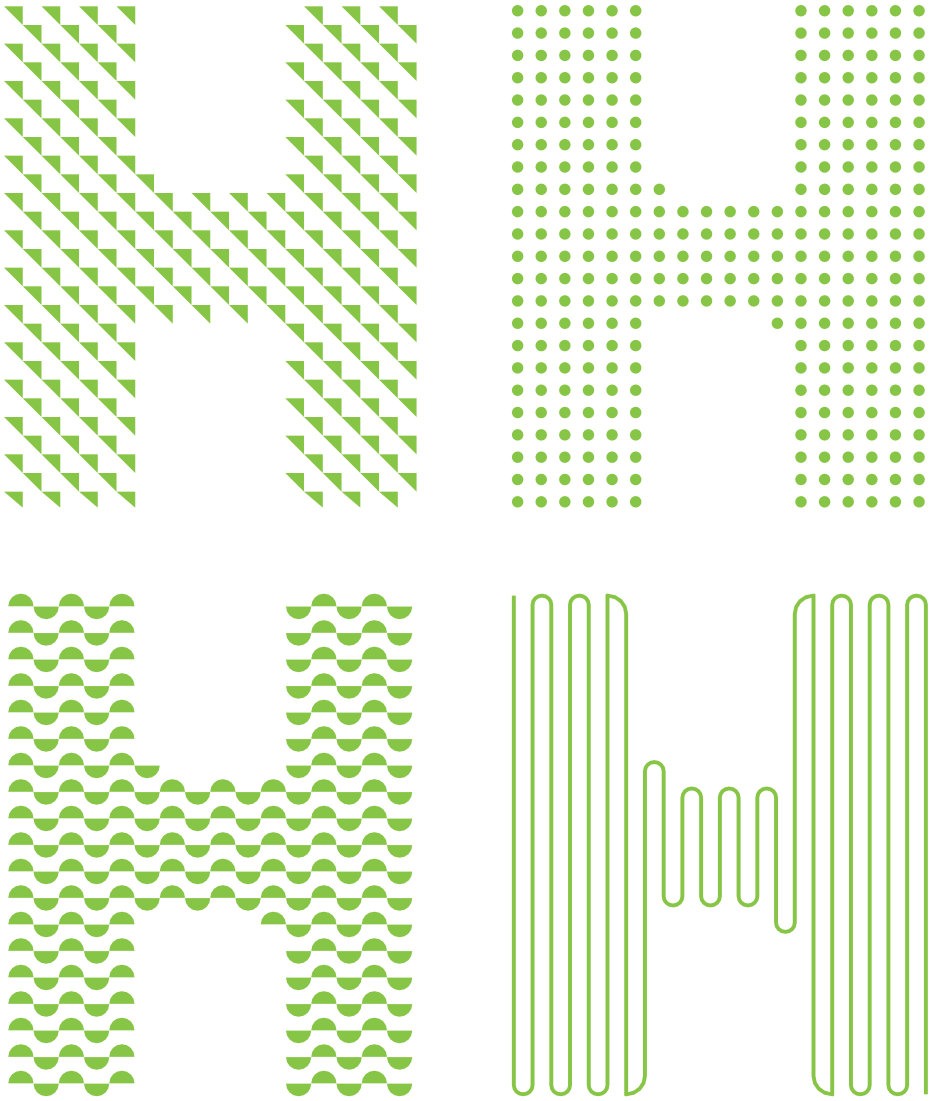

2025 Provider Manual

HUMANA HEALTHY HORIZONS IN OHIO

Humana
Healthy Horizons®
in Ohio

Humana Healthy Horizons in Ohio is a Medicaid product of Humana Health Plan of Ohio, Inc

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Introduction

Welcome and thank you for becoming a participating healthcare provider with Humana Healthy Horizons® in Ohio.

We strive to work with our providers to make it as easy as possible to do business with us. This strong partnership helps facilitate a high quality of care and respectful experience for our members.

We are a community-based health plan that serves Medicaid consumers throughout Ohio.

Our goal is to provide integrated care for our members. We focus on prevention and partnering with local providers to offer the services our members need to be healthy.

As a managed care organization (MCO), Humana Healthy Horizons in Ohio improves the health of our members by utilizing a contracted network of high-quality providers. Primary care providers (PCPs) within the network provide a range of services to our members and coordinate patient care by referring them to specialists when needed and ensuring timely access to healthcare services and appropriate preventive services.

Humana Healthy Horizons distributes member rights and responsibility statements to the following groups after their enrollment and annually thereafter:

- New members
- Existing members
- New providers
- Existing providers

Non-Discrimination

Humana and its subsidiaries comply with applicable federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status or need for health services. (Source **www.humana.com/legal/non-discrimination-disclosure**)

About us

Humana is the nation's premier health benefits innovator. We leverage our deep Medicaid experience and capitalize on proven expertise, a diverse suite of resources and capabilities, established relationships and infrastructure. Humana Healthy Horizons has the expertise, competencies and resources to make healthcare delivery simpler, while lowering costs and improving health outcomes. Our members receive the highest quality of care and services because we offer:

- Care management and care transitions programs
- Analytical tools to identify members who might benefit from special programs and services
- An ongoing focus on customer service, health education and activities to promote health and wellness
- Community engagement and collaboration to ensure the comprehensive needs of members are addressed
- Access to behavioral health services that includes crisis intervention and a dedicated hotline
- An award-winning history in member services, training, clinical programs and customer satisfaction
- The ability to scale, innovate and provide ongoing support to our extensive provider network

Humana makes a difference

Humana brings a history of innovative programs and collaborations to ensure that our members receive the highest quality of care and ensure equitable access to – and the delivery of – services to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds or disabilities; and regardless of gender, sexual orientation or gender identity. With a focus on preventive care and continued wellness, our approach is simple: we want to make it easier for our members to get the healthcare they need, when they need it. Through a focus on health equity and community-based partnerships and services, we help our members successfully navigate complex healthcare systems.

Humana has more than 50 years of managed care experience with the expertise and resources that come with it.

Our services include:

- Provider relations
- Member eligibility/enrollment information

- Claim processing
- Decision-support informatics
- Quality improvement
- Regulatory compliance
- Special investigations for fraud, waste and abuse
- Member services, including a member call center and a 24-hour nurse advice line

In addition to the above, our care management programs include:

- Case management (in-person and telephonic)
- Onsite case management (clinics and facilities)
- Emergency department diversion
  - Higher than normal emergency department utilization (targeted at members with frequent utilization)
  - 24-hour nurse advice line
- Maternal and healthy baby program
- Discharge planning and transitional care support
- Chronic condition management programs

Compliance and ethics

At Humana Healthy Horizons, we serve a variety of audiences: members, providers, government regulators and community partners. We serve them best by working together with honesty, respect and integrity. We are all responsible for complying with all applicable state and federal regulations along with applicable Humana Healthy Horizons policies and procedures. Humana Healthy Horizons is committed to conducting business in a legal and ethical environment.

Humana Healthy Horizons established a compliance plan that:

- Formalizes Humana Healthy Horizons' commitment to honest communication within the company and within the community, inclusive of our providers, members and employees
- Develops and maintains a culture that promotes integrity and ethical behavior
- Facilitates compliance with all applicable local, state and federal laws and regulations
- Implements a system for early detection and noncompliance reporting with laws and regulations; fraud, waste and abuse concerns; or noncompliance with Humana Healthy Horizons policy, professional, ethical or legal standards
- Allows us to resolve problems promptly and minimize negative impact on our members or business, including financial losses, civil damages, penalties and sanctions

We have the following general compliance and ethics expectations for providers:

- Act according to professional ethics and business standards
- Notify us of suspected violations, misconduct or fraud, waste and abuse concerns
- Cooperate fully with any investigation of alleged, suspected or detected violations of applicable state or federal laws and regulations
- Notify us if you have questions or need guidance for proper protocol

For questions about provider expectations, please contact your Provider Relations representative or call Provider Services at **877-856-5707**. We appreciate your commitment to compliance with ethics standards and the reporting of identified or alleged violations of such matters.

Accreditation

Humana Healthy Horizons holds a strong commitment to quality. We demonstrate our commitment through programs based on national standards, when applicable. Humana Healthy Horizons maintains its accreditation from the National Committee for Quality Assurance (NCQA) for our Medicaid lines of business.

Basic plan information

General contact information

Provider Services: **877-856-5707 (TTY:711)** (7 a.m. to 8 p.m., Monday through Friday)

24-hour nurse advice line (24/7/365): **866-376-4827** Other helpful phone numbers:

- For assistance with prior authorization (PA) submissions for medical procedures and behavioral health: 877-856-5707
- Neonatal Intensive Care Unit (NICU) Admissions: 855-391-8655, Monday – Friday, 8:30 a.m. – 5 p.m., Eastern time
- Medicaid case management: **877-856-5707**
- Availity Essentials™ customer service/tech support: **800-282-4548**
- Fraud, Waste and Abuse
  - Special Investigations Unit (SIU) Hotline: **800-614-4126** (24/7 access)
  - Ethics Help Line: **877-5-THE-KEY** (877-584-3539)

Note: Humana is closed on the following days: New Year's Day, Martin Luther King Jr. Day, Memorial Day, Juneteenth, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving and Christmas Day. If the holiday falls on a Saturday, we will be closed on the Friday before. If the holiday falls on a Sunday, we will be closed the Monday after.

Mail Correspondence
Humana Healthy Horizons in Ohio
P.O. Box 14601
Lexington, KY 40512

Provider complaints
Humana Healthy Horizons in Ohio
P.O. Box 14601
Lexington, KY 40512-4601

Member grievance and appeals
Humana Healthy Horizons in Ohio
P.O. Box 14546
Lexington, KY 40512-4546

Fraud, waste and abuse
Humana Healthy Horizons in Ohio.
Special Investigations Unit
1100 Employers Blvd.
Green Bay, WI 54344

Provider representative information

Humana Healthy Horizons has knowledgeable provider representatives assigned to each Ohio Medicaid region available to resolve issues raised by providers.

Please use the following links to find the provider relations representative in your area:
OHMedicaidProviderRelations@humana.com

Provider relations representative assignment:
https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=4572074

Provider relations representative assignment map by county:
https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=4572061

Provider resources

Helpful websites

Providers may obtain plan information from **Ohio Medicaid for Providers - Humana**

This information includes, but is not limited to, the following:

- Answers to frequently asked questions
- Availity Essentials
- Behavioral and physical health clinical coverage policies
- Behavioral health tool kit
- Claims and payments
- Clinical practice guidelines
- Communications and network notices
- Documents and resources
- External medical review
- Join our network
- Optimization of pregnancy outcomes
- Pharmacy
- Pharmacy clinical coverage policies
- Prior authorization
- Provider network management
- Services for children
- Telehealth services
- Training materials

For help or more information regarding web-based tools, please call Provider Services at **877-856-5707**.

Availity Essentials

Healthcare providers must submit all prior authorization requests and claim submissions through Availity Essentials. Healthcare providers who want to work with Humana Healthy Horizons online need to register to receive an OH ID number for ODM's Provider Network Management (PNM) system. Please visit **www.ohid.ohio.gov** to create an account; if you would like more information, please visit the PNM and Centralized Credentialing website at **https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing**. Providers also need to register for Availity Essentials. This multipayer portal allows providers to interact securely with Humana Healthy Horizons and other participating payers without learning to use multiple systems or remembering different user IDs and passwords for each payer. Many tools specific to Humana Healthy Horizons are accessible from Availity Essentials. To learn more, call Availity at **800-282-4548** or visit **Availity.com**.

Availity Essentials lets you:

- Submit claims
- Check eligibility and benefits
- View claim status (claim submission, updates and attachments)
- Verify authorization submission and inquiry (authorization updates and attachments should be submitted via Availity Essentials)
- View remittance advice (electronic remittance advice and electronic funds transfer enrollment should be submitted)
- View member summaries
- Confirm/remedy overpayment
- Confirm/remedy appeal

Member enrollment and eligibility

Medicaid eligibility

Medicaid eligibility is determined by the Ohio Department of Medicaid in the county where the member resides.

The Ohio Department of Medicaid provides eligibility status to Humana Healthy Horizons on a daily basis via an 834 file. Eligibility begins on the first day of each calendar month for consumers joining Humana Healthy Horizons.

Newborn enrollment

Humana Healthy Horizons begins coverage of newborns on the date of birth when the newborn's mother is a Humana Healthy Horizons-covered patient. Although a prior authorization for the delivery is not required, the notification of birth is required. The County Department of Job and Family Services must be notified by Humana Healthy Horizons in Ohio of a birth within 5 business days of the birth or immediately on learning of the birth. The delivery hospital is required to complete and send the Humana Healthy Horizons in Ohio Notice of Birth form, found at **https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=5019248**, to our Utilization Management (UM) department within 24 business hours of the delivery. Instructions are included on the form. Once a newborn is enrolled, you can verify eligibility for the newborn via Availity Essentials.

Disenrollment

Members are disenrolled from Humana Healthy Horizons for a number of reasons. If a member loses Medicaid eligibility, they lose eligibility for Humana Healthy Horizons benefits. Humana Healthy Horizons, ODM or the member can initiate disenrollment.

Member disenrollment can be initiated for:

- Unauthorized use of a member ID card
- Use of fraud or forgery to obtain medical services
- Disruptive or uncooperative behavior to the extent that it seriously impairs the provider's ability to deliver care to the member or other patients

Please notify member services if any of the previously listed situations occur. Please see the section below for procedures for dismissing noncompliant members from your practice. We can counsel the member or, in severe cases, initiate a request to DCBS for disenrollment. DCBS reviews each member disenrollment. Requests and determines if the request should be granted. Disenrollment from Humana Healthy Horizons always occurs at the end of the effective month.

Involuntary dismissal

Participating providers can request that a Humana Healthy Horizons member be involuntarily dismissed from their practice if a member does not respond to recommended patterns of treatment or behavior.

Examples include:

- Noncompliance with medication schedules
- Violating no-show office policies
- Failing to modify behavior as requested

After a member misses three consecutive appointments, providers can request assistance from the Humana Healthy Horizons Care Management department by sending an email to OHMCDCareManagement@humana.com. Humana Healthy Horizons requires that a provider's office make at least 3 attempts to educate the member about noncompliant behavior and document them in the patient's record. Please remember that Humana Healthy Horizons can assist you in educating the member. After three attempts, providers may initiate dismissal procedures using the following guidelines:

- The provider's office must notify the member of the dismissal by certified letter. The letter should include the reason for the disenrollment request and the specific dates of the three documented unsuccessful education attempts.
- A copy of the letter must be sent or faxed to Humana Healthy Horizons in Ohio via the following methods:
  Humana Provider Relations
  Grievance and Appeal Department
  P.O. Box 14546
  Lexington, KY 40512-4546
  Fax: **800-949-2961**

For PCPs only, the letter must contain the following specific language:

- The member must contact Humana Healthy Horizons Member Services to choose another PCP.
- The reason for the disenrollment request should include at least one of the following:
  - Incompatibility of the PCP-patient relationship

- Patient has not utilized a service within 1 year of enrollment in the PCP's practice; includes the specific dates of documented unsuccessful contact attempts by mail and phone on at least 6 separate occasions during the year
- Inability to meet the medical needs of the patient

- The dismissing PCP serves the affected patient until a new PCP can serve the patient, barring ethical or legal issues.

Referrals for release due to ethical reasons

Humana Healthy Horizons-contracted providers are not required to perform treatments or procedures that are contrary to the provider's conscience, religious beliefs or ethical principles, in accordance with 42 C.F.R 438.102.

In those instances, the provider refers the member to another provider who is licensed, certified or accredited to provide care for the individual service appropriate to the patient's medical condition. The provider must be actively enrolled with ODM to provide Medicaid services to beneficiaries.

The provider also must be in Humana Healthy Horizons' provider network.

In such circumstance, where the provider's conscience, religious beliefs or ethical principles require involuntary dismissal of the member as his or her physician, the provider's office must notify the member of the dismissal by certified letter.

The letter should include:

- Reason for the disenrollment request
- Referral to another provider licensed, certified or accredited to provide care for the individual service appropriate to the patient's medical condition

(The provider must be actively enrolled with ODM to provide Medicaid services to beneficiaries and must be in Humana Healthy Horizons' provider network)

- Instructions to contact Humana Healthy Horizons Member Services at 877-856-5702 for assistance in finding a preferred in-network provider.
- A copy of the letter must be mailed or faxed to Humana Healthy Horizons in Ohio at the following address:
  Humana Provider Relations
  Grievance and Appeal Department
  P.O. Box 14546
  Lexington, KY 40512-4546
  Fax: 800-949-2961

Please call Provider Services at **877-856-5707** if you have questions about disenrollment reasons or procedures.

Automatic renewal

If Humana Healthy Horizons members lose Medicaid eligibility, but become eligible again within 90 days, they are automatically re-enrolled in Humana Healthy Horizons and assigned to the same PCP, if possible.

New member kits

Each new member household receives a new member kit and an ID card for each person in the family joining Humana Healthy Horizons. New member kits are mailed separately from the ID card.

The new member kit contains:

- A welcome letter
- Provider directory postcard
- A member handbook that explains how to access plan services and benefits and language assistance services
- A health risk assessment survey
- Member continuity of care form
- Notice of Advance Directives
- Notification of privacy protections
- Other preventive health education materials and information

Member ID cards

All new Humana Healthy Horizons members receive a Humana Healthy Horizons member ID card. A new card is issued only when the information on the card changes, if a member loses a card or if a member requests an additional card.

The member ID card only identifies a Humana Healthy Horizons member; it does not guarantee eligibility or benefits coverage. Members may disenroll from Humana Healthy Horizons and retain their previous ID card. Likewise, members may lose Medicaid eligibility at any time.

Therefore, it is important to verify member eligibility prior to every service. Please refer to the "Verify eligibility" section of this manual for more information.

- Member name
- Date of birth – Member's date of birth
- Humana Healthy Horizons in Ohio member plan ID number
  - Members' Humana Healthy Horizons in Ohio plan identification number
  - Do not use this number to bill Humana Healthy Horizons (begins with a "H").
- Medicaid member ID number – Use this number for Ohio Medicaid member identification on claims submitted to Humana (begins with "number").
- Primary care provider/clinic name – Each member chooses a participating provider to be his or her primary care provider (PCP). If a choice is not made, a PCP is assigned.
- Member services – Phone number and TTY for the hearing impaired.
- 24-hour nurse advice line – Phone number to reach a registered nurse 24/7/365
- Website – Our website contains plan information and access to special functionality, including eligibility verification, claim and prior authorization submission, Coordination of Benefits (COB) check and more.
- CSP – If member is enrolled in Coordinated Service Program
- OhioRISE – If member is enrolled in OhioRISE program
- Provider services – Use this toll-free phone number if you have questions or need to verify eligibility.
- Pharmacy – Call Provider Services at **877-856-5707** if you have questions about pharmacy benefits and services.

Please note: Humana Healthy Horizons may be notified by the Ohio Department of Medicaid (ODM) that a member has lost eligibility retroactively. This occurs occasionally, and in those situations, Humana Healthy Horizons in Ohio will take back payments made for dates when a member lost eligibility. The take-back code will appear on the provider's next Explanation of Payment (EOP) for impacted claims.

Member support services and benefits

Humana Healthy Horizons provides a wide variety of educational services, benefits and supports to our members to facilitate their use and understanding of our services, to promote preventive healthcare and to encourage appropriate use of available services. We are always happy to work with you to meet the healthcare needs of our members.

Member Services

Humana Healthy Horizons can assist members who have questions or concerns about services, such as case management, disease management, nonemergency transportation coordination as well as regarding benefits. Representatives are available by telephone by calling **877-856-5702**, Monday through Friday, 7 a.m. to 8 p.m. Eastern time, except on observed holidays. If the holiday falls on a Saturday, we are closed on the Friday before. If the holiday falls on a Sunday, we are closed the Monday after.

24-hour nurse advice line

Humana Healthy Horizons' Nurse Advice Hotline offers 24-hour, 7 days-a-week access to health information and medical triage services to Humana Healthy Horizons members. Members have access to the free service by calling **866-376-4827**. Services offered through the Nurse Advice Hotline include:

- Access to a nurse available via telephone to answer health-related questions, make a systematic assessment of symptoms, and make recommendations for the most appropriate treatment, clinical resources and care setting (e.g., home, virtual consultation, retail clinic, doctor's office, urgent care, emergency room [ER], etc.).
- Urgent and non-urgent care advice
- Health and wellness education, reminders and resources
- Condition, procedure and treatment explanations
- Medication information, including drug interactions, appropriate use, and adherence benefits and strategies

Emergency and crisis behavioral health hotline

Behavioral health crisis hotline

Ohioans who are experiencing a mental health or addiction crisis –as well as their family members – can call, text or chat the 988 Suicide & Crisis Lifeline to reach a trained specialist who can offer help and support. The easy-to-remember, three-digit number provides 24/7, free and confidential support to Ohioans in a behavioral health crisis. 988 provides a direct connection to compassionate, accessible care and support for anyone experiencing mental health related distress.

For more information about the 988 Suicide & Crisis Lifeline in Ohio, email 988ohio@mha.ohio.gov. If you, or someone you know, is in crisis, call, text or chat 988.

Listserv subscriptions

Sign-up to receive news and information from the Ohio Department of Medicaid website at **https://medicaid.ohio.gov/home/govdelivery-subscribe**.

Centers for Medicare & Medicaid Services – **Medicaid.gov**

Council for Affordable Quality Healthcare Inc. (CAQH) – CAQH For Providers: **https://www.caqh.org/providers**

Claims payment systemic error report

A claims payment systemic error (CPSE) is defined as the MCO's claims adjudication incorrectly underpaying, overpaying or denying claims that impact five or more providers. A report containing all active CPSEs is updated monthly and can be found by visiting Humana's CPSE reporting website at **https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=4572048**.

Provider advisory council

The Humana Healthy Horizons in Ohio Provider Advisory Council (HUM OH PAC) analyzes and evaluates results from provider forums to recommend policy decisions, institutes needed action to address deficiencies and ensures appropriate follow-up occurs.

HUM OH PAC allocates a forum for members of the committee to engage in review, coordination and direction of the Humana Healthy Horizons in Ohio provider network. The committee is charged with overseeing provider concerns and measurement of quality activities on a regular basis.

The HUM OH PAC selects a wide array of provider types to participate, including dental and behavioral health providers. Meetings take place no less than semi-annually, and attendees can attend in person, by phone or by webinar. The HUM OH PAC discusses various topics that enable Humana to gather input, discuss and learn about issues affecting providers, identify challenges and barriers, problem-solve, share information, and collectively find ways to improve and strengthen the healthcare service delivery system.

Provider policies

The Humana Healthy Horizons in Ohio Provider Manual is the primary source for information regarding Humana policy and procedures. Humana sends providers network bulletins and posts policy notices at **Humana.com/OHNotices** to advise network and out-of-network providers of changes to policy and procedure.

Provider Services Call Center information

Provider Services: **877-856-5707 (TTY: 711)** – Hours of operation are Monday through Friday, 7 a.m. to 8 p.m., Eastern time.

Note: Humana is closed on the following days: New Year's Day, Martin Luther King Jr. Day, Memorial Day, Juneteenth, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving and Christmas Day. If the holiday falls on a Saturday, we are closed on the Friday before. If the holiday falls on a Sunday, we are closed the Monday after.

Provider trainings

Education

Humana Healthy Horizons conducts an initial educational orientation (either online or in-person) for all newly contracted providers. Additional training can be scheduled to provide targeted education as needed or when requested by providers.

Provider education of required compliance-based materials

Providers are expected to adhere to all Humana-identified compliance-based training programs. This adherence includes a completed attestation by all participating providers and staff members trained on compliance material. Training includes the following required annual training modules:

- Cultural competency
- Health, safety and welfare education
- General compliance, fraud, waste
- Others, as required

Online training modules

Providers and their office staff can access these online training modules 24 hours a day, 7 days a week via Availity Essentials at Availity.com. Providers also can manually complete the training by visiting **Humana.com/providercompliance**.

If an individual provider is not directly contracted with Humana, but is employed or contracted by a provider entity contracted with Humana, the individual provider:

- Must still complete the training
- Does not have to submit an attestation to Humana

It is the responsibility of the contracted entity to track the training completion of each individual supporting Humana. Providers are expected to train all staff members on the following two topics, although no attestation is required:

- Fraud, waste and abuse
- General compliance

Providers also must adhere to requirements outlined in Humana's policies on compliance and standards of conduct.

