Provider Orientation and Training

Information for Florida Medicaid Healthcare Providers and Administrators

2022

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

Humana
Healthy Horizons™
in Florida

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Notable changes

This overview is provided to list the key points of notable changes and the sections in which they are detailed.

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Training topics

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Training topics are based on the following:

- Humana's contract with the Florida Agency for Health Care Administration (AHCA)
- Humana's policies and procedures

Training topics – continued

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About Humana

- Health and wellness services
- Solutions for employer groups, Medicare- and Medicaid-eligible consumers
- Commercial, Medicare and Medicaid (in select markets)
- Plans include health, dental, vision and behavioral health
- 14.3 million medical members
- 7 million specialty members

About Humana Healthy Horizons™ in Florida

- In 2018 Humana was once again awarded 11 regions to serve as a comprehensive plan for Florida's Statewide Medical Managed Care Program (SMMC).
- Comprehensive plans are awarded to managed care plans that are eligible to provide managed medical assistance (MMA) and long-term-care (LTC) services to eligible recipients.
- Comprehensive plans must meet high standards in network, member quality and clinical performance metrics.
- Humana Healthy Horizons in Florida is available to all eligible Medicaid recipients in the state of Florida.

Statewide Medical Managed Care Program (SMMC) Purpose and Eligibility

SMMC is designed to care for all eligible individuals by providing access to:

LTC

- Adults with disabilities and elders who meet nursing-home level of care

Eligibility requirements:

- 18 or older
- Resides in Florida
- Meets physical and financial requirements as determined by the Agency for Health Care Administration (AHCA)

Humana
Long-Term Care

MMA

- Managed Medical Assistance (MMA)

Eligibility requirements:

- Beneficiary ages – birth to 21 and 21 and older
- Resides in Florida
- Meets the eligibility requirements as established by the AHCA

Comprehensive

- Includes MMA and LTC

Humana Healthy Horizons in Florida

The SMMC Program has three components:

- **Long-term Care (LTC)**
  Medicaid recipients who qualify and enroll in the Florida Long-term Care Managed Care (LTCMC) program receive LTC services through an LTC-managed care plan.

- **Managed Medical Assistance (MMA)**
  Medicaid recipients who qualify and enroll in the Florida MMA program receive all healthcare services other than long-term care though a managed care plan.

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

Florida MMA Program

- Florida's MMA program is designed to provide a statewide managed care delivery system that improves outcomes, consumer satisfaction as well as reducing and controlling costs.

- The Florida MMA program focuses on four key objectives to support successful implementation:

  1. Preserve continuity of care (COC).
  2. Require sufficient and accurate provider networks with scheduling room to onboard patients; allows for an informed choice of plans for recipients and the ability to make appointments.
  3. Pay providers fully and promptly to preclude provider cash flow or payroll issues and give providers ample opportunity to learn and understand the plan's prior-authorization procedures.
  4. Coordinate with the Choice Counseling call center and website operated by the agency's contracted enrollment broker.

The foundation for Humana Healthy Horizons in Florida

Our focus on member well-being through a coordinated care and engagement strategy and strong support infrastructure simultaneously benefits each of our members on his or her journey to better health.

MEMBER ENGAGEMENT

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

PROVIDER ENGAGEMENT

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

COMMUNITY ENGAGEMENT

- Advisory panels
- Healthy Start collaboration
- Community outreach

SUPPORT INFRASTRUCTURE

- Member and provider services
- Quality management and improvement
- Compliance
- Administrative services
- Collaboration and alignment with AHCA

STRATEGY & IMPLEMENTATION APPROACH

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

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

Keys to success

Humana has a proven track record in providing high-quality care to Florida members, with:

- Florida-based market support team
- Experience with Florida and its unique populations
- Seamless and scalable network
- Community integration and outreach
- Dedication to lifelong well-being
- Focus on measurable outcomes

3. Covered services

Covered Services

Humana Healthy Horizons in Florida, through its contracted healthcare providers, is required to arrange for the following medically necessary services for each patient. Covered service descriptions and details can be found in the member handbook.

Adult companion care	Clinic services
Adult day healthcare	Community mental health services
Advanced registered nurse practitioner (ARNP) services	County health department services
Ambulatory surgical centers (ASC)	Durable medical equipment (DME) and medical supplies
Assisted living	Early intervention services (EIS)
Assistive care services	Emergency behavioral health services
Attendant nursing care	Emergency services
Behavioral health services — inpatient and outpatient	Family planning services and supplies
Birth center services	Federally qualified health center services
Care coordination/case management	Healthy Start services
Caregiver training	Hearing services
Child health targeted case management	Home accessibility adaptation services
Chiropractic services	Home-delivered meals

Covered services – continued

Home health services and nursing care	Podiatry services
Homemaker services	Prescribed drug services
Hospice	Primary care case management services
Hospital services — inpatient and outpatient	Primary care services
Imaging services	Prosthetics and orthotics
Immunizations	Renal dialysis services
Intermittent and skilled nursing	Respite care
Laboratory services	Rural health clinic services
Licensed midwife services	Specialty provider services
Medical foster care	Targeted case management
Medication administration	Therapy services
Medication management	Transplant services
Nursing facility services	Transportation services
Nutritional assessment/risk reduction services	Vision services
Personal care	Well-child visits
Personal Emergency Response System (PERS)	X-ray services, including portable X-rays
Physician assistant services	

Telemedicine

Telemedicine is the practice of healthcare delivery by a practitioner who is at a location other than the patient's for the purposes of evaluation, diagnosis or recommendation of treatment. Telephone conversations, chart review, electronic mail messages or faxes are not considered telemedicine and are not reimbursed.

- Florida Medicaid reimburses the practitioner who provides the evaluation, diagnosis or treatment recommendation and is located at a site other than where the recipient is located. Practitioners must include modifier GT on the CMS-1500 claim form.
- Florida Medicaid does not reimburse for equipment required to provide telemedicine services.
- The practitioner must implement telemedicine fraud and abuse protocols.
- Physicians are encouraged to contact their provider relations representative if they offer or plan to offer these services to patients with Humana Medicaid coverage.

Humana Healthy Horizons in Florida Pharmacy Benefit Summary

No Copayments

Medicaid members have a $0 copay at network pharmacies.

State-mandated Preferred Drug List (PDL)

All plans use AHCA's formulary. Online access found at Humana.com/Medicaid/Florida/MMA

34-day Supply

Medications are limited to a 34-day supply. Select maintenance medications may receive a 100-day supply.

Over-the-Counter (OTC) Benefit

$25 per household per month OTC benefit allowance through PrescribeIT.

Pharmacy benefit

Request an authorization

- Fast and easy electronic submission via www.CoverMyMeds.com/epa/Humana
- Fax **877-486-2621**
- Call Humana Pharmacy Clinical 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.

http://ahca.myflorida.com/medicaid/Prescribed_Drug/pdf/FL_Consent_Form_Psychotropic_Medications.pdf

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 prior authorization.

