-1500 or CMS-1450 (UB-04) for facilities. Submit paper claims to the address listed on the back of the member's ID card or to the appropriate address listed below:

Humana MMA and specialty claims

Humana Healthy Horizons MMA Plan
Attn: Claims Department
P.O. Box 14601
Lexington, KY 40512-4601

Behavioral health claims

Region A
Access Behavioral Health
Attn: Claims Dept.
1221 W. Lakeview Ave.
Pensacola, FL 32501

Humana LTC and comprehensive claims

Humana LTC C/O Humana Inc.
P.O. Box 14732
Lexington, KY 40512

Encounters

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

Behavioral health claims

Regions B through I
Carelon Behavioral Health
P.O. Box 1870
Hicksville, NY 11802-1870

Importance of encounter submissions in Medicaid

AHCA requires 100% encounter submissions.

Goal: 95% pass rate through state system

Key items for compliance:

- Initial submission—Managed care plan shall submit encounter data no later than 7 days from the date the managed care plan adjudicated the claim.
- Accuracy—Encounter line submissions must pass Florida Medicaid Management Information System (FLMMIS) edits.
- Provider—Billing and rendering provider information on the encounter submissions must be recognized by the FLMMIS system.
- Encounter provider information must match provider information filed with AHCA.

Consequences for noncompliance:

- Fines
- Enrollment freezes
- Claim rejections

Encounters that identify members who received services:

- Decrease the need for medical record review during Healthcare Effectiveness Data and Information Set (HEDIS®) surveys
- Are critical for the future of Medicaid risk adjustment
- Help identify members receiving preventive screenings and decreases members listed in gap reports

Encounter submission errors and how to avoid them

Common reasons for rejection or denial:

- Providers submitting an incorrect NPI/ZIP code/taxonomy code/address/NPI type
- Encounters missing NPI/ZIP code/taxonomy code/address/NPI type
- Providers submitting with a billing and/or rendering NPI that is not enrolled/registered for Medicaid with AHCA

How to avoid these errors:

- Confirm the provider information submitted matches exactly the provider information registered with AHCA and in accordance with the services provided (e.g., NPI, taxonomy code, ZIP code + 4, address).
- Ensure the billing and rendering NPIs on the claim are correct and are enrolled/registered for Medicaid with AHCA.
- Verify enrollment within the Provider Master List (PML) at the Florida Medicaid Web Portal.
- Follow AHCA's PML Tip Sheet for claim submissions.

Claim submissions errors and how to avoid them

Common rejection or denial reasons:

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

How to avoid these errors:

- Confirm patient information received and submitted is accurate and correct.
- Ensure all required claim form fields are complete and accurate.
- Obtain proper authorization and/or referrals for services rendered.
- Submit billed charges.
- Ensure you have a valid Medicaid ID for the billing/rendering NPIs submitted on the claims. NPIs must exactly match those listed in the applicable active PML record.

Billing guidance

- Humana Healthy Horizons aligns to AHCA's guidance. Please ensure you submit claims based on your enrollment and information on the PML.
- Submitted claims that do not match the provider information appearing on the PML will be rejected.
- To keep claims from being rejected, denied or impacted by future recoupments, be sure to bill according to the appropriate PML record fields:
  - NPI Type (1-Indvidual or 2-Organization)
  - Taxonomy
    - Please review the Taxonomy Master List to ensure the appropriate taxonomy codes for the provider's specialty are submitted on the application.
  - Service Location Address ZIP code+4
  - Service Location Address 1
- Please visit the PML on the registration portion of the Florida Medicaid web portal. Here, you can see how your information appears on the PML.
  - Once you open the PML spreadsheet, you can search by your NPI.
  - If your PML record(s) need to be updated, you can make changes through the secured provider web portal or by calling 800-289-7799, select option 4, Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

NPI mapping logic

The current NPI mapping logic will have the following updates:

- The system will only consider provider Medicaid IDs with a date of service that falls within the provider's contract effective and end dates.
  - The default logic will be modified to automatically select the provider's Medicaid ID within the most recent contract effective date ranges.
  - Claims that do not pass the logic are subject to recovery or rejections prior to payments being made.

For more information about the NPI initiative, visit the NPI Initiative FAQ page.

Timely filing

- **Initial claims:** Participating providers must submit claims within 6 months of the date of service to Humana Healthy Horizons. Nonparticipating providers have 12 months from the date of service to submit a claim.
- **Corrected claims:** Participating and nonparticipating providers must submit corrected claims within 12 months of the original process date of the initial claim.
- **MMA and LTC crossover:** Questions regarding specifics of timely filing should be directed to MMA/Comprehensive/Specialty Provider Services at 800-477-6931, Monday – Friday, 8 a.m. – 8 p.m., Eastern time or LTC Provider Services at 888-998-7735, Monday – Friday, 8 a.m. – 5 p.m., Eastern time.
- **Encounter claims** should be submitted within 7 days of the adjudication date for initial encounters and 30 days for the resubmission of corrected encounters.
- **Timely filing of claims and HEDIS:**
  - Providers are required to file their claims/encounters for all services rendered to members in a timely manner. Timely filing is an essential component reflected in Humana's HEDIS reporting and can ultimately affect how a plan and its providers are measured in member preventive care and screening compliance.

Availity Essentials

Electronic claims can be submitted through Availity Essentials. Availity Essentials also provides access to:

- Eligibility and benefits lookup
- Claim submission and status
- Authorization and referral submission and management
- ERA
- EFT enrollment

Sign in to Availity Essentials (registration required).

From the Payer Spaces menu, select Humana.

For additional training opportunities, sign in to Availity Essentials, and select "Help & Training" in the upper right-hand corner.

Claim payment: EFT and ERA

Receive Humana Healthy Horizons payments via direct deposit into the bank account of your choice.

Receive HIPAA-compliant ERA transactions.*

Get paid up to 7 days faster than mail.

Have remittances sent to your clearinghouse or view them online.

Reduce the risk of lost or stolen checks.

Reduce paper mail and time spent on manual processes.

* HIPAA stands for the Health Insurance Portability and Accountability Act of 1996.

ERA/EFT resources

Contact us if your organization needs:

Payments deposited in more than 1 bank account

Separate remittance information for different providers or facilities

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

To set up ERA/EFT:

1. Sign in to Availity Essentials (registration required).
2. From the Payer Spaces menu, select Humana.
3. From the Applications tab, select the ERA/EFT Enrollment app. (If you don't see the app, contact your Availity Essentials administrator to discuss your need for this tool.)

Overpayments

Providers should report all claim overpayments to Humana Healthy Horizons. Providers are expected to submit such claims within 60 calendar days of the date on which the overpayment was identified.

Humana Healthy Horizons provides written notice to the provider at least 30 business days before an adjustment for overpayment is made. If a dispute is not received from the provider, adjustments to the overpayment are made on a subsequent reimbursement.

Refund checks for overpayments can be mailed to:

Humana Healthcare Plans
P.O. Box 931655
Atlanta, GA 31193-1655

Balance billing

- The provider is prohibited from balance billing members for covered services referenced in the Medicaid Addendum of the provider contract. Do not balance bill members or bill for missed appointments.
- State requirements and federal regulations prohibit providers from billing Humana Healthy Horizons members for medically necessary covered services except under very limited circumstances. Providers also may not bill members for missed and/or cancelled appointments.
- Humana monitors this billing policy activity based on complaints of billing from members. Failure to comply with regulations after intervention may result in both criminal charges and termination of your agreement with Humana Healthy Horizons.

Claim inquiry process

Step 1: Call the number on the back of the member's ID card: 800-477-6931 or 888-998-7735.

- Record the reference number issued to you by the Provider Services call center.
- If your issue is not resolved by the call center representative, you can ask for a supervisor.

Step 2: If there is a factual disagreement with a response, please:

- Email FLMedicaidResolution@humana.com
- Call MMA/Comprehensive/Specialty Provider Services at 800-477-6931, Monday – Friday, 8 a.m. – 8 p.m., Eastern time
- Email LTC Provider Services at FLMedicaidResolutionLTSS@humana.com, or
- Call 888-998-7735, Monday – Friday, 8 a.m. – 5 p.m., Eastern time or contact your contract specialist.

For additional information, please refer to our Claim-Payment Inquiries webpage.

Information regarding the provider complaint system is available in the Humana Healthy Horizons in Florida Provider Handbook located on our Provider education and training webpage.