For additional provider training, please visit Humana's website at **Humana.com/provider/medical-resources/self-service-portal**.

Please note: Humana's separate Compliance Policy and Standards of Conduct documents are available for review and download at **Humana.com/fraud**.

Forms

- **Link to ODM forms page:** **https://medicaid.ohio.gov/stakeholders-and-partners/legal-and-contracts/forms/forms**
- **Consent form:** **https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=4677595**
- **Hysterectomy, abortion and sterilization form(s)**
  - Abortion certification form: **https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Resources/Publications/Forms/ODM03197fillx.pdf**
  - Acknowledgement of hysterectomy information: **https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Resources/Publications/Forms/ODM03199fillx.pdf**
  - Consent for sterilization: **https://opa.hhs.gov/sites/default/files/2022-07/consent-for-sterilization-english-2025.pdf**
- **Standardized appeal form:** **https://provider.humana.com/coverage-claims/payment-integrity/reconsiderations-appeals**
- **SUD Residential Treatment Notification of Admission form:** **https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Resources/Publications/Forms/ODM10294Fillx.pdf**
- **Medicaid Managed Care Provider Addenda:** **https://medicaid.ohio.gov/resources-for-providers/managed-care/mc-policy/managed-care-program-appendix/managed-care-program-addenda**
- **Medicaid Addendum:** **https://medicaid.ohio.gov/resources-for-providers/managed-care/medicaid-addendum**
- **Out-of-network Provider Application:** **https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Resources/Publications/Forms/ODM10282Fillx.pdf**
- **Ohio Medicaid Provider Agreement:** **https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Resources/Publications/Forms/ODM10283Fillx.pdf**
- **Prior authorization resources for Humana Healthy Horizons in Ohio**: **Humana.com/provider/medical-resources/ohio-medicaid/prior-authorization**

Provider responsibilities

Health Insurance Portability and Accountability Act and protected health information

Personally identifiable information and protected health information

In the day-to-day business of patient treatment, payment and healthcare operations, Humana Healthy Horizons and its providers routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, there are various standards and industry best practices that guide how PII is appropriately protected when stored, processed and transferred in the course of conducting normal business. As a provider, you should be taking measures to secure your patients' data.

You also are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to secure all protected health information (PHI) related to your patients. There are many administrative, physical and technical controls you should have in place to protect all PII and PHI.

Providers should always:

- Use a secure message tool or service to protect data sent via email.
- Have policies and procedures in place to address the protection of paper documents containing patient information, including secure storage, handling and destruction of documents.
- Encrypt all laptops, desktops and portable media, such as CD-ROMs and USB flash drives, that may potentially contain PHI or PII.

Member privacy

The HIPAA Privacy Rule requires health plans and covered healthcare practitioners to develop and distribute a notice that provides a clear, user-friendly explanation of individuals' rights with respect to their personal health information, as well as the privacy practices of health insurance plans and healthcare practitioners.

As a provider, please follow HIPAA regulations and make only reasonable and appropriate use and disclosure of protected health information for treatment, payment and healthcare operations.

Provider obligations for oral translation, oral interpretation, and sign language services

Providers are required to provide oral interpretation, oral translation services and sign language assistance at no cost.

Hospital and nonhospital providers are required to abide by federal and state regulations related to the sections 504 and 508 of the Rehabilitation Act, Americans with Disabilities Act (ADA), Executive Order 13166 and Section 1557 of the Affordable Care Act (ACA) in the provision of effective communication. These provisions include in-person or video-remote interpretation for deaf patients and over-the-phone interpretation with a minimum 150 languages available for non-English speakers.

These services are available at no cost to the member per federal law.

Cultural competency and linguistics services

Cultural competency information, as well as languages spoken by office location, are collected in ODM's Provider Network Management (PNM) system and utilized to populate ODM's centralized provider directory. Additionally, this information for credentialed providers will be transmitted to the MCOs on a weekly basis for them to align their directories with the information contained in the PNM.

Participating providers are expected to provide services in a culturally competent manner that includes, but is not limited to, removing all language barriers to service and accommodating the special needs of the ethnic, cultural and social needs of the patient.

Participating providers also must meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care including, but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act and the Rehabilitation Act of 1973.

Humana Healthy Horizons recognizes cultural differences and the influence that race, ethnicity, language and socioeconomic status have on the healthcare experience and health outcomes. It is committed to developing strategies that eliminate health disparities and address gaps in care.

Annual national healthcare disparity reports from the Agency for Healthcare Research and Quality (AHRQ) at (**https://www.ahrq.gov**) confirm these gaps persist in the American healthcare system.

Communication is paramount in delivering effective care. Mutual understanding may be difficult during cross- cultural interaction between patients and providers.

Some disparities may be attributed to miscommunication between providers and patients, language barriers, cultural norms and beliefs and attitudes that determine healthcare- seeking behaviors. Providers can address racial and ethnic gaps in healthcare with an awareness of cultural needs and an effort to improve communication with a growing number of diverse patients.

Humana Healthy Horizons developed a number of initiatives to deliver better care to all members regardless of ethnicity, socioeconomic status, culture and primary language. These include language assistance services, race and ethnicity data collection and analysis, internal staff training and Spanish resources. Other initiatives give providers resources and materials, including tools from health-related organizations, that support awareness of gaps in care and information on culturally competent care.

A copy of Humana's cultural competency plan is available at no charge to the provider. To request a paper copy, please call Humana Healthy Horizons in Ohio Provider Services at **877-856-5707**. Humana also offers training material on this topic at **Humana.com/providercompliance**.

Clear communication

Limited English proficiency (LEP) describes the degree to which a member's inability or limited ability to speak, read, write or understand the English language affects effective interactions between the member and healthcare providers or health plan members.

Language Assistance Program (LAP) for Limited English Proficient (LEP) members

Humana Healthy Horizons is committed to providing free language assistance services for its members with LEP.
This assistance includes:

- Free interpretation services for all languages. Providers may call Humana Healthy Horizons at the phone number listed on the member's Humana ID card to access interpretation services while the member is in the office.
- Spanish versions of Humana's non-secure website and member materials
- TTY/TDD services

Members can request a written translation of Humana documentation mailed to them. Members should call the member service phone number listed on the back of their Humana Healthy Horizons ID card to request translated materials.

Subcultures and populations

Subculture is a term that describes ethnic, regional, economic or social groups that exhibit characteristic behavior patterns that distinguish them from others within an embracing culture or society. Understanding the many different subcultures that exist within our own culture also is an important aspect of cross-culture healthcare.

To address the health issues within different ethnicities, providers must work to understand the values, beliefs and customs of their patients. A few examples of cultural aspects that may impact health behavior include:

- Eye contact – Some cultures use deferred eye contact to show respect. Deferred eye contact does not mean the patient is not listening to you.
- Personal space – Cultures have varying approaches to personal space and touching. Some cultures may expect more physical contact when greeting people.
- Respect for authority – Some cultures are very hierarchical and view doctors with a lot of respect. These patients may feel uncomfortable questioning doctors' decisions or asking questions.

Health literacy

Health literacy describes a member's ability to obtain, process and understand basic health information and services needed to make appropriate decisions. Limited health literacy can result in a lack of understanding of what's required to care for their health.
Limited health literacy is associated with:

- Poor management of chronic diseases
- Poor understanding of and adherence to medication regimens
- Increased hospitalizations and poor health outcomes

Humana Healthy Horizons develops member communications based on health literacy and plain-language standards, per the federal Plain Writing Act of 2010. The reading ease of Humana Healthy Horizons written member materials is tested using the widely recognized Dale-Chall Readability tool.

Seniors and people with disabilities

Humana Healthy Horizons develops individualized care plans that include consideration of special and unique member needs in accordance with the Americans with Disabilities Act (ADA). People with disabilities must be consulted before an accommodation is offered or created on their behalf. Some considerations in treating seniors and people with disabilities include:

- Disease and multiple medications
- Caregiver burden/burnout
- Cognitive impairment and mental health
- Visual impairment
- Hearing impairment
- Physical impairment
- Use of clear signage throughout provider offices and adequate handicapped parking.

Provider rights and responsibilities

Provider rights

Each healthcare provider who contracts with ODM or subcontracts with Humana Healthy Horizons to furnish services to Humana Healthy Horizons members is assured of the following rights:

1. To not be prohibited from acting within the lawful scope of their practice when advising or advocating on behalf of a Humana Healthy Horizons member for the following:
   a) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
   b) Any information the member needs to decide among all relevant treatment options
   c) The risks, benefits, and consequences of treatment or non-treatment
   d) The member's right to participate in decisions regarding their healthcare, including the right to refuse treatment and to express preferences about future treatment decisions
2. To receive information on the grievance, appeal and fair hearing procedures.
3. To have access to Humana Healthy Horizons' policies and procedures covering the authorization of services.
4. To be notified of any decision by Humana Healthy Horizons to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested.
5. To challenge, on behalf of Humana Healthy Horizons members, the denial of coverage of, or payment for, medical assistance.
6. To be free from discrimination from Humana Healthy Horizons' provider selection policies and procedures when serving high-risk populations or specializing in conditions that require costly treatment.
7. To be free from discrimination for the participation, reimbursement or indemnification of any provider who acts within the scope of their license or certification under applicable state law, solely on the basis of that license or certification.

HealthTrack

HealthTrack is a database operated by ODM that tracks member and provider complaints. When providers file a complaint with ODM, Humana Healthy Horizons receives notice of the complaint through HealthTrack. Within 5 business days of receipt of a complaint, Humana Healthy Horizons notifies the provider (verbally or in writing) that the complaint was received. Humana Healthy Horizons then researches the complaint and contacts the provider to present our findings within 15 business days. If additional time to resolve a complaint is needed, Humana Healthy Horizons advises the provider of the delay and requests an extension from ODM. Humana Healthy Horizons notifies the provider and ODM of the resolution within the required time frame.

Provider responsibilities

- Meet compliance and ethics expectations:
  - Have an effective compliance program in place
- Review and adhere to the requirements outlined within these separate Humana documents updated annually:
  - Ethics Every Day for Contracted Healthcare Providers and Third Parties
  - Compliance Policy for Contracted Healthcare Providers and Third Parties
- Adopt the preceding documents or have materially similar content in place, along with supporting processes, to create a strong foundation to year-over- year compliance. These documents can be accessed at **Humana.com/providercompliance**
- Act according to professional ethics and business standards
- Conduct exclusion screenings prior to hire/contract and monthly thereafter of those slated to support Humana Healthy Horizons, promptly remove any excluded party from supporting us and notify us in a timely manner of the exclusion and action(s) taken
- Complete separate, required trainings on multiple topics and, when required, submit at an organization-level attestation certifying completion. Additional, related information is in the "Required Training" section.
- Take disciplinary action when your organization or we identify noncompliance, fraud or abuse
- Notify us in a timely manner of suspected violations, misconduct or fraud, waste and abuse concerns and action(s) taken
- Cooperate fully with any investigation of alleged, suspected or detected violations of applicable state or federal laws and regulations
- Maintain current contact information (e.g., service address) and key identifying information (e.g., NPI and Ohio Medicaid ID) in ODM's PNM system
- Notify us if you have questions or need guidance for proper protocol

Primary care provider care coordination

The PCP serves as the member's initial and most important point of interaction with the plan's provider network. A PCP is an individual physician, advance practice nurse practitioner or physician assistant within the specialty types of family/general practice, internal medicine, pediatrics or obstetrics/gynecology (OB/GYNs). The PCP is the member's point of access for preventive care or an illness and may treat the member directly, refer the member to a specialist (secondary/tertiary care), or admit the member to a hospital.

- All Humana Healthy Horizons members choose or are assigned to a PCP upon enrollment in the plan.
- Members select a PCP from the Humana Healthy Horizons' Provider Directory.
- Members have the option to change to another participating PCP as often as needed.
- Members initiate the change by calling Member Services. PCP changes are effective the first day of the month following the requested change.

PCPs must:

- Comply with the following triage requirements:
  - Members with emergency care needs must be triaged and treated immediately on presentation at the PCP site
  - Members with persistent symptoms must be treated no later than the end of the following working day after their initial contact with the PCP site
  - Members with requests for routine care must be seen within six weeks.

PCP care coordination responsibilities include, at a minimum, the following:

- Assisting with coordination of the member's overall care, as appropriate for the member
- Providing services which are medically necessary, as described in rule 5160-1-01 of the Administrative Code
- Serving as the ongoing source of primary and preventative care
- Recommending referrals to specialists, as required
- Triaging members in accordance with previously state triage requirements

PCP care coordination responsibilities include, at a minimum, the following:

- Treating Humana Healthy Horizons members with the same dignity and respect afforded to all patients – including the same high standards of care and operating hours.
- Managing and coordinating the medical and behavioral healthcare needs of members to ensure that all medically necessary services are made available in a timely manner.

- Referring patients to specialists/subspecialists groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available; communicating with all other levels of medical care to coordinate and follow up on care delivered to patients.
- Maintaining a medical record of all services rendered by the PCP and a record of referrals to other providers and any documentation provided by the rendering provider to the PCP for follow-up and/or coordination of care.
- Developing a plan of care to address a patient's risks and medical needs and other responsibilities as defined in this section.
- Working with Humana Healthy Horizons case managers to develop plans of care for members receiving care management services.
- Conducting screenings for common behavioral issues including, but not limited to, depression, anxiety, trauma/adverse childhood experiences (ACEs), substance use, early detection, identification of developmental disorders/delays, social-emotional health and social determinants of health (SDOH) to determine whether the member needs behavioral health services.
- Providing phone coverage for handling patient calls 24 hours a day, 7 days a week.
- Following all prior authorization policies and procedures as outlined in this manual.
- Complying with the quality standards of Humana Healthy Horizons and ODM, as outlined in this manual.
- Discussing advance medical directives with all members as appropriate.
- Obtaining patient records from facilities visited by Humana Healthy Horizons-covered patients for emergency or urgent care, if notified of the visit.
- Ensuring demographic and practice information is up to date for directory and member use.
- Understanding and agreeing that provider performance data can be used by Humana Healthy Horizons.
- Transferring information using Ohio's health information exchange (HIE).

Comprehensive primary care

- Comprehensive primary care (CPC) practices must offer at least one alternative to traditional office visits to increase access to patient care team and clinicians in ways that best meet the needs of the population, i.e., e-visits, phone visits, group visits, home visits, alternate location visits or expanded hours in the early mornings, evenings and weekends.
- Must provide access to a PCP with access to the member's medical record within 24 hours of initial request.
- The practice also must make clinical information of the member available through paper or electronic records, or telephone consultation to on-call staff, external facilities and other clinicians outside the practice when the office is closed.

Release due to ethical reasons

Humana Healthy Horizons-contracted providers are not required to perform treatments or procedures that are contrary to the provider's conscience, religious beliefs or ethical principles, in accordance with 42 C.F.R. 438.102. Providers should notify Humana Healthy Horizons of treatments or procedures that they don't provide due to ethical reasons by sending an email to one of the following email addresses:

- **Medical providers:** OhioNetworkSpecialist@humana.com
- **Behavioral health providers:** OHBHMedicaid@humana.com

The provider refers the member to another provider who is licensed, certified or accredited to provide care for the individual service appropriate to the patient's medical condition. The provider must be actively enrolled with Ohio Medicaid to provide Medicaid services to beneficiaries. The provider also must be in Humana Healthy Horizons' provider network.

Required training

We expect adherence to all training programs identified as compliance-based by the contract and the Ohio Medicaid Managed Care Program. This includes ODM-delivered provider training as mandated by ODM and agreement and assurance that training on identified compliance material is conducted by your organization for all affiliated participating providers, supporting healthcare practitioners and staff with member interaction*.

*Member interaction can involve any of the following: face-to-face and/or over-the-phone conversations, as well as review and/or handling of member or member-related correspondence via mail, email or fax.

All new providers receive the Ohio Medicaid Managed Care Program orientation, found at **https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=4490304**.

Additionally, compliance training must be conducted by your organization on the following topics on contract/ hire and annually thereafter for those supporting Humana Healthy Horizons:

- General compliance**
- Combating fraud, waste and abuse (FWA)**
- Humana orientation
- Medicaid provider orientation
- Cultural competency
- Health, safety and welfare/abuse, neglect and exploitation of members

**Your organization may develop or adopt another organization's training on the separate topics of general compliance and combatting FWA.

Please note: An attestation at the organization level must be submitted annually to us, on request, to certify that your organization has a plan in place to comply with and conduct training on any or all the above topics.

The training on the topics outlined above is designed to ensure:

- Sufficient knowledge of how to effectively perform the contracted function(s) to support the membership of Humana Healthy Horizons
- The presence of specific controls to prevent, detect and/or correct potential, suspected or identified noncompliance and/or fraud, waste or abuse

Online Humana training modules for the topics listed above, as well as an organization-level attestation form, can be accessed online within Availity Essentials at **Availity.com** or by anyone at **Humana.com/providercompliance**.
For additional provider training, please visit **Humana.com/HealthyOH**.

Required provider identifiers

All providers must be eligible for participation in the Medicaid program. If a provider is currently suspended or involuntarily terminated from the Ohio Medicaid program, whether by contract or sanction, other than for purposes of inactivity, that provider is not considered an eligible Medicaid provider.

It is a provider's responsibility to ensure they are fully enrolled with Ohio Medicaid. Each provider is required to have a National Provider Identifier (NPI) Humana Healthy Horizons may deny reimbursement for covered services if it determines that the provider does not have a current Ohio Medicaid provider number at the time it adjudicates the claim.

Changes to provider practice demographic information

ODM expects Humana Healthy Horizons to utilize the PNM system to populate their data. Therefore, it is important that providers keep their records up to date in ODM's PNM system so that their information is displayed accurately in Humana Healthy Horizons' directories and internal systems. Examples of changes that require notification include, but are not limited to:

- Change to Tax Identification Number (TIN)
- Providers added to or leaving group
- Service address changes, e.g., new location, phone or fax numbers
- Access to public transportation
- Standard hours of operation and after hours
- Billing address updates
- Credentialing updates
- Panel status
- Acceptance of new patients
- Gender
- Languages spoken in office

Providers are strongly encouraged to indicate their race, ethnicity and languages spoken so that Humana Healthy Horizons can refer to them members who make requests to see a provider who shares their race, ethnicity or language.

If providers have additional questions, they may email Humana Healthy Horizons at:

- **Medical providers:** OhioNetworkSpecialist@humana.com
- **Behavioral health providers:** OHBHMedicaid@humana.com

Procedure to notify managed care organization of changes in member circumstances

Humana Healthy Horizons notifies ODM no later than 30 calendar days after being notified of a death of a member, and within one business day of becoming aware of changes in the member's address, phone, email address or other contact information. We ask providers to educate members to call our member hotline to provide Humana Healthy Horizons with updates to their contact information so Humana Healthy Horizons can update ODM.

Advance medical directives

The Patient Self-Determination Act of 1990 and state law provide every adult member the right to make certain decisions concerning medical treatment. Members have the right, under certain conditions, to decide whether to accept or reject medical treatment, including whether to continue medical treatment that would prolong life artificially. All providers have the responsibility to discuss advance medical directives with adult members at the first appointment or visit, consistent with 42 CFR Part 489 Subpart I. The discussion should subsequently be charted in the permanent medical record of the member. A copy of the advance directive should be included in the member's medical record inclusive of other mental health directives.

If the member is incapacitated at the time of admission or at the start of care and is unable to receive information (due to the incapacitating conditions or a mental disorder) or articulate whether or not they executed an advance directive, then the provider may give advance directive information to the member's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated member or to a surrogate or other concerned persons, in accordance with state law. The provider is not relieved of its obligation to provide this information to the member once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the member directly at the appropriate time.

Providers should discuss potential medical emergencies with the member and document that discussion in the member's medical record.

- All member records must contain documentation that the member was provided with written information concerning the member's rights regarding advance directives (i.e., written instructions for living will or power of attorney), including whether the member has executed an advance directive (42 CFR 438.3(j)(3)).
- Neither the managed care plan, nor any of its providers can, as a condition of treatment, require the member to execute or waive an advance directive (42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5)).

Value-based payment programs

Humana Healthy Horizons is committed to fostering high-value care in the communities we serve. Humana Healthy Horizons participates in the Ohio Department of Medicaid's value-based payment (VBP) models, including Comprehensive Primary Care (CPC) and CPC for Kids and Comprehensive Maternity Care (CMC). To learn more about these programs, please reach out to your Provider Relations or Engagement Representatives, or visit ODM's value-based payments site at **https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/payment-innovation/payment-innovation**.

In addition to ODM's VBP models, Humana Healthy Horizons-contracted providers can participate in a variety of value-based programs that allow them to earn financial incentives and rewards based on quality, cost and clinical outcomes. The programs are designed based on the provider's panel size and readiness, as well as participation in ODM's programs or other specific contracting arrangements. Program terms and metrics are reviewed annually and modified as appropriate. Quality (pay-for-performance) incentives are reviewed and reimbursed annually, one quarter in arrears to allow for reporting and data collection. Shared savings or two-sided arrangements are reconciled on an agreement-specific basis. To learn more about Humana Healthy Horizons' available VBP programs, please contact your provider relations or engagement representatives.

Ohio Health Information Exchange

ODM requires that all Humana Healthy Horizons-contracted providers participate with Ohio's health information exchange (HIEs). HIEs provides a common, secure electronic information infrastructure that meets national standards to

ensure interoperability across various health systems, while affording providers the functionality to support preventive health and disease management.

Providers connected to HIE are capable of exchanging PHI, connecting to inpatient and ambulatory electronic health records, connecting to care coordination information technology system records and supporting secure messaging or electronic querying between providers, patients and the health plan. This includes, but is not limited to, using the HIEs for admission, discharge, and transfer (ADT) data and closing referral loops for SDOH.

Hospitals are required to provide ADT data to both Ohio HIEs. Information on the Ohio HIEs can be found on CliniSync's website at **https://clinisync.org**.

Abuse, neglect and exploitation

Reporting abuse, neglect and exploitation

Ohio providers must report when there is reasonable cause to believe abuse, neglect, exploitation, misappropriation of greater than $500, or unexplained death has occurred to a member. You can call Humana Healthy Horizons at **877-856-5707** and one of the following appropriate Ohio agencies:

- Reports of adult abuse can be made to local adult protective services or by calling **855-OHIO-APS (855-644-6277)** 24 hours a day, 7 days a week.
- To report suspected abuse or neglect of a child, call the state of Ohio child abuse reporting directory, toll-free at **855-OH-CHILD (855-642-4453)**.

Critical incident reporting

Critical incidents include, but are not limited to, abuse, neglect, exploitation, misappropriation greater than $500, accidental/unnatural death, self-harm or suicide resulting in ER/hospitalization, missing or lost individual, or prescribed medication issues, per Ohio Administrative Code 5160-44-05.

Participating providers are required to report critical incidents to Humana Healthy Horizons as soon as possible after the discovery of the incident, and no later than 24 hours after the critical incident occurred. Call us at **877-856-5707** and be prepared to share the following details:

- Facts relevant to the incident, such as a description of what happened
- Incident type
- Date of the incident
- Location of the incident
- Names and contact information of all persons involved; and
- Any actions taken to ensure the health and welfare of the individual.

Humana Healthy Horizons and participating providers must immediately (i.e., not to exceed 24 hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members.

Americans with Disabilities Act

All Humana Healthy Horizons-contracted healthcare providers must comply with the Americans with Disabilities Act (ADA), as well as all applicable state and/or federal laws, rules and regulations. More details are available in the Humana provider agreement under "Compliance with Regulatory Requirements."

Humana Healthy Horizons develops individualized care plans that take into account members' special and unique needs. Healthcare providers with members who require interpretive services may contact their provider relations representative with questions.

If you have members who need sign language interpretation services, either the provider or member can call **877-320-2233** or call the number on the back of their member ID card or visit Humana's accessibility resources website at **Humana.com/legal/accessibility-resources**.

Marketing activities

Healthcare providers cannot orally or in writing compare benefits or provider networks among health plans, other than to confirm whether they participate in a health plan's network. If a provider can assist members in an objective assessment of their needs and potential options to meet those needs, the provider may do so. Providers may engage in

discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.

Healthcare providers may announce a new affiliation with a health plan through general advertising (e.g., radio, television, websites). Providers may give their patients a list of health plans with which they contract.