To find preferred products, please visit Humana.com/HealthyFlorida

Medication Intake Team preauthorization list

For drugs administered in the physician's office, authorization may be obtained by calling **866-461-7273.**

If you prefer, complete the appropriate form at Humana.com/medpa and fax it to Humana**.**

Prescriber quick reference guide

Humana Clinical Pharmacy Review (HCPR)

For medication supplied by a pharmacy and billed through the pharmacy benefit: medication prior authorization (PA), step therapy, quantity limits and medication exceptions. To view Humana drug list, go to **Humana.com/druglists**

Authorization process	• Obtain forms at **Humana.com/PA** or submit your request electronically by going to www.covermymeds.com/epa/humana • Submit request by fax to 877-486-2621 • Call HCPR at **800-555-CLIN (800-555-2546)**
Requirements for prior authorization fax form	• National Provider Identifier (NPI) • Address of member • Address of prescriber • Time period and outcome of past therapy tried/failed **NOTE:** Include medical records ONLY for medical necessity or off-label-use review (not for every submission)
Questions	**800-555-CLIN (800-555-2546)**; Monday through Friday, 8 a.m. to 6 p.m. local time
Exceptions by mail	**Medicare:** HCPR, Attn: Medicare Coverage Determination, P.O. Box 33008, Louisville, KY 40232 **Commercial and Medicaid:** HCPR, Attn: Prior Authorizations, P.O. Box 33008, Louisville, KY 40232

Humana Medication Intake Team (MIT)

For medication supplied and administered in a physician's office and billed as a medical claim (Part B for Medicare); also considered medication preauthorization/precertification

Precertification process	• Obtain forms at **Humana.com/medPA** • Submit request by fax to **888-447-3430** • View preauthorization and notification lists at **Humana.com/PAL**
Questions	**866-461-7273**; Monday through Friday, 6 a.m. to 8 p.m. Eastern time

General Humana contact information

Claims address	Located on the patient's Humana member ID card
Pharmacy appeals	**Commercial and Medicaid:** Humana Appeals, P.O. Box 14546, Lexington, KY 40512-4546; Fax: 800-949-2961 **Medicare:** Humana Appeals, P.O. Box 14165, Lexington, KY 40512-4165; Fax: 800-949-2961 To file a Part D redetermination online: **Humana.com/providers/pharmacy/exceptions_appeals.aspx**

Humana Pharmacy

Humana Pharmacy® (mail-delivery pharmacy for maintenance medications and durable medical equipment)	**800-379-0092** (Fax: **800-379-7617**), Monday through Friday, 8 a.m. to 1 p.m., Eastern time; Saturday, 8 a.m. to 6:30 p.m., Eastern time; **HumanaPharmacy.com**
Humana Specialty Pharmacy® (mail-delivery pharmacy for specialty medications)	**800-486-2668** (Fax: **877-405-7940)**, Monday through Friday, 8 a.m. to 8 p.m., Eastern time; Saturday, 8 a.m. to 6 p.m., Eastern time; **HumanaPharmacy.com/Specialty**
PrescribeIt RX ® (mail delivery for Florida Medicaid)	**800-526-1490** (Fax**: 800-526-1491**), Monday through Friday, 8 a.m. to 5 p.m. Eastern time; **PrescribeItRx.com**

Humana recognizes that your patients have the sole discretion to choose their pharmacy. Also, we support your independent medical judgment when advising patients about their pharmacy choices. Other pharmacies are available in our network. Humana members should check their plan documents to verify their prescription benefits.

4. Humana Healthy Horizons in Florida’s expanded sercies

Expanded services

- Expanded services are those benefits offered by Humana Healthy Horizons in Florida 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 services descriptions and details can be found in the member handbook.

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

Expanded benefits

- Acupuncture services for adults – unlimited
- Assisted living facility (ALF) bed-hold increase (30 days)
- Assisted living facility move-in basket for LTC members
- Assessment services – unlimited
- Behavioral health
- Biometric equipment
- Caregiver transportation for LTC members
- Cellular phone service expansion
- Chiropractic services for adults – unlimited
- Computerized cognitive behavioral therapy – unlimited
- CPAP and oxygen supplies for adults – unlimited
- Day trip meal reimbursement/allowance for adults
- Day services/day treatment – unlimited
- Disaster relief meals for adults
- Doula services
- Financial literacy
- Glucose pads for adults – unlimited
- Go365 Pediatric Wellness Program
- Group therapy – unlimited
- Hearing service expansion for adults
- Home delivered meals for adults
- Housing assistance for adults ($500 allowance per lifetime)
- Home visits by a clinical social worker – unlimited
- Increased transition assistance (nursing facility to community – $5,000 per lifetime)
- Individual/Family therapy – unlimited
- Individual therapy sessions to caregivers – unlimited
- Intensive outpatient treatment – unlimited
- Massage therapy for adults – unlimited
- Medical services: drug screening – unlimited
- Medical services: medication management – unlimited
- Medical services: verbal interaction – unlimited
- Medication-assisted treatment
- Monitoring supplies for continuous glucose monitoring for adults – unlimited
- Newborn circumcisions
- Non-emergency transportation increase for LTC for adults
- Nutritional counseling for adults – unlimited
- Occupational therapy for adults
- Over-the-counter (OTC) drugs and supplies, $25 per month household limit
- Outpatient hospital – no financial caps on services
- Post-discharge meals
- Prenatal/Perinatal visits and breast pump rental – unlimited
- Prevention Kit – Flu/Pandemic
- Primary care visits for non-pregnant adults – unlimited
- Psychosocial rehabilitation, unlimited
- Respiratory therapy for adults
- Screening services – unlimited
- Speech therapy for adults
- Substance abuse treatment or detox services (outpatient) – unlimited
- Swimming lessons (drowning prevention)
- Targeted case management – unlimited
- Therapeutic behavioral on-site services – unlimited
- Tutoring
- Vaccines: Flu, pneumonia, shingles and TDAP (for pregnant adults)
- Vision service expansion for adults
- Waived copayments

5. Contracting and credentialing

Contractual and demographic changes

- As a contracted provider, notifying Humana of legal and demographic changes is required and ensures provider directory and claim processing accuracy.
- Contracted providers are required to notify Humana of changes to their Tax Identification Number (TIN).
- The following changes should be sent to Humana using a standard roster or Humana form:
  - New providers added to group
  - Providers leaving group
  - Service address changes, i.e., new location, phone, fax
  - Accessible to public transportation
  - Standard hours of operation and after hours
  - Billing address updates
  - Credentialing updates (i.e. licensure changes, professional liability insurance changes)
  - Panel status
  - Languages spoken in office

Contractual and demographic changed – continued

Please contact your regional contracting representative.
Please refer to the FL contact list by county.

Humana MMA:

- **North & Central Florida:** NorthFLCentralizedProviderRelations@humana.com
- **South Florida:** Humana_SFL_Centralized_Provider_Relations@humana.com
- **Humana LTC**: LTCNetworkrequests@humana.com

For additional ways to contact us, please visit: Humana.com/provider/contact

Contracting process – required information

- Physician/practice/facility name
- Service address with phone, fax and email information (please provide counties served)
- Mailing address, if different than service address
- TIN
- Specialty
- Medicaid provider number for both NPI types, group/billing and rendering (enrolled or limited with corresponding registered provider specialty code and provider type code)
- National Provider Identifier (NPI)
- Council for Affordable Quality Healthcare (CAQH®) number
- Indicate which lines of business are of interest (e.g., Medicaid, Medicare, etc.)
- Type of contract (e.g., individual, group, facility)
- Disclosure of Ownership
- Practitioner Office Site Evaluation Tool (POSET)
- PCP patient load attestation
- For LTC: Florida state license and proof of insurance

Credentialing

- Humana participates with the Council for Affordable Quality Healthcare (CAQH®) for applicable provider types.
  - To aid with credentialing and recredentialing activities, please continually maintain your CAQH application to ensure it is complete and current.
- Healthcare providers must be credentialed prior to network participation to treat Humana-covered patients.
- Provider office site evaluations must be completed for all PCP and OB-GYN provider locations prior to participation with Humana and during recredentialing.
- Prior to participation with Humana and during recredentialing, primary care providers are required to attest that their total active patient load is not more than the Medicaid standard.
- Recredentialing occurs at least every three years. Some circumstances require shorter recredentialing cycles.
  - Humana will leverage applications via CAQH during the recredentialing cycle, as applicable by provider type.
  - If we are unable to access your CAQH application, CAQH does not support your provider type, or the supporting documentation available via CAQH is expired or incomplete, providers will receive a request to provide the necessary documentation prior to the 36-month anniversary date of the last credentialing cycle.
- Healthcare providers must have an active Florida Provider Medicaid ID to be considered for participation.
- In addition to being in good standing with Medicare, federal, state and local agencies, healthcare providers must be free from active sanctions imposed by the Agency for Health Care Administration (AHCA).

Further details regarding Humana's credentialing/recredentialing requirements can be found in Humana's Provider Manual at Humana.com/provider/medical-resources/medicare-medicaid/florida-medicaid/education-materials

CAQH Proview® streamlined credentialing process

Physicians and healthcare professionals need to use the CAQH ProView tool to provide credentialing information to Humana. Please note: This excludes facilities as they are not supported by CAQH at this time.