Utilization management

Utilization management

Utilization management (UM) helps maintain the quality and appropriateness of healthcare services provided to Humana Healthy Horizons members.

- Includes PA, concurrent reviews, discharge planning and other activities such as monitoring inpatient and outpatient admissions
- Reviews medical necessity, appropriateness of care and service and existence of coverage
- Places appropriate limits on a service based on criteria applied under the Medicaid state plan and applicable regulations, such as medical necessity.
- UM involves:
  - Providing on-site (at specific facilities) and telephonic concurrent review and discharge planning
  - Promoting effective level of care based on member's individual needs
  - Providing disease-specific education
  - Referring to appropriate Humana Healthy Horizons programs

Referrals and second opinions

Specialist referrals

A referral is a request for services from the PCP to another provider. All specialist visits require a referral, with the following exclusions:

- OB-GYN
- Dental or vision anesthesia services not covered under the applicable dental/vision vendor
- Certain pediatric services, such as early intervention services (EIS) or Early and Periodic Screening, Diagnostic and Treatment (EPSDT) cases related to testing, treating or screening conditions, do not require a referral.

You can submit referrals through Availity Essentials.

Second opinions

Humana Healthy Horizons will arrange for out-of-network care if we are unable to provide members with necessary covered services within our network.

Alternatively, we will arrange for a second opinion if a network healthcare provider is not available.

Payment will be coordinated with the out-of-network provider to confirm that any cost to the member is not greater than it would be if the service were provided in-network.

Prior authorization

Humana Healthy Horizons requires PA for some services to facilitate care coordination and maximize benefits for your patients, as well as to confirm services are provided according to AHCA coverage policies.

PA

- PA (e.g., preauthorization, precertification, preadmission) is a process through which Humana Healthy Horizons requires a healthcare provider to obtain advance plan approval to cover an item or service.

List of services requiring PA

- You can find a full list of services requiring PA on our Provider prior authorization and notification lists page. The Humana Healthy Horizons PAL details the items, services and medications that require PA. You must get PA when requesting an item or service on the PAL.

Requesting authorization

- Visit the provider portal at Availity Essentials and complete an authorization request.
- Call 800-523-0023 Monday – Friday, 8 a.m. – 8 p.m., Eastern time, and follow the menu prompts for authorization requests, depending on your needs, to speak to a live representative.
- Requesting/referring providers, rendering/treating providers, and rendering/treating facilities must include their NPI on all PA requests. Any submission without an NPI will be returned.

Humana Healthy Horizons in Florida—MMA/Specialty

1. Call 800-523-0023 (available 24 hours a day) for automated requests. Representatives are available Monday – Friday, 8 a.m. – 8 p.m., Eastern time, (excluding major federal holidays).
2. Press “0” or say “representative” for live help.
3. Provide Tax Identification Number (TIN).

Humana Healthy Horizons in Florida—LTC/Comprehensive

- The member’s care coach requests PA.
- Provider receives a faxed copy of the authorization.

Retrospective reviews

- PA must be obtained prior to services being rendered, and Humana Healthy Horizons will not pay claims in which authorization is required but not obtained.
- In certain circumstances, retrospective reviews are conducted to determine whether authorization will be granted for those services in which authorization was not obtained prior to the service being rendered.
- Providers may request a retrospective review of medical necessity.
- Requests for retrospective review that exceed the contracted time frames will be denied and ineligible.
- Providers can submit retrospective requests by calling Utilization Management at 866-856-8974, Monday – Friday, 8 a.m. – 5 p.m., Eastern time, or faxing 813-321-7220.

Contracting and credentialing

Credentialing

- Providers seeking participation with Humana Healthy Horizons must complete an application with required documentation and a signed contract. Humana Healthy Horizons requires that you maintain active status with licensure and insurance coverage and provide proper documentation annually as documents expire.
- To be credentialed and recredentialed, healthcare providers must:
  - Have an active Florida provider Medicaid ID to be considered for participation
  - Be in good standing with Medicare, federal, state and local agencies
  - Be free from active sanctions imposed by the AHCA
- Recredentialing occurs at least every 3 years. Some circumstances require shorter recredentialing cycles.
- Prior to participation with Humana and during recredentialing:
  - Provider office site evaluations must be completed for all PCP and OB-GYN provider locations.
  - PCPs are required to attest that their total active member load is no more than 3,000 members per PCP.
- Humana participates with the Council for Affordable Quality Healthcare (CAQH®) for applicable provider types. Be sure to include your CAQH provider ID number when submitting credentialing documents. It is essential that all documents are complete and current.
- Further details regarding Humana's credentialing/recredentialing requirements can be found in Humana's Provider Handbook.

CAQH Proview streamlined credentialing process

Humana Healthy Horizons is a participating organization with CAQH, a nonprofit alliance of leading health plans, networks and trade associations. Humana Healthy Horizons requires use of CAQH ProView® for gathering credentialing information for all network providers.

How this affects you:

- Initial applicants must use CAQH for credentialing requests.
- Healthcare professionals due for recredentialing must submit their information through CAQH.
- If you are not registered with CAQH, please complete a registration form on Proview's registration page. Once registration is submitted, you should receive an email from CAQH containing a CAQH provider ID. Please use the provider ID to complete the online CAQH application and grant Humana authorization to review/receive your information.
- If you are already registered with CAQH, please ensure your information is current and complete and that you grant Humana authorization to review/receive the credentialing information.
- During recredentialing, healthcare professionals who have outdated or missing information will be contacted via fax and/or email and asked to provide current information and/or documentation.
- Email questions to CredentialingInquiries@humana.com.

Contracting process—required information

- An updated roster that includes all providers and group or facility name
- Service address with phone, fax and email information
- A list of counties where services are rendered
- Billing address, if different than service address
- TIN and NPI
- Provider or facility specialty and registered taxonomies
- Medicaid provider number for all NPI, group/billing and rendering providers
  - Indicate enrolled or limited status with corresponding registered provider specialty code and provider type code.
- CAQH number
- Disclosure of ownership
- Business area of interest (e.g., Medicaid, Medicare)
- Type of contract (e.g., individual, group, facility)
- Practitioner Office Site Evaluation Tool (POSET) form
- Americans with Disabilities Act (ADA) form
- PCP patient load attestation
- For LTC providers: Florida state license and proof of insurance

Contractual and demographic changes

As a network provider, you are responsible for notifying Humana Healthy Horizons of demographic changes as outlined in your provider handbook and under the terms of your contract with Humana Healthy Horizons.

Notify your contract specialist immediately of changes, such as:

- Physical address change
- TIN/billing address change (W-9 required)
- Demographic changes (e.g., telephone, fax, email or administrative staff changes)
- New member indicator
- Name and ownership change (35-day notice)

This notification will ensure your information is properly listed in the provider directory and all payments made are properly reported to the Internal Revenue Service. Failure to comply with this section could lead to a delay in payments.

In the event there are changes that will affect your ability to provide services to Humana Healthy Horizons members, please notify the Provider Contracting department immediately.

You can notify us of changes by email:

- Humana MMA: humana_fl_centralized_provider_relations@humana.com
- Humana LTC: LTCNetworkRequests@humana.com
- For additional ways to contact us, please visit the Contact Humana webpage.

Covered services

MMA covered services

Humana Healthy Horizons, through its contracted healthcare providers, covers the following medically necessary services for each **MMA** member. You can find additional information about covered services in our Provider Handbook.

MMA covered services	
Advanced practice registered nurse (APRN)	Hospice services
Ambulatory surgical center services	Hospital services
Assistive care services	Immunizations
Behavioral health services	Laboratory and imaging services
Birth center and licensed midwife services	Medical foster care services
Child health checkup	Medical supplies, equipment, prostheses and orthoses
Clinical services	Nursing facility services
Chiropractic services	Optometric and vision services
EIS	Physician assistant services
EPSDT	Podiatric services
Emergency services	Prescribed drug services
Family planning services and supplies	Renal dialysis services
Hearing services	Therapy services
Healthy Start services	Transportation services
Home health services and nursing care	

LTC covered services

Humana Healthy Horizons, through its contracted healthcare providers, covers the following medically necessary services for each **LTC** member. You can find additional information about covered services in our Provider Handbook.