Member rights and responsibilities

Member rights

Members of Humana Healthy Horizons have the following rights:

- Receive all services Humana Healthy Horizons is required to provide pursuant to the terms of their provider agreement with the Ohio Department of Medicaid (ODM).
- Be treated with respect and with due consideration for their dignity and privacy.
- Be ensured of confidential handling of information concerning their diagnoses, treatments, prognoses and medical and social history.
- Be provided information about their health. Such information also should be made available to the individual legally authorized by the member to have such information or the person to be notified in the event of an emergency when concern for the member's health makes it inadvisable to give them such information.
- Be given the opportunity to participate in decisions involving their healthcare.
- Be given the opportunity to make recommendations regarding the member rights and responsibilities policy.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand, regardless of cost or benefit coverage.
- Maintain auditory and visual privacy during all healthcare examinations or treatment visits.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Request and receive a copy of their medical records, and to be able to request that their medical records be amended or corrected.
- Be afforded the opportunity to approve or refuse the release of information except when release is required by law.
- Be afforded the opportunity to refuse treatment or therapy. Members who refuse treatment or therapy are counseled relative to the consequences of their decision and documentation is entered into the medical record accordingly.
- Be afforded the opportunity to file grievances, appeals or state hearings pursuant to the provisions of rule 5160-26-08.4 of the Administrative Code.
- Be provided written member information from Humana Healthy Horizons:
  - At no cost to the member
  - In the member's preferred language
  - In alternative formats and in an appropriate manner that takes into consideration the special needs of members.
- Receive necessary oral interpretation and oral translation services at no cost.
- Receive necessary services of sign language assistance at no cost.
- Be informed of specific student practitioner roles and the right to refuse student care.
- Refuse to participate in experimental research.
- Formulate advance directives and to file any complaints concerning noncompliance with advance directives with the Ohio Department of Health.
- Change PCPs no less often than monthly. Humana Healthy Horizons must mail written confirmation to the member of his or her new PCP selection prior to or on the effective date of the change.
- Appeal to or file directly with the U.S. Department of Health and Human Services' Office of Civil Rights all complaints of discrimination on the basis of race, color, national origin, age or disability in the receipt of health services.
- Appeal to or file directly with the ODM office of civil rights all complaints of discrimination on the basis of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services in the receipt of health services.
- Be free to exercise their rights and to be assured that exercising their rights does not adversely affect the way Humana, Humana Healthy Horizons' providers or ODM treats the member.
- Be assured that Humana Healthy Horizons must comply with all applicable federal and state laws and other laws regarding privacy and confidentiality.
- Choose their health professional to the extent possible and appropriate.

- For members, to obtain direct access to a woman's health specialist within the network for covered care necessary to provide women's routine and preventive healthcare services. This is in addition to a member's designated PCP if the PCP is not a woman's health specialist.
- Be provided a second opinion from a qualified healthcare professional that participates with Humana Healthy Horizons. If such a qualified health care professional is not available within the network, then Humana Healthy Horizons must arrange for a second opinion outside the network, at no cost to the member.
- Request a practitioner that has their same race, ethnicity and language, if an appropriate practitioner is available in the network.
- Receive information on their Humana Healthy Horizons plan, its services, practitioners and providers and member rights and responsibilities.

Member responsibilities

Members of Humana Healthy Horizons have the following responsibilities:

- Work with their PCP to protect and improve their health.
- Find out how the health plan coverage works.
- Listen to the PCP's advice and ask questions when in doubt.
- Call or go back to the PCP if they do not get better or ask to see another provider.
- Treat healthcare staff with respect.
- Tell Humana Healthy Horizons if they have problems with any healthcare staff by calling Member Services at **877-856-5702 (TTY: 711).**
- Keep appointments or call as soon as possible to cancel existing appointments.
- Use the emergency department only for emergencies.
- Call the PCP when medical care is needed, even if it is after-hours.
- Make recommendations to the Humana Healthy Horizons member rights and responsibilities policy.

Members of Humana Healthy Horizons must be sure to:

- Know their rights.
- Follow Humana Healthy Horizons and ODM policies and procedures.
- Know about their service and treatment options.
- Take an active part in decisions about their personal health and care and lead a healthy lifestyle.
- Understand as much as they can about their health issues.
- Take part in reaching goals in agreement with the healthcare provider.
- Let Humana know if they are unhappy with us or one of their providers.
- Use only approved providers.
- Report suspected fraud, waste or abuse.
- Keep scheduled doctor visits (e.g., be on time and, if they have to cancel, call at least 24 hours in advance).
- Follow the advice and instructions for care in agreement with doctors and other healthcare providers.
- Always carry and show their member ID card when receiving services.
- Never let anyone use their member ID card.
- Let Humana Healthy Horizons know of a name, address or phone number change, or a change in the size of their family (e.g., birth, death, etc.).
- Call the assigned PCP after going to an urgent care center, a medical emergency, or receiving medical care outside of the Humana Healthy Horizons in Ohio service area.
- Let Humana Healthy Horizons and ODM know if they have other health insurance coverage.
- Provide the information that Humana Healthy Horizons and healthcare providers need to provide care.
- Notify Humana Healthy Horizons immediately of any worker's compensation claim, a pending personal injury or medical malpractice lawsuit, or if/when they've been in an auto accident.

Humana Healthy Horizons advises members of changes to our member rights and responsibilities on our website at **Humana.com/HealthyOhio**.

Provider enrollment, credentialing and contracting

Provider enrollment (ODM functions)

General provider information/enrollment information

Pursuant to 42 Code of Federal Regulations (CFR) 438.602, the Ohio Department of Medicaid (ODM) is required to screen, enroll, and revalidate all managed care organization (MCO) network providers. This provision does not require MCO network providers to render services to fee-for-service (FFS) beneficiaries.

There are many resources available on the Ohio Department of Medicaid website about the requirements to become a participating provider. Please visit https://medicaid.ohio.gov/resources-for-providers/enrollment-and-support/enrollment-and-support for several useful documents that answer relevant questions.

Organizational provider types will be required to pay a fee. The fee does not apply to individual providers and practitioners or practitioner groups. The fee is a federal requirement described in 42 CFS 455.460 and in OAC5160-1-17.8. The fee for 2024 is $709 per application and is not refundable. The fee will not be required if the enrolling organizational provider has paid the fee to either Medicare or another state Medicaid agency within the past five years. However, Ohio Medicaid will require that the enrolling organizational providers submit proof of payment with their application. See OAC 5160-1-17.8(A)(1)

Termination, suspension or denial of ODM provider enrollment

For a list of termination, suspension and denial actions initiated by the state against a provider or applicant that allow for hearing rights, please refer to Ohio Revised Code 5164.38.

For a list of termination, suspension and denial actions initiated by the state Medicaid agency against a provider or applicant that allow for reconsideration, please refer to OAC 5160-70-02.

Loss of licensure

In accordance with OAC 5160-1-17.6, a Medicaid provider agreement will be terminated when any license, permit or certification that is required in the provider agreement or department rule has been denied, suspended, revoked, not renewed or is otherwise limited and the provider is afforded the opportunity for a hearing, in accordance with the hearing process established by the official, board, commission, department, division, bureau or other agency of state or federal government.

Enrollment and reinstatement after termination or denial

If a provider's Medicaid provider agreement is terminated or an applicant's application is denied, the applicant/provider should call Ohio Medicaid via the Provider Enrollment Hotline at 800-686-1516 to discuss the requirements to reapply. This process may include conversations with the ODM Compliance unit who will provide specific instruction on re- instatement requirements, if applicable.

Provider maintenance

The Provider Network Management (PNM) system serves as the system of record for provider data for ODM and the MCOs. As a result, data in the PNM system is used in both claims payment, the MCO's provider directory and ODM provider directory. To ensure provider information remains current, it is important for providers to keep their information up to date in the PNM system Please remember, as an ODM provider and in accordance with your provider agreement, providers are responsible to notify ODM of changes within 30 days (see OAC 5160-1-17.2-F).

Updating the PNM system: When there is a change in a provider's information, please log in to the PNM system, choose the provider you are editing, and click the appropriate button to begin an update. Self service functions include, but are not limited to: location changes, specialty changes and key demographic (e.g., name, NPI etc.) changes. Once information is accepted into the PNM system, accepted information is sent to the MCOs daily for use in their individual directories. The provider must update their information in the PNM system first. The MCOs are required to direct providers back to the PNM system if there are changes.

Important note: The active Ohio Medicaid provider number submitted to the MCO on a provider roster must exactly match the OH Medicaid ID as reflected in ODM's PNM system (formerly known as Medicaid Information Technology Information System [MITS]). Also, the NPI submitted to the MCO on a provider roster must exactly match the NPI as reflected in ODM PNM system.

Integrated Help Desk/ODM provider call center

If you have questions or need assistance with your Ohio Medicaid enrollment, call the ODM Integrated Helpdesk at **800-686-1516** through the interactive voice response (IVR) system. It provides 24-hour, 7 days-a-week access to information regarding provider information. Provider representatives are available via the IVR system weekdays from 8 a.m. to 4:30 p.m.

Helpful information

- **ODM Medicaid provider resources:** https://medicaid.ohio.gov/resources-for-providers/enrollment-and-support/enrollment-and-support
- **Federal guidelines for enrollment and screening (42 CFR 455 Subpart E):** https://www.law.cornell.edu/cfr/text/42/part-455/subpart-E
- **Ohio Revised Code, Chapter 5160:** https://codes.ohio.gov/ohio-revised-code/chapter-5160
- **Ohio Revised Code, Chapter 3963:** https://codes.ohio.gov/ohio-revised-code/chapter-3963
- **Ohio Administrative Code 5160:** https://codes.ohio.gov/ohio-administrative-code/5160

Provider contracting (MCO functions)

Contracting process

Our network resources webpage at Provider.humana.com includes information for providers interested in joining the Humana Healthy Horizons network.

Humana Healthy Horizons contracts with providers who are licensed and/or certified by the appropriate Ohio licensing body or standard-setting agency and are enrolled with ODM as a qualified Medicaid provider. If a provider is not active in ODM's provider network management system, Humana Healthy Horizons must direct the provider to ODM's portal to submit an application for screening, enrollment and credentialing prior to contracting.

Requests for Humana Healthy Horizons medical and behavioral health network participation should be sent by:

- Emailing **OhioNetworkSpecialist@humana.com**
- Calling **877-856-5707**, Monday through Friday, 7 a.m. to 8 p.m., Eastern time

A written response approving or denying participation must be sent to providers who submit a network participation request. The request is sent via U.S. mail, fax or email within 90 days of receipt of the request.
A sample of the participation agreement can be found at **https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=4698226**.

Medicaid addendum

Network provider contracts must include the appropriate ODM-approved Model Medicaid Addendum, which incorporates all applicable OAC rule requirements.

The ODM Medicaid Addendum supplements the Base Contract or Agreement between the managed care organization and provider and runs concurrently with the terms of the Base Contract or Agreement. The Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members. Attachments are only needed when providers are offering different services or practitioners through this plan contract than are identified in the PNM system. Attachment A is needed for all PCPs to identify the providers' capacity and service location. Attachment A is also required when a provider has specific practitioner affiliates identified in the PNM who are agreeing to provide services under this plan contract. Attachment C is only required when the contract between the managed care entity and the provider includes particular specialties rather than all specialties the provider identified in the PNM system. The most current Medicaid Addendum is posted on the ODM Managed Care Provider Addenda site at **https://medicaid.ohio.gov/resources-for-providers/managed-care/mc-policy/managed-care-program-appendix/managed-care-program-addenda**.

The addendum must be completed along with the MCO provider contract.

Termination, suspension or denial of contract

Denial of contract

The decision to deny participation may be based on a variety of factors including, but not limited to, Ohio Medicaid program enrollment status, specialty coverage, network adequacy, geographic considerations and/or provider's cost efficiency.

Written responses to denial of network participation requests must include:

- The reason for the adverse decision declining participation
- The provider's right to appeal the denial and request for additional documented information in support of the provider's view on the decision
- Notification that after expiration of one year from the date of the final notification letter, provider may reapply to Humana for a reconsideration of network participation

Provider appeals process for denial of contract

Providers may appeal an adverse decision declining participation. If a provider appeals an adverse decision from participation, the request from the provider must be submitted to Humana in writing as follows:

1. Submit a request to appeal any denial of participation in writing to:
   Humana Healthy Horizons in Ohio
   485 Metro Place, S. 5th Floor
   Dublin, OH 43017
2. Attach any additional documented information the physician requests Humana reviews to support the provider's appeal
3. Include the name and address of contact person for provider with request
4. Date and postmark the request for appeal not more than 30 calendar days from the date of the adverse decision notification from Humana

Please note that the provider must submit all documentation and supporting information they wish Humana to consider at least one day prior to the date of the scheduled meeting to consider the provider's appeal.

On receipt of written request from a provider for an appeal, Humana schedules a meeting to discuss the appeal. The provider is then sent a letter that contains notification of the date of the scheduled meeting and a due date for all information to be submitted. Once a decision is made on the appeal, a written response is sent to the provider indicating Humana's final decision.

Suspension

When ODM notifies Humana that a provider has been suspended, Humana Healthy Horizons immediately suspends the provider, including all payments to the provider. Humana must continue to suspend the provider until it receives notice from the ODM to lift the suspension. When ODM notifies Humana that a provider is no longer suspended, Humana must lift the suspension and process any suspended claims.

Termination

Humana notifies providers of a participation agreement (i.e., contract) termination or non-renewal according to the terms outlined in the participation agreement or, if not specified, then no less than 90 calendar days prior to the effective termination date or as otherwise required by state or federal regulations or accreditation requirements.

Provider must provide Humana with notice according to the terms outlined in the participation agreement regarding any termination or non-renewal to allow Humana to comply with the member notification time frames required by applicable state and/or federal law, accreditation standards and ODM contract requirements. The notification to Humana must be in writing and comply with the contractual requirements for notice to initiate the participation agreement termination.

Non-contracted or unenrolled providers

Contracting and enrollment are two separate processes. Both should be completed if you want to provide services to managed care enrolled Medicaid beneficiaries. Contracting is the process a provider completes with the MCO whereas enrollment is a process completed with the ODM. All providers who are billing for services for Medicaid managed care enrolled beneficiaries should enroll with ODM through its PNM system. 42 CFR § 438.602 requires ODM to "screen and enroll, and periodically revalidate, all network providers of MCOs." Federal regulations allow for a 120-day temporary agreement for providers who require more time to enroll in the PNM system. To complete the temporary 120 agreement while you wait for your ODM enrollment to process you must complete the ODM **10295 form**.

Provider education and training resources for PNM, including how to enroll, are located on ODM's website at **PSE Provider Registration Portal - Resources (maximus.com)**.

Humana Healthy Horizons Provider Call Center

The Humana Healthy Horizons in Ohio Provider Services center is available Monday through Friday, 7 a.m. to 8 p.m. Eastern time, by calling **877-856-5707**. Humana Healthy Horizons uses an IVR line to assist providers with questions and requested information including contracting process and contracting status.

Credentialing/recredentialing process

ODM credentialing process

Credentialing is done by ODM for any provider.

ODM is responsible for credentialing all Medicaid managed care providers. The credentialing and recredentialing processes are paired with enrollment and revalidation, respectively, in ODM's PNM system. This process adheres to National Committee for Quality Assurance (NCQA) and Centers for Medicare & Medicaid Services (CMS) federal guidelines for both processes and the types of providers who are subject to the credentialing process.

Please note: Providers are not able to render services to Medicaid members until they are fully screened, enrolled and credentialed (if required) by Ohio Medicaid. For a complete list of provider types that require credentialing, please refer to OAC rule 5160-1-42.

For individual providers, the general guidance is that licensed providers who can practice independently under state law are required to go through Ohio Medicaid's credentialing process. Medical students, residents, fellows and providers who practice strictly in an inpatient setting are exempt from credentialing. It is recommended that providers begin the contracting process with each MCO they want to participate with while enrolling and being credentialed with ODM to render services as of their effective date. While the credentialing process is centralized at the state Medicaid level, providers are still required to contract with the MCOs.

When providers submit their initial application to be an Ohio Medicaid provider, they can designate MCO interest in the PNM system. Once your application is submitted, demographic data for your provider is transmitted automatically to the MCOs so they can start contracting with you.

Delegated services, policies and procedures

Scope

The guidelines and responsibilities outlined in this appendix are applicable to all contracted Humana delegated entities (delegate). The policies in Humana Healthy Horizons in Ohio's Provider Manual (i.e., manual) also apply to delegated entities. ODM must approve any delegation of Humana's responsibilities under the Next Generation Provider Agreement.

The information provided is designed primarily for the delegate's administrative staff responsible for the implementation or administration of certain functions that Humana has delegated to an entity.

Oversight

Although a health plan can delegate the authority to perform a function, it cannot delegate the responsibility or accountability for ensuring the function is performed in an appropriate and compliant manner. Since Humana Healthy Horizons remains responsible for the performance and compliance of any function that is delegated, Humana Healthy Horizons must provide oversight of the delegate.

Oversight is the formal process through which Humana Healthy Horizons performs auditing and monitoring of the delegate's:

- Ability to perform the delegated function(s) on an ongoing basis
- Compliance with accreditation organization standards, state and federal rules, laws and regulations, Humana policies and procedures, as well as their underlying contractual requirements pertaining to the provision of healthcare services
- Financial soundness (if delegated for claims adjudication and payment)

The delegation process begins with Humana Healthy Horizons performing a pre-delegation audit prior to any function being delegated to a prospective entity, which includes evaluation of a prospective delegate's compliance and performance capacity. After approval and the execution of a delegation agreement, Humana Healthy Horizon will perform an annual audit on an ongoing basis until the delegation agreement is terminated. At a minimum, these audits include a review of the following applicable items:

- Policies and procedures

- Program descriptions and work plans
- Forms, tools and reports
- Sub-delegation agreements
- Audit(s) of contracted sub-delegate's program, including policies, procedures and program documents
- Letters of accreditation
- Financial solvency (claims delegation only)
- File audit
- Federal/state exclusion screenings
- Offshore contracting

Humana Healthy Horizons continues to monitor all delegated entities through the collection of periodic reporting outlined within the delegation agreement. Humana Healthy Horizons provides the templates and submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or updated Humana Healthy Horizons standards. All changes are communicated to the delegate at such time.

Corrective action plans

Failure of the delegate to adequately perform any of the delegated functions in accordance with Humana Healthy Horizons requirements, federal and state laws, rules and regulations or accreditation organization standards, may result in a written corrective action plan (CAP). The delegate must then provide a written response describing how they plan to meet the requirements in which it was found to be noncompliant, including an expected remediation date of compliance.

Humana Healthy Horizons cooperates with the delegate or its subcontractors to correct any failure. Any failure by the delegate to comply with its contractual requirements found in this manual, or any request by Humana Healthy Horizons for the development of a CAP, may result, at Humana Healthy Horizons' discretion, in the immediate suspension or revocation of all or any portion of the functions and activities delegated. This includes withholding a portion of the reimbursement or payment under the contract agreement.

Humana legal, regulatory and accreditation requirements

The delegate must comply with the following requirements:

- Submit any material change in the performance of delegated functions to Humana Healthy Horizons for review and approval prior to the effective date of the proposed changes.
- Obtain and maintain, in good standing, a third-party administrator license/certificate and/or a utilization review license or certification (if required by state and/or federal law, rule or regulation).
- Ensure personnel who carry out the delegated services have appropriate training, licensure and/or certification.
- Adhere to Humana Healthy Horizons' record retention policy for all delegated function documents, which is 10 years (identical to the CMS requirement).

Sub-delegation

The delegate must have Humana Healthy Horizons' prior written approval for any sub-delegation by the delegate of any functions and/or activities and notify Humana Healthy Horizons of any changes to functions being delegated. The delegate must provide Humana Healthy Horizons with documentation of the pre-delegation audit that delegate performed of the subcontractor's compliance with the functions and/or activities to be delegated.

In addition, Humana Healthy Horizons must notify CMS within 30 days of the contract signature date of any location outside the United States or a U.S. territory that receives, processes, transfers, stores or accesses Medicare beneficiary protected health information in oral, written or electronic form.

Please note: State Medicaid contracts generally prohibit Medicaid enrollee data from leaving the United States or U.S. territory, so any form of sub-delegation must be approved by the appropriate Medicaid and regulatory compliance team.

If Humana Healthy Horizons approves the sub-delegation, the delegate provides Humana Healthy Horizons documentation of a written sub-delegation agreement that:

- Is mutually agreed on.
- Describes the activities and responsibilities of the delegate and the sub-delegate.
- Requires at least semiannual reporting of the sub-delegate to the delegate.
- Describes the process by which the delegate evaluates the sub-delegate's performance.

- Describes the remedies available to the delegate if the sub-delegate does not fulfill its obligations, including revocation of the delegation agreement.
- Allows Humana Healthy Horizons access to all records and documentation pertaining to monitoring and oversight of the delegated activities.
- Requires delegated functions be performed in accordance with Humana Healthy Horizons' and delegate's requirements, state and federal rules, laws and regulations and accreditation organization standards and is subject to the terms of the written agreement between Humana Healthy Horizons and the delegate.
- Retains Humana Healthy Horizons' right to perform evaluation and oversight of the subcontractor.

The delegate is responsible for providing adequate oversight of the subcontractor and any other downstream entities.

The delegate must provide Humana Healthy Horizons with documentation of such oversight prior to delegation and annually thereafter. Humana Healthy Horizons retains the right to perform additional evaluation and oversight of the subcontractor if deemed necessary by Humana Healthy Horizons. Furthermore, Humana Healthy Horizons retains the right to modify, rescind or terminate, at any time, any one or all delegated activities, regardless of any sub-delegation previously approved.

The delegate agrees to monitor the subcontractor for federal and state government program exclusions on a monthly basis for Medicaid providers and maintain such records for monitoring activities. If the delegate finds that a provider, subcontractor or employee is excluded from any federal and/or state government program, they are removed from providing direct or indirect services for Humana Healthy Horizons members immediately.

Appeals and grievances

Humana Healthy Horizons member appeals/grievances and expedited appeals processes are not delegated, including any appeal made by a physician/provider on the member's behalf, except clinical decision making in certain special circumstances. Therefore, the delegate must:

- Forward all standard member appeals/grievances to Humana within 1 business day by calling **877-856-5702** or faxing **800-949-2961**.
- Forward all expedited appeals immediately on notification/receipt by calling **877-856-5702** or faxing **800-949-2961**.
- Provide the following information when forwarding member appeals or grievances: date and time of receipt, member information, summary of the appeal or grievance, all denial information, if applicable, and summary of any actions taken, if applicable.
- Promptly effectuate the appeal decision as rendered by Humana Healthy Horizons and support any requests received from Humana Healthy Horizons in an expedited manner.
- Handle all participating physician, provider, hospital and other healthcare professional provider claim payment and payment denial disputes. Humana Healthy Horizons handles all non-participating physician, practitioner, hospital and other healthcare professional provider claim payment and payment denial disputes or requests for reconsiderations.

Utilization Management delegation

Delegation of UM is the process by which the delegated entity evaluates the necessity, appropriateness and efficiency of healthcare services provided to members. Generally, a review coordinator gathers information about the proposed hospitalization, service or procedure from the patient and/or provider, then determines whether it meets established guidelines and criteria. Reviews can occur prospectively, concurrently (including urgent/emergent) and/or retrospectively.

Utilization Management activities and responsibilities

All delegates performing UM activities must comply with and meet the rules and requirements for processing of UM requests established or implemented by the state. In addition, they must conduct all UM activities in accordance with NCQA standards, the member's plan, and Humana Healthy Horizons in Ohio's policies and procedures. Humana Healthy Horizons retains the right and final authority to review decisions for its members regardless of any delegation of such functions or activities to delegate. Refer to your delegation agreement for specifics.

Delegates are responsible for the following activities regarding initial standard and expedited/urgent determinations:

- Maintain policies and procedures that address all aspects of the UM process including a member's right to a second opinion.
  - Policies and procedures must be formally reviewed, revised, dated and signed annually. Effective dates are present on policies or on a policy master list.