CAQH ProView is the trusted source and industry standard for self-reported provider data and eliminates redundant applications, including state applications, required by a healthcare professionals' contracted health plans, including Humana. Using CAQH reduces the amount of time healthcare professionals spend on credentialing and recredentialing by allowing them to submit information to the tool once and then update it via the attestation process.

How this affects you:

- **Initial applicants** must use CAQH for credentialing requests submitted **Jan. 1, 2017, and after.**
- Healthcare professionals due for **recredentialing Sept. 1, 2017, and after** must submit their information through CAQH.
- If you **are not registered** with CAQH, please complete a registration form via https://proview.caqh.org/PR/Registration. 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.
- Questions may be emailed to CredentialingInquiries@Humana.com

6. Access to care requirements

Access to care requirements

The PCP provides or arranges coverage of services, consultation or approval for 24/7 referrals from Florida Medicaid-enrolled providers who accept Medicaid reimbursement. This coverage consists 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. The after-hours coverage must be accessible using the medical office's daytime telephone number. The PCP should arrange for coverage of primary care services during absences due to vacation, illness or other situations that make the PCP unavailable. A Medicaid-eligible PCP must provide coverage. Members should be triaged and provided appointments for care within the time frames listed on the following slide.

Access to care requirements – continued

Appointments for urgent medical or behavioral healthcare services shall be provided:

a) Within 48 hours of a request for medical or behavioral healthcare services that do not require prior authorization.

b) Within 96 hours of a request for medical or behavioral healthcare services that do require prior authorization.

Appointments for non-urgent care services shall be provided:

a) Within seven days post-discharge from an inpatient behavioral health admission for follow-up behavioral health treatment.

b) Within 14 days for initial outpatient behavioral health treatment.

c) Within 14 days of a request for ancillary services for the diagnosis or treatment of injury, illness or other health condition.

d) Within 30 days of a request for a primary care appointment.

e) Within 60 days of a request for a specialist appointment after the appropriate referral is received by the specialist.

EIS Early Steps shall be provided:

Within 30 days of an Individualized Family Support Plan (IFSP) completed for children enrolled in the Early Steps Program to receive early intervention services.

For more information, please review the Access to Care Requirements for Humana Healthy Horizons in Florida Members **flyer**.

Transfer for cause process

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

To ensure an access-to-care issue does not occur, the transfer-for-cause (TFC) process details the steps healthcare providers should follow when submitting a member transfer request to Humana due to disruptive, unruly, abusive, or uncooperative member/caregiver behavior that seriously impairs a 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 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 Manual or the Provider Request to Transfer Process FAQ flyer.

7. Preauthorized and notification

Preauthorized and notification

Humana requires preauthorization for certain services to facilitate care coordination and maximize benefits for your patients with Humana Healthy Horizons in Florida coverage, as well as to confirm that the services are provided according to AHCA coverage policies. For LTC, call Provider Relations at **888-998-7735**. Please note:

- Preauthorization is required for many services and medications.
- Physicians or other healthcare providers should review current Humana Healthy Horizons in Florida Preauthorization and Notification List online at **Humana.com/PAL**.
- Preauthorization must be obtained prior to the date of service.

Preauthorized for medical procedures

Humana Healthy Horizons in Florida - MMA

- Call **800-523-0023** (available 24 hours a day) for automated requests
- Representatives available 8 a.m. to 8 p.m., Eastern time, Monday through Friday (excluding major holidays)
- Press “0” or say “representative” for live help
- Have TIN available

Humana Healthy Horizons in Florida - LTC

- Authorizations are requested by the provider or the member’s care manager
- Provider receives a faxed copy of the authorization

8. Claims processing

Electronic claim submission

Claims clearinghouses:

Availity Portal	Availity.com	800-282-4548
Change Healthcare (formerly Emdeon)	ChangeHealthcare.com	866-371-9066
TriZetto	Trizettoprovider.com	800-969-3666
RelayHealth	Relayhealth.com	800-388-2316
SSI Group	TheSSIGroup.com	800-820-4774

NOTE: Availity is Humana's preferred clearinghouse and there are no service fees when submitting Humana electronic claims. Some clearinghouses and vendors charge a service fee. Contact the clearinghouse for more information.

Humana MMA providers

- Go to Humana.com/ClaimResources
- Choose “Claims and encounter submission.”

Payer IDs

When filing electronic claims, you will need to utilize one of the following payer IDs:

Humana MMA

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

Humana LTC

- **61115** for all claims
- **61105** for delegated providers

Please submit questions about MMA or LTC to Availity.com

Paper claims submission

Submit paper claims to the address listed on the back of the member's ID card or to the appropriate address listed below:

Medical claims

Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Encounters

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

Behavorial health claims

Regions 1 and 2
Access Behavioral Health
1221 W. Lakeview Ave.
Pensacola, FL 32501

Behavorial health claims

Regions 3 — 11
Beacon Health Options
P.O. Box 1870
Hicksville, NY 11802-1870

Humana LTC claims

Humana Long-Term Care Plan
P.O. Box 14732
Lexington, KY 40512-4732

Importance of encounter submissions in Medicaid

AHCA requires 100% encounter submissions.

- **Goal**: 95% pass rate through state system
- Three key items for compliance:

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

Importance of encounter submissions in Medicaid – continued

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 future world of Medicaid Risk Adjustment
- Helps 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 (Note: NPI, taxonomy code and ZIP + 4 are referred to as the NPI Crosswalk.)
- Encounters missing NPI/ZIP code/ taxonomy code.
- Providers submitting with a billing and/or rendering NPI that is not enrolled/registered for Medicaid with AHCA.

How to avoid these errors:

- Confirm that the provider information submitted matches exactly the provider information registered with AHCA and in accordance with the services provided (e.g., NPI, Medicaid number, taxonomy code, ZIP + 4, provider specialty code, provider type code).
- Ensure that 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) located in the Florida Medicaid Web Portal

Claims 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/registered for Medicaid with AHCA

How to avoid these errors:

- Confirm that patient information received and submitted is accurate and correct.
- Ensure that all required claim form fields are complete and accurate.
- Obtain proper authorizations and/or referrals for services rendered.
- Must submit billed charges.
- Ensure you have a valid Medicaid ID for the billing/rendering NPIs submitted on the claims.

Timely filling

- **MMA**: Fee-for-service claims should be filed as soon as possible, but no later than **six** months after date of service.
- **LTC**: Claims should be filed as soon as possible, but no later than **six** months after the date of service.
- **MMA and LTC crossover:** Questions regarding specifics around timely filing should be directed to customer service.
- **Encounter claims** should be filed within **30** days of the date of service.
- Timely filing of claims and HEDIS:
  - Providers are required to timely file their claims/encounters for all services rendered to members. 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.

Claim inquiry process

Step 1: Call the number on the back of the member's ID card.

- 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 the response, send a secure email with the reference number to:

- **FLMedicaidResolution@humana.com**

For additional information, please refer to Claims Payment Inquiry Resources - Humana

Information regarding the Provider Complaint System is available in the Humana Healthy Horizons in Florida Provider Manual located at Humana.com/HealthyFL.

Claims payment: Electronic funds transfer (EFT) and electronic remittance advice (ERA)

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

Receive HIPAA-compliant ERA transactions.

Get paid up to seven days faster than via 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.

eBusiness resources

Contact us if your organization needs:

Payments deposited in **more than one bank account.**

Separate remittance information for different providers or facilities.

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

eBusiness resources – continued

To set up ERA/EFT:

1. Sign in to Availity Portal at Availity.com (registration required).
2. From the Payer Spaces menu, select Humana.

   From the Applications tab, select the ERA/EFT Enrollment app. (If you don’t see the app, contact your Availity administrator to discuss your need for this tool.)

Balance billing

Per Humana Healthy Horizons in Florida's provider manual:

The provider is prohibited from balance billing members for ***covered*** services referenced in the Medicaid Addendum of the provider contract.