LTC covered services	
Adult companion care	Medical equipment and supplies
Adult day health care	Medication administration
Assistive care services	Medication management
Assisted living	Nutritional assessment/risk reduction services
Attendant nursing care	Nursing facility services
Behavioral management	Personal care
Caregiver training	Personal emergency response systems (PERS)
Care coordination/case management	Physical therapy
Home accessibility adaption services	Occupational therapy
Home-delivered meals	Respiratory therapy
Homemaker services	Respite care
Hospice	Speech therapy
Intermittent and skilled nursing	Transportation

Expanded benefits

Expanded benefits are those offered by Humana Healthy Horizons that are not otherwise covered or that exceed limits outlined in the Medicaid state plan, Florida Medicaid coverage policies and the Florida Medicaid fee schedules.

Expanded benefits descriptions and details can be found in the Member Handbook.

All expanded benefits have waived copayments. Therefore, providers must not charge members copayments. However, there are some expanded benefits that, if a member requests them, are paid out of pocket first and subsequently reimbursed when Humana Healthy Horizons receives proper documentation.

Expanded benefit	MMA	HIV	SMI	LTC
Adult additional primary care services	Yes	Yes	Yes	No
Adult visual aid services	Yes	Yes	Yes	Yes
Assisted living facility—bed hold expansion	No	No	No	Yes
Assisted living facility—move-in basket	No	No	No	Yes
Baby and Me meals	Yes	Yes	Yes	No
Behavioral health—individual therapy sessions to caregivers	No	No	No	Yes
Behavioral health housing assistance	No	No	Yes	No
Convertible car seat or portable crib	Yes	Yes	Yes	No
Criminal expungement services	Yes	Yes	Yes	No
Day trip—meal reimbursement/allowance	Yes	Yes	Yes	Yes
Disaster preparedness meals	Yes	Yes	Yes	No
Doula services	Yes	Yes	Yes	No
Durable medical equipment services and supplies	Yes	Yes	Yes	Yes
Expanded prenatal/perinatal visits	Yes	Yes	Yes	No
Fall prevention kit	No	No	No	Yes
Financial literacy coaching	Yes	Yes	Yes	No
General Educational Development (GED) testing	Yes	Yes	Yes	No
Hearing services for adults	Yes	Yes	Yes	Yes
Home-delivered meals	Yes	Yes	Yes	No
Home-based asthma interventions	Yes	Yes	Yes	No
Hospital services—outpatient	Yes	Yes	Yes	Yes
Housing assistance	Yes	Yes	Yes	No
Housing supports	Yes	Yes	Yes	No
Humana tranquility goods	Yes	Yes	Yes	No
Maternal and infant virtual care	Yes	Yes	Yes	No
Newborn circumcision	Yes	Yes	No	No

Expanded benefits (continued)

Expanded benefit	MMA	HIV	SMI	LTC
Nonmedical transportation (NMT) for behavioral health parent/guardian	Yes	No	Yes	No
NMT for LTC	No	No	No	Yes
NMT social needs	Yes	Yes	Yes	No
Nutrition shakes	Yes	Yes	No	No
Occupational therapy for adults	Yes	Yes	Yes	No
Over-the-counter (OTC) medications and supplies	Yes	Yes	Yes	Yes
Pathway licensure and/or certification	Yes	Yes	Yes	No
Physical therapy for adults	Yes	Yes	Yes	No
Post discharge meal	Yes	Yes	Yes	No
Respiratory therapy for adults	Yes	Yes	Yes	No
Respite services for members on home- and community-based services (HCBS) waiver waiting list	Yes	No	No	No
Respite services for medically complex children	Yes	No	No	No
Return-to-home meals for families of nursing facility children	Yes	No	No	No
Smartphone service	Yes	Yes	Yes	Yes
Sports physical	Yes	Yes	Yes	No
Support to stay in community living	No	No	No	Yes
Swimming lessons (drowning prevention)	Yes	Yes	Yes	No
Therapy for families of nursing facility children	Yes	No	No	No
Transition assistance deposit for nursing facility children	Yes	No	No	No
Transition assistance into community living	No	No	No	Yes
Virtual exercise classes	Yes	Yes	No	No
Waived copayments	Yes	Yes	Yes	Yes
Youth academic support	Yes	Yes	Yes	No

Telemedicine

Telemedicine is defined as the practice of healthcare delivery by a provider who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis or treatment. This applies to any person or entity prescribing or reviewing a request for Florida Medicaid services and to all providers of Florida Medicaid services that are enrolled in or registered with the Florida Medicaid program.

Humana Healthy Horizons reimburses providers for telemedicine services that use interactive telecommunications equipment that includes, at a minimum, audio equipment permitting two-way communication between a member and provider.

Humana Healthy Horizons will not reimburse the following:

- Chart reviews
- Email messages
- Fax transmissions
- Equipment required to provide telemedicine services

Behavioral health

For behavioral health crises, members can use the 988 Suicide & Crisis Lifeline, which is a 3-digit calling code used to reach a crisis agent. Members can call or text 988 or visit 988lifeline.org to chat and receive immediate help 24 hours a day, 7 days a week.

Members should contact a behavioral health provider in their area to address their mental health needs and access substance use services. PCPs and pediatricians are expected to collaborate with behavioral health providers and Humana Healthy Horizons' case management team to provide a holistic, integrated model of care.

Providers and members in regions B through I with inquiries related to behavioral health should call Humana Healthy Horizons' behavioral health provider, Carelon Behavioral Health, at 800-397-1630, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Providers and members in Region A should call Humana Healthy Horizons' behavioral health provider, Access Behavioral Health, at 866-477-6725, Monday – Friday, 9 a.m. – 6 p.m., Eastern time.

Dental services

Type of dental service(s)	Dental plan covers:	Health plan (Humana Healthy Horizons) covers:
Emergency dental services in a facility	___	All emergency dental services and reimbursement to the facility
Nonemergency scheduled dental services in a facility	Dental services by a dental provider	Reimbursement to the facility, anesthesiologist and ancillary services
Dental services with sedation in an office setting	Dental services by a dental provider with a required sedation permit D-codes when rendered by the dental provider	Anesthesiologist (M.D. or ARNP) when required for sedation
Dental services (general or specialty) without sedation in an office setting, county health department (CHD) or federally qualified health center (FQHC)	Dental services by a dental provider	Dental services provided by a nondental provider
Pharmacy	___	Drugs prescribed by a healthcare provider or a dental provider within scope of practice
Transportation	___	Transportation to all dental services provided by the dental or health plan, including expanded dental benefits

Member rewards

Go365 for Humana Healthy Horizons® is a wellness program for qualifying members that gives them the opportunity to earn rewards for healthy actions.

Providers must submit claims to help members earn their rewards.

A full listing of healthy activities that earn rewards for members can be found in your Provider Handbook.

Healthy Behaviors Program

Go365 for Humana Healthy Horizons

About Go365 for Humana Healthy Horizons

- Launched in April 2021
- A wellness program that offers members the opportunity to earn rewards for taking healthy actions
- Once members download the Go365 for Humana Healthy Horizons app on their mobile devices and create an account, they can:
  1. See programs they are eligible to participate in
  2. Complete the HRA
  3. Earn and redeem rewards

Target population

- All ages
- Dual-eligible members
- Members can call Humana Healthy Horizons for program details and how to join a program
- PCPs may be asked to provide program goals and accomplishments

Rewards

Members can:

- Redeem rewards in the Go365 mall.
- Choose from a selection of gift cards from popular retailers.
- Receive e-gift cards via email.

Healthy Behaviors Programs (continued)

HRA

- Complete HRA within 90 days of enrollment: $20
- Complete HRA after 90 days of enrollment: $10

All ages

To complete HRA: Patients can call 855-351-7877 (TTY: 711).

Annual well-visit program

- Annual well-visit PCP: $20

18 years and older

Outbound team encourages members to visit PCP during welcome call.

HumanaBeginnings

- Enroll in and complete HumanaBeginnings program: $20
- Visit OB-GYN during first trimester or within 42 days of enrollment with the plan: $15
- Visit OB-GYN for a postpartum visit within 7–84 days of delivery: $15

13 years and older

To enroll: You or your patient can call 800-322-2758, ext. 1394119.

Well-child visit program

- Wellness visit with PCP: $20
- The plan will contact and remind members overdue for a well-child visit to schedule an appointment.

Younger than 18 years

Outbound team encourages parent/guardian to schedule appointment.

Mammogram

- Annual mammogram screening: $20

40 years and older*

Outbound team encourages members to get their screening.

* Mammogram also available to members younger than 40 who are at high risk.