- Utilize Humana Healthy Horizons' prior authorization list (PAL)
  - If the delegate is delegated for both UM and claim payment, the delegate may develop their own PAL. However, the delegate's PAL may not be more stringent than Humana Healthy Horizons' PAL. If the delegate is not delegated to process claims on Humana Healthy Horizons' behalf, the delegate must utilize Humana Health Horizons' PAL.
- Perform preadmission review and authorization, including medical necessity determinations based on approved criteria, specific benefits and member eligibility.
- Perform UM activities for outpatient/ambulatory care.
- Perform UM activities for out-of-service areas and out-of-network providers as dictated by the contract.
- Maintain documentation of pertinent clinical information gathered to support the decision.
- Understand that all UM files and supporting documentation are Humana Healthy Horizons' property.
  - Should the contract between the delegate and Humana Healthy Horizons be dissolved for any reason, the delegate is expected to make available to Humana Healthy Horizons either the original or quality copies of all UM files for Humana Healthy Horizons members.
- Use Humana Healthy Horizons' step therapy preauthorization list when implementing a step therapy regimen.
- Perform UM activities for out-of-service areas and out- of-network providers as dictated by contract.
- Notify member, facility and provider of decision on initial determination using Humana Healthy Horizons approved letter templates.
- The delegate is to perform the following concurrent review activities relevant to inpatient and SNF stays:
  - Provide on-site or telephone review for continued stay assessment using approved criteria.
  - Identify potential quality-of-care concerns including sentinel events and never events, and notification to the local health plan for review within 24 hours of identification or per contract. Humana Healthy Horizons does not delegate quality-of-care determinations.
  - Provide continued stay determinations and maintain a denial log for submission to Humana Healthy Horizons as directed.
  - Notify member, facility and provider of decision on concurrent determination.

The delegate performs discharge planning and retrospective review activities related to inpatient and SNF stays. The delegate also conducts retrospective review functions as related to ambulatory care.

The delegate will provide applicable UM reporting requirements outlined within the contract and related addenda or attachments. Humana Healthy Horizons will provide the template and submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or Humana Healthy Horizons standards. Any changes will be communicated to the delegate at such time.

In full-risk arrangements, Humana Healthy Horizons will perform UM when review decisions by the delegate are not timely, are contrary to medical necessity criteria and/or when Humana Healthy Horizons must resolve a disagreement among the delegate, providers and the member. In some local health plans, Humana Healthy Horizons may assume total responsibility for this function. Refer to your delegation agreement for specifics.

Population health management delegation

Delegation of population health management (PHM) must include the following:

- **Complex case management:** Complex case management (CCM) is the coordination of care and services provided to members who experience a critical event or diagnosis that requires extensive use of resources and who need help navigating the healthcare system to facilitate appropriate delivery of care and services.
- **Disease management:** Disease management (DM) is a multidisciplinary, continuum-based approach to healthcare delivery that proactively identifies populations with, or at risk for, established medical conditions.

Delegate should provide applicable PHM reports as outlined within the contract and related addenda or attachments. Humana Healthy Horizons provides the template and submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or Humana Healthy Horizons standards. All changes are communicated to the delegate at such time.

Claims delegation

Claims delegation is a formal process by which a health plan gives a participating provider (i.e., a delegate) the authority to process claims on its behalf. Humana Healthy Horizons retains the right and final authority to pay all claims for its members regardless of any delegation of such functions or activities to delegate. Amounts authorized for payment

by Humana Healthy Horizons of such claims may be charged against the delegate's funding. Refer to your provider agreement for funding arrangement details.

Claims performance requirements: All delegates performing claims processing functions must comply with the rules and requirements for the processing of all Medicaid claims established or implemented by the state.

In addition, delegates must conduct claims adjudication and processing in accordance with the member's plan and Humana Healthy Horizons' policies and procedures. Delegate must meet, at a minimum, the following claims adjudication and processing requirements:

- Delegate must accurately process at least 95% of all delegated claims according to Humana Healthy Horizon requirements and in accordance with state and federal laws, rules and regulations and/or any regulatory to which Humana Healthy Horizons is subject.
- Delegate must process all claims in accordance with state and federal prompt pay requirements to which Humana Healthy Horizons is subject.
- Delegate must pay any and all interest amounts on claims in accordance with applicable state and federal requirements.
- Delegate must maintain an accuracy rate of 99% of total dollars paid, for any given calendar month.
- Delegate must meet applicable state and/or federal requirements to which Humana Healthy Horizons is subject for denial and appeals language in all communications made to members and use Humana Healthy Horizons' member letter template.
- Delegate should use and maintain a claims processing system that meets current legal, professional and regulatory requirements.
- Delegate must submit claim/encounter data in the format defined in the Process Integration Attachment.
- Delegate must use Humana Healthy Horizons' member letter templates for all member-facing communications.
- Delegate should print its name and logo on applicable written communications, including letters or other documents, related to adjudication or adjustment of member benefits and medical claims.
- Delegation should forward all nonparticipating reconsideration requests to Humana Healthy Horizons on receipt.
- Delegate must provide a financial guarantee, acceptable to Humana Healthy Horizons, prior to implementation of any delegation of claims processing, such as a letter of credit, to ensure its continued financial solvency and ability to adjudicate and process claims. Delegate must submit appropriate financial information on request as proof of its continued financial solvency.
- Delegate should provide applicable claim reports as outlined within the contract and related addenda or attachments. Humana Healthy Horizons provides the template and submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or Humana Healthy Horizons standards. Any changes are communicated to the delegate at such time.
- Delegate must retain and maintain legal, claims and encounter documents for the period of time and in the manner required by state and federal law or Humana Healthy Horizons, including, without limitation, HIPAA and/or all requirements of regulatory or accreditation organization to which Humana Healthy Horizons is subject, whether voluntarily or not. Delegate must make available, as requested by Humana Healthy Horizons, all original files, records and documentation pertaining to Humana Healthy Horizons members, or copies thereof on the termination of the performance of delegated functions and/or the expiration, nonrenewal or termination of the agreement, regardless of the cause.

Continuous quality improvement delegation

All delegates are expected to function within a framework of continuous quality improvement and cooperate with Humana Healthy Horizons' quality improvement program. Additionally, some managed behavioral health organizations (MBHOs), or other entities, may be delegated for a formal quality improvement function. This includes the following:

- Select quantifiable standards, goals and benchmarks for each monitoring activity.
- Collect, analyze and discuss data for each monitoring activity. At a minimum, the delegate's quality improvement committee should discuss the data. Humana Healthy Horizons should approve data collection methods.
- Plan and implement corrective actions to improve performance.
- Re-measure to determine success of corrective action interventions.
- Cite quantifiable care and service improvements related to the tracking and trending of Humana Healthy Horizons members.

Covered services

General services

It is the responsibility of Humana Healthy Horizons to notify ODM as soon as they become aware of medical situations in which the ODM medical policy isn't clearly defined. ODM recognizes that these medical situations may occur from time to time and will address on a case-by-case basis.

More detailed information on Medicaid policy for services and benefits may be found in the corresponding provider manual for each service and provider type. These manuals are available electronically on ODM's website at **https://medicaid.ohio.gov**.

Humana Healthy Horizons in Ohio is required to provide its Medicaid members "medically necessary" care, at the very least, at current limitations for the services listed below. Medically necessary services are those services utilized in the Ohio Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Ohio statutes and regulations, the state plan, and other Ohio policies and procedures. While appropriate and necessary care must be provided, Humana Healthy Horizons is not bound by the current variety of service settings.

List of covered services – covered services/core benefits

- Acupuncture
- Allergy services
- Ambulance and ambulette services
- Ambulatory surgical center services
- Audiology services
- Behavioral health services
- Blood glucometers and blood glucose test strips
- Chiropractic services
- Dental services
- Developmental therapy
- Durable medical equipment (DME) and medical supplies
- Emergency/post-stabilization services
- Family planning services and supplies
- Free-standing birth center services
- Home health and private-duty nursing services
- Hospice care
- Immunizations
- Inpatient hospital services
- Laboratory and X-ray services
- Medical and surgical services, including but not limited to those provided by physicians, physician assistants, nurse practitioners, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Outpatient Health Facilities (OHF)
- Medical nutrition therapy services
- Nursing facility stays for aged, blind and disabled (ABD) and modified adjusted gross income (MAGI) members
- Occupational therapy
- Outpatient hospital services
- Physician-administered drugs and services provided by pharmacist providers
- Pharmacy/prescription drugs
- Physical therapy
- Podiatry services
- Pregnancy services, including nurse midwife and doula services
- Preventive services
- Renal dialysis services
- Respite services for Supplemental Security Income (SSI) members younger than 21 with long-term care or behavioral health needs
- Screening and counseling for obesity

- Screening, diagnosis, and treatment services for children younger than 21 through Healthchek, Ohio's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.
- Services for members with a primary diagnosis of autism spectrum disorder (ASD)
- Speech therapy
- Substance use disorder treatment services
- Targeted case management services
- Telemedicine services
- Transportation
- Vision care services, including eyeglasses
- Additional services

Behavioral health and substance-use services

Behavioral health and substance-use services are covered services for Humana Healthy Horizons members. Humana Healthy Horizons recognizes that behavioral health and physical health function as a part of the whole person, and one can affect the other. Therefore, we use a holistic approach to address behavioral health and substance use. Humana Healthy Horizons is not required to cover behavioral health services for members enrolled in the OhioRISE plan, except for certain behavioral health services in accordance with the OhioRISE Mixed Services Protocol developed by ODM.

Humana Healthy Horizons provides a comprehensive range of behavioral health services, including:

- Outpatient coverage for medication management, therapy services (individual, group and family therapy) and case management offered through key providers
- A broad range of high-intensity services for both behavioral health and substance dependence disorders, including:
  - Peer support services
  - Care management/care coordination services (community psychiatric supportive treatment, therapeutic behavioral services, psychosocial rehabilitation, substance use disorder case management)
  - Mental health day treatment
  - Substance-use disorder intensive outpatient
  - Substance-use disorder partial hospitalization
  - Crisis stabilization
  - Substance-use disorder residential treatment
  - Long- and short-term inpatient stays based on medical necessity

Providers, members or other responsible parties can call Humana Healthy Horizons at **877-856-5707** to verify available behavioral health and substance use benefits and to seek a referral or direction for obtaining behavioral health and substance use services.

Humana Healthy Horizons' network focuses on improving the health of our members through efforts aimed at increasing well-being and using person-centered, evidence-based practices. Our goal is for our members to receive the highest level of care needed by the member in the least restrictive setting – the right care, at the right time and in the right setting.

Screening and evaluation

Humana Healthy Horizons requires PCPs to have screening and evaluation procedures in place for the detection and treatment of, or referral for, known or suspected behavioral health problems and disorders.

PCPs may provide clinically appropriate behavioral health services within the scope of their practice. When assessing members for behavioral health services, Humana Healthy Horizons and its providers must use the most current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) classification. Humana Healthy Horizons may require use of other diagnostic and assessment instrument/outcome measures in addition to the most current version of DSM. Providers should document DSM diagnosis and assessment/outcome information in the member's medical record.

Humana Healthy Horizons provides training to network PCPs on how to screen and identify behavioral health disorders, Humana Healthy Horizons' behavioral health services referral process and on clinical coordination requirements for such services. Humana Healthy Horizons also includes coordination and quality-of-care training, education on the OhioRISE program for multi-system youth, and new models of behavioral health interventions.

List of covered services – value-added benefits

Humana Healthy Horizons offers members extra benefits, tools and services, at no cost to the member, that are not otherwise covered or that exceed limits outlined in the Ohio Plan and Ohio Medicaid Fee Schedules. These added benefits are in excess of the amount, duration and scope of those services listed above.

In instances where an added benefit also is a Medicaid covered service, Humana Healthy Horizons administers the benefit in accordance with all applicable service standards pursuant to our contract, the Ohio Medicaid State Plan and all Medicaid coverage and limitations handbooks.

Humana Healthy Horizons Medicaid members have specific enhanced benefits:

Value-added benefit	Details and limitations
Baby and Me Meals	Up to 2 pre-cooked home-delivered meals per day for 10 weeks for pregnant members who are high risk.
Caregiver assistance	**Childcare support includes:** • Support to identify childcare options, including childcare centers, family day care homes, nanny agencies, babysitter search tools, back-up/on-demand childcare • Special needs support information: support groups, advocates, childcare for special needs children, socialization groups, special needs services (e.g., ABA therapy) **Counseling and caregiving support includes:** • Behavioral health counseling and support for caregivers of a Humana Healthy Horizons member (up to 3 sessions). Authorization is required. **Legal and financial support includes:** • Support for do-it-yourself document preparation - Wills/living wills • Consultations with attorneys, mediators, CPAs and financial professionals • Under the legal/financial piece of the MAP program, members have access to free 30-minute consultations with attorneys/financial consultants, depending on the issue for which they seek support. Members also can receive support for budget preparation through this service, and if members need to retain an attorney, the program (and pricing) includes a 25% discount for the legal services.
Childcare assistance	For members 14 and older, up to $50 per quarter, up to 4 times per year, for reimbursement for childcare expenses for caretakers who are seeking employment. Member must participate in a workforce program to be eligible.
Convertible car seat or portable crib	Pregnant members who enroll and actively participate in our HumanaBeginnings® Care Management program and complete a comprehensive assessment and at least 1 follow-up call with a HumanaBeginnings care manager can select 1 convertible car seat or portable crib per infant, per pregnancy.
Dental services	1 dental cleaning annually for members 21 and older.
GED testing	General Educational Development (GED) test preparation assistance for members 16 and older, including a bilingual advisor, access to guidance and study materials and unlimited use of practice tests. Test preparation assistance is provided virtually to allow maximum flexibility for member. Also includes test pass guarantee to provide member multiple attempts at passing the test. 16–18 years: must provide additional documentation. Underage test-takers must enroll in the state's official Adult Education Program and take free classes until they are ready to sit for the exam. They also need documentation from the school system that indicates they officially withdrew.

Value-added benefit	Details and limitations
Home-based asthma interventions	Asthmatic members in the Humana Healthy Horizons care or disease management programs can receive an allowance of up to $200 per year to alleviate the cost of services such as allergen-free bedding, carpet cleaning and/or an air purifier.
Housing assistance	For members 18 and older, up to $500 per member per year to assist with the following housing expenses: • Apartment rent or mortgage payment (late payment notice required) • Utility payment for electric, water or gas (late payment notice required) • Trailer park and lot rent if it's the member's permanent residence (late payment notice required) • Moving expenses via licensed moving company when transitioning from a public housing authority Plan approval required: • Member must not live in a residential facility or nursing facility • Funds are not paid directly to the member If the bill is in the spouse's name, a marriage certificate may be submitted as proof.
Post-discharge meal	14 refrigerated home-delivered meals following discharge from an inpatient or residential facility, limited to 4 discharges per year.
Smartphone services	With a smartphone, members have easy access to health-related information and can stay connected to their care team and health plan. Any member who qualifies for the Federal Lifeline program will be eligible to receive a free cell phone with monthly talk minutes, text and data.
Tobacco and vaping cessation coaching	The tobacco cessation is focused on tobacco and vaping cessation coaching for members 12 and older. The program is designed as a 6-month engagement for a total of 8 coaching calls, but members have 12 months to complete the program if needed. Humana Healthy Horizons' tobacco and vaping cessation health coaching program offers support for both over the counter (OTC) and prescription nicotine replacement therapy (NRT) for members 18 and older.
Transportation	All members receive up to 15 round trips (or 30 one-way trips) up to 30 miles for non-medical transportation per year to locations such as social support groups, wellness classes, WIC and SNAP appointments, and food banks. This benefit also offers transportation to locations providing social benefits and community integration for members such as community and neighborhood centers, parks, recreation areas and churches. All members receive 30 one-way (15 round) trips that are less than 30 miles per calendar year. (Case manager approval not required) for non-emergency medical transportation (NEMT) A. Trips in this category include: • Doctor, dental and vision appointments B. Additional transportation may be available for members enrolled in Humana Healthy Horizons case management programs • BH/SUD: Must be actively engaged in one of the following courses of treatment: • Outpatient and residential BH services • Intensive outpatient treatment (IOP) • Coverage for parents to visit their child in the NICU and parents to visit their child in a residential or inpatient BH facility

Value-added benefit	Details and limitations
	C. Unlimited chronic conditions requiring in-person treatment (care manager not necessary): • Dialysis • Organ transplant • Radiation chemotherapy • Wound care • Diabetes management • Prenatal trips • Hospital discharge • Urgent care • Postpartum trips (up to 12 months to doctor appointments)
Weight- management coaching	Weight-management coaching delivers weight management intervention for members 12 and older. Upon receiving physician clearance, the member can complete six weight-management coaching sessions with a wellness coach; approximately one call per month for a period of six months.
Vision services	For members 21-59: • 1 eye exam per year • Up to $200 allowance for one set of glasses (frames and lenses) or contacts (not both) during the plan year • Member pays any cost more than $200

List of covered services – incentive programs

Go365 for Humana Healthy Horizons©

Go365 for Humana Healthy Horizons is a wellness program that offers members the opportunity to earn rewards for taking healthy actions. Most of the rewards are earned by Humana Healthy Horizons' receipt of the provider's claim for services rendered.

Humana Healthy Horizons recommends that all providers submit their claims on behalf of a member by March 15, 2026. This allows the member time to redeem their reward. A member has 90 days from one plan year to another, assuming they remain continuously enrolled, to redeem their rewards.

Go365 is available to all members who meet the requirements of the program. Rewards are not used to direct the member to select a certain provider. Rewards are non-transferrable to other managed care plans or other programs, and have no cash value. E-gift cards may not be used for tobacco, alcohol, firearms, lottery tickets and other items that do not support a healthy lifestyle.

Members can qualify to earn rewards by completing one or more of the following healthy activities:

Healthy activity	Reward
Annual wellness visit	Annual $50 reward for members 3 and older for completing a wellness visit with a primary care provider (PCP)
Health risk assessment (HRA) completion	One-time $30 reward for completing a health risk assessment. Must be completed within 90 days of enrollment.
Breast cancer screening	Annual $50 reward for members 40 and older who obtain a mammogram.
Cervical cancer screening	Annual $50 reward for members 21 and older who obtain a Pap test.
Chlamydia screening	Annual $25 reward for members who obtain a chlamydia screening when sexually active and as recommended by their healthcare provider.

Healthy activity	Reward
Colorectal cancer screening	Annual $25 reward for members 45 and older who obtain a colorectal cancer screening as recommended by their PCP.
Diabetic retinal exam	Annual $25 reward for diabetic members 21 and older who complete a retinal eye exam.
Diabetic screening	Annual $30 reward for diabetic members 21 and older who obtain a screening with their PCP for HbA1c.
Digital onboarding	One-time $10 reward for downloading the Go365 for Humana Healthy Horizons app and completing registration.
Flu vaccine	Annual $20 reward for members who receive an annual flu vaccine from their provider or pharmacy, or if the member self-reports after receiving the vaccine from another source.
Follow-up after high-intensity care for substance use disorder	$25 reward for members who received follow-up care within 30 days of an inpatient hospital discharge, residential treatment or detoxification visit for a diagnosis of substance use disorder.
Follow-up after hospitalization for mental illness	$25 reward for members who received follow-up care within 30 days after a hospital discharge for a diagnosis of select mental illnesses or intentional self-harm.
Human papillomavirus (HPV) vaccine	One-time $30 reward for members who receive 2 doses of the HPV vaccine between their 9th and 13th birthdays.
Level of care video	Annual $5 reward after watching a short educational video about when to access the emergency room.
Notification of Pregnancy (NOP)	$25 reward when pregnant members notify Humana Healthy Horizons of pregnancy prior to delivery, in the Go365 for Humana Healthy Horizons app. Available to pregnant members once per pregnancy.
Postpartum visit	$50 reward for all postpartum members who complete 1 postpartum visit within 7 to 84 days after delivery. Available to members once per pregnancy.
Prenatal visit	Pregnant members can earn $10 per prenatal visit, up to 10 prenatal visits, for a total of up to $100. Available to pregnant members once per pregnancy.
Tobacco & vaping cessation coaching	Members 12 and older who enroll in the tobacco and vaping cessation program have 2 opportunities to earn rewards annually: • $25 reward for completing 2 calls within 45 days of enrollment in the program • $25 rewards for completing the full program
Weight management coaching	Members who enroll in weight management coaching have 2 opportunities to earn rewards: • $15 reward for completing a wellbeing check-up • $15 reward for completing the program
Well-baby visits (0-15 months)	Up to $60 in rewards for members who complete routine well-child visits. Members can receive $10 in rewards per visit with a 6-visit limit.
Well-child visits (16-30 months)	Up to $20 in rewards for members who complete routine well-child visits. Members can receive $10 in rewards per visit with a 2-visit limit.

Pharmacy

Humana Healthy Horizons provides coverage of medically necessary medications prescribed by Medicaid-certified licensed prescribers in the state. Humana Healthy Horizons adheres to state and federal regulations on medication coverage for our members. Humana Healthy Horizons and other health plans in the state are required to use a single pharmacy benefit manager (SPBM), Gainwell Technologies. For more information about Ohio's SPBM, please refer to the SPBM section in this manual. Humana Healthy Horizons is not required to cover pharmacy services other than the limited pharmacy services described in this manual. All other pharmacy benefits are covered by ODM's SPBM.

Drug coverage
Gainwell Technologies utilizes a uniform preferred drug list (PDL) and UM, developed by ODM. ODM notifies providers of changes to the PDL, found at **https://medicaid.ohio.gov/stakeholders-and-partners/phm**.

Gainwell is responsible for providing pharmacy benefits, including prior authorizations, for all Ohio Medicaid individuals.

Copay
Medicines on the PDL have a $0 copay when filled at a network pharmacy.

Medication therapy management
Humana Healthy Horizons offers a medication therapy management (MTM) program that helps ensure patients achieve the best possible outcomes from their medications. The patient-centered MTM program promotes collaboration between the pharmacist, patient and prescriber to optimize safe and effective medication use. The goal of this program is to optimize therapeutic outcomes by focusing on safety, effectiveness, lower-cost alternatives and adherence.

Prescribers with questions about the program may call **888-210-8622 (TTY: 711)**, Monday through Friday, from 8 a.m. to 7 p.m., Eastern time.

Coordinated services program
The coordinated services program (CSP) is designed for individuals enrolled in Humana Healthy Horizons who need help managing their use of prescription medications. It is intended to limit overuse of benefits and reduce unnecessary costs to Medicaid while providing an appropriate level of care for the member. Members who meet the program criteria are locked into one specific pharmacy location initially for a total of 2 years. Members receive written notification from Humana Healthy Horizons, along with the designated lock-in pharmacy's information and the member's right to appeal the plan's decision. Members are notified as to whether the request for the change is approved or denied.

Excluded from enrollment in CSP are members who:
- Have a current diagnosis of cancer and receive chemotherapy or radiation treatment
- Resides in a long-term care facility
- Receives hospice services
- Are enrolled in both Medicaid and Medicare programs

Requirements regarding the submission and processing of requests for specialist referrals

Humana Healthy Horizons members may see any participating network provider, including specialists and inpatient hospitals. Humana Healthy Horizons does not require referrals from PCPs to see participating specialists; however, prior authorization must be obtained for nonparticipating providers. Members may self-refer to any participating provider. PCPs do not need to arrange or approve these services for members, as long as applicable benefit limits have not been exhausted.

Second opinions from nonparticipating providers
A second opinion is not required for surgery or other medical services. However, providers or members may request a second opinion at no cost. The following criteria should be used when selecting a provider for a second opinion.

The second opinion provider:
- Must participate in the Humana Healthy Horizons in Ohio network. If not, prior authorization must be obtained.
- Must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.
- Must be in an appropriate specialty area.

Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

Humana Healthy Horizons arranges for out-of-network care if it is unable to provide necessary covered services, a second opinion or if a network healthcare provider is unavailable. In these situations, Humana Healthy Horizons coordinates payment 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.

Transportation vendor contact information

Non-emergency medical transportation

Members can obtain transportation through Humana Healthy Horizons non-emergent medical transportation vendor MTM Health by calling 855-739-5986. Members also can call the Medicaid transportation coordinator at the local county Ohio Department of Job & Family Services (CDJFS) office for trips that are under 30 miles. The main phone number for each CDJFS is included in a list available on ODM's website at **https://jfs.ohio.gov** and selecting "County Directory." Members can also contact Member Services for transportation assistance at **877-856-5702 (TTY: 711)**, Monday through Friday, from 7 a.m. to 8 p.m., Eastern Time.

Transportation policies/coverage

Transportation is covered when the member must travel 30 miles or more from the member's home to receive a medically necessary Medicaid-covered service provided by Humana Healthy Horizons and pharmacy services provided by the SPBM. The plan also covers non-ambulatory transportation.