Medicaid enrollment for claims 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 Agency for Health Care Administration (AHCA). To meet AHCA requirements, Humana can pay only those claims and/or encounters submitted by physicians and healthcare providers with valid Medicaid enrollment. The following are some of the criteria indicating a physician or healthcare professional is properly enrolled:

- Physicians and other healthcare professionals can verify their enrollment via the Provider Master List (PML) on the AHCA website at http://portal.flmmis.com/FLPublic/Provider_ManagedCare/Provider_ManagedCare_Registration/tabId/77/Default.aspx?linkid=pml
- Active PML on the AHCA portal
- Listing that shows “enrollment” or “limited” in the enrollment type column
- Active (A) listing in the current Medicaid Enrollment Status column
- Accurate 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 and Medicaid ID

Please note that the Centers for Medicare & Medicaid Services (CMS) defines atypical providers as providers that do not provide healthcare.

9. Continuity of care (COC)

Transition/continuity of care (COC): Enrollee services/care coordination/utilization management

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

Transitioning process		Florida-based case managers
 **Continue Care Plan As Is For Up To 60 Days**	 **Reassess And Update Personalized Plan Of Care**	 **Pair With New Case Manager**
• Ensure no care disruptions • Emphasize maintaining member's well-being and safety while addressing unmet needs • Contract with nonparticipating providers	• Identify members to transition • Determine unmet needs and put necessary services in place • Coordinate and build relationships with providers	• Based on location to ensure familiarity with local resources • Assign PCP Center to facilitate coordinated care with PCP • Consider cultural and language needs

Transition/continuity of care (COC): Enrollee services/care coordination/utilization management – continued

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

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

Authorization is not required for COC of transitioning members.

Coordination with carved-out service contractors

- Humana's referral processes, whether Humana services, Medicaid fee-for-service (FFS) delivery system or prepaid dental plan, support the best possible quality outcomes for enrollees throughout the healthcare system.
- Humana's proactive approach enables identification of services needed that are covered by Medicaid FFS or prepaid dental plan, and coordinates a referral.
- The process identifies enrollees who may qualify for Medicaid FFS or prepaid dental plan services through a variety of resources, including the following:
  - Outbound and inbound calls with enrollees
  - Case management program, supports and assessments
  - Disease management
- Providers can call Humana to coordinate a Medicaid FFS or dental referral:
  - Humana Healthy Horizons in Florida - MMA member/provider services – **800-477-6931**

Coordination with carved-out service contractors – continued

Humana will coordinate a referral for the following services that are not provided by the managed care plan, but are available to eligible Medicaid recipients through the Medicaid FFS delivery system:

- County health department-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 or related conditions (ICF/IID) services
- School-based services provided through the Medicaid-certified school match program
- Model HCBS waiver services
- Newborn hearing services
- Prescribed pediatric extended care services (PPEC)
- Program for all-inclusive care for children services
- Behavior analysis services
- Substance abuse county match program services
- Programs of All-inclusive Care for the Elderly (PACE) services

Coordination with carved-out service contractors – dental

Under the new SMMC contract, eligible adults and children can select a prepaid dental plan offered by the following contractors:

- Managed Care of North America – www.mcnafl.net/
- DentaQuest of Florida – https://www.dentaquest.com/state-plans/regions/florida/member-page/member-documents/
- Liberty Dental Plan of Florida – www.libertydentalplan.com/Florida/Florida-Providers/Florida-Medicaid.aspx

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

Dental plan or health plan: Who covers what?

Type of dental service(s)	Dental plan covers:	Health plan covers:
Emergency dental services in a facility	___	All emergency dental services and reimbursement to the facility
Non-emergency (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 or federally qualified health center	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

10. Member special needs consideration

Member special needs consideration

- Healthcare providers must make efforts to understand the special needs required by members. The member 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, end-stage renal disease (ESRD), isolation, depression and polypharmacy are some of the challenges facing these members each day.
- Recognizing the significant needs of members, Humana incorporates person-centered care planning, coordination and treatment in our care coordination program.

Member special needs consideration – continued

- Care management is delivered within a multidisciplinary team (MDT) structure and holistically addresses the needs of each member.
- The member and/or his/her authorized caregiver are maintained at the core of the model of care, ensuring person-centered care and supported self-care.
- The Humana case manager leads the member's MDT and links closely to the member's PCP to support him/her in ensuring the member gets the care needed across the full spectrum of medical, behavioral health and other services. PCP participation in the MDT is a critical component in the success of the member's care.
- Humana's predictive model, based on claims history and analytics, is used to determine each member's risk level and level of intervention required in order 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.

11. Member screening for alcohol or substance abuse

Member screening for alcohol abuse or substance abuse

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

- Initial contact with a new enrollee
- Routine physical examinations
- Initial prenatal contact
- When the enrollee shows evidence of serious overutilization of medical, surgical, trauma or emergency services
- When documentation of emergency room visits suggests the need
- Education regarding Screening, Brief Intervention, and Referral to Treatment (SBIRT) of pregnant patients is available at SBIRT Provider Education

Benefits of Substance Alcohol or Substance Abuse Screening[1]

- 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.
- Research has shown that approximately 90 percent of substance use disorders go untreated.

Detecting Risk Factors Early[1]

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.

Member screening for alcohol or substance abuse – continued

In addition, 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 above indicators may be referred to an appropriate participating behavioral health provider or to Humana Healthy Horizons to enroll in the Substance Abuse Program by calling **800-229-9880**.

12. Clinical management programs

Clinical management programs

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

- To learn more, visit **Humana.com/HealthWellness**

Health services and utilization management

Utilization management

- Provide on-site and telephonic concurrent review and discharge planning
- Promote effective level of care based on member's individual needs
- Provide disease-specific education
- Refer to appropriate Humana programs

Utilization management

Front-end review team responsibilities:

- Evaluates the medical necessity and appropriateness of all inpatient acute medical requests using evidence based criteria.

Concurrent/post-acute team responsibilities:

- Facilitates the coordination of appropriate care and services in the acute/post-acute setting and facilitates timely discharge planning, continuity and appropriate setting of care and services, where applicable.
- Conducts medical necessity reviews on members with continued inpatient stays.
- Collaborates daily with member's healthcare team to maximize member's benefits and resources and identifies member's anticipated discharge planning needs.
- Conducts medical necessity reviews for post-acute level of care requests in collaboration with medical director.
- Identifies and refers members to internal Humana CM/DM programs.
- Refers member to community resources or Humana social worker, when social issues place member at risk for readmission.

Health services and case management

Case management

Collaboration takes place when an MMA, LTC or MMA/LTC member is an inpatient and discharge needs are identified. When the member has both MMA and LTC benefits, LTC case management is primary.

- 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 three days of discharge, when applicable
- Identifies gaps in care, addresses post-discharge needs and assists in making follow-up appointment with PCP and specialists
- Stratifies members into various acuities using some of the following criteria:
  - Readmission Predictive Model Score
  - Admission history
  - Metric reports (e.g., high-cost members, etc.)

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 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 an individualized 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)
- Participate in interdisciplinary case conferences for complex members to identify the best course of action for improved outcomes
- Does not replace or interfere with the care members receive from their physicians
- Reinforces the physician's plan of care and facilitates use of services that promote wellness and prevent unnecessary hospital admissions

Health services and care management

MMA Programs

- Diabetes
- Asthma
- COPD
- CHF
- Hypertension
- HIV/AIDS
- Cancer
- Sickle Cell
- Pain Management

LTC Disease Management Programs

- Dementia and Alzheimer's
- End-of-life issues/advance directives
- And all other MMA program conditions listed above

Goal

- Help empower our 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 some of the following criteria:
  - Admission history
  - Stability of symptoms
  - Understanding/compliance of disease/plan of care

Case management

Case management programs responsibilities:

- Complete a comprehensive assessment of the member's current health status
- Create an individualized 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 manager does not replace or interfere with care that members receive from their physicians.
- Case management nurses will reinforce the physician's plan of care and facilitate utilization of services that promote wellness and prevent unnecessary hospital admissions.