Healthy Behaviors Programs (continued)

Weight management

- Enroll in the program and complete initial well-being visit with PCP: $10
- Complete 6 telephonic coaching sessions within 12 months. At the end of the sixth coaching session: $30

12 years and older

To enroll: You or your patient can call 855-330-8053.

Tobacco cessation

- Complete 2 telephonic coaching sessions with a health coach within the first 45 days of enrollment in the program: $25
- Complete 6 additional telephonic coaching sessions (total of 8) with a health coach within 12 months of the first coaching session: $25

12 years and older

To enroll: You or your patient can call 855-330-8053.

Substance use disorder

- Enroll and complete 3 coaching calls within 3 months: $15
- Complete 3 additional coaching calls (total of 6) within 6 months: $15
- Participate actively in an outpatient program for 28–30 days: $20

18 years and older

To enroll: You or your patient can call 800-229-9880.

Cervical cancer screening

- Annual cervical cancer screening: $20

21 years and older

Outbound team encourages members to have their screening.

Colorectal cancer screening

- Annual colorectal cancer screening: $20

45 years and older

Outbound team encourages members to visit PCP during welcome call.

Healthy Behaviors Program

Provider responsibilities

Humana Healthy Horizons in Florida Healthy Behaviors Weight Management Program delivers weight management intervention for members who are 12 years and older and are enrolled in either an MMA plan (medical), Comprehensive (MMA and LTC), SMI or HIV/AIDS Specialty plan and would like to achieve or maintain a healthy weight.

Prior to enrolling in this program, members must get a completed signed **Medical Clearance Form** from their providers which providers can fax to 855-324-7685, or your patient can take a picture of the completed form and upload it via the Go365 for Humana Healthy Horizons app.

This program offers:

- Targeted weight management telephonic coaching to members who are attempting to manage their weight
- Coaching, which could include education on stress management, weight management, nutrition, fitness, high blood pressure, high cholesterol, blood glucose or back care with the overarching goal of weight management

Members can earn:

- $10 in rewards for enrolling and submitting a completed and signed **Medical Clearance Form**
- $30 for completing coaching, 6 calls total, within 12 months of enrolling

The member's PCP provides ongoing supervision while the member is enrolled in the program. The member's incentives depend on coordination with the PCP to obtain medical clearance to enroll in the program. Enrollment, interventions and rewards are available once per year.

To enroll, you or your patients can call 855-330-8053 (TTY: 711) Monday – Friday, 7 a.m. – 7 p.m., Eastern time. When prompted, select option 2.

Pharmacy

Humana Healthy Horizons pharmacy benefit summary

34-day supply

Medications are limited to a 34-day supply.

OTC benefit

Medicaid recipients have a $50 per-household-per-month OTC benefit allowance through CenterWell®.

No copayments

Medicaid recipients have a $0 copay at network pharmacies. Copays for adults ages 21 and older are waived for all services as an expanded benefit.

State-mandated PDL

Find AHCA's formulary online on our Pharmacy resources webpage.

Pharmacy benefit

Request PA

- Fast and easy electronic submission via the CoverMyMeds Humana page
- Fax 877-486-2621
- Call Humana Clinical Pharmacy Review (HCPR) at 800-555-CLIN (800-555-2546)

Psychotropic informed consent

Informed consent must accompany prescriptions for psychotropic drugs when prescribed for children younger than 13. Download the Informed Consent for Psychotherapeutic Medication form.

Hemophilia

AHCA contracts with Coram® and Caremark CVS® to provide statewide care management and pharmacy benefits management for eligible Medicaid beneficiaries with hemophilia or Von Willebrand disease.

Opioids

For the treatment of opioid dependency, some medication-assisted treatment (MAT) products are available on the formulary without PA.

To find preferred products, please visit the Humana Healthy Horizons in Florida pharmacy resources webpage.

Medication Intake Team PA list

For drugs administered in the provider's office, you can obtain PA by calling 866-461-7273, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

If you prefer, complete the appropriate form on the Prior authorization for professionally administered drugs webpage and fax it to 888-447-3430.

Pharmacy Lock-In Program

The Lock-in Program is designed for individuals enrolled in Medicaid in Florida who need help managing their use of prescription medications.

It is intended to limit overuse, while providing an appropriate level of care for the member.

Humana Healthy Horizons members who meet the program criteria will be locked in to one pharmacy.

Members identified to be enrolled in the Lock-In Program receive written notification from Humana Healthy Horizons, along with the designated pharmacy's information.

Case management

Case management

Case management program responsibilities:

- Complete a comprehensive assessment of the member's current health status.
- Create a person-centered care plan with the member and work toward identified goals.
- Address HEDIS measures for members on gap reports or with alerts on file.
- Refer to internal and external programs and community resources as needed (e.g., behavioral health, social work, transplant).

Please note:

- Case management does not replace or interfere with care members receive from their providers.
- Case management nurses will reinforce the healthcare provider's plan of care and facilitate utilization of services that promote wellness and prevent unnecessary hospital admissions.

Additional features for LTC members in a disease management program:

- Education based on the member assessment of health risks and chronic conditions
- Symptom management, including addressing needs such as working with the member on health goals
- Emotional issues of the caregiver
- Behavioral management issues of the member
- Communicating effectively with providers
- Medication management, including the review of medications a member takes to ensure the member does not suffer adverse effects or interactions from contraindicated medications

Complex case management

Complex case management responsibilities:

- Manages and coordinates care for members requiring ongoing case management based on assigned acuity (with varying contact expectations and required time in program for each)
- Identifies triggers for emergency room (ER) visit/admission and partners with members and their healthcare providers to prevent/reduce ER visits and unplanned inpatient admissions
- Completes a comprehensive assessment of the member's current health status
- Creates a person-centered care plan with the member and works toward identified goals
- Addresses HEDIS measures for members' gap reports or alerts on file
- Refers to internal and external programs and community resources as needed (e.g., behavioral health, social work, transplant)
- Participates in interdisciplinary case conferences for members with complex needs to identify the best course of action for improved outcomes
- Does not replace or interfere with the care members receive from their providers
- Reinforces the provider's plan of care and facilitates use of services that promote wellness and prevent unnecessary hospital admissions

Steps in case management

Humana Healthy Horizons uses a holistic and fully integrated health management program to address a member's physical and behavioral healthcare needs as well as SDOH issues.

Humana Healthy Horizons includes the following steps in its case management:

- Identifies members through referrals from on-site/telephonic UM nurses, PCPs, specialists, member self-referral, health needs assessment, predictive model algorithms, post-discharge assessments, etc.
- Obtains member's permission/agreement to participate
  - Members can opt out at any time.
- Completes a comprehensive assessment, incorporating physical and behavioral health as well as SDOH
- Identifies key people of member's multidisciplinary care team and engages the PCP
- Creates a person-centered, comprehensive care plan with the member and works toward identified goals
- Makes the person-centered care plan available to providers by contacting Humana Healthy Horizons

Clinical management programs

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

- To learn more, visit Health and wellness resources for providers.

The care coach and case manager

Case management

Collaboration is needed when an MMA, LTC or MMA/LTC member receives inpatient services and discharge needs are identified.

When the member has both MMA and LTC benefits, LTC case management is primary.

The care coach (for LTC members) and case manager (for MMA and specialty members):

- Receives referrals from on-site/telephonic UM nurses following discharge, PCPs, specialists, self-referral, internal/external programs, community partners, etc.
- Educates members on disease process, self-care and value-added benefits, such as unlimited medical transportation, vision and dental coverage
- Completes post-discharge or post-ER visit telephonic outreach within 3 days of discharge, when applicable
- Identifies gaps in care, addresses post-discharge needs and assists in making follow-up appointments with PCP and specialists
- Stratifies members into various acuities using:
  - Readmission predictive model score
  - Admission history
  - Metric reports (e.g., high-cost members)

Case management programs

MMA chronic disease management programs	
• Anxiety disorders • Asthma • Attention deficit hyperactivity disorder (ADHD) • Bipolar disorder • Cancer and cancer prevention • Cardiovascular disease • Chronic kidney disease • Chronic obstructive pulmonary disease (COPD) • Dementia	• Depression and depression prevention (including suicide prevention) • Diabetes and diabetes prevention • End-stage renal disease (ESRD) • HIV • Hypertension • Osteoporosis • Parkinson's disease • Sickle cell disease • Substance use disorders

LTC chronic disease management programs comanaged with:	
• Cancer and cancer prevention • COPD • Dementia and Alzheimer's • Depression and depression prevention (including suicide prevention)	• Diabetes and diabetes prevention • End-of-life issues/advance directives • HIV, AIDS and HIV prevention • Hypertension

Goal

Help empower Humana Healthy Horizons members and their families through education and the development of self-management skills that foster treatment plan compliance and better health outcomes.