Transportation services for members enrolled in OhioRISE

The MCO must arrange and provide transportation for members who are enrolled with the OhioRISE plan in a manner that ensures that children, youth and families served by the OhioRISE plan do not face transportation barriers to receive services regardless of Medicaid payer. The MCO is responsible for arranging transportation in cases when transportation of families, caregivers and siblings (or other minor residents of the home) is needed to facilitate treatment needs of the member, even when the member is not being transported.

Emergency and post-stabilization care services

In accordance with Section 1852(d)(2) of the Social Security Act and 42 C.F.R. §§ 438.114(b), 422.113(c), and 438.114(d), Humana Healthy Horizons must cover and pay for emergency and post-stabilization care services. This includes ensuring the determination of the attending emergency physician, or the provider treating the member, when the member is sufficiently stabilized for transfer or discharge is binding on the plan and the state for coverage and payment of emergency and post-stabilization care services.

1.6.18.1 Emergency Services – In accordance with Section 1932(b)(2) of the Social Security Act and 42 C.F.R. §§ 438.114(c)(1)-(2) and 438.114(c)(1)(ii)(A)-(B), Humana Healthy Horizons must:

- Pay non-participating providers for emergency services no more than the amount that would have been paid if the service had been provided under Ohio's fee-for-service Medicaid program.
- Cover and pay for emergency services regardless of whether the provider that furnished the services has a contract with the plan.
- Not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual (or, for a pregnant person, the health of the person or their unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- Not deny payment for treatment obtained when a representative of the plan instructs the member to seek emergency services.
- Provide coverage and payment for services until the attending emergency provider, or the provider actually treating the member, determines that the member is sufficiently stabilized for transfer or discharge.

In accordance with 42 C.F.R. §§ 438.114(d)(1)-(2), Humana Healthy Horizons must not:

- Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
- Refuse to cover emergency services based on the emergency room provider, hospital or fiscal agent not notifying the member's PCMH or the plan, or applicable state entity of the member's screening and treatment within 10 calendar days of presentation for emergency services.
- Hold a member who had an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose or stabilize the condition.

Definition of Post-Stabilization Care Services

Post-Stabilization Care Services – As defined in OAC rule 5160-26-01, covered services related to an emergency medical condition that a treating provider views as medically necessary after an emergency medical condition has been stabilized

to maintain the stabilized condition, or under the circumstances described in 42 CFR 422.113 to improve or resolve the member's condition. For assistance obtaining coverage and payment for emergency and post-stabilization services, including behavioral health post stabilization services, please call Provider Services at 877-856-5707.In accordance with 42 C.F.R. §§ 438.114I, 422.113(c)(2)(i)-(ii), and 422.113(c)(2)(iii)(A)-(C), Humana Healthy Horizons must cover post-stabilization care services that are:

- Obtained within or outside its network that are:
  - Pre-approved by a plan provider or representative.
  - Not pre-approved by a plan provider or representative but administered to maintain the member's stabilized condition within 1 hour of a request to the plan for pre-approval of further post-stabilization care services.
- Administered to maintain, improve or resolve the member's stabilized condition without preauthorization, and regardless of whether the member obtains the services within the Humana Healthy Horizons network when the plan:
  - Did not respond to a request for pre-approval within 1 hour.
  - Could not be contacted.
  - Representative and the treating physician could not reach agreement concerning the member's care and a plan provider was not available for consultation.

In accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c) (2)(iv), Humana Healthy Horizons must limit charges to member for post-stabilization care services to an amount no greater than what Humana Healthy Horizons would charge the member if they obtained the services through a Humana Healthy Horizons-contracted provider.
In accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c) (3)(i)-(iv), Humana Healthy Horizons' financial responsibility for post-stabilization care services, if not pre-approved, ends when:

- A Humana Healthy Horizons-contacted provider with privileges at the treating hospital assumes responsibility for the member's care.
- A Humana Healthy Horizons-contracted provider assumes responsibility for the member's care through transfer.
- A Humana Healthy Horizons representative and the treating provider reach an agreement concerning the member's care.
- The member is discharged.

Early and Periodic Screening, Diagnosis and Treatment and Healthchek

Healthchek is Ohio's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. EPSDT is a federally mandated program developed available to individuals younger than 21 enrolled in Medicaid. All Humana Healthy Horizons members within this age range should receive age-recommended EPSDT preventive exams, health screens and special services needed to address health issues as soon as identified or suspected through an EPSDT visit. Providers must utilize ODM-developed standard screening tools. The screening tools and more information are available at ODM's Healthchek program website at **https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives**. EPSDT benefits are available at no cost to members. On identifying a member as pregnant, Humana Healthy Horizons delivers a pregnancy-related services form as designated by ODM. Specifications of Healthchek components are provided to eligible members, as specified in OAC 5160-1-14.

EPSDT preventive services

Healthchek is designed to provide comprehensive preventive healthcare services at regular age intervals. Regular EPSDT preventive visits find health issues early (including physical health, mental health, growth and developmental) so additional testing, evaluation or treatment can start right away. EPSDT preventive services are available at the recommended ages and at other times when needed.

EPSDT stresses health education to children and their caretakers related to early intervention, health and safety risk assessments at every age, referrals for further diagnosis and treatment of problems discovered during exams and ongoing health maintenance.

Covered services EPSDT preventive exam components include:

- Comprehensive health and development history
- Comprehensive unclothed physical examination
- Laboratory tests, including (where indicated) blood-lead level screening/testing, anemia test using hematocrit or hemoglobin determinations, sickle-cell test, complete urinalysis, testing for sexually transmitted diseases, tuberculin test and pelvic examination

- Developmental screening/surveillance, including autism screening
- Sensory screenings and referrals for vision and hearing
- Nutritional assessment, including body mass index (BMI) and blood pressure
- Dental screenings and referrals to a dentist, as indicated (dental referrals are recommended during a child's first year of life and are required at 2 years and older)
- Psychological/behavioral assessments, substance-use assessments and depression screenings
- Assessment of immunization status and administration of required vaccines
- Health education and anticipatory guidance (e.g., age- appropriate development, healthy lifestyles, accident and disease prevention, at-risk and risk behaviors, and safety)
- Referral for further evaluation, diagnosis and treatment
- Routine screening for postpartum depression should be integrated into well-child visits at 1, 2, 5 and 6 months

EPSDT special services

Under the EPSDT benefit, Medicaid provides comprehensive coverage for all services described in section 1905(a) of the Social Security Act. EPSDT special services include coverage for other medically necessary healthcare, evaluation, diagnostic services, preventive services, rehabilitative services and treatment or other measures not covered under Ohio Medicaid, including:

- Preventive, diagnostic or rehabilitative treatments, or services that are medically necessary to correct or ameliorate the individual's physical, developmental or behavioral condition.
- Medically necessary services available regardless whether those services are covered by Ohio Medicaid.
- Medical necessity is determined on a case-by-case basis.
- EPSDT special services that are subject to medical necessity often require prior authorization.
- Consideration by the payer source must be given to the child's long-term needs, not only immediate needs and consider all aspects such as physical, developmental, behavioral, etc.

EPSDT exam frequency

The Humana Healthy Horizons in Ohio EPSDT Periodicity Schedule is updated frequently to reflect current recommendations of the American Academy of Pediatrics (AAP) and Bright Futures. To view updates to the schedule, please visit **aap.org**.

Infancy:

- Newborn
- 3-5 days
- Younger than 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months

Early childhood:

- 15 months
- 18 months
- 24 months
- 30 months
- 3 years
- 4 years

Middle childhood:

- 5 years
- 6 years
- 7 years
- 8 years
- 9 years
- 10 years

Adolescence and young adults:

- 11 years
- 12 years
- 13 years
- 14 years
- 15 years
- 16 years
- 17 years
- 18 years
- 19 years
- 20 years
- 21 years (through the end of the member's 21st birthday month

Child blood-lead screenings

Federal regulation requires that all children receive a blood test for lead at:

- 12 months and 24 months
- 36 months and 72 months for children who have not had a previous blood-lead screening

This is a required part of the EPSDT exam provided at these ages. Additionally, Ohio law requires all healthcare providers to administer blood-lead tests to children at age 1 and 2, or up to age 6 if no previous test has been completed based on the following criteria: the child is on Medicaid, lives in a high-risk ZIP code, or has certain other risk factors. More information on child lead poisoning and high-risk ZIP codes can be found at the ODH Child Lead Poisoning Program website at **https://odh.ohio.gov/know-our-programs/childhood-lead-poisoning/for-healthcare-providers**.

Immunizations

Immunizations are an important part of preventive care for children and should be administered during well-child/ Healthchek exams as needed. Humana Healthy Horizons in Ohio endorses the same childhood immunization schedule recommended by the CDC and approved by the Advisory Committee on Immunization Practices (ACIP), the Birth-18 Years Immunization Schedule for Healthcare Providers at the CDC's website at **https://www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html**, Bright Futures/American Academy of Pediatrics (AAP) Medical Periodicity Schedule at **https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf** and the American Academy of Family Physicians (AAFP). This schedule is updated annually and current updates can be found on the AAP website at **aap.org**.

Annual Healthchek education

Humana Healthy Horizons provides Healthchek education to all network contracted providers on an annual basis that includes:

- Required components of a Healthchek exam, pursuant to OAC rule 5160-01-14
- A list of the intervals at which members younger than 21 should receive screening examinations, as indicated by the most recent version of the document "Recommendations for Preventive Pediatric Health Care" published by Bright Futures/American Academy of Pediatrics
- A list of common billing codes and procedures related to Healthchek services (e.g., immunizations, well-child exams, laboratory tests, and screenings), available on ODM's website at **https://downloads.aap.org/AAP/PDF/Coding%20Preventive%20Care.pdf**

Additional information on Healthchek can be found at the Ohio Department of Medicaid Healthchek Program website at **Healthchek (ohio.gov)**.

Optimization of pregnancy outcomes: Ohio Perinatal Quality Collaborative

Ohio Perinatal Quality Collaborative (OPQC). OPQC is a statewide consortium of perinatal clinicians, hospitals, policy makers and governmental entities that aim to reduce preterm births and improve maternal and birth outcomes across Ohio. OPQC involves subject matter experts, uses successful evidence-informed strategies and employs data-driven quality improvement methods and project management processes.

Learn more about OPQC on their website at **https://www.opqc.net**.

Pregnancy Risk Assessment Form

The Pregnancy Risk Assessment Communication (PRAF) is Ohio Medicaid's preferred method for providers to notify the state and Humana Healthy Horizons of an individual's pregnancy. You can submit this information via a paper or online form. The form is called PRAF 2.0 online.

The PRAF 2.0:

- Is ODM's preferred notification of pregnancy
- Is the only pregnancy notification that automatically:
  - Updates Medicaid eligibility, which helps to prevent loss of Medicaid coverage during pregnancy
  - Prevents payment delays
  - Notifies us of a pregnancy
  - Assesses for additional patient needs

Submit a completed PRAF 2.0 by visiting Ohio's PRAF 2.0 website at **https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/praf/praf**.

Physicians can find the official ODM PRAF 2.0 online at **https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/praf/praf**.

Benefit manager

DentaQuest

Humana Healthy Horizons contracts with DentaQuest to provide members with routine and value-added dental benefits.

For more information, please call Ohio Provider Relations by phone at **833-615-0432** or send an email to **OHproviderengagement@dentaquest.com**.

EyeMed

Humana Healthy Horizons contracts with EyeMed to provide members with routine and value-added vision benefits.

For more information, please call the EyeMed Provider Call Center at **844-744-3888** or log into EyeMed's Provider Portal (called inFocus) on their website at **https://www.eyemedinfocus.com**.

Tivity

Plan members receive covered chiropractic and acupuncture management services with participating providers through WholeHealth Living, a Tivity company. For more information, providers can call Tivity WholeHealth Living at **888-502-0848** or visit **www.wholehealthpro.com**.

Non-covered services

Humana Healthy Horizons will not pay for services or supplies received that are not covered by Medicaid, including:

- Services that are experimental in nature and are not performed in accordance with standards of medical practice
- Services related to forensic studies
- Autopsy services
- Services for the treatment of infertility
- Abortion services that do not meet the criteria for coverage in accordance with OAC rule 5160-17-01.
- Services pertaining to a pregnancy that is a result of a contract for surrogacy services.
- Assisted suicide and other measures taken actively with the specific intent of causing or hastening death
- Services that do not meet the criteria for coverage set forth in any other rule in OAC Agency 5160.

The following services are not covered by the Ohio Medicaid program:

- Services or supplies not medically necessary
- Treatment of obesity unless medically necessary
- Voluntary sterilization if younger than 21 or legally incapable of consenting to the procedure
- Reversal of voluntary sterilization procedures
- Plastic or cosmetic surgery not medically necessary (These services could be deemed medically necessary if medical complications or conditions, in addition to the physical imperfection, are present)
- Sexual or marriage counseling
- Biofeedback services

- Paternity testing
- Services determined by another third-party payer as not medically necessary
- Drugs not covered by the Ohio Medicaid pharmacy program
- Medical services if the service was caused by a provider-preventable condition
- Non-emergency services or supplies provided by out-of-network providers, unless the member followed the instructions in the Managed Care Plan member handbook for seeking coverage of such services, or unless otherwise directed by ODM.

Telehealth services

The following responsibilities are required by ODM when your office provides telehealth services:

- Telehealth services must be delivered in accordance with all state and federal laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any HIPAA related directives from the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) issued during COVID-19 national emergency and 42 C.F.R. part 2 (Jan. 1, 2020).
- The practitioner site is responsible for maintaining documentation in accordance with HIPAA requirements for the healthcare service delivered through the use of telehealth and to document the specific telehealth modality used.
- Services must be delivered in accordance with rules set forth by their respective licensing board and accepted standards of clinical practice.
- If telehealth services are rendered to a member for a period longer than 12 consecutive months, providers are expected to conduct at least one in-person annual visit or refer the member to a practitioner or their usual source of clinical care that is not an emergency department for an in-person annual visit.
- Telehealth does not replace provider choice and/or member preference for in-person service delivery.
- Telehealth is not considered an alternative to meeting provider network access requirements.

Transplant care management program

Transplant authorizations for transplant evaluation and transplant approvals for Ohio Medicaid recipients are obtained through the Ohio Solid Organ Transplant Consortium or the Ohio Hematopoietic Stem Cell Transplant Consortium.

Humana's transplant care management program serves as a single point of contact for members who require an organ transplant, a stem cell transplant, placement of a ventricular assist device (VAD), total artificial heart (TAH), or immune effector cell therapy (IEC), including chimeric antigen receptor T cell therapy (CAR-T). The Humana transplant services team helps members and their providers navigate transplant care and make informed decisions by:

- Explaining the benefit structure and helping members maximize their benefits (including travel and lodging, if eligible)
- Helping members choose a transplant program
- Dedicating transplant care managers for CM services
- Dedicating specially trained staff to handle claims quickly and efficiently

For further assistance with transplant services, please call 866-421-5663, Monday through Friday, 8 a.m. to 8 p.m., Eastern time, email transplant@humana.com or fax 502-508-9300. Messages left after hours will receive a response the next business day.

Grievance, appeal, and state hearing procedures and time frames

This section outlines the member's appeal rights and grievance process. For provider claim disputes regarding any provider inquiries, complaints, or requests for reconsiderations ranging from general questions about a claim to a provider disagreeing with a claim denial, please see the **Claim Dispute Process section** of this manual.

Grievances (complaints)

Members may file a grievance when they are dissatisfied with Humana Healthy Horizons or a provider.

Providers may assist members in filing a grievance when the member provides written consent. Grievances can be filed verbally or in writing by:

- Calling Member Services at **877-856-5702**
- Filling out a grievance or appeal form online at **https://www.humana.com/medicaid/ohio/support/grievance-or-appeal**

- Writing a letter that includes the following information:
  - Member name
  - Member identification number from the front of the Humana Healthy Horizons ID card
  - Member address and phone number in the letter
  - Explanation of issue

Written grievances:
Mail the form or letter to:
Humana Healthy Horizons in Ohio
Grievance and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546

Fax the form or letter to **800-949-2961**.

Humana Healthy Horizons acknowledges claims-related and non-claims-related grievances within 3 business days of the day the grievance is received.

Following Humana Healthy Horizons' review, a decision letter is sent within:
- 2 business days for grievances related to access to services
- 30 calendar days for non-claim-related grievances
- 60 calendar days for claims-related grievances

Negative actions are not taken against a member who files a grievance or a provider that supports a member's grievance or files a grievance on behalf of a member, with written consent.

Appeals

If the member isn't satisfied with a decision or action Humana Healthy Horizons takes, an appeal can be filed by the member or their authorized representative. Appeals must be filed within 60 calendar days from the date on the Notice of Action (NOA) from us.

Appeals can be filed by:
- Calling Member Services at **877-856-5702**
- Filling out the standardized appeal form
- Writing a letter that includes the following information:
  - Member name
  - Member identification number from the front of the Humana Healthy Horizons ID card
  - Member address and phone number in the letter
  - Any information that will help explain the appeal

Mail the form or letter to:
Humana Healthy Horizons in Ohio
Grievance and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546

Fax the form or letter to **800-949-2961**

Humana Healthy Horizons acknowledges the member's request within 3 business days of the day we receive the appeal.

If we extend the time frame for the appeal we make reasonable efforts to provide prompt oral notice of the delay. Humana Healthy Horizons also sends written notice, within 2 calendar days of the reason for the decision to extend the time frame. We also inform the member of the right to file a grievance if there is disagreement with that decision.

After we complete the review of the appeal, we send a letter within 15 calendar days for standard appeals, advising of our decision.

The member or someone that the member choses can:
- Review all the information used to make the decision
- Provide more information throughout the appeal review process

- Examine the member's case file before and during the appeals process
  - This includes medical, clinical records, other documents and records, and all new or additional evidence considered, relied upon, or generated in connection with the appeal
  - Upon request, this information will be provided, free of charge and sufficiently in advance of the resolution time frame

If the member or appointed representative feel waiting for the 15 calendar-day time frame to resolve an appeal could seriously harm the member's health, they can request that we expedite the appeal. To expedite an appeal, it must meet the following criteria:

- A delay could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain or regain maximum function.

We make decisions on expedited appeals within 72 hours or as fast as needed based on the member's health.

Negative actions will not be taken against:

- A member who files an appeal
- A provider that supports a member's appeal or files an appeal or expedited appeal on behalf of a member with written consent

Humana Healthy Horizons determines within 1 business day of the appeal request whether the expedite criteria is met. We make reasonable efforts to provide a prompt oral notice as well as written notice of the decision to expedite or not expedite the appeal resolution.

If we extend the time frame for the expedited appeal, we make reasonable efforts to provide prompt oral notice of the delay. Humana Healthy Horizons also sends written notice within 2 calendar days of the reason for the decision to extend the time frame. We also inform the member of the right to file a grievance if there is disagreement with that decision.

State fair hearings

Members, or their appointed representative, also have the right to ask for a state fair hearing from the Ohio Department of Job and Family Services (ODJFS) Bureau of State Hearings or local County Department of Job and Family Services (CDJFS) after Humana Healthy Horizons completes its appeal process. Requests must be made within 90 calendar days from the date on the Humana Healthy Horizons' appeal decision letter.

To request a state fair hearing:

- Call: Call the ODJFS Consumer Access Line at **866-635-3748**. Follow the instructions for State Hearings.
- Write:
  ODJFS Bureau of State Hearings
  P.O. Box 182825
  Columbus, OH 43218-2825
- Email: **bsh@jfs.ohio.gov**. In the subject line, put "State Hearing Request."
- Fax: **614-728-9574**

Continuation of Benefits

Unless a member requests that previously authorized benefits not be continued, Humana Healthy Horizons will continue the member's services during the appeal and Medicaid Fair Hearing process when all of the following conditions are met:

- The member requests an appeal or state fair hearing within 15 calendar days of the date on the notice of action letter,
- The appeal involves services the member is already receiving, including services that are being reduced or terminated; and
- The authorization period has not expired.

Member benefits continue until one of the following occurs:

- The original authorization period for services has ended
- 15 calendar days pass after we mail the appeal decision, if the member fails to request a state fair hearing
- The member withdraws the appeal
- The bureau of state hearings issues a Medicaid Fair Hearing decision that is not in the member's favor

For more information, please see the **Member Grievances, Appeals and State Fair Hearing Requests section** of this manual.

If the appeal or Medicaid Fair Hearing decision is not in the member's favor, the member may be required to pay for the services that were provided while the appeal or Medicaid Fair Hearing was pending.

Utilization Management

Utilization Management (UM) helps maintain the quality and appropriateness of healthcare services provided to Humana Healthy Horizons members. Utilization review determinations are based on medical necessity, appropriateness of care and service and existence of coverage. Humana Healthy Horizons does not reward providers or our staff for denying coverage or services. There are no financial incentives for Humana Healthy Horizons staff to encourage decisions that result in underutilization. Humana Healthy Horizons does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition. Humana Healthy Horizons establishes measures designed to maintain quality of services and control costs that are consistent with our responsibility to our members.

We place appropriate limits on a service based on criteria applied under the Humana Healthy Horizons plan, and applicable regulations, such as medical necessity; and place appropriate limits on a service for utilization control, provided the service furnished can reasonably be expected to achieve its purpose. Services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports.

The UM department performs all UM activities including prior authorization, concurrent review, discharge planning and other utilization activities. We monitor inpatient and outpatient admissions and procedures to ensure that appropriate medical care is rendered in the most appropriate setting, using the most appropriate resources. We also monitor the coordination of medical care to ensure its continuity. Referrals to the Humana Healthy Horizons Care Management team are made, if needed.

Humana Healthy Horizons completes an assessment of Provider satisfaction with the UM process on an annual basis, identifying areas for improvement opportunities.

Services that require prior authorization

Physicians or other healthcare providers should review the Ohio Medicaid Prior Authorization List online at **Humana.com/PAL**. Inpatient psychiatric prior authorization requests for members younger than 21 should be submitted to the OhioRISE Plan. Humana Healthy Horizons will deny these authorization requests because this service is covered by another payer.

Prior authorization submission – process and format

Healthcare providers must submit all prior authorization requests, including physician-administered drug requests and associated attachments, through Availity Essentials via one of the following methods:

- Practice management system: Prior authorization submissions sent from a provider's practice management system
- Direct entry into Availity Essentials

For both of the above methods, select the following payor descriptions from the dropdown menu in Availity Essentials:

- Humana (medical)
- Humana Behavioral Health

Providers should review the Ohio Medicaid prior authorization list online at **Humana.com/PAL**.

Humana Healthy Horizons does not require authorizations for home health assessments.

Humana Healthy Horizons allows providers to submit authorization requests for unplanned and/or emergency inpatient admissions the next business day and the Plan utilization review staff will review within the appropriate timeframes for decision making. Providers can request prior authorization to exceed coverage or benefit limits for members 21 or younger.

Inpatient facility providers please note, Humana Healthy Horizons in Ohio cannot complete medical necessity reviews without supporting documentation. To avoid denials for lack of information, please submit all requests with clinical documentation via Availity Essentials. To meet state required turnaround times after requests are received, admission notifications received on Thursday – Saturday without clinical documentation may result in denials for lack of information. If you do not have adequate clinical documentation prior to a weekend, please be aware you may delay admission notice until Monday when you have clinical information available. Authorization requests received after discharge are considered Retrospective and will be worked in 30 calendar days.

UM review

- All decisions are based on eligibility, coverage and medical necessity criteria.
- Humana Healthy Horizons uses ODM-developed medical necessity criteria and, in those instances when guidance does not exist, Milliman Care Guidelines (MCG™), American Society of Addiction Medicine (ASAM), and Humana medical coverage policies, as appropriate, based on OAC rules and member condition.
- As Humana Healthy Horizons applies coverage policies and medical necessity criteria, we consider individual member needs and an assessment of the local delivery system.

Behavioral health services

- Humana Healthy Horizons does not require prior authorization for certain behavioral health services, including Children and Adolescents Needs and Strengths (CANS) assessments and up to 72 hours of Mobile Response Stabilization Services (MRSS) (except in accordance with OAC rule 5160-27.13).
- Humana Healthy Horizons requires prior authorization for admissions to inpatient psychiatric facilities, including Institutions for Mental Disease (IMD).

Please note: Authorization decisions for IMD admissions are based on medical necessity criteria and clinical information provided at time of the request. Authorizations are not a guarantee of payment.

Billed services are based on medical necessity, appropriate setting, billing/coding, total days paid for current month and eligibility at the time service was rendered.

Humana Healthy Horizons follows contractual agreements, state and federal regulations regarding IMD reimbursement for mental health and substance use disorder.