Case management – continued

Additional features for LTC members in a disease management program:

- Education based on the enrollee 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 that a member is taking to ensure that the enrollee does not suffer adverse effects or interactions from contra-indicated medications

Health services and other programs for MMA members

Other health services programs

Moms First

- Manages prenatal and postpartum members from onset of pregnancy up to 12 weeks postpartum or until gap(s) closed.
- Facilitates care coordination with WIC, 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 worker

- Assists members with social needs including transportation and community resources.
- Receives referrals from CM, DM and utilization management nurse

Pediatric case management and pediatric utilization management

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

Healthy Behaviors Program: Go365 for Humana Healthy Horizons

About Go365

- Launched in April 2021
- A Wellness Program that offers members the opportunity to take healthy actions
- Members must download the Go365 App to engage in activities, earn and redeem e-gift cards

Target Population

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

Rewards

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

Healthy behaviors programs designed for our members

Health Risk Assessment (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 us at **855-351-7877 (TTY: 711)**

Annual Well Visit Program)

- Annual Well Visit with primary care physician within 90 days of enrollment: $20

18 years and older

Outbound Team encourages members to visit PCP during welcome call

Moms First

- Enroll in program: $10
- Visit OB-GYN during first trimester or within 42 days of enrollment with the plan: $20
- Visit OB-GYN for a postpartum visit within 60 days after delivery: $20

18 years and older

To enroll: You or your patient can call us at **800-322-2758,** ext. **1500290**

Well-child Visit Program

- Wellness visit with PCP: $20
- Members who are overdue for a well-child visit, the plan will contact and remind them to do so

Younger than 18 years old

Member Engagement Team encourages parent/guardian to schedule appointment

COVID-19 Vaccine Program

- Members 12 years and older who get a complete COVID-19 vaccine: $20

12 years and older

Outbound Team encourages members to get COVID-19 vaccine

Weight Management

- Enroll in the program* AND complete initial well-being visit with PCP: $10
- Complete six telephonic coaching sessions within 12 months. At the end of the sixth coaching session, members must complete the final well-being check up with PCP: $20

12 years and older

To enroll: You or your patient can: Call: 1-855-330-8053 | Fax: 855-324-7685 | Email: EXD_CoachMailbox@Humana.com

Substance Abuse

- Complete a total of six coaching calls within three months of the first coaching session: $20
- Participate actively in an outpatient program for 28-30 days: $20

18 years and older

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

Tobacco Cessation

- Complete two telephonic coaching sessions with a health coach within the first 45 days of enrollment in the program: $25
- Complete six additional telephonic coaching sessions (total of eight) 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: 1-855-330-8053 | Fax: 855-324-7685 | Email: EXD_CoachMailbox@Humana.com

13. Electronic Health Records

Electronic health records (EHRs)

- An 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 the medical and treatment histories of patients, an EHR system is built to go beyond standard clinical data collected in a provider's office and can be inclusive of 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 in a meaningful manner.

EHRs – continued

EHR advantages:

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**
- S**haring electronic information** securely with patients and other clinicians
- Helping providers more effectively **diagnose patients, reduce medical errors and provide safer care**

EHRs – continued

EHR advantages:

- Improving patient and provider interaction and communication, as well as **healthcare convenience**
- Enabling safer, **more reliable prescribing**
- Helping promote **legible, complete documentation** and accurate, streamlined coding and billing
- Enhancing **privacy and security** of patient data
- Helping providers **improve productivity** and **work-life balance**

EHRs – continued

For assistance:

Regional extension centers

If providers need assistance with 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 for Health Information Technology (ONC), 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 www.healthit.gov/faq/where-can-i-find-local-electronic-health-record-implementation-support for more information.

Florida Health Information Exchange (Florida HIE)

If providers need assistance in technically connecting to other providers, they can reach out to the Florida HIE or visit www.florida-hie.net. The Florida HIE enables the secure exchange of health information between healthcare providers.

14. Patient-centered medical home (PCMH)

PCMH

- PCMH is a model of care that strengthens the physician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship.

- Humana 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.

PCMH – continued

According to the Agency for Healthcare Research and Quality (AHRQ), a PCMH program includes the following functions that transform traditional primary care into advanced primary care:

- **Comprehensive care:** A team that includes physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators and care coordinators to guide patients through the healthcare delivery system.
- **Patient-centered care:** The patient is primary in the relationship and drives decisions that influence his or her health. Physicians provide education and establish a comprehensive plan of care.
- **Coordinated care:** The PCP communicates with the healthcare delivery team and manages coordination of care.

PCMH – continued

- **Accessible services:** The patient's access-to-care preferences are important. 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, are taken into consideration by the physician.
- **Quality and safety:** The PCP uses evidence-based medicine and clinical decision-support tools to guide the patient and healthcare delivery.

PCPs who are interested in the PCMH program, certification requirements and the benefits may contact:

Latoya Powell, PCMH CCE
Phone: **305-626-5746**
Email: PCMH@Humana.com

15. Medicaid Risk Adjustment (MRA)

MRA 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 ICD-10 diagnosis codes to 72 CDPS categories in Florida within 19 major categories corresponding to major body systems (e.g., cardiovascular) or type of disease (e.g., diabetes).
- CDPS condition categories are groups of ICD-10 codes, typically identified at the three-digit level but occasionally codes are grouped at the fourth- or fifth-digit level and up to seven digits for ICD-10.

Medicaid prescription (MRx)

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

CDPS + Rx

- 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.

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 persons with disabilities
- Severely mentally ill members

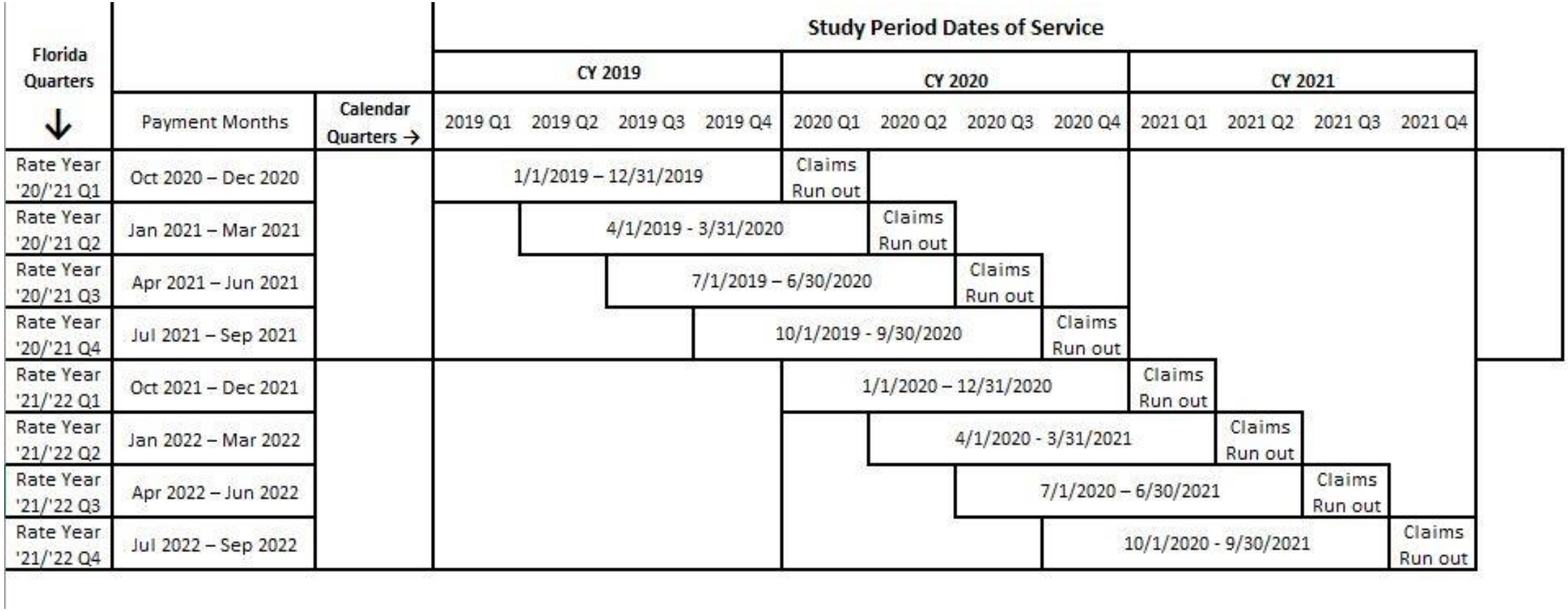
Excluded

- 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 six months of eligibility during the observation period