Overview

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

Other programs for MMA members

HumanaBeginnings

- Manages prenatal and postpartum members from onset of pregnancy up to 12 weeks postpartum or until gap(s) are closed
- Facilitates care coordination with Women, Infants, Children (WIC) program, Healthy Start and other internal/external programs
- Ensures provision of healthy behavior reward for program participation and visit compliance
- Works with member and provider to ensure compliance with prenatal and postpartum appointments

Social workers

- Assists members with social needs including transportation and community resources
- Receives referrals from case management, disease management and UM nurse

Pediatric case management and pediatric UM

- Provides telephonic case and disease management for pediatric members
- Provides enhanced care coordination to special needs pediatric members with private duty nursing, members residing in a nursing facility or members in medical foster care
- Manages all pediatric inpatient utilization
- Provides case management for pediatric members receiving BA services

Member special needs consideration

- Healthcare providers must make efforts to understand members' special needs. Members may have challenges that include physical compromises as well as cognitive, behavioral, social and financial issues. Multiple comorbidities, complex conditions, frailty, disability, end-of-life issues, ESRD, isolation, depression and polypharmacy are some of the challenges facing these members each day.
- Recognizing members' significant needs, Humana Healthy Horizons incorporates person-centered care planning, coordination and treatment in our care coordination program.
- Care management is delivered within a multidisciplinary team (MDT) structure and holistically addresses the needs of each member.
- Members and/or their authorized caregivers are maintained at the core of the model of care, ensuring person-centered care and supported self-care.
- Humana Healthy Horizons case managers lead the members' MDTs and link closely to the members' PCPs to support them in ensuring members get needed care across the full spectrum of medical and behavioral health and other services. PCP participation in the MDT is a critical component in the success of members' care.
- Humana Healthy Horizons' predictive model, based on claims history and analytics, is used to determine each member's risk level and the level of intervention required to channel the member to the required level of coordination.
- A comprehensive assessment is completed for each member to evaluate his or her medical, behavioral and psychosocial status to determine the plan of care.

Member screening for alcohol or substance use

Participating PCPs must screen members for signs of alcohol or substance use as part of prevention evaluations during:

- Initial contact with a new member
- Routine physical examinations
- Initial prenatal contact
- Times when the member shows evidence of serious overutilization of medical, surgical, trauma or emergency services
- Times when documentation of ER visits suggests the need

Education regarding screening, brief intervention and referral to treatment (SBIRT) of pregnant patients is available on our Provider education and training webpage.

Participating providers are encouraged to use AHCA's newly adopted SBIRT codes for screening (H0049) and brief intervention (H0050).

Members who meet one of the indicators may be referred to an appropriate participating behavioral health provider or to Humana Healthy Horizons to enroll in the substance use program by calling MMA Case Management at 800-229-9880 or emailing fl_mma_cm_referrals@humana.com. You can also submit a referral form on our Provider education and training page.

Benefits of alcohol or substance use screening:

- Detect current health problems related to at-risk alcohol and substance use at an early stage—before they result in more serious disease or other health problems.
- Detect alcohol and substance use patterns that can increase future injury or illness risks.
- Intervene and educate about at-risk alcohol and other substance use.

Detecting risk factors early:

- Screening can be a significant step toward effective intervention.
- The clinician is often the first point of contact.
- Early identification and intervention lead to better outcomes.
- Patients are often seen by a clinician because of a related physical problem.

Continuity of care

Transition/continuity of care

PA is not required for continuity of care of transitioning members. We ensure transitioning members still receive care even if their current provider is not contracted with Humana Healthy Horizons.

Transitioning process

Continue care plan as is for up to 60 days

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

Reassess and update person-centered plan of care

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

Florida-based case managers

Pair with new case manager

- Based on location to ensure familiarity with local resources
- Assign PCP center to facilitate coordinated care with PCP
- Consider cultural and language needs

The following services may continue past 60 days from the member's transition to Humana Healthy Horizons:

- Prenatal/postpartum care, up to 6 weeks after birth
- Transplant services, up to 1 year post-transplant
- Current round of oncology treatment
- Full course of hepatitis C treatment drugs

Coordination with carved-out service contractors

Humana Healthy Horizons' referral processes, whether to Humana services, the Medicaid FFS delivery system or the prepaid dental plan, support the best possible quality outcomes for members.

- Humana Healthy Horizons' proactive approach identifies needed services covered by Medicaid FFS or prepaid dental plan and coordinates a referral.
- The process identifies members who may qualify for Medicaid FFS or prepaid dental plan services through a variety of resources, including:
  - Outbound and inbound calls with members
  - Case management program, supports and assessments
  - Disease management
- Providers can call Member/Provider Services at 800-477-6931 to coordinate a Medicaid FFS or dental referral.

Humana Healthy Horizons coordinates referrals for the following services. These services are available to eligible Medicaid recipients through the Medicaid FFS delivery system:

- CHD-certified match program services
- Developmental disabilities individual budgeting (iBudget) HCBS waiver services
- Familial dysautonomia HCBS waiver services
- Hemophilia factor-related drugs distributed through the comprehensive hemophilia disease management program services
- Intermediate care facilities for individuals with an intellectual disability (ICF/IID) or related conditions services
- School-based services provided through the Medicaid-certified school match program
- Model HCBS waiver services
- Newborn hearing services
- Prescribed pediatric extended care services
- Program for all-inclusive care for children services
- Behavior analysis services
- Substance use disorder county match program services
- Programs of All-inclusive Care for the Elderly services
- Forensic assertive community treatment services

Coordination with prepaid dental plans

Eligible adults and children can select a prepaid dental plan offered by the following contractors:

- Managed Care of North America
- DentaQuest of Florida
- Liberty Dental Plan of Florida

Humana Healthy Horizons will assist members with the prepaid dental plan enrollment process and coordinate services and referrals.

Member grievances and appeals

Member grievances and appeals

Grievances

Members or their authorized representatives can file a grievance at any time, orally or in writing, if they are dissatisfied with Humana Healthy Horizons or any aspect of their care.

Appeals

Members or their authorized representatives can file an oral or written appeal request within 60 days of the date on the adverse benefit determination. Members can request assistance from Member/Provider Services at 800-477-6931 or LTC Provider Services at 888-998-7735.

Contact information

Mail
Humana Healthy Horizons
P.O. Box 14546
Lexington, KY 40512-4546

Phone
800-477-6931,
Monday – Friday, 8 a.m. – 8 p.m.,
Eastern time

Member grievances and appeals (continued)

Grievances

- We will resolve the member's grievance as quickly as the member's health condition requires.
- Grievances will be resolved within 30 days of the date we receive the request.
- We may extend the time frame by up to 14 days if we need more information and extending the time frame is beneficial to the member.

Appeals

- We will resolve appeals as quickly as the member's health condition requires.
- Standard appeals will be resolved no later than 30 days from the date we receive the request.
- If the member's life, physical or mental health, or ability to attain, maintain or regain maximum function would be at risk following the standard appeal time frame, an expedited appeal can be requested.
- Expedited appeals will be resolved within 48 hours of receipt.
- We may extend the appeal timeframe by up to 14 days if we need more information and extending the time frame is beneficial to the member.

Medicaid state fair hearing

If the appeal decision is not fully in the member's favor, the member or the member's authorized representative can appeal to AHCA by requesting a state fair hearing. Medicaid state fair hearing requests must be filed within 90 calendar days of the date on the Humana Healthy Horizons appeal decision letter.

To request a state fair hearing:

Call: 877-254-1055

Fax: 239-338-2642

Email:
MedicaidHearingUnit@ahca.myflorida.com

Mail state fair hearing requests to:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906

Critical incident reporting

Critical incident reporting

- Humana Healthy Horizons' risk management program includes a critical and adverse incident reporting and management system for critical events that negatively impact the health, safety and welfare of our members.
- Report critical and adverse incidents during the provision of HCBS that occur:
  - In adult day care
  - During adult family home care
  - In the healthcare provider's office
  - During home health services
- Call 911 if the member is in immediate danger.
- Report suspected abuse, neglect and exploitation of a member immediately in accordance with F.S. 39-201 and F.S. 415 to appropriate agency (e.g., police, Department of Children and Family, Adult Protective Services).
- Report the critical and/or adverse incident to the Humana Risk Management department by emailing RiskManagementAdministration@humana.com within 24 hours of knowledge of the incident.
- Humana Healthy Horizons has the right to take corrective action as needed to ensure its staff, participating providers and direct service providers comply with the critical incident reporting requirements.