If you have any questions, please contact our provider service line and/or claims/billing for assistance.

Second opinions

Humana Healthy Horizons allows members to obtain a second medical opinion at no cost to the member.

Out-of-network services

Humana Healthy Horizons authorizes out-of- network care based on medical necessity, and if an in-network provider is not available to provide members with medically necessary covered services in a timely manner.

- Authorization requests must be submitted via Availity Essentials at **Availity.com** for members to receive out-of-network services.
- If the out-of-network provider is not an active provider in ODM's provider network management system, Humana Healthy Horizons verifies the provider's licensure, conducts federal database checks and executes a single-case agreement.
- The out-of-network provider is required to submit an application via the ODM portal for screening, enrollment and credentialing. If an out-of-network provider is not willing to become an active ODM provider, the single case agreement is terminated.

Time frames for responding to standard and expedited PA requests (medical and behavioral health)

Standard

Notice of decision as expeditiously as the member's health condition requires, but no later than 10 calendar days following receipt of the request for service.

Concurrent determination

Notice of decision as expeditiously as the member's health condition requires, but no later than three calendar days from the date of request.

Expedited/Urgent/IP behavioral health determination

When a provider indicates, or Humana Healthy Horizons determines, that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, Humana Healthy Horizons completes an expedited authorization as expeditiously as the member's health condition requires but no later than 48 hours after receipt. Please specify if you believe the request should be expedited.

Provider appeal procedures

Peer-to-peer consultations

Providers may request a peer-to-peer consultation when Humana Healthy Horizons denies a prior authorization request. The peer-to-peer consultations will be conducted amongst healthcare professionals who have clinical expertise in treating the member's condition with the equivalent or higher credentials as the requesting/ordering provider. The peer-to-peer consultation must clearly identify what documentation the provider must provide to obtain approval of the specific item, procedure or service; or a more appropriate course of action based upon accepted clinical guidelines.

If you want to request a peer-to-peer discussion on a determination with a Humana physician reviewer, please send an email to **p2prequest@humana.com**, fax your request to **877-701-6524** or leave a voicemail describing your request at **877-207-0153**.

A peer-to-peer request must be made within 5 business days of the determination.

Provider appeals

Providers may request a provider appeal if Humana Healthy Horizons denies a prior authorization request in accordance with ORC 5160.34. The provider appeal is separate from the peer-to-peer or member appeal processes. Provider appeals will be responded to within 48 hours for urgent care services and within 10 calendar days for all other matters.

If a provider appeal is not fully resolved, the resolution will include next steps if a provider disagrees and include the opportunity for external review if the claim denial was due to medical necessity.

Retrospective determination

Notice of a retrospective determination decision is sent within 30 calendar days of receipt of request.

External medical review

External medical review (EMR) – The review process conducted by an independent, external medical review entity indicated by a provider who disagrees with an MCO's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity.

In the Next Generation Medicaid managed care program, the EMR will be conducted by Permedion. This vendor has a contract with ODM to perform the EMR.

To request an EMR, providers must first appeal the decision to deny, limit, reduce, suspend or terminate a covered service for lack of medical necessity using the Humana Healthy Horizons' internal provider appeal or claim dispute resolution process. Failure to exhaust Humana Healthy Horizons' internal appeals or claim dispute resolution process will result in the provider's inability to request an EMR.

EMR is only available to providers for services delivered to members enrolled in Medicaid managed care and/or OhioRISE. The EMR process is not currently available in the MyCare Ohio and SPBM programs.

An EMR can be requested by a provider as a result of:

- A Humana Healthy Horizons' service authorization denial, limitation, reduction, suspension or termination (includes pre-service, concurrent or retrospective authorization requests) based on medical necessity; or
- A Humana Healthy Horizons' claim payment denial, limitation, reduction, suspension or termination based on medical necessity
- If Humana Healthy Horizons does not issue its response to the provider's internal appeal of its decision to deny, limit, reduce, suspend or terminate a covered service for lack of medical necessity within 30 business days or within 15 business days for provider claim disputes

Denials, limitations, reductions, suspensions or terminations based on lack of medical necessity include, but are not limited to, decisions made by the plan where:

- Clinical documentation or medical record review is required in making the decision to deny (includes preservice, concurrent, and retrospective reviews).
- Clinical judgment or medical decision making (i.e., referred to a licensed practitioner for review) is involved.
- A clinical standard or medical necessity requirement (e.g., InterQual®, MCG®, ASAM or OAC 5160-1-01, including EPSDT criteria and/or Humana Healthy Horizons' clinical coverage or UM policy or policies) is not met.

Humana Healthy Horizons is required to notify providers of their option to request an EMR.

Requesting EMR

The request for an EMR must be submitted to Permedion within 30 calendar days of the written notification that the internal appeals or provider claim dispute process has been exhausted. The external medical review is available at no cost to you.

Providers must complete the "Ohio Medicaid MCE External Review Request" form located on Permedion's website at **https://www.gainwelltechnologies.com/permedion** (select Contract Information and Ohio Medicaid) and submit to Permedion together with the required supporting documentation that includes:

- Copies of all adverse decision letters from Humana Healthy Horizons (initial and appeal)
- All medical records, statements or letters from treating healthcare providers, or other information that the provider wants considered in reviewing the case.

Providers must upload the request form and all supporting documentation to Permedion's provider portal at **https://www.gainwelltechnologies.com/permedion**. Please note that new users will send their documentation through secured email to **IMR@gainwelltechnologies.com** to establish portal access.

Please note: When requesting an EMR, providers may submit new or other relevant documentation as part of the EMR request.

If Humana Healthy Horizons determines the provider's EMR request is not eligible for an EMR and the provider disagrees, ODM or its designee will determine if an EMR is appropriate.

The EMR process does not interfere with the provider's right to request a peer-to-peer review, or a member's right to request an appeal, state hearing, or the timeliness of appeal and/or state hearing resolutions.

Once the provider submits the EMR request, they do not need to take further action.

The EMR review

After the EMR request has been submitted, Permedion will share any documentation from the provider with Humana Healthy Horizons. Following its review of this information, Humana Healthy Horizons may reverse its denial in part or in whole. If Humana Healthy Horizons reverses any part of its decision, a written decision letter will be issued to the provider within 72 hours. If Humana Healthy Horizons decides to reverse its decision in part, the remaining will continue as an EMR.

Permedion has 30 calendar days for a standard request and 3 business days for an expedited request to perform its review and issue a decision.

- If the decision reverses Humana Healthy Horizons' coverage decision in part or in whole, that decision is final and binding on Humana Healthy Horizons.
- If the decision agrees with Humana Healthy Horizons' decision to deny, limit, reduce, suspend or terminate a service, that decision is final.

For reversed service authorization decisions, Humana Healthy Horizons must authorize the services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from when Humana Healthy Horizons receives the EMR decision.

For reversed decisions associated solely with provider payment (i.e., the service was already provided to the member), Humana Healthy Horizons must pay for the disputed services within the time frames established for claims payment in Appendix L of the Provider Agreement.

For more information about the EMR, please call Permedion at **800-473-0802**, and select option 2.

Criteria

Humana Healthy Horizons currently uses the following criteria to make medical necessity determinations of inpatient acute, behavioral health, rehabilitation and skilled nursing facility admissions:

- Federal or state regulations, including medical criteria published in the Ohio Administrative Code, Chapter 5160.
- Nationally accepted, evidence-based clinical guidelines: MCG (formerly Milliman Care Guidelines),
- American Society of Addiction Medicine (ASAM) Level of Care Adolescent Guidelines and American Society of Addiction Medicine Patient Placement Criteria
- Humana Healthy Horizons in Ohio clinical policies

- In the case of no guidance from above, additional information that the clinical reviewer will consider, when available, includes;
  - Clinical practice guidelines and reports from peer reviewed medical literature, from which a higher level of evidence and study quality is more strongly considered in determinations.

These guidelines are intended to allow Humana Healthy Horizons to provide all members with care consistent with national quality standards and evidence-based guidelines. These guidelines are not intended as a replacement for a physician's medical expertise; they are to provide guidance to our physician providers related to medically appropriate care and treatment. Providers can access clinical criteria or clinical rationale used in UM determinations online at **Medical and Pharmacy coverage policies (Humana.com)** and the Provider newsletter Provider Publications | Humana, or upon request by contacting the Ohio Medicaid UM department at **877-856-5707**, or via fax at 216-609-3725.

If a patient's clinical information does not meet the criteria for approval, the case is forwarded to a medical director for further review and determination.

Access to staff

Providers can contact the Utilization Management staff with any UM questions.

Medical health inquiries: Call **877-856-5707** or email **OHMCDUM@humana.com**

Behavioral health inquiries: Call **877-856-5707** or email **OHMCDUMBH@humana.com**

Please keep the following in mind when contacting UM staff:

- Staff are available Monday through Friday, 8 a.m. to 5 p.m., Eastern time.
- Staff can receive inbound communication regarding UM issues after normal business hours.
- Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- Staff are available to respond to email inquiries regarding UM issues.
- Staff are accessible to answer questions about the UM process.

In the best interest of our members and to promote positive healthcare outcomes, Humana Healthy Horizons supports and encourages continuity of care and coordination of care between medical providers as well as between behavioral health providers.

Our members' health is always our No. 1 priority. Physician reviewers from Humana Healthy Horizons are available to discuss individual cases with attending physicians on request.

Clinical criteria used in making UM determinations is available on request by contacting our UM department.

Continuity of care for new members

Humana Healthy Horizons must allow a new member to receive services from network and out-of-network providers in the following circumstances:

- If Humana Healthy Horizons confirms that the Group VIII-Expansion member is currently receiving care in a nursing facility on the effective date of enrollment with Humana Healthy Horizons
- If the member is pregnant and in the third trimester of pregnancy
- If a member's practitioner is terminated from the Humana Healthy Horizons network

Group VIII-Expansion

If Humana Healthy Horizons confirms that the Group VIII-Expansion member is currently receiving care in a nursing facility on the effective date of enrollment with Humana Healthy Horizons, Humana Healthy Horizons will cover the nursing facility care at the same facility until a medical necessity review is completed and, if applicable, a transition to an alternative location has been documented in the member's person-centered care plan.

Pregnant members

If Humana Healthy Horizons is aware of a pregnant member's enrollment, Humana Healthy Horizons will identify the member's maternal risk and facilitate connection to services and supports in accordance with ODM's Guidance for Managed Care Organizations for the Provision of Enhanced Maternal Care Services guidance. Also, Humana Healthy Horizons must allow the pregnant member to continue with an out-of-network provider if the member is in their third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital.

Provider termination

If a practitioner's contract is discontinued, Humana Healthy Horizons allows affected members continued access to the practitioner, as follows:

- Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.
- Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.

Transition of care: prior authorizations

If the member has a prior authorization approved before their transition, Humana Healthy Horizons must honor the prior authorization through the expiration of the authorization, regardless of whether the authorized or treating provider is in- or out-of-network with Humana Healthy Horizons.

Humana Healthy Horizons may conduct a medical necessity review for previously authorized services if the member's needs change to warrant a change in service. Humana Healthy Horizons must render an authorization decision pursuant to OAC rule 5160-26-03.1.

Humana Healthy Horizons may assist the member to access services through a network provider when any of the following occur:

- The member's condition stabilizes and Humana Healthy Horizons can ensure no interruption to services
- The member chooses to change their current provider to a network provider
- If there are quality concerns identified with the previously authorized provider

Humana Healthy Horizons must cover scheduled inpatient or outpatient surgeries approved and/or precertified, pursuant to OAC rule 5160-2-40. Surgical procedures also include follow-up care as appropriate.

Humana Healthy Horizons must cover organ, bone marrow or hematopoietic stem-cell transplants, pursuant to OAC rule 5160-2-65 and as described in Appendix B, Coverage and Services, of their provider agreement.

Claims information

Process and requirements for the submission of claims

Providers may submit claims, prior authorizations, and associated attachments through Availity Essentials at **Availity.com**.

ODM Provider Network Management System Direct Data Entry

Providers may submit eligibility inquiries through the Provider Network Management (PNM) system at **https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing**.

Electronic data interchange (EDI) submission of provider claims

Providers may submit claims, eligibility inquiries, claim status inquiries and associated attachments using EDI by being a trading partner (TP) authorized by ODM or by contracting with an ODM-authorized TP. Providers can find out more about becoming a TP by visiting the ODM TP website at **https://medicaid.ohio.gov/resources-for-providers/billing/trading-partners/trading-partners**.

ODM's expectation is that for each Medicaid provider Humana Healthy Horizons' system and data are current and consistent with information held by ODM's system of record, the PNM system. Therefore, it is important that providers keep their records up to date in ODM's PNM system. With the PNM system as the ODM's system of record, MCOs have been instructed to direct providers to update their ODM record in the PNM system when discrepancies are identified between the MCO's data and the PNM PMF. Humana Healthy Horizons is instructed by ODM to not accept changes from providers into their own systems that are inconsistent with PNM system data shared through the PNM for their Medicaid line of business.

All payable claims, via EDI, must be submitted through the provider's EDI, which must be an ODM fiscal intermediary/EDI as an established trading partner. Healthcare providers must submit manual claims and associated attachments through Availity Essentials at **Availity.com**.

Humana's payer ID is 61103 for fee-for-service claims.

Please note: Humana's traditional payer ID for fee-for- services claims (61101) cannot be used to submit Humana Healthy Horizons in Ohio claims. Humana rejects all claims submitted in this manner.

Paper claim submissions are prohibited.

Claim submissions

Claims must be submitted within 365 days from the date of service or discharge date. Corrected claims must be submitted within 365 days from the date of service or 180 days from the date Medicare or the other insurance plan paid the claim.

All claims must include the following information:

- Patient address
- Insured's ID number: Be sure to provide the complete member ID for the patient.
- Patient's birth date: Always include the member's date of birth so we can identify the correct member.
- Place of service: Use standard CMS location codes.
- International Classification of Diseases, Tenth Edition, Clinical Modification (ICD-10-CM) diagnosis code(s)
- HIPAA-compliant Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code(s) and modifiers when modifiers are applicable
- Units, where applicable (anesthesia claims require number of minutes)
- Date of service: Please include dates for each individual service rendered; date ranges are not accepted, even though some claim forms contain from/to formats. Please enter each date individually.
- Prior authorization number, when applicable: A number is needed to match the claim to the corresponding prior authorization information. This is only needed if the service provided required a prior authorization.
- National Provider Identifier (NPI): Please refer to the location of provider NPI, TIN and member ID number section.
- Federal Tax ID number or provider Social Security number: Every provider practice (e.g., legal business entity) has a different Tax ID number
- Billing and rendering taxonomy codes that match the ODM Master Provider List (MPL)

- Billing and rendering addresses that match the ODM MPL
- Signature of physician or supplier: The provider's complete name should be included. If we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.

We do not pay claims with incomplete, incorrect or unclear information.

Federally qualified health center (FQHCs) and rural health clinic (RHCs) wrap-around payments
The following Medicaid provider numbers are to be used when submitting documents for wrap-around payments to Humana Healthy Horizons:

Line of business – Region:
- Medicaid – Aged, Blind or Disabled (ABD)
  - Humana's Medicaid ID number: 0461038
- Medicaid – Covered Families and Children (CFC)
  - Humana's Medicaid ID number: 0462285

Timely filing requirements

Providers have 365 days to timely file a claim, including any timely filing exceptions, in accordance with Ohio Administrative Code (OAC) rule 5160-1-19.

Providers have 365 days from the date of service or from discharge to submit a claim. If the claim is submitted after the applicable timely filing term, the claim is denied for timely filing.

If a member has Medicare and Humana Healthy Horizons is secondary, the provider may submit for secondary payment within 180 days from the Medicare adjudication date.

If a member has other insurance and Humana Healthy Horizons is secondary, it is recommended that the provider submit for secondary payment within 180 days from the other insurance payment date.

Claims status

You can track the progress of submitted claims at any time through Availity Essentials at **Availity.com**. Claim status is updated in real time and provides information on claims submitted in the previous 24 months. Searches by member ID number, date of birth, claim number, service dates or HIPAA standard are available.

You can find the following claim information with Availity Essentials:
- Reason for payment or denial
- Check number(s) and date
- Procedure/diagnostic
- Claim payment date
- Remittance advice

Claims payments by Humana Healthy Horizons to providers are accompanied by an itemized accounting of the individual claims in the payment that includes, but is not limited to, the member's name, the date of service, the procedure code, service units, the reimbursement amount and identification of Humana Healthy Horizons entity.

By agreement, Humana Healthy Horizons adheres to the following guidelines and will be responsible for:
- Paying 90% of all submitted clean claims within 21 calendar days of the date of receipt
- Paying 99% of all submitted clean claims within 60 calendar days of the date of receipt
- Paying 100% of all submitted clean claims within 90 calendar days of the date of receipt

Monitoring claims; Explanation of Benefits

In accordance with 42 CFR 455.20, Humana Healthy Horizons verifies with members whether services billed by providers were received.

Humana Healthy Horizons mails Explanation of Benefits (EOB) letters each month to a random sample of members to include claims with a paid date within the last 45 days. The EOB mailing complies with all state and federal regulations regarding release of personal health information, outlines the recent medical services identified as provided to the member and requests that the member report any discrepancies to Humana Healthy Horizons.

Payment in full information

State requirements and federal regulations prohibit providers from billing Humana Healthy Horizons members for medically necessary covered services except under very limited circumstances. Members cannot be billed and will be held harmless for services that are administratively denied. The only exception is if a Humana Healthy Horizons member agrees in advance, in writing, to pay for a non-Medicaid covered service. This agreement must be completed prior to providing the service and the member must sign and date the agreement acknowledging member financial responsibility.

A Medicaid recipient cannot be billed when a Medicaid claim has been denied for any of the following reasons:

- Unacceptable or untimely submission of a claim;
- Failure to request a prior authorization; or
- A retroactive finding by a peer review organization (PRO) that a rendered service was not medically necessary.

A provider may bill a Medicaid recipient for a Medicaid covered service in lieu of submitting a claim to the Ohio department of Medicaid (ODM) only if all of the following conditions are met:

- The provider explains to the Medicaid recipient that the service is a covered Medicaid service and other Medicaid providers may render the service at no cost to the individual;
- Prior to each date of service for the specific service rendered, the provider notifies the Medicaid recipient in writing that the provider will not submit a claim to ODM for the service;
- The Medicaid recipient agrees to be liable for payment of the service and signs a written statement to that effect before the service is rendered; and
- The Medicaid covered service is not a prescription for a controlled substance as defined in section 3719.01 of the Revised Code.
- Services that are not covered by the Medicaid program, including services requiring prior authorization that have been denied by ODM, may be billed to a Medicaid recipient when the conditions in paragraphs (C)(2) to (C)(4) of this rule are met.
- Any individual not covered by Medicaid on the date of service is financially responsible for those services unless the individual qualifies for the hospital care assurance program (HCAP) in accordance with section 5168.14 of the Revised Code.

Please see OAC 5160-1-13.1 for additional information.

Providers who knowingly and willfully bill a member for a Medicaid-covered service are guilty of a felony and, on Conviction, are fined, imprisoned or both, as defined in the Social Security Act. Providers should call Provider Services at **877-856-5707** for guidance before billing members for services.

Member copayments

Humana Healthy Horizons does not require member copayments.

Missed appointments

In compliance with federal and state requirements, Humana Healthy Horizons members cannot be billed for missed and/or cancelled appointments. Humana Healthy Horizons encourages members to keep scheduled appointments and to call to cancel ahead of time, if needed.

Process and requirements for appeal of denied claims

Humana Healthy Horizons follows the claim reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. It is critical that all provider addresses and phone numbers on file with Humana Healthy Horizons are up to date to ensure timely claims processing and payment delivery.

Please note: Failure to include ICD-10 codes on submitted claims will result in claim denial.

Provider claim dispute resolution process

Provider claim disputes are any provider inquiries, complaints, appeals, or requests for reconsideration, ranging from general questions about a claim to a provider disagreeing with a claim denial. Providers may file a claim dispute within

12 months from the date of service or 60 calendar days after the payment, denial or partial denial of a timely claim submission, whichever is later. Providers may submit claim disputes verbally or in writing, including through Availity Essentials at **Availity.com**.

Participating providers may contest the amount of payment, denial of payment, or nonpayment of a claim within a period of 18 months following the date such claim was paid, denied or partially denied by Humana Healthy Horizons.

Claim disputes can come in through multiple channels, including:

- Via Availity Essentials: Complete Claims Status application at **Availity.com**
- Verbally by calling Provider Services at **877-856-5707**
- Mail to: Humana Healthy Horizons in Ohio
  Provider Claims Dispute
  P.O. Box 14601
  Lexington, KY 40512-4601

Humana Healthy Horizons may reject a provider's claim dispute submission if the provider's claim dispute request is incomplete, not submitted within the time frame specified and does not meet all of the requirements as specified above.

Humana Healthy Horizons resolves and provides written notice to the provider of the claim dispute within 15 business days of receipt of the dispute. Within 5 business days of receipt of a dispute, Humana Healthy Horizons notifies the provider (verbally or in writing) that the dispute was received.

If additional time is needed to resolve a dispute in excess of 15 business days, then Humana Healthy Horizons provides a status update to the provider every 5 business days, beginning on the 15th business day, until the dispute is resolved.

Humana Healthy Horizons reprocesses and pays disputed claims, when the resolution determines disputed claims were paid/denied incorrectly, within 30 calendar days of the written notice of the resolution, except in instances when a system fix is needed; in those instances, additional time is allotted.

This provider dispute system is utilized as the sole remedy to dispute the denial of payment of a claim or, in the case of a contracted, in-network provider, to dispute Humana Healthy Horizons' policies, procedures, rates, contract disputes or any aspect of Humana Healthy Horizons' administrative functions. Providers not otherwise acting in the capacity of an authorized representative of a Medicaid managed care member do not have appeal rights with ODM.

For claim payment inquiries or complaints, please contact Humana Healthy Horizons at **877-856-5707** or your provider contracting representative.

External medical review

After exhausting Humana Healthy Horizons' provider claims dispute resolution process, a provider may request an external medical review (EMR) if the claim payment denial, limitation, reduction, suspension or termination was based on medical necessity. For more information on EMR, please see the **Utilization Management section** of this manual.

Electronic funds transfer (EFT)/Electronic remittance advice (ERA)

EFT/ERA enrollment through Humana Healthy Horizons in Ohio

Get paid faster and reduce administrative paperwork with EFT and ERA. Providers can enroll in ERA through ODM's state portal.

For EFT, providers can use the ERA/EFT enrollment tool found in Availity Essentials. To access the tool:

1. Sign into the Availity Essentials at **Availity.com** (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 administrator to discuss your need for the tool.)

Here are some commonly used clearinghouses. Please note that some clearinghouses may charge a fee.

Submitting electronic transactions

Provider portal

Humana Healthy Horizons partners with Availity Essentials to allow providers to reference member and claim data for multiple payers using one login. Availity Essentials provides the following benefits:

- Eligibility and benefits
- Remittance advice

To learn more, call **800-282-4548** or visit Availity Essentials at **Availity.com**. For information regarding electronic claim submission, contact your local Provider Relations representative, visit **Humana.com/providers** and choose "Coverage and Claims" then "Claim submissions" or visit **Revenue Cycle Management Healthcare Solutions | Availity**.

EDI clearinghouses
EDI is the computer-to-computer exchange of business data in standardized formats. EDI transmissions must follow the transaction and code set format specifications required by HIPAA. Our EDI system complies with HIPAA standards for electronic claim submission.

To submit claims electronically, providers must work with an electronic claim clearinghouse.

Please note: Humana's traditional payer ID for fee-for-services claims, 61101, cannot be used to submit Humana Healthy Horizons Ohio claims. Humana rejects all claims submitted with this payer ID, as well as claims entered directly with the fee-for-services payer ID, into Availity Essentials for Ohio Medicaid member claims.

Here are some commonly used clearinghouses. Please note that some clearinghouses may charge a fee.

Availity	**Availity.com**	**800-282-4548**
Tizetto	**Trizetto.com**	**800-556-2231**
Change Healthcare	**Changehealthcare.com**	**800-792-5256**
SSI Group	**Thessigroup.com**	**800-820-4774**

Please contact the clearinghouse of your choice to begin electronic claim submission.

5010 transactions
In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic healthcare and pharmacy transactions. This action was taken in preparation to implement ICD-10 CM codes in 2015. The new standard is the HIPAA 5010 format.