Comparing risk-adjustment models

Medicare Advantage	Florida Medicaid
CMS HCC Model	**CDPS + Rx Model**
Prospective (Future payments adjusted twice per year and one 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)
Three annual data submission deadlines (March, September and January)	Four annual data submission deadlines (March, June, September and December)
ICD-10 codes grouped into 79 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 2020-2022)



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

Best documentation practices for diagnosis coding

LEGIBLE

- Makes entire medical record legible to any objective reader of the record

CLEAR

- Communicates the documenter's intent to all readers

CONCISE

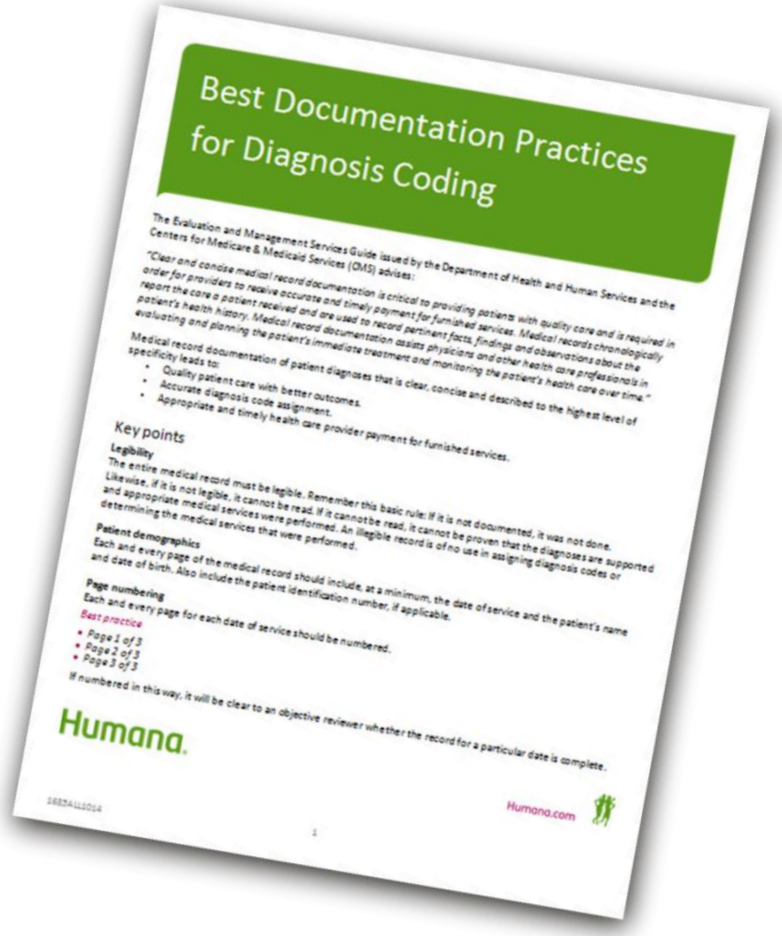
- Describes each diagnosis succinctly and to the highest level of specificity
- Limits or avoids altogether the use of abbreviations

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


Best Documentation Practices for Diagnosis Coding

The Evaluation and Management Services Guide issued by the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) advises:

"Clear and concise medical record documentation is critical to providing patients with quality care and is required in order for providers to receive accurate and timely payment for furnished services. Medical records chronologically report the care a patient received and are used to record pertinent facts, findings and observations about the patient's health history. Medical record documentation assists physicians and other health care professionals in evaluating and planning the patient's immediate treatment and monitoring the patient's health care over time."

Medical record documentation of patient diagnoses that is clear, concise and described to the highest level of specificity leads to:

- Quality patient care with better outcomes.
- Accurate diagnosis code assignment.
- Appropriate and timely health care provider payment for furnished services.

Key points

Legibility

The entire medical record must be legible. Remember this basic rule: If it is not documented, it was not done. Likewise, if it is not legible, it cannot be read. If it cannot be read, it cannot be proven that the diagnoses are supported and appropriate medical services were performed. An illegible record is of no use in assigning diagnosis codes or determining the medical services that were performed.

Patient demographics

Each and every page of the medical record should include, at a minimum, the date of service and the patient's name and date of birth. Also include the patient identification number, if applicable.

Page numbering

Each and every page for each date of service should be numbered.

Best practice

- Page 1 of 3
- Page 2 of 3
- Page 3 of 3

If numbered in this way, it will be clear to an objective reviewer whether the record for a particular date is complete.

Humana.

Humana.com

Clinical coding example

Excerpt from full medical record

History of present illness: 49-year-old homeless diabetic male presents complaining of right ankle wound. He lost his balance while coming down stairs at a facility. Unable to check blood sugars given his living situation, but 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

Example coded as:

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

16. Service Level Agreements (SLA)

Service Level Agreement (SLA)

SMMC-contracted MCOs must adhere to certain service-level agreements for the following categories:

- Birth outcomes
- Transportation
- Network adequacy
- Claims payment
- Service authorization
- Enrollee call center metrics
- Provider call center metrics

Find out more about these SLAs at Humana.com/FLMedicaidSLAs

17. AHCA provider-based marketing guidelines

AHCA provider-based marketing guidelines

- If the managed care plan chooses to utilize its provider network to distribute marketing materials, the managed care plan shall ensure through its provider agreements that providers shall remain neutral.

- The managed care plan may permit providers to make available and/or distribute managed care plan marketing materials as long as the provider does so for all managed care plans with which the provider participates.

- The managed care plan may permit providers to display posters or other materials in common areas, such as the provider's waiting room.

- The managed care plan may permit LTC facilities to provide materials in admission packets announcing all managed care plan contractual relationships.

The above information was extracted directly from AHCA contractual requirements.

AHCA provider-based marketing guidelines – continued

Providers 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 one 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.*

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.*

The above information was extracted directly from AHCA contractual requirements.

* Materials must be reviewed/approved by the plan and submitted to AHCA for approval, as necessary, before distributing.

AHCA provider-based marketing guidelines – continued

Materials that indicate 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.

The above information was extracted directly from AHCA contractual requirements.

* Materials must be reviewed/approved by the plan and submitted to AHCA for approval, as necessary, before distributing.

AHCA provider-based marketing guidelines – continued

Providers may not:

- Offer marketing/appointment forms.
- Make phone calls or direct, urge, or attempt to persuade potential enrollees 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 enrollees 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.

The above information was extracted directly from AHCA contractual requirements.

18. Additional training requirements

Additional training requirements

Providers must complete required compliance training on the following topics:

- Cultural competency
- Others as required

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

- **Humana.com/ProviderCompliance** (public)
- **Availity.com** (secure, registration required)

19. Fraud, waste and abuse (FWA)

FWA reporting requirement and reporting options

Anyone who suspects or detects an FWA violation is required to report it either to Humana or within his/her respective organization, which then must report it to Humana:

Telephone:

- Special Investigations Unit (SIU) direct line: **800-558-4444** (Monday through Friday, 8 a.m. to 4 p.m., Eastern time)
- 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

Web: EthicsHelpLine.com

Fax: 920-339-3613

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.

FWA reporting requirement and reporting options – continued

Suspected fraud, waste and abuse pertaining to Florida MMA/LTC must be reported to:

- Medicaid Program Integrity (MPI) administrator by calling **850-412-4600**
- Florida Agency Consumer Complaint Hotline by calling **888-419-3456**
- Florida Attorney General by calling **866-966-7226**
- AHCA FWA Complaint Form on the web at apps.ahca.myflorida.com/MPI-ComplaintForm

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 that provides notice to 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 brought rise to the matter.

False Claims Act

- The False Claims Act also 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.

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.com/fraud

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 which the government sustains because of that act
- A person or company who violates the False Claims Act is also liable to the government.

20. Health, safety and welfare

Abuse

What is abuse?