Critical incident reporting (continued)

Participating providers should report the following events during the delivery of HCBS services:

- Member death (unexpected, homicide, suicide, or resulting from abuse/neglect/exploitation)
- Member brain damage, spinal damage or permanent disfigurement
- Fracture or dislocation of bones or joints
- Conditions that require definitive or specialized medical attention not consistent with the routine management of the patient's case or patient's preexisting physical condition
- Conditions requiring surgical intervention to correct or control
- Conditions resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care
- Conditions extending the patient's length of stay
- Conditions resulting in a limitation of neurological, physical or sensory function, which continues after discharge from the facility
- Suspected abuse/neglect/exploitation
- Injury or major illness as a result of care provided
- Sexual battery
- Medication error
- Suicide attempt
- Altercations requiring medical intervention
- Elopement (missing for 24 hours or more)

Electronic health records (EHRs)

EHRs

- An electronic health record (EHR) is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users. While an EHR does contain patients' medical and treatment histories, an EHR system is built to go beyond standard clinical data collected in a provider's office and can include a broader view of a patient's care.
- Florida Medicaid-eligible hospitals and professionals as defined by the Health Information Technology for Economic and Clinical Health (HITECH) Act are required to use certified EHRs.
- If providers need assistance selecting an EHR system, they can contact their local regional extension center (REC). RECs offer unbiased EHR implementation support throughout the implementation process. These organizations, funded by the Office of the National Coordinator (ONC) for Health Information Technology, also can serve as a two-way pipeline to local and federal resources. RECs can help with EHR implementation and project management, vendor selection, workflow redesign, privacy and security, training, ongoing technical assistance, and more. Visit HealthIT.gov's Frequently Asked Questions page for more information.
- If providers need assistance connecting to other providers, they can contact the Florida health information exchange (HIE) or visit Florida HIE Services. The Florida HIE enables the secure exchange of health information between healthcare providers.

Advantages of using EHRs

EHRs and the ability to exchange health information electronically can help you provide higher quality and safer care for patients while creating tangible enhancements for your organization. EHRs help providers better manage care for patients and provide better healthcare by:

- Providing accurate, up-to-date and complete information about patients at the point of care
- Enabling quick access to patient records for more coordinated, efficient care
  - Learn more at the HealthIT.gov Improve Care Coordination page.
- Sharing electronic information securely with patients and other clinicians
- Helping providers more effectively diagnose patients, reduce medical errors and provide safer care
  - Learn more at the HealthIT.gov Improved Diagnostics & Patient Outcomes page.
- Improving patient and provider interaction and communication, as well as healthcare convenience
  - Learn more at the HealthIT.gov Clinical Quality and Safety page.
- Enabling safer, more reliable prescribing
- Helping promote legible, complete documentation and accurate, streamlined coding and billing
- Enhancing privacy and security of patient data
  - Learn more at the HealthIT.gov Security Risk Assessment Videos page.
- Helping providers improve productivity
  - Learn more at the HealthIT.gov Medical Practice Efficiencies & Cost Savings page.

Patient-centered medical home (PCMH)

PCMH

- PCMH is a model of care that strengthens the provider-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship.
- Humana Healthy Horizons implemented the PCMH program to empower patients as they interact with their PCPs and healthcare delivery teams (e.g., family, therapist, specialist, diagnostic center, hospital and laboratory). The PCMH program focuses on a team-based approach to healthcare delivery. Open communication between the healthcare team and patient allows the patient to be more involved in healthcare decisions with a potential for better health outcomes and cost-effective treatment of ongoing health conditions.
- PCPs who are interested in the PCMH program, certification requirements and benefits can email <Rosemary Burgos> at FL_Medicaid_PCMH@humana.com.

Functions of a PCMH program

According to the Agency for Healthcare Research and Quality, a PCMH program includes functions that transform traditional primary care into advanced primary care, such as:

- **Comprehensive care:** A team including physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators and care coordinators guides patients through the healthcare delivery system.
- **Patient-centered care:** Patients are primary in the relationship and drive decisions that influence their health. Providers educate and establish a comprehensive plan of care.
- **Coordinated care:** The PCP communicates with the healthcare delivery team and manages coordination of care.
- **Accessible services:** The patient's access-to-care preferences are important. The provider considers shorter wait times, same-day appointments for urgent needs, after-hours and around-the-clock access, as well as openness to different types of communication besides the telephone.
- **Quality and safety:** The PCP uses evidence-based medicine and clinical decision-support tools to guide the patient and healthcare delivery.

Medicaid risk adjustment

Medicaid risk adjustment disclaimer

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

History and risk model definitions

Chronic Illness and Disability Payment System (CDPS)

- The model was developed in 1996 using Medicaid claims data on disabled beneficiaries.
- The model was modified in 2000 using additional data for both disabled and Temporary Assistance for Needy Families (TANF) beneficiaries.
- The model maps severely acute and chronic ICD-10* diagnosis codes to condition categories corresponding to major body systems (e.g., cardiovascular) or type of disease (e.g., diabetes). Florida has created additional state-specific categories.
- The University of California San Diego owns the CDPS model and provides version updates annually.

Medicaid prescription (MRx)

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

CDPS + Pharmacy

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

* International Classification of Diseases, Tenth Revision

Hierarchies and comorbidities

- CDPS categories are hierarchical within each major category.
- Weights/cofactors are additive across major categories.
- Within major categories, only the most severe diagnosis counts.
- CDPS categories allow an accounting of comorbidities across medical and pharmacy.

When it comes to coding comorbidities, for which Medicaid allows up to 12 diagnosis codes on electronic forms, please consider the following:

- The diagnosis shown in the record to be chiefly responsible for the services delivered should be coded first.
- All documented conditions that coexist and require or affect patient care, treatment or management should be coded.

Risk-adjusted populations

Included

- TANF
- Adult (14 and older)
- Children (1–13 years old)
- Supplemental Security Income (SSI) persons with disabilities
- Severely mentally ill members

Excluded

- TANF children (younger than 1 year old)
- SSI children (younger than 1 year old)
- Dual eligible (duals are risk-adjusted by Medicare hierarchical condition categories [HCCs])
- Stand-alone long-term care
- Members with less than 6 months of eligibility during the observation period

Comparing risk-adjustment models

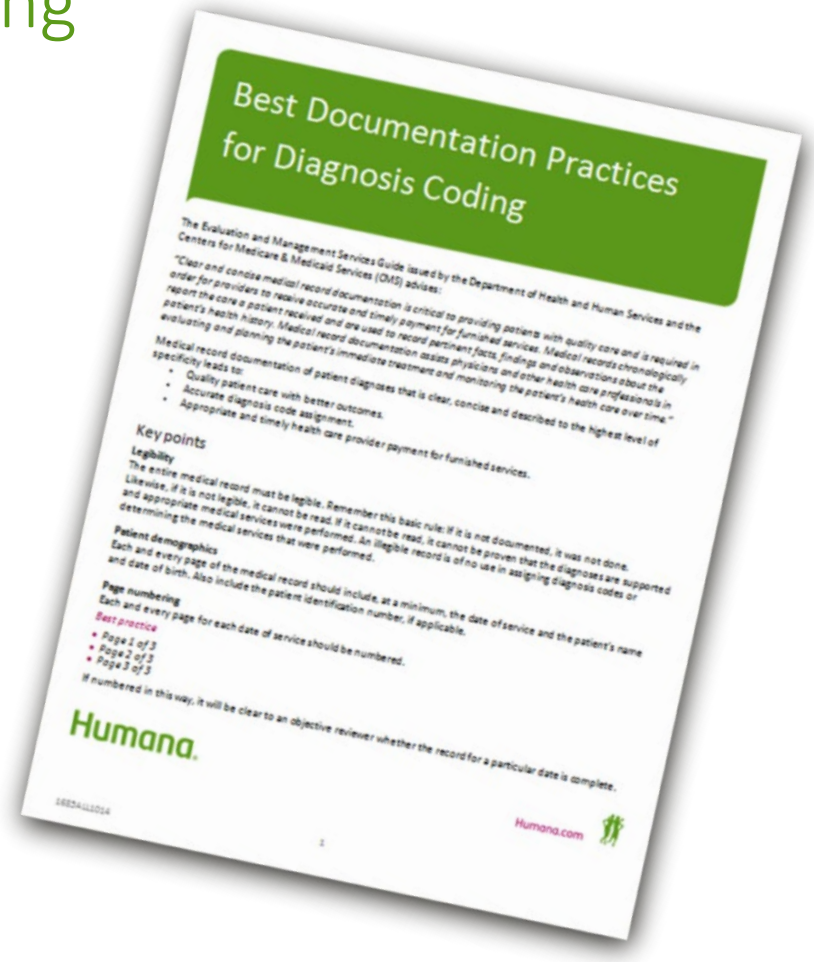
Medicare Advantage	Florida Medicaid
Centers for Medicare & Medicaid (CMS) HCC model	**CDPS + Pharmacy model**
Prospective (future payments adjusted twice per year and 1 lump sum reconciliation payment)	Prospective (future payments adjusted quarterly)
Risk score based on age, gender, diagnosis and geography	Risk score based on age, gender, diagnosis, geography and Medicaid population (TANF, SSI)
Individual member risk scores	Individual member risk scores grouped at plan level, population types and age band (e.g., rate cells)
3 annual data submission deadlines (March, Sept. and Jan.)	Four annual data submission deadlines (March, June, Sept. and Dec.)
ICD-10 codes grouped into HCCs	ICD-10 and NDC codes grouped into 58 CDPS categories and 15 MRx categories
Unlimited risk adjustment payments (theoretically)	Zero-sum settlement/budget neutral
MCO may code diagnoses	MCO cannot code diagnoses—only providers can code diagnoses