The following transactions are covered under the 5010 requirements:
- 837 Claims encounters
- 276/277 Claim status inquiry
- 835 Electronic remittance advice
- 270/271 Eligibility
- 278 Prior-authorization requests
- 834 Enrollment

Importance of encounter submissions in Medicaid
Encounters identify members who received services and:
- Decreases the need for medical record review during Healthcare Effectiveness Data and Information Set (HEDIS®) audits
- Is critical to future implementation of Medicaid risk adjustments
- Helps identify members receiving preventive screenings and decreases the number of members listed in gaps-in-care (GAP) reports

Encounters data submissions helps establish data quality standards and requirements for Ohio's Medicaid Managed Care program and evaluates the member's access to quality services. This data is reviewed to help determine what performance measures are needed, for utilization reviews, care coordination and care management, and for determining provider incentives.

Procedure and diagnosis codes
Federal law establishes various standards for all covered transactions under HIPAA, including electronic medical claims. Those standards currently include these standard code sets:

- Healthcare Common Procedure Coding System (HCPCS), which includes
  - Current Procedural Terminology (CPT®) codes, available from the **American Medical Association**
  - HCPCS Level II codes, available from the **Centers for Medicare & Medicaid Services**
- National Drug Codes (NDC), available from the **U.S. Food and Drug Administrations**
- ICD-10-CM, available from the **Centers for Disease Control and Prevention**
- ICD-10-PCS, available from the **Centers for Medicare & Medicaid Services**

Code sets also are typically available in various media from vendors licensed to publish them.

Please note: Humana Healthy Horizons also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on providers and health plan organizations. Local or proprietary codes are no longer allowed.

National Provider Identifier, Tax Identification Number and taxonomy

Your National Provider Identifier (NPI) and Tax Identification Number (TIN or Tax ID) are required on all claims, in addition to your provider taxonomy and specialty type codes (e.g., federally qualified health center, rural health center and/or primary care center) using the required claim type format (X12 837 Format) for the services rendered.

ODM implemented a policy under Administrative Code 5160-1-17 that requires all providers obtain a NPI and keep it on file with ODM. In accordance with Administrative Code rule 5160-1-17, all providers with an available taxonomy are required to have a NPI on file with ODM. This includes certified providers of waiver services through the Ohio Department of Developmental Disabilities (DODD), the Ohio Department of Aging (ODA), and providers of state plan services through ODM.

Location of provider NPI, TIN and member ID number

Humana Healthy Horizons accepts electronic claims in the 837 ANSI ASC X12N (005010A1) file format for both professional and hospital claims.

On 5010 (837P) professional claims:

The provider NPI should be in the following location:
- Medicaid: 2010AA Loop – Billing provider name
- 2010AA Loop – Billing provider name
- Identification code qualifier – NM108 = XX
- Identification code – NM109 = billing provider NPI
- 2310B Loop – rendering provider name
- Identification code qualifier – NM108 = XX
- Identification Code – NM109 = rendering provider NPI

The billing provider TIN must be submitted as the secondary provider identifier using a REF segment, which is either the employer identification number for organizations (EIN) or the Social Security number (SSN) for individuals:
- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing provider TIN or SSN
- The billing provider taxonomy code in box 33b on 5010 (837I) institutional claims

On all electronic claims:
The Humana Healthy Horizons in Ohio Member ID number should go on:
- 2010BA Loop = Subscriber name
- NM109 = Member ID number

Electronic visit verification

Network providers are required to use, ODM's electronic visit verification (EVV) system, or an alternative EVV system certified by ODM's EVV vendor, for the following services, or as otherwise specified by ODM:
- Home health aide G0156
- Registered nurse (RN) G0299
- Licensed practical nurse (LPN) G0300
- Private duty nursing/independent nursing T1000
- Registered nurse assessment T1001

- Nursing RN T1002
- Nursing LPN T1003
- Home care attendant S5125
- Personal care aide T1019
- Waiver services not otherwise specified T2025
- Physical therapy G0151
- Occupational therapy G0152
- Speech language pathology G0153

The data collected from the EVV data collection system is used to validate all claims against EVV data (100% review) during the claim adjudication process.

Providers who need assistance using the EVV data collection system can call Provider Services at **877-856-5707**.

Out-of-network claims

Humana Healthy Horizons established guidelines for payments to out-of-network providers for pre-authorized medically necessary services. These services are reimbursed at no less than 100% of the Ohio Medicaid fee schedule. Subject to federal and state laws and/or regulations, if the service rendered by a nonparticipating provider was not preauthorized, Humana Healthy Horizons may reimburse that provider less than the applicable Medicaid fee-for-service rate.

- Providers enrolled with ODM, but non participating with Humana Healthy Horizons
- Non-participating provider will be paid at default rate of 90%
  - If the non-participating provider wants more than the default rate, they will need to work with their Provider Engagement Representative.

Claim processing guidelines

Coordination of Benefits

- Coordination of Benefits (COB) requires a copy of the appropriate remittance statement from the primary carrier payment:
  - Electronic claims
  - Primary carrier's payment information
  - EOB from primary carrier
- Medicare COB claims - Appropriate remittance statement must be received within 90 days of the last submission.
- Non-Medicare primary payer – Appropriate remittance statement must be received within 90 days from date of service or discharge.
- If a claim is denied for COB information needed, the provider must submit the appropriate remittance statement from the primary payer within the remainder of the initial claims timely filing period.

Newborn claims

A child is automatically eligible for medical assistance as of the child's date of birth and remains eligible until the child reaches the age of 1 year, provided the person who gave birth has applied for, been determined eligible for, and is receiving medical assistance on the date of the child's birth. A child also is covered if labor and delivery services were furnished prior to the date of application and the person who gave birth's Medicaid eligibility is based on retroactive coverage. This coverage for the person who gave birth continues for 12 months after the baby's birth.

Other claim requirements

Abortion, sterilization and hysterectomy procedure claims submissions must include completed consent forms. The forms can be found at:

Abortion:

ODM Abortion Form: **https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Resources/Publications/Forms/ODM03197fillx.pdf**

Sterilization:

ODM Sterilization Consent Form (English): **https://opa.hhs.gov/sites/default/files/2022-07/consent-for-sterilization-english-2025.pdf**

ODM Sterilization Form (Spanish): **https://opa.hhs.gov/sites/default/files/2022-07/consent-for-sterilization-spanish-2025.pdf**

Hysterectomy:
ODM Acknowledgement of Hysterectomy Information (English): https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Resources/Publications/Forms/ODM03199fillx.pdf
ODM Acknowledgement of Hysterectomy Information (Spanish): https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Resources/Publications/Forms/Spanish/ODM03199SPA.pdf

Claims indicating that a member's diagnosis was caused by the member's employment are not paid. The provider is advised to submit the charges to Workers' Compensation for reimbursement.

Claims compliance standards

Submitting corrected claims
A corrected claim replaces a previously submitted claim and includes a change in the material information. Material information is information that could impact the way a claim is processed if that information were considered. If a healthcare provider identifies that a previously submitted claim is incorrect or incomplete, a corrected claim with accurate information should be submitted via ODM's PNM.

Please note: For the corrected claim and for HIPAA compliance, the 5010 format requires a 7 to be in the third digit of the Type of Bill in the CLM05-03 claim frequency type code.

ASC X12 format (electronic method)
Please note, Humana prefers to receive corrected claims electronically.

If you have additional questions about corrected claims, please follow industry guidance according to the Health Care Claim Implementation Guide (https://www.cms.gov/files/document/837p-cms-1500pdf), using 837P for professional claims or 837I for institutional claims. For more information on Health Insurance Portability and Accountability Act of 1996 (HIPAA) X12 837 Health Care Claim transactions, please visit the Washington Publishing Company (WPC) website at https://wpc-edi.com.

Code editing and payment policies

Humana Healthy Horizons processes accurate and complete provider claims in accordance with Humana's normal claims processing procedures including, but not limited to, claims processing edits (Humana.com/provider/medical-resources/claims-payments/processing-edits), claims payment policies (Humana.com/provider/medical-resources/claims-payments/claims-payment-policies), and applicable state and/or federal laws, rules and regulations. See the providers' section of Humana.com to access a summary of changes to claims processing procedures; this summary of changes to claims processing procedures is not intended to be an exhaustive list.

Such claims processing procedures include review of the interaction of various factors. The result of Humana Healthy Horizons' claims processing procedures depend on the factors reported on each claim. Accordingly, it is not feasible to provide an exhaustive description of claims processing procedures, but examples of the most commonly used factors are:

- The complexity of a service
- Whether a service is one of multiple same-day services such that the cost of the service to the provider is less than if the service had been provided on a different day. For example:
  - Two or more surgeries performed the same day
  - Two or more endoscopic procedures performed the same day
  - Two or more therapy services performed the same day
- Whether a co-surgeon, assistant surgeon, surgical assistant or any other provider who is billing independently is involved
- When a charge includes more than one claim line, whether any service is part of or incidental to the primary service that was provided, or if these services cannot be performed together
- Whether the service is reasonably expected to be provided for the diagnosis reported
- Whether a service was performed specifically for the enrollee
- Whether services can be billed as a complete set of services under one billing code

Humana Healthy Horizons develops claims processing procedures in our sole discretion based on our review of correct coding initiatives, national benchmarks, industry standards and industry sources that include the following (and all successors of the same):

- Ohio Department of Medicaid regulations, manuals and other related guidance

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

Changes to any one of the sources may lead Humana Healthy Horizons to modify current or adopt new claims processing procedures.

These claims processing procedures may result in an adjustment or denial of reimbursement, a request for the submission of relevant medical records prior to or after payment, or the recoupment or refund request of a previous reimbursement. You can access more information about this process at **Humana.com**.

An adjustment in reimbursement as a result of claims processing procedures is not an indication that the service provided is a noncovered service. Providers can submit a dispute request of any adjustment produced by these claims processing procedures by submitting a timely request to Humana Healthy Horizons. For additional information, see the **Provider Disputes section** of this manual.

Providers are required to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. Claims indicating provider-preventable conditions are not paid.

Humana Healthy Horizons provides notification of upcoming code editing changes. We publish new code editing rules and our rationales for these changes on the first Friday of each month at **Humana.com/Edits**.

Suspension of provider payments

A network provider's claim payments are subject to suspension when ODM, Division of Program Integrity notifies Humana Healthy Horizons that it determined there is a credible allegation of fraud, in accordance with 42 C.F.R. 455.23.

Coordination of Benefits

Humana Healthy Horizons in Ohio collects COB information for our members. This information helps us ensure we pay claims appropriately and comply with federal regulations that Medicaid programs are the payer of last resort.

- COB requires a copy of the appropriate remittance statement from the primary carrier processing:
  - Claims: primary carrier's payment information
- Humana Healthy Horizons' timely filing limits for provider claims are at least 90 days from the date of the remittance advice that indicates adjudication or adjustment of the third-party claim by the third-party payer
- If a claim is denied for COB information needed, the provider must submit the appropriate remittance statement from the primary payer within the remainder of the initial claim timely filing period

COB overpayment

When a provider receives a payment from another carrier after receiving payment from Humana Healthy Horizons for the same items or services, Humana Healthy Horizons considers this an overpayment. Humana Healthy Horizons provides written notice to the provider at least 30 calendar 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. Providers also can issue refund checks to Humana Healthy Horizons for overpayments and mail them to:

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

Providers should not refund money paid to a member by a third party.

Member termination claim processing

From Humana Healthy Horizons to another plan
In the event of a member's termination of enrollment with Humana Healthy Horizons into a different Medicaid plan, Humana Healthy Horizons may submit voided encounters and notify providers of adjusted claims using the following process:

- Humana Healthy Horizons determines whether claims were paid for dates of service in which the member was afterward identified as ineligible for Medicaid benefits with Humana Healthy Horizons.
- Humana Healthy Horizons sends out a notice to each affected provider that recoupment of payment will occur for the claim(s) identified in the recoupment letter. The provider is allowed 30 calendar days from receipt of the letter to respond to the notice.
- Once the minimum 30 calendar days expires and the affected provider has not attempted to appeal the recoupment of payment or has not submitted a refund check, Humana Healthy Horizons adjusts the payment(s) for the affected claims listed in the notice letter.

From another plan to Humana Healthy Horizons
If a member was previously enrolled with another Medicaid plan and is now eligible with Humana Healthy Horizons, providers are required to submit a copy of the EOP reflecting recoupment of payment and documentation from the previous MCO to validate the original encounter was voided and accepted by ODM.

These items are used to support an override for timely filing, if eligible. If a claim exceeds timely filing due to retro-eligibility from another Medicaid plan, the provider has 90 days from the date of the accepted voided encounter to submit the claim to Humana Healthy Horizons to avoid timely filing denials.

Provider disputes

A provider dispute may be filed via telephone, online, by mail or in person.

On receipt of a dispute, the assigned Provider Dispute Resolution team investigates each dispute, applying any applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying Humana Healthy Horizons' written policies and procedures. The Provider Dispute Resolution team works to resolve the issue within the time period identified in the table "Dispute Q&A" below.

Provider claim disputes are any provider inquiries, complaints or requests for reconsiderations, ranging from general questions about a claim to a provider disagreeing with a claim denial. While these disputes can be sent through any avenue (e.g., provider call center, provider advocates, an MCO's provider portal), they do not include inquiries that come through ODM's Provider Web portal (HealthTrack).

Disputes can be submitted using the following avenues:

- Electronically, via Availity Essentials – **Availity.com**
- Verbally, via telephone, by calling **877-856-5707**. Hours of operation are 7 a.m. to 8 p.m., Eastern time, Monday through Friday.
- In writing, via mail:
  Humana Healthy Horizons in Ohio
  Attn: Provider Disputes
  P.O. Box 14601
  Lexington, KY 40512-4601
- Verbally in person
- Via a visit with a Provider Relations representative or other Humana staff member (e.g., care manager, nurse, etc.)
- Via a Humana Healthy Horizons in Ohio office

Claims Dispute FAQ Topic	Response
What is the time frame for a provider to submit a claims dispute?	Providers must file a claim dispute no later than 12 months from the date of service or 60 calendar days after the payment, denial or partial denial of a timely claim submission, whichever is later.
What communication and resolution time frame can be expected?	Written complaints: • An acknowledgement letter is sent within 5 business days of receipt of the dispute. • A resolution letter is sent within 15 business days of receipt. • A status letter may be sent every 5 business days starting on the 15th business day until the dispute is resolved. Verbal disputes: • An acknowledgement letter is sent within 5 business days, notifying the provider of receipt. If a dispute is made through the Provider Services call center and resolved during first call resolution, no additional follow-up with the provider is needed. • A resolution letter is sent within 15 business days of receipt, if not resolved on the initial phone call. • A status letter may be sent every 5 business days starting on the 15th business day until the dispute is resolved. Digital disputes: • An acknowledgement letter is sent within five business days of receipt of the dispute. • A resolution letter is sent within 15 business days of receipt. • A status letter may be sent every 5 business days starting on the 15th business day until the dispute is resolved.

The information included in the submission should include:

- Name of person calling, submitting or speaking, including phone number and/or email address
- Provider/facility Tax ID number
- Provider/facility name
- Member ID and name
- Claims number(s)
- Authorization/referral number(s)
- Details of dispute/issues

Care coordination/care management for physical health and behavioral health

Description of the care coordination and care management programs

Humana Healthy Horizons members have access to care managers and care guides who provide a holistic approach to addressing physical and behavioral healthcare needs, including social determinants of health (SDOH) issues. We recognize that members who experience complex behavioral and/or physical health needs often have strong, established relationships with their care providers. Rather than disrupt these relationships with our own personnel, our Comprehensive Care Services (CCS) team structure incorporates and supports existing case management services provided to our members through our network providers, OhioRISE, state agencies or community-based organizations. In addition, Care Managers and Care guides can support members with SDOH needs. Humana Healthy Horizon care coordination team can be reached by calling **877-856-5702** or emailing **OHMCDCareManagement@humana.com**.

This coordination is enhanced through data-sharing via our provider portal, support through our provider communication lines, and participation in multi-disciplinary care team (MDT) meetings led by our Care Management team or provider-led case management team (Behavioral Health Care Coordination [BHCC]/Care Management Entity[CME]/Care Coordination Entity [CCE]), based on member preference and need. In addition, Care Managers and Care guides can support members with SDOH needs. Humana Healthy Horizon care coordination team can be reached by calling **877-856-5702** or emailing OHMCDCareManagement@humana.com.

Humana Healthy Horizons offers chronic condition management programs for behavioral health and substance use. Humana Healthy Horizons providers can refer members needing care management assistance by calling **877-856-5702** or emailing **OHMCDCareManagement@humana.com**.

Humana Healthy Horizons offers a maternal health program called HumanaBeginnings. This program provides perinatal and neonatal care management. Nurses are available to help manage high-risk pregnancies and premature births by working in conjunction with providers and members. HumanaBeginnings can be reached by email at **OHMCDMaternity@humana.com** or by calling **877-856-5702**.

All Humana Healthy Horizons Care coordination/Care management programs are voluntary, free of charge, and members may enroll or disenroll at any time. Humana Healthy Horizons adheres to a no-wrong-door approach to care management referrals.

Collaboration with OhioRISE/CMEs

Providers may submit referrals for member evaluations for OhioRISE to **OHMCDOhioRISE@humana.com**. Humana Healthy Horizons' Care Coordination staff reach out to the member and their family to coordinate a timely CANS assessment which is needed in order to determine OhioRISE eligibility. An individual enrolled in the OhioRISE program keeps their managed care enrollment for their physical health benefit. Humana Healthy Horizons collaborates with the member's OhioRISE care team and participate in the OhioRISE Child and Family Team meetings based on the member's needs and choice.

Provider coordination for behavioral health

Network providers are required to coordinate care when members are experiencing behavioral health conditions that require ongoing care.

Primary care providers are required to:

- Provide basic behavioral health services to members to include:
  - Mental health and substance use screening during routine and emergent visits
  - Prevention and early intervention
  - Medication management
  - Treatment for mild to moderate behavioral health conditions
- Request consultation and refer to specialized behavioral health services for severe or chronic behavioral health conditions.
- Follow up with behavioral health providers to coordinate integrated and non-duplicitous care to the member.
- Obtain necessary signed release of information for sharing personal health information, including compliance with 42CFR Part II requirements around behavioral health and substance use disorder.

Behavioral health providers are required to:

- Notify the primary care provider (PCP) when a member initiates behavioral health services with the provider
- Prior to sharing information with the primary care provider, obtain signed release of information for sharing of personal health information in compliance with 42CFR Part II requirements around behavioral health and substance use disorder.
- Provide initial and summary reports to the primary care provider (after receiving above release of information).
- Refer members with known or suspected and/or untreated physical health problems or disorders to their PCP for examination and treatment, with the member's or the member's legal guardian's consent. Behavioral health providers may only provide physical healthcare services if they are licensed to do so.

Humana Healthy Horizons assists with provider referrals, scheduling appointments and coordinating an integrated approach to the member's health and well-being by coordinating care between behavioral health providers, PCPs and specialists.

Continuation of treatment for behavioral health

For members receiving inpatient behavioral health services, Humana Healthy Horizons requires providers to schedule an outpatient follow-up appointment prior to the member's discharge from the facility. The outpatient follow-up must be scheduled to occur within 7 calendar days from the date of discharge. Behavioral health providers are expected to contact members within 24 hours of a missed appointment to reschedule.

Humana Healthy Horizons case managers are available to promote a holistic approach to addressing a member's physical and behavioral healthcare needs as well as social determinant issues. We offer chronic condition management programs for behavioral health and substance use, as well as care management programs based on the member's level of need. Humana Healthy Horizons provides comprehensive and integrated care management services through medical and behavioral health nurses, social workers, licensed behavioral health professionals and outreach specialists. We provide personal member interaction and connect members with community-based resources to address social determinants of health (SDOH) needs, including food pantry access and utility assistance.

Role of provider in care coordination and care management programs in accordance with OAC rule 5160-26-05.1

Providers are responsible for identifying members that meet "Humana Healthy Horizons" care management criteria, including the following conditions:

- High-risk maternity
- Multiple uncontrolled chronic conditions
- Homelessness
- Active substance use disorder
- Children enrolled in Early Intervention
- Serious and persistent mental illness (SPMI)
- High persistent unmet social needs

Providers who have a Humana Healthy Horizons-covered patient with chronic conditions you believe would benefit from this program, ask your patient to reach us directly, or submit a referral by calling 877-856-5707 or via email to:

- **Medical care management:** OHMCDCareManagement@humana.com
- **Behavioral health care management:** OHMCDCareManagement_BH@humana.com
- **Maternity Health Care Management:** OHMCDMaternity@humana.com

We encourage you to refer members who might need individual attention to help them manage special healthcare challenges.

Humana Healthy Horizons adheres to a no-wrong-door approach to care management referrals, assisting with provider referrals, appointment scheduling and coordination of an integrated approach to the member's health and well-being. Behavioral health providers are required to send initial and quarterly summary reports to the member's PCP and to refer members to PCP for untreated physical health concerns to better coordinate care between behavioral health providers, primary care providers and specialists.

Services

- Care guide support for low-risk members
- Care management for moderate-risk members

- Intensive care management for high-risk members
- Complex care management for members with complex condition needs
- Transitional care management
- Behavioral health and substance-use services
- HumanaBeginnings prenatal program
- Chronic condition management program

High-risk members

Members in complex care management are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH. Members involved in this level of care management receive, at a minimum, monthly contacts to review plans of care and quarterly reassessment for changing needs.

Care management activities may integrate community health worker, peer or specialist support. Case managers focus on implementing the member's plan of care, preventing institutionalization and other adverse outcomes, and supporting the member in self-managing their care goals.

Prenatal care management

HumanaBeginnings provides perinatal and neonatal care management. Nurses are available to help manage high-risk pregnancies and premature births by working in conjunction with providers and members.

The program is open to any pregnant member who wants to participate. Referrals to HumanaBeginnings can be sent via email to **OHMCDMaternity@humana.com**.

Ohio Medicaid pregnancy notifications

There are two sources for notification of pregnancy:

1. Report of Pregnancy (ROP) – Early pregnancy notification submitted only once by any non- obstetrical services provider that initially identifies a member is pregnant. Provider types include:
   a. Local health departments (LHDs)
   b. Primary care providers
   c. Emergency department providers
   d. Community clinics
   e. Ohio Equity Institute (OEI) Community Based Organizations

Pregnancy Risk Assessment Form (PRAF) – Submitted by obstetrical services providers during the first prenatal visit or when there is a significant change in medical condition, risk factors or needs.

Electronic ROP and electronic PRAF (e-PRAF)

Submission of the electronic ROP and e-PRAF/e-PRAF 2.0 via NurtureOhio has multiple benefits with one, simple submission:

- Ensures pregnant members maintain Medicaid eligibility
- Streamlines communications among multiple entities, facilitating connection of pregnant members to needed services
- Provides an automatic referral to ODH Home Visiting and Women, Infant and Children (WIC)

Submitting the e-PRAF using NurtureOhio

1. User will need to establish an Ohio ID account to access the Provider Network Management System
2. With PNM access, next step will be to register within the NurtureOhio website at **https://progesterone.nurtureohio.com/login**.
3. Instructions for completion and submission of PRAF can be found on ODM's website at **https://progesterone.nurtureohio.com/media/PRAFProviderUserGuide10-1-22.pdf**.
4. If you need assistance, please email the Ohio Department of Medicaid at **MomsandBabies@Medicaid.ohio.gov**.

Enhanced reimbursement for electronic submission

Electronic ROP — Providers receive a $30 payment when the claim is coded with HCPS code T1023. e-PRAF – Providers receive a $90 payment when the claim is coded with HCPS code H1000 with modifier 33.

For more information, including paper forms and how to submit completed forms, please visit ODM's PRAF website at **https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/praf/praf**.

Claims submission instructions for obstetrical services providers
When submitting claims, service code H1000 with modifier 33 should be used to indicate that an e-PRAF was completed in NurtureOhio to receive the enhanced rate of $90, per OAC 5160-1-60.

Provider benefits of submitting an e-PRAF
The e-PRAF has multiple benefits with one, simple submission:
- The submission maintains a pregnant woman's Medicaid eligibility without disruption in coverage, resulting in prompt provider payment for services throughout the member's pregnancy.
- Information within the PRAF will inform the MCO and other entities of identified needs including physical, behavioral health and SDOH allowing care coordination and services.
- Allows providers to submit additional PRAF's to report change in condition or needs.