- Non-accidental infliction of physical and/or emotional harm.
- Sexual abuse upon a disabled adult, an elderly person or child by a relative, caregiver, household member or any other person.
- Active encouragement of any person by a relative, caregiver or household member to commit an act that inflicts or could reasonably be expected to result in physical or psychological/emotional injury to a disabled adult, an elderly person or child.

Physical abuse and sexual abuse

Physical abuse of customer

- Non-accidental use of force that results in bodily injury, pain or impairment, including, but not limited to, being slapped, burned, cut, bruised or improperly physically restrained.

Physical abuse

- Infliction of physical pain or injury to a disabled adult, an elderly person or child.

Sexual abuse

- Includes unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an adult with disabilities.
- Means touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with a disabled adult, an elderly person or child when the person is unable to understand, unwilling to consent, threatened or physically forced to engage in sexual activity.

Psychological (verbal/emotional) abuse

Verbal abuse

- Includes, but is not limited to, name calling, intimidation, yelling and swearing. May also include ridicule, coercion and threats.

Emotional abuse

- Verbal assaults, threats of maltreatment, harassment or intimidation intended to compel a disabled adult, an elderly person or child to engage in conduct from which he or she wishes and has a right to abstain or to refrain from conduct in which the older person wishes and has a right to engage.

Neglect

- **Neglect of customer** – The failure of another individual to provide a disabled adult, an elderly person or child with, or the willful withholding the necessities of life including, but not limited to, food, clothing, shelter or medical care.
- **Neglect** – Repeated conduct or a single incident of carelessness that results or could reasonably be expected to result in serious physical or psychological/emotional injury or substantial risk of death.
- **Self-neglect –** Individual does not attend to his/her own basic needs, such as personal hygiene, appropriate clothing, feeding or tending appropriately to medical conditions.
- **Passive neglect –** A caregiver's failure to provide a disabled adult, an elderly person or child with the necessities of life including, but not limited to, food, clothing, shelter or medical care. This definition does not create a new affirmative duty to provide support to eligible adults; nor shall it be construed to mean that an eligible adult is a victim of neglect because of healthcare services provided or not provided by licensed healthcare professionals.

Exploitation

Exploitation is the act of a person who stands in a position of trust and confidence with a disabled adult or an elderly person and knowingly, by deception, intimidation or force:

- Obtains control over the person's funds, assets or property
- Deprives the person of the use, benefit or possession of funds, assets or property. This intentional action can be temporary or permanent
- Uses the person's funds, assets or property for the benefit of someone other than the disabled adult, an elderly person or child.

Exploitation of customer

- The illegal use of assets or resources of a disabled adult, an elderly person or child. It includes, but is not limited to, misappropriation of assets or resources of the alleged victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion or in a manner contrary to law.

Financial exploitation

- The misuse or withholding of resources by another person to the disadvantage of the person or the profit or advantage of a person other than the disabled adult, an elderly person or child.

Increased risk factors and traits – members

Likelihood of abuse, neglect or exploitation occurring increases for members in the presence of one or more risk factors. These include:

- Dependency on others for personal care
- Dependency on others for financial management
- Isolation from information about own rights and health
- Diminished mental capacity
- Serious health problems
- Taking medications that affect cognitive status
- Depression, anxiety or fearfulness
- Recent losses, including the loss of a spouse, home or friend

Increased risk factors and traits – caregiver

Contributing factors exhibited by caregivers at risk to abuse, neglect or exploit include:

- Alcoholism
- Mental illness
- Stress
- Chronic fatigue
- Frequent medical consultation
- History of marital violence and/or child abuse
- Previous relationship difficulties
- Conflicting demands of other family members
- Problems with housing, finances and/or employment
- Lack of support
- Lack of respite

Identifying victims of human trafficking

Typically, victims of human trafficking display the following signs*:

- Lack of identification documents and possible claim to be “just visiting” a certain area.
- No fixed address or possibly unable to specifics about where he or she is living.
- Appears under the control of another, possibly the person accompanying him or her. The other person may attempt to speak on behalf of the victim.
- Exhibits fear, depression, submissiveness or acute anxiety.
- Typically not in control of his/her own money or identification documents.
- Unable or reluctant to explain the nature of an injury.

If you suspect trafficking, call the National Human Trafficking Hotline at 888-373-7888.

* List from Florida Office of the Attorney General

Steps to take for prevention

- When a provider suspects there is a risk of abuse, neglect or exploitation, he/she should work with the Humana care manager assigned to the member via the Integrated Care Team.
- When a care manager determines that a member is at risk for abuse or neglect, but does not display signs or symptoms, the care manager will include specific interventions to reduce the member's risk in the plan-of-care.

What is a mandated reporter?

A mandated reporter is an individual who is required by law to report situations immediately if he/she suspects a disabled adult, an elderly person or child may have been abused, neglected or exploited or is at risk of being abused, neglected or exploited.

Rights of mandated reporters

- Most states allow for:
  - Immunity from civil and criminal liability unless the report was made in bad faith or with malicious intent.
  - Identity protection. Your consent must be given to reveal your identity.
  - The court may order the identity of the reporter revealed. The court can then release confidential information without penalty.

Important reporting processes

- Provider must report any suspected abuse, neglect or exploitation to the appropriate state agency. (See appendix for state-specific information.)
- Provider also must report suspected abuse, neglect or exploitation to the Humana care manager participating on the member's interdisciplinary care team.
- Humana care manager also will report the suspected abuse, neglect or exploitation to the appropriate state agency.
- Humana care manager will follow internal Humana associate reporting procedures as well.

General reporting requirements including, but not limited to:

- Can you identify the person being abused? If known, provide address and/or location.
- What is the approximate age of the person?
- Does an emergency exist?
- Can you describe the circumstances of the alleged abuse, neglect or exploitation?
- What are the names and relationships of other members of the household, if applicable?
- Is the person incapacitated?
- Do you know the name and address of the caregiver – if applicable?
- Do you know the name and relationship of the alleged perpetrators?
- Are there other people who may have knowledge?
- Do you know the name of the person's physician?
- What is your name, address, phone number? (You can report anonymously.)

21. Critical incident reporting

Critical incident reporting

- Humana’s 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 that occur during the provision of home and community-based services that occur in the following:
    - Adult day care
    - Adult family home care
    - Doctor’s office
    - During home health services

Critical incident reporting – continued

Participating providers should report the following events:

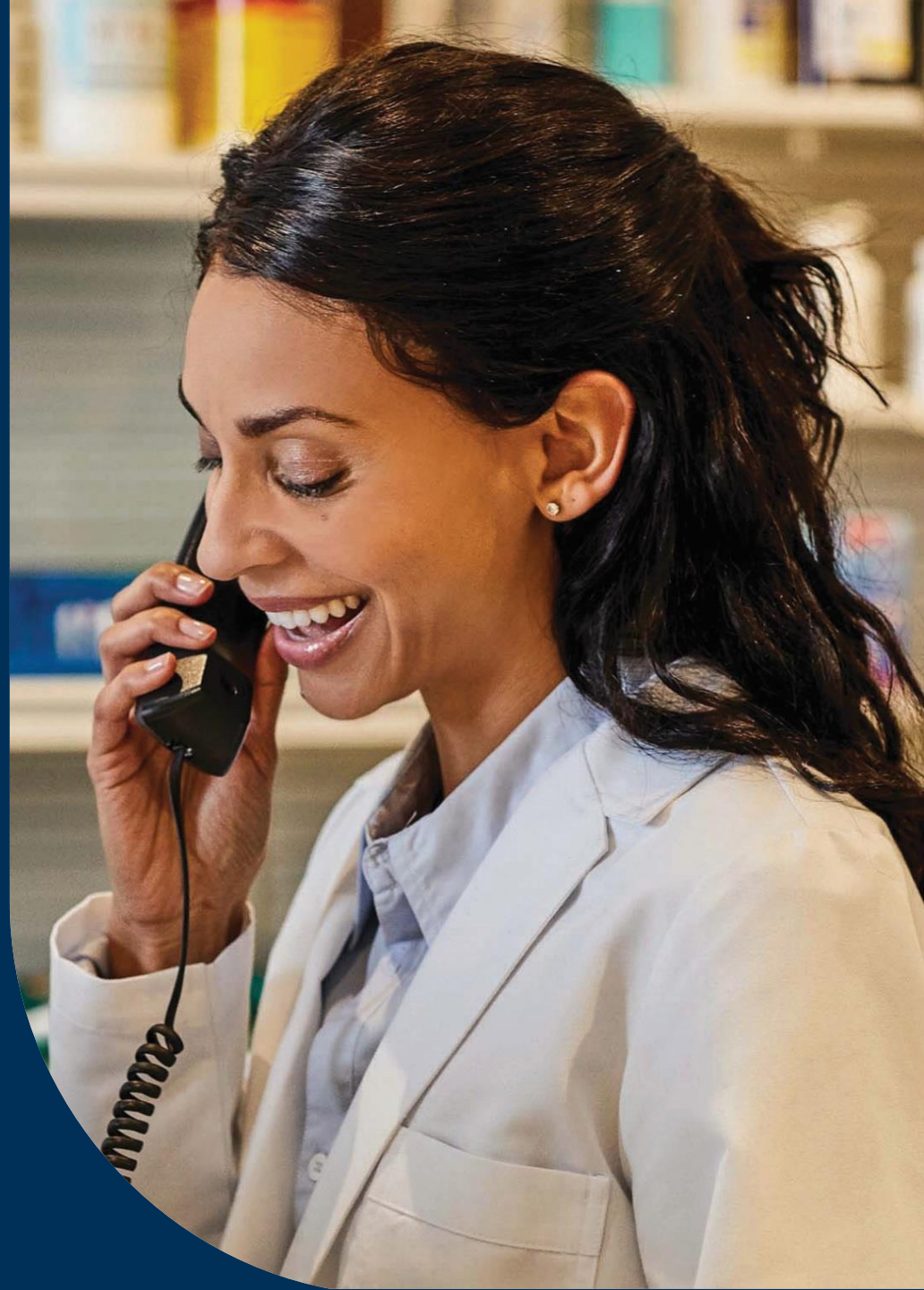
- Member unexpected death, brain damage, spinal damage or permanent disfigurement
- Fracture or dislocation of bones or joints
- Conditions that require definitive or specialized medical attention not consistent with the routine management of the patient's case or patient's pre-existing physical condition
- Conditions that require surgical intervention to correct or control
- Conditions that result in transfer of the patient, within or outside the facility, to a unit providing more acute level of care
- Conditions that extend the patient's length of stay
- Conditions that result 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 provider
- Sexual battery
- Medication error
- Suicide attempt
- Altercations requiring medical intervention
- Elopement

Critical incident reporting – continued

- 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 (i.e., police, Department of Children & Family, Adult Protective Services)
- Report the critical and/or adverse incident to Humana Health Plan Risk Management Department at **855-281-6067** and/or via email to **RiskManagementAdministration@Humana.com** within 24 hours of having knowledge of the incident.

Humana 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.

22. Managed Medical Assistance Physician Incentive Program (MPIP)



Managed Medical Assistance Physician Incentive Program (MPIP)

The aim of the MPIP is to promote quality of care for our Medicaid members and recognize those physicians who demonstrate high levels of performance for selected criteria.

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

Physicians eligible and qualified to participate in the MPIP are the physician types listed below who meet plan-specific medical and/or quality criteria:

- **Pediatric primary care physicians (PCPs) –** Pediatricians, family practitioners and general practitioners who provide medical services to enrollees younger than 21. Practicing as a primary care physician meeting the program required pediatric panel size*of assigned Humana Family Medicaid membership and meets Medical or HEDIS criteria for the measurement period.

  *Regions : 2,3,4,5,7,8 = **50 or more pediatric members** Regions : 1,6,9,10,11 = **200 or pediatric members**

- **OB-GYNs –** OB-GYNs who had at least 10 Medicaid deliveries for the measurement period and meet Medical and HEDIS criteria for the measurement period.
- **Pediatric specialists** – Physicians who provide medical services to enrollees younger than 21.

MPIP – continued

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

- Physicians not participating in Humana Healthy Horizons in Florida's network
- OB-GYNs with fewer than 10 deliveries for the measurement period
- Primary care physicians with a pediatric panel size * less than the program requirements during the measurement period (*Regions : 2,3,4,5,7,8 = **Less than 50** Regions : 1,6,9,10,11 = **Less than 200**)
- Primary care physicians with an adult panels
- Federally qualified health centers (FQHCs)
- Rural health clinics (RHCs)
- County health departments (CHDs)
- Medical school faculty plans

Complete information regarding the incentive program and timelines can be found on the AHCA website at http://ahca.myflorida.com/medicaid/statewide_mc/mma_physician_incentive.shtml.

23. Humana web resources and contact numbers

Provider website – public

Medical Resources for Humana Healthcare Providers
Humana.com/Provider

- Claims and payments policies
- Credentialing
- Preauthorization/referrals
- Clinical practice guidelines
- Drugs prior authorizations
- News and provider publications (including provider manual)
- Join our network
- Reconsideration and appeals
- Health and wellness programs
- Pharmacy services
- Quality resources
- Self-service portal
- EFT/ERA resources
- What's new?

Humana Healthy Horizons in Florida - LTC
Humana.com/FLLTC

- Provider manual
- Provider directory
- Provider education

Humana Healthy Horizons in Florida - MMA
Humana.com/HealthyFL

- Provider manual
- Provider resource guide
- Provider education
- Provider newsletter
- COVID webpage
- Pharmacy, quality and training materials

Provider self-service help

For help or more information regarding web-based tools:

Humana Healthy Horizons in Florida – MMA

For help with registration or questions about the Availity Portal, please call Availity Client Services at 800-AVAILITY (800-282-4548).

Humana Healthy Horizons in Florida – LTC

Please call **888-998-7735.**

For training:

Humana Healthy Horizons in Florida – MMA

Please visit:

- **www.humana.com/FLEducation**
- **www.Humana.com/FLTraining**

Humana Healthy Horizons in Florida – LTC

Please visit **www.humana.com/FLLTC.**

Working with Humana online?
Use the multipayer Availity Provider Portal

Availity Provider Portal 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

- Co-founded by Humana
- Humana's clearinghouse for electronic transactions (EDI) with providers

How to register

- Go to **Availity.com**

Join us for a training session

- Visit **Humana.com/ProviderWebinars** to learn about training opportunities and reserve your space.

Questions?

- Availity help with registration and tools: Call 800-AVAILITY (800-282-4548).

Helpful numbers

Humana Healthy Horizons in Florida customer service:

Please call the number on the back of the member's ID card for the most efficient call routing.

Prior authorization (PA) assistance for medical procedures:

800-523-0023 Monday through Friday, 8 a.m. to 8 p.m., Eastern time

PA for medication billed as medical claim:

866-461-7273 Monday through Friday, 8 a.m. to 6 p.m., Eastern time

PA for pharmacy drugs:

800-555-2546 Monday through Friday, 8 a.m. to 6 p.m., Eastern time

Provider relations:

- **MMA: 800-477-6931** Monday through Friday, 8 a.m. to 8 p.m., Eastern time, for fee schedule requests, demographic changes and credentialing status
- **LTC Customer Service: 888-998-7735**
- **Provider Relations**: **888-998-7735**

Helpful numbers – continued

- **Commercial case management: 800-327-9496**
- **Medicaid Case Management: 800-229-9880**
- **Referrals: FL_MMA_CM_Referrals@Humana.com**
- **Medicaid Moms First: 800-322-2758, ext. 1500290 or email FL_MMA_OB_Referrals@Humana.com**
- Commercial concurrent review: **800-545-6775**
- **Medicare/Medicaid concurrent review: 800-322-2758**
- **Clinical management program information: 800-491-4164**
- **PrescribeIT: 800-526-1490**
- **Availity customer service/tech support: 800-282-4548**
- **Ethics and compliance concerns: 877-5 THE KEY (1-877-584-3539)**
- **Fraud, waste and abuse reporting: 800-614-4126**
- **Questions about arranging interpretation services for member appointments: 877-320-1235**

Humana

Healthy Horizons™ in Florida