Florida MMA risk-adjustment timeline (rate years 2023–2025)

Florida Quarters ↓			Study Period Dates of Service											
			CY 2022				CY 2023				CY 2024			
	Payment months	Calendar Quarters →	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2023 Q1	2023 Q2	2023 Q3	2023 Q4	2024 Q1	2024 Q2	2024 Q3	2024 Q4
Rate Year ’23/’24 Q1	Oct 2023 – Dec 2023		1/1/2022 – 12/31/2022				Claims Run out							
Rate Year ’23/’24 Q2	Jan 2024 – March 2023			4/1/2022 – 3/31/2023				Claims Run out						
Rate Year ’23/’24 Q3	April 2024 – June 2024				7/1/2022 – 6/30/2023				Claims Run out					
Rate Year ’23/’24 Q4	July 2024 – Sept 2024					10/1/2022 – 9/30/2023				Claims Run out				
Rate Year ’24/’25 Q1	Oct 2024 – Dec 2024						1/1/2023 – 12/31/2023				Claims Run out			
Rate Year ’24/’25 Q2	Jan 2025 – March 2025							4/1/2023 – 3/31/2024				Claims Run out		
Rate Year ’24/’25 Q3	April 2025 – June 2025								7/1/2023 – 6/30/2024				Claims Run out	
Rate Year ’24/’25 Q4	July 2025 – Sept 2025									10/1/2023 – 9/30/2024				Claims Run out

Sources: Agency for Health Care Administration (AHCA) and Milliman Care Guidelines (MCG)

Best documentation practices for diagnosis coding



Legible

- Makes entire medical record legible to any objective reader

Clear

- Communicates the documenter's intent to all readers

Concise

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

Consistent

- Avoids conflicts or contradictions

Complete

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

Clinical coding example

Excerpt from full medical record

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

Physical exam:

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

Clinical coding example (continued)

Assessment:

- Diabetes mellitus, type 2, uncontrolled with hyperglycemia
- Diabetic ulcer right ankle involving skin only
- Diabetic peripheral neuropathy

Plan:

- Keep wound clean and dry
- Follow-up visit in 10 to 14 days
- Prescription given for Keflex 500 mg by mouth twice daily for 10 days
- Over-the-counter (OTC) Tylenol® for pain as directed
- X-ray right ankle
- Sent to lab for CBC, CMP, TSH, HbA1c, random urine albumin, urine albumin creatinine ratio
- Diabetic teaching with nutrition consult for diabetic diet

Clinical coding example (continued)

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

Complete coding	
E11.622	Type 2 diabetes with other skin ulcer
L97.311	Non-pressure chronic ulcer of right ankle limited to breakdown of skin
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
E11.65	Type 2 diabetes mellitus with hyperglycemia
J59.10	Inadequate housing

Access-to-care requirements

Accessibility and availability standards and methods of identifying compliance

Providers must offer hours of operation that are no less than the hours of operation offered to commercial managed care plan members or comparable Medicaid FFS recipients if the provider serves only Medicaid recipients.

Participating PCP and medical/behavioral health specialists are required to ensure adequate accessibility for healthcare 24 hours a day, 7 days a week. An after-hours telephone number must be available to members. Voicemail is not permitted.

Humana Healthy Horizons' provider network must meet ACHA time and distance standards, and members should have access to care for PCP services and referrals to specialists for medical and behavioral health services available on a timely basis.

Compliance with availability and accessibility standards are monitored regularly through random sampling, review of member concerns and member satisfaction surveys to ensure members have reasonable access to providers and services.

Appointment time standards

Service	Appointment requirements
Medical or behavioral healthcare services that do **not** require PA	Within 48 hours of a request
Medical or behavioral healthcare services that **do** require PA	Within 96 hours of a request
Follow-up behavioral treatment after discharge from inpatient behavioral health admission	Within 7 calendar days of a request
Initial outpatient behavioral health treatment	Within 14 calendar days
Ancillary services deemed necessary for the diagnosis or treatment of injury, illness or other health condition	Within 14 calendar days of a request
Primary care appointment	Within 30 calendar days of a request
EIS (Individual Family Service Plan [IFSP] must be completed for children enrolled in the Early Steps program)	Within 30 calendar days of a completed IFSP
Specialist appointment after the appropriate referral is received by the specialist	Within 60 calendar days of a request

For more information, please review the access-to-care requirements for Humana Healthy Horizons in the Florida members flyer.

Access-to-care requirements for PCPs and after-hours coverage

Access-to-care requirements for PCPs include the following:

- The PCP (and/or OB-GYN for pregnant members) must provide or arrange for coverage of services, consultation or approval for referrals 24 hours a day, 7 days a week by Medicaid-enrolled providers who will accept Medicaid reimbursement.
- This coverage must consist of an answering service, call forwarding, provider call coverage or other customary means approved by AHCA.
- The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision.

Requirements for after-hours coverage include the following:

- The after-hours coverage must be accessible using the medical office's daytime telephone number.
- The PCP must arrange for coverage of primary care services during absences due to vacation, illness or other situations that require the PCP to be unable to provide services.
- A Medicaid-eligible PCP must provide coverage.

AHCA provider-based marketing and activities guidelines

AHCA provider-based marketing and activities guidelines

If you choose to distribute marketing materials for Humana Healthy Horizons, you must:

- Remain neutral
- Make available and/or distribute marketing materials for all managed care plans with which you participate

If you choose to distribute marketing materials for Humana Healthy Horizons, you may:

- Announce new or continuing affiliations with the managed care plan through general advertising (e.g., radio, television, websites).
- Make new affiliation announcements within the first 30 days of the new provider agreement.
- Make 1 announcement to patients of a new affiliation that names only the managed care plan when such announcement is conveyed through direct mail, email or phone.*
- Display posters or other materials in common areas, such as the provider's waiting room.
- Provide materials in admission packets announcing all managed care plan contractual relationships (LTC facilities only).