Ensuring prompt care
Every pregnant woman with Medicaid coverage should be linked to needed services on her very first prenatal visit. An online e-PRAF submission ensures:
- Medicaid coverage for mother and baby without disruption through the immediate post-partum period.
- Serves as pregnancy notification to managed care plans and initiation of timely health care and connection to added resources, like care management, important for at-risk pregnancies.

Neonatal Intensive Care Unit care management program
Humana Healthy Horizons' Neonatal Intensive Care Unit (NICU) case managers provide telephone-based services for the parents of eligible infants admitted to a NICU.

Case managers in the "Humana Healthy Horizons" NICU Case Management program are registered nurses who help families understand the treatment premature babies receive while they are in the hospital and prepare to care for the infants at home. They engage families during and after the baby's hospital stay. Case managers work closely with physicians and hospital staff to coordinate care during the infant's stay in the hospital and after discharge. They also help parents arrange for home health nurses, ventilators, oxygen, apnea monitors and other equipment and services needed to care for the infant at home. After the infant is discharged from the hospital, nurses call the family to provide additional support. For more information about this program, please call **855-391-8655**. Hours of operation are Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time.

Population health module
The population health module helps primary care providers monitor the clinical measures identified and executed for their assigned members. Providers can access the population health module by logging into Availity Essentials and navigating to the "Humana Payer Spaces" section to view "Resources." Selecting the "Ohio Medicaid Care Management" link then directs providers to the "Population Health Dashboard." This feature allows providers to view member's assessments, care plans, authorizations, ADT, assigned care management program and care manager contact information.

The population health module allows for effective population health management by involving all providers in a patient's care team, while also giving providers the ability to track the clinical measures taken for patient's health improvement by the care management program.

What is Coordinated Services Program (CSP)?
CSP is a health and safety program in which use of abuse potential drugs is monitored and member claims are reviewed for potential assignment to a designated pharmacy. Please visit Coordinated Services Program (ohio.gov) for additional information.

Health education
Humana Healthy Horizons members receive health information from Humana Healthy Horizons through a variety of communication methods, including easy-to-read newsletters, brochures, phone calls and personal interaction. Humana Healthy Horizons also sends preventive care reminder messages to members via mail and automated outreach messaging.

Reporting

Member medical records – MCO documentation, legibility, confidentiality, maintenance, and access standards for member medical records; member's right to amend or correct medical record in accordance with OAC rule 5160-26-05.1

Providers must maintain a comprehensive health record that reflects all aspects of care for each Humana Healthy Horizons-covered patient. Providers must maintain medical records in a secure, timely, legible, current, detailed, accurate and organized manner to permit effective and confidential patient care and quality review. Providers must have a process for members to amend or correct their medical records, in accordance with OAC rule 5160-26-05.1. Records should be safeguarded against loss, destruction or unauthorized use and must be accessible for review and audit. Such records should be readily available to ODM and/or its designee and contain all information necessary for the medical management of each Medicaid member.

Providers must maintain individual health records for each Medicaid member. Procedures also should exist to facilitate the prompt transfer of patient care records to other in- or out-of-network providers.

Standards for member medical records

Member medical records, at a minimum, must include the following:

- Member/patient identification information on each page
- Personal/biographical data, including date of birth, age, gender, marital status, race, ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship information
- Date of data entry and date of encounter
- Provider identification by name
- Allergies, adverse reactions and all known allergies noted in a prominent location
- Past medical history, including serious accidents, operations and illnesses
- For children, past medical history includes prenatal care and birth information, operations and childhood illnesses (e.g., documentation of chickenpox)
- Identification of current problems
- Consultation, laboratory and radiology reports filed in the medical record containing the ordering provider's initials or other documentation indicating review
- Documentation of immunizations
- Identification and history of nicotine, alcohol use or substance use disorder
- Follow-up visits provided secondary to reports of emergency room care
- Hospital discharge summaries
- Advanced medical directives (for adults)
- All written denials of service and reasons for denials
- Signature and title or initials of the provider rendering the service. If more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials.
- Record legibility to at least a peer of the writer. Any record judged illegible by one reviewer is evaluated by another reviewer.

A member's medical record must include the following minimal detail for individual clinical encounters:

- History and physical examination for presenting complaints, containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health and substance use status
- Diagnosis or medical impression
- Objective finding(s)
- Assessment of patient's findings
- Unresolved problems, referrals and results from diagnostic tests, including results and/or status of preventive screening services (e.g., EPSDT) are addressed from previous visits
- Plan of treatment, including:
  - Medication history, medications prescribed, including the strength, amount, directions for use and refills
  - Therapies and other prescribed regimen

- Health education provided
- Follow-up plans including consultation and referrals and directions, including time to return

A member's medical record must include, at a minimum, the following for hospital and mental hospital visits:

- Identification of the beneficiary
- Provider name
- Date of admission and dates of application for and authorization of Medicaid benefits, if application is made after admission; the plan of care (as required under 42 C.F.R. 456.172 [behavioral health hospitals] or 42 C.F.R.456.70 [hospitals])
- Initial and subsequent continued-stay review dates (described under 42 C.F.R. 456.233 and 42 C.F.R. 465.234 [for behavioral health hospitals] and 42 C.F.R. 456.128 and 42 C.F.R. 456.133 [for hospitals])
- Reasons and plan for continued stay, if applicable
- Other supporting material appropriate to include
- For non-behavioral health hospitals only:
  - Date of operating room reservation
  - Justification of emergency admission, if applicable

The member's medical record is the property of the provider who generates the record. Medical records generally should be preserved and maintained by the provider for a minimum of 5 years unless federal requirements mandate a longer retention period (e.g., immunization and tuberculosis records are required to be kept for a person's lifetime).

PCPs and obstetrics and gynecology (OB-GYNs) providers acting as PCPs may be reviewed for their compliance with medical record documentation standards. Identified areas for improvement are tracked and corrective actions are taken as indicated. Effectiveness of corrective actions is monitored until problem resolution occurs.

Confidentiality of member information must be maintained at all times. Records are to be stored securely with access granted to authorized personnel only. Access to records should be granted to Humana Healthy Horizons, or its representatives, without a fee to the extent permitted by state and federal law. Providers must have procedures in place to permit the timely access and submission of health records to Humana Healthy Horizons on request. Information from the health records review may be used in the recredentialing process.

Policies and procedures for MCO action in response to undelivered, inappropriate, or substandard healthcare services in accordance with OAC rule 5160-26-05.1

Humana Healthy Horizons complies with the federal Health Care Quality Improvement Act and has an active peer review committee.

It is the policy of Humana Healthy Horizons:

- To improve the quality and safety of healthcare services provided to our members by our providers through a Provider Quality Review Process and other Humana quality management processes
- To investigate select episodes of care to determine if intervention is appropriate
- To intervene as necessary to bring about provider improvement in care, to protect members, or both
- To offer an opportunity for a hearing and review when Humana Healthy Horizons recommends certain actions that may adversely affect a provider's status for more than 30 days
- To treat and manage confidentially all information, documents, records and reports relating to this and other quality management processes

Interventions may take many forms, including corrective action plans, limitations on provider status, suspensions or termination. Humana Healthy Horizons reports all individual providers who resign after the Provider Quality Review process begins to the National Practitioner Data bank. Humana Healthy Horizons complies with the specific laws of the state in which the activity takes place, including any reporting requirements. To the extent that Humana Healthy Horizons' policy is inconsistent with the laws of the state in which review takes place, state law governs.

To comply with the requirements of accrediting and regulatory agencies, Humana Healthy Horizons adopted certain responsibilities for participating providers that are summarized below. This is not a comprehensive, all-inclusive list. Additional responsibilities are presented elsewhere in this manual and in the Humana Health Plan provider agreement.

Providers must:

- Have a professional degree and a current, unrestricted license to practice medicine in the state in which provider's services are regularly performed.
- Agree to comply with Humana Healthy Horizons' quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures established and revised by Humana Healthy Horizons.
- Maintain full participation status in the Ohio Medicaid program with ODM.
- Certify that the provider and its principals, employees, agents and subcontractors are not excluded, suspended or debarred from participation in any federal healthcare program or the Ohio Medicaid program.
- Be credentialed by ODM's credentialing verification organization (CVO) and meet credentialing and recredentialing standards as required by the National Committee for Quality Assurance (NCQA).
- Provide documentation on their experience, background, training, ability, malpractice claims history, disciplinary actions or sanctions, and physical and mental health status for credentialing purposes.
- Possess a current, unrestricted Drug Enforcement Administration (DEA) certificate, if applicable and/or a state Controlled Dangerous Substance (CDS) certificate or license, if applicable.
- Have a current Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.
- Be a medical staff member in good standing with a participating network hospital(s) if he/she makes plan member rounds and has no record of hospital privileges being reduced, denied or limited, or if so, provide an explanation that is acceptable to the plan.
- Comply with all state and federal law/requirements for database screening and criminal background checks of new hires and current employees and staff who have direct contact with Humana Healthy Horizons members and/or access to Humana Healthy Horizons members' protected health information. Participating providers are prohibited from employing or contracting with individuals or entities that are excluded or debarred from participation in Medicare, Medicaid or any federal healthcare program. Participating providers are required to conduct initial screenings and criminal background checks and to comply with ongoing monitoring requirements of all employees and contractors in accordance with state and federal law. The participating provider is required to immediately report to Humana Healthy Horizons any exclusion information discovered. ODM reserves the right to deny enrollment or terminate a provider agreement with a participating provider as provided under state and/or federal law.
- Assume responsibility for member's receiving post-stabilization care at a hospital at which the provider has privileges until either the member is transferred, agreement is reached between the treating provider and Humana Healthy Horizon concerning the member's care or is discharged.
- Inform Humana Healthy Horizons in writing within 24 hours of any revocation or suspension of their Bureau of Narcotics and Dangerous Drugs number and/or of suspension, limitation or revocation of their license, reduction and/ or denial of hospital privileges, certification, Clinical Laboratory Improvement Amendments (CLIA) certificate or other legal credential authorizing them to practice in any state in which the provider is licensed.
- Inform Humana Healthy Horizons immediately of changes in licensure status, TINs, NPI, telephone numbers, addresses, status at participating hospitals, provider status (additions or deletions from provider practice), loss or decrease in amounts of liability insurance below the required limits and any other change that would affect his/ her participation status with Humana Healthy Horizons.
- Not discriminate against members as a result of their participation as members, their source of payment, age, race, color, national origin, religion, sex, sexual orientation, health status or disability.
- Meet the requirements of all applicable state and federal laws and regulations, including Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act and the Rehabilitation Act of 1973.
- Serve the target population.
- Assure the availability of services to Humana Healthy Horizons members 24 hours a day, 7 days a week when medically necessary.
- Arrange for on-call and after-hours coverage by a participating and credentialed Humana Healthy Horizons provider. (After-hours voicemail is not acceptable.)
- Refer members only to participating providers, except when participating providers are not reasonably available or in an emergency.

- Admit members only to participating network hospitals, skilled nursing facilities and other facilities and work with hospital-based physicians at participating hospitals or facilities in cases of need for acute hospital care, except when participating providers or facilities are not reasonably available or in an emergency.
- Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Humana Healthy Horizons member, other than for copayments, deductibles, coinsurance or other fees that are the member's responsibility under the terms of their benefit plan.
- Provide services in a culturally competent manner, (e.g., removing all language barriers, arranging and paying for interpretation services for limited English proficient [LEP] and the hearing/visually impaired) as required by state and federal law. Care and services should accommodate the special needs of ethnic, cultural and social circumstances of the patient. (Additional information and resources for delivering culturally competent care are available from the U.S. Department of Health and Human Services, Office of Minority Health at minorityhealth.hhs.gov).
- Provide or arrange for continued treatment to all members including, but not limited to, medication therapy, on expiration or termination of the agreement.
- Retain all agreements, books, documents, papers and medical records related to the provision of services to members as required by state and federal laws and in accordance with relevant Humana Healthy Horizons in Ohio policies.
- Treat all member records and information confidentially, and not release such information without the written consent of the member, except as indicated herein, or as allowed by state and federal law, including HIPAA regulations.
- Provide an electronic automated means, on request of Humana Healthy Horizons in Ohio and, at no cost for Humana Healthy Horizons in Ohio and all its authorized vendors acting on behalf of Humana Healthy Horizons in Ohio, to access member clinical information, including, but not limited to, medical records, for all payer responsibilities, including, but not limited to, case management, utilization management, claims review and audit and claims adjudication.
- Transfer copies of medical records for the purpose of continuity of care to other Humana Healthy Horizons in Ohio providers on request and at no charge to Humana Healthy Horizons in Ohio, the member or the requesting party, unless otherwise agreed.
- Submit a report of an encounter for each visit when the member is seen by the provider, if the member receives a Healthcare Effectiveness Data and Information Set (HEDIS®) service. Encounters should be submitted electronically or recorded on a CMS-1500 claim form and submitted according to the time frame listed in the agreement.
- Provider agrees to cooperate with and assist Humana Healthy Horizons in its efforts to comply with its ODM contract and/or rules and regulations and to assist Humana Healthy Horizons in complying with corrective action plans necessary for Humana Healthy Horizons to comply with such rules and regulations.
- Understand and agree that nothing contained in the agreement or this manual is intended to interfere with or hinder communications between providers and members regarding a member's medical condition or available treatment options or to dictate medical judgment.
- Agree to submit a claim on behalf of the member in accordance with timely filing laws, rules, regulations and policies.
- Agree and understand that provider performance data can be used by Humana Healthy Horizons.
- Have an effective compliance program in place that includes review and adherence to the requirements outlined within these separate Humana Healthy Horizons documents:
  - Ethics Every Day for Contracted Healthcare Providers and Third Parties
  - Compliance Policy for Contracted Healthcare Providers and Third Parties

  Completing the training documents listed above, or having materially similar content in place, along with supporting processes, is a strong foundation to year-over-year compliance. These documents can be accessed at **Humana.com/providercompliance**.
- Take disciplinary action when your organization or we identify noncompliance, fraud or abuse.
- Notify us in a timely manner of suspected violations, misconduct or fraud, waste and abuse concerns and action(s) taken.
- Cooperate fully with any investigation of alleged, suspected or detected violations of applicable state or federal laws and regulations.
- Notify us if you have questions or need guidance for proper protocol.

Reporting provider preventable conditions/hospital-acquired conditions (HACs)

Humana Healthy Horizons in Ohio does not pay for services resulting from a provider preventable condition (PPC) as defined in 42 CFR 447.26: a condition that meets the definition of a "healthcare-acquired condition" that also meets the following criteria:

a. Is identified in the Ohio Medicaid state plan;
b. Has been found by the state-based on a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
c. Has a negative consequence for the beneficiary;
d. Is auditable;
e. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
f. Did not exist prior to the initiation of treatment by the provider in question.

Category 1 – Healthcare-acquired conditions (for any inpatient hospitals settings in Medicaid)

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma, including fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock
- Catheter-associated urinary tract infection (UTI)
- Vascular catheter-associated infection
- Manifestations of poor glycemic control, including diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity
- Surgical site infection following:
  - Coronary artery bypass graft (CABG) – mediastinitis
  - Bariatric surgery, including laparoscopic gastric bypass, gastroenterostomy and laparoscopic gastric restrictive surgery
  - Orthopedic procedures, including spine, neck, shoulder and elbow

Category 2 – Other provider preventable conditions (for any healthcare setting)

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

Members access to care or services must not be affected by the prohibition of payment.

Claims data is reviewed to identify services billed as a result of PPC. Identified claims are researched to determine if the claims were accurately billed as a PPC and ensure prohibition of payment of PPC services. Humana Healthy Horizons implements vendor logic for the providers to self-report when a provider-preventable condition has occurred.

Incident reporting

Providers are required to assure the immediate health and safety of members when becoming aware of any abuse, neglect, exploitation, misappropriation greater than $500, self-harm resulting in hospitalization/ER, and accidental/unnatural deaths. If actions were not taken to assure the immediate health and safety of the member, the provider must do so immediately. Such actions may include calling police or EMS, reporting to county Adult Protective Services (APS), the county Public Child Services Agency (PCSA) or regulatory agencies such as the Ohio Department of Health. Providers are required to report these types of incidents to Humana Healthy Horizons within 24 hours of becoming aware of the incident in accordance with OCA rule 5160-44-05. Providers can report by calling us at **877-856-5707**.

How to submit an incident to the MCO

Critical incidents include, but are not limited to, abuse, neglect, exploitation, misappropriation greater than $500, accidental/unnatural death, self-harm or suicide with ER/hospitalization, missing or lost individual, or prescribed medication issues, as per OAC 5160- 44-05. Participating providers are required to report critical incidents to Humana Healthy Horizons as soon as possible after the discovery of the incident, and no later than 24 hours after the critical incident occurred. Please call 877-856-5707 and be prepared to share the following details:

- Facts relevant to the incident, such as a description of what happened
- Incident type
- Date of the incident
- Location of the incident
- Names and contact information of all persons involved
- Any actions taken to ensure the health and welfare of the individual

Humana Healthy Horizons and participating healthcare providers are required to take immediate action, not to exceed 24 hours after an incident is discovered, to prevent further harm to any and all members and respond to any emergency needs of patients.

Next generation managed care program

OhioRISE

Ohio Resilience through Integrated Systems and Excellence (OhioRISE) is a Medicaid managed care program for children and youth with complex behavioral health and multisystem needs. Children and youth with multisystem needs are often involved in multiple community systems such as juvenile justice, child protection, developmental disabilities, education, mental health and addiction, and others. OhioRISE aims to support these children and youth succeed in their schools, homes, and communities. This support is provided through care coordination and specialized services that are proved in home or in the young person's community.

An individual enrolled in OhioRISE has their physical health services covered by their managed care organization or fee-for-service Medicaid. The OhioRISE plan, Aetna Better Health of Ohio, covers their behavioral health services. The MCO is included in the child or youth's care coordination team, whenever their inclusion is requested by the member and family. OhioRISE care coordinators can also help OhioRISE members and families access support from their MCO.

OhioRISE eligibility:

- Enrolled in Ohio Medicaid – either managed care or fee-for-service.
- Be 20 years old or younger at the time of enrollment
- Not be enrolled in a MyCare Ohio plan.
- Meet a functional needs threshold for behavioral healthcare, as identified by the Child and Adolescent Needs and Strengths (CANS) assessment or be inpatient in a hospital with a primary diagnosis of mental illness or substance use disorder.

OhioRISE services:

In addition to the behavioral health services provided through chapter 5160-27 of OAC, the following services are available through OhioRISE:

- Care coordination: Depending on a child or youth's needs, they will receive one of three levels or "tiers" of care coordination. This service is delivered by Aetna or their care management entities (CMEs) in a child or youth's community. OhioRISE members are assigned a care coordinator who has experience working with children, youth, and their families. Care coordinators assist young people and their families with:
  - Making a care plan to ensure the young person's behavioral health needs are met.
  - Helping young people access services and resources.
  - Talking to and providing information to other providers who are involved in the child or youth's care.
- Intensive home-based treatment (IHBT): Provides intensive, time-limited behavioral health services for children, youth and families in their homes. IHBT helps stabilize and improve a young person's behavioral health.
- Psychiatric Residential Treatment Facility (PRTF): PRTFs are facilities, other than hospitals, that provide inpatient psychiatric services to individuals 20 years or younger. Ohio's PRTF service aims to keep young people with the most intensive behavioral health needs in-state and closer to their families and support systems.
- Behavioral health respite: Provides short-term, temporary relief to a child's/youth's primary caregiver(s) in a home or community-based environment.
- Flex Funds: Provides funding of $1,500 in a 365-day period to purchase services or items that address a need in a child or youth's service plan. These items should otherwise not be provided through Medicaid. Funds must be used to purchase services or items that:
  - Reduce the need for other Medicaid services
  - Keep young people and their families safe in their homes
  - Help a child or youth be better integrated into the community

For additional services available for youth enrolled in the OhioRISE waiver see Ohio Administrative Code Rule 5160-59-05.

Additional information on OhioRISE services is available in chapter 5160-59 of the OAC.

Additional information regarding billing for behavioral health services provided to youth who are enrolled in the OhioRISE plan and information for providers to determine to which entity to submit claims is located in the OhioRISE Provider Enrollment and Billing Guidance and the OhioRISE Mixed Services Protocol on the OhioRISE website at **https://managedcare.medicaid.ohio.gov/managed-care/ohiorise/06-community-and-provider-resources.**

Aetna Better Health of Ohio can be reached by calling **833-711-0773** or emailing **OHRISE-Network@aetna.com**.

Single Pharmacy Benefit Manager

The Single Pharmacy Benefit Manager (SPBM) is a specialized managed care program operating as a prepaid ambulatory health plan (PAHP) that provides pharmacy benefits for the entire Medicaid managed care population (excluding MyCare Ohio members). ODM selected Gainwell Technologies to serve as the SPBM. An additional integral component to the new pharmacy model is the Pharmacy Pricing and Audit Consultant (PPAC), which conducts Ohio actual acquisition cost surveys, cost of dispensing surveys, and perform oversight and auditing of the SPBM. ODM selected Myers and Stauffer, L.C. to serve as the PPAC.

The SPBM consolidates the processing of pharmacy benefits and maintains a pharmacy claims system that integrates with the Ohio Medicaid Enterprise System (OMES), new MCOs, pharmacies and prescribers. The SPBM also works with pharmacies to ensure member access to medications, supporting ODM's goals of providing more pharmacy choices, fewer out-of-network restrictions, and consistent pharmacy benefits for all managed care members. SPBM also reduces provider and prescriber administrative burden by using a single set of clinical policies and prior authorization procedures, as well as a single pharmacy program point of contact for all members.

All Medicaid managed care members are automatically enrolled with the SPBM under a 1915(b) waiver.

Additionally, Gainwell Technologies is required to contract with all enrolled pharmacy providers who are willing to accept the SPBM contract terms, resulting in a broad pharmacy network that ensures access for all members statewide.

SPBM provides coverage for medications dispensed from contracted pharmacy providers. Provider-administered medications supplied by non-pharmacy providers, such as hospitals, clinics and physician practices, continue to be covered by the MCOs or the OhioRISE plan, as applicable.

To view current medical and pharmacy coverage policies, please visit **Medical and Pharmacy Coverage Policies webpage.**

For more information about the SPBM or PPAC initiatives, please email **MedicaidSPBM@medicaid.ohio.gov** or visit the Gainwell Technologies website at **https://spbm.medicaid.ohio.gov**.

Quality improvement

Overview

Humana Healthy Horizons' Quality Improvement Program (QI Program) is a comprehensive quality improvement program that is focused on health equity and encompasses clinical care, preventive care, population health management and the health plan's administrative functions. It is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable medical and behavioral healthcare and services. Strategies are identified and activities implemented in response to findings. Using a continuous quality improvement methodology, the QI Program works to:

- Monitor system-wide issues
- Identify opportunities for improvement
- Determine the root cause of problems identified
- Explore alternatives and develop a plan of action
- Activate the plan, measure the results, evaluate effectiveness of actions, and modify the approach, as needed

The QI Program activities include monitoring clinical indicators or outcomes, quality studies, HEDIS measures and/or medical record audits. The Quality Improvement Committee (QIC) is delegated by Humana's Board of Directors to monitor and evaluate the results of program initiatives and to implement corrective action when the results are less than desired or when areas needing improvement are identified. The QIC is accountable to the Humana Healthy Horizons Executive Management Team.

The goals of the QI Program are:

- To develop clinical strategies and provide clinical programs that look at the whole person, while integrating behavioral and physical healthcare.
- To identify and resolve issues related to member access and availability to healthcare services.
- To address healthcare disparities and ensure equitable access to and the delivery of services to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds or disabilities, and regardless of gender, sexual orientation or gender identity.
- To provide a mechanism in which members, practitioners, and providers can express concerns to Humana Healthy Horizons regarding care and service.
- To monitor coordination and integration of member care across provider sites.
- To monitor, evaluate and improve the quality and appropriateness of care and service delivery to members through peer review, performance improvement projects (PIPs), medical/case record audits, performance measures, surveys and related activities.
- To provide a comprehensive strategy for population health management that addresses member needs across the continuum of care.
- To develop QI activities and initiatives to improve population health outcomes.
- To provide mechanisms to assess the quality and appropriateness of care furnished to members with special healthcare needs.
- To guide members to achieve optimal health by providing tools that help them understand their healthcare options and take control of their health needs.
- To adopt reimbursement models that incentivize the delivery