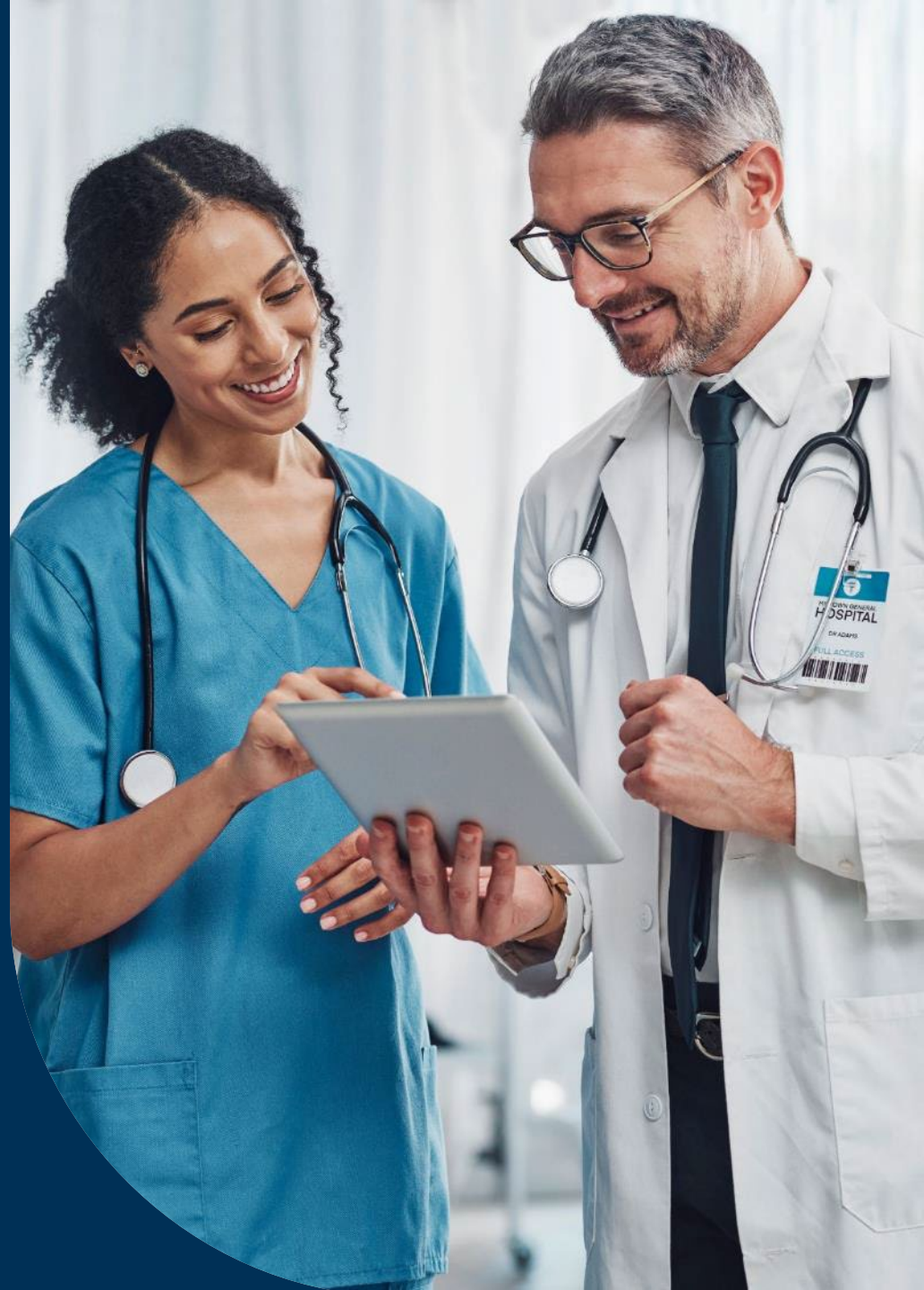
* Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all managed care plans with which the provider has agreements. Materials must be reviewed/approved by the plan and submitted to AHCA for approval, as necessary, before distributing. Materials indicating the provider has an affiliation with certain managed care plans and that only list managed care plan names, logos, product taglines, telephone contact numbers and/or websites do not require agency approval.

AHCA provider-based marketing and activities guidelines (continued)

If you choose to distribute marketing materials for Humana Healthy Horizons, you may not:

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

MMA Physician Incentive Program



MMA Physician Incentive Program

The aim of the MMA Physician Incentive Program (MPIP) is to promote quality of care for Medicaid beneficiaries and recognize those providers who demonstrate high levels of performance for selected criteria.

The MPIP provides the opportunity for designated providers to earn enhanced payments equivalent to the appropriate Medicare FFS rate, as established by AHCA, based on the achievement of key access and quality measures.

Providers eligible to participate in the MPIP are those listed below who meet the state-designed MPIP program's specific medical and/or quality criteria:

- Pediatric PCPs—Pediatricians, family practitioners and general practitioners who provide medical services to members younger than 21
- There are 2 ways pediatric PCPs can qualify:
  1. PCMH recognized on or before Oct. 1, 2023, by:
     - NCQA
     - Accreditation Association for Ambulatory Health Care (AAAHC)
     - The Joint Commission (TJC)
     - Utilization Review Accreditation Commission (URAC)
  2. A site with 50 Humana Healthy Horizons pediatric members and meeting or achieving all HEDIS benchmarks included in program

Please visit AHCA's MPIP site to learn more about the program-qualifying measures.

Qualifying OB-GYNs and pediatric specialists

- OB-GYNs—There are 2 ways OB-GYN providers can qualify:
  1. Recognized by NCQA as a patient-centered specialty practice (PCSP) on or before Oct. 1, 2023, or PCMH by one of the following organizations:
     - NCQA
     - AAAHC
     - TJC
     - URAC
  2. A site must achieve or exceed the benchmark for all 3 of the following metrics:
     - Timeliness of prenatal care ≥ 83.53%
     - Postpartum care ≥ 76.18%
     - Florida Medicaid c-section rate ≤ 35%
- Pediatric specialists—Providers who provide medical services to members younger than 21

Providers that do not qualify for MPIP

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

- Providers not participating in the Humana Healthy Horizons network
- PCPs without PCMH accreditation or fewer than 50 members who did not meet all the program HEDIS measures
- OB-GYNs without PCSP accreditation, PCMH accreditation or who do not meet the benchmark for all 3 defined quality measures
- PCPs with adult panels
- FQHCs
- RHCs
- CHDs
- Medical school faculty plans

Complete information regarding the incentive program and timelines can be found on the AHCA MPIP website.

Fraud, waste and abuse (FWA)

FWA definitions

Fraud

Fraud is defined as the intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Waste

Waste is defined as overutilization or inappropriate utilization of services and misuse of resources and typically is not a criminal or intentional act.

Abuse

Abuse is defined as provider practices inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes eligible and member practices that result in unnecessary cost to the Medicaid program.

FWA reporting requirement and methods

Anyone who suspects or detects an FWA violation is required to report it either to Humana Healthy Horizons or within their respective organization, which then must report it to Humana Healthy Horizons.

Suspected FWA pertaining to Florida MMA/LTC must be reported to:

- Medicaid program integrity administrator by calling 850-412-4600, Monday – Friday, 8 a.m. – 5 p.m., Eastern time
- Florida AHCA consumer complaint hotline by calling 888-419-3456, Monday – Friday, 8 a.m. – 5 p.m., Eastern time
- Florida attorney general by calling 866-966-7226, Monday – Friday, 8 a.m. – 5 p.m., Eastern time
- Medicaid Fraud and Abuse Complaint Form online

Telephone:

- SIU hotline: 800-614-4126 (24/7 access)
- Ethics help line: 877-5-THE-KEY (877-584-3539)

Email: SIUReferrals@humana.com or Ethics@humana.com

Online: EthicsHelpLine.com

Fax: 920-339-3613

In addition to reporting as indicated above, if the suspected fraud appears to be substantial, AHCA will be notified immediately. All final resolutions of a case include a written statement notifying the provider or member that the resolution in no way binds the state of Florida nor precludes the state of Florida from taking further action for the circumstances that caused the matter.

All information will be kept confidential.
Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Humana has a zero-tolerance policy for retaliation or retribution against any person who reports suspected misconduct.

False Claims Act

- The False Claims Act permits a person with knowledge of fraud against the U.S. government to file a lawsuit (plaintiff) on behalf of the government against the person or business that committed the fraud (defendant). The state of Florida has a statute matching the Federal False Claims Act that allows for the recovery of Medicaid funds by the state of Florida.
- Individuals who file such suits are known as “whistleblowers.” If the action is successful, the plaintiff is rewarded with a percentage of the recovery. Retaliation against individuals for investigating, filing or participating in a whistleblower action is prohibited.

Liability (31 U.S.C. 3729(a)(1) and (a)(3)): Liability for the foregoing acts includes:

- A civil penalty of $5,000 – $10,000
- Three times the amount of damages the government sustains because of that act

A person or company who violates the False Claims Act is also liable to the government.

Disallowed Actions (31 U.S.C. §§ 3729-3733)
Links to the above provisions of this act are listed within Humana’s Compliance Policy for Contracted Health Care Providers and Business Partners, which is available on Humana's Addressing fraud, waste and abuse page.

Thank you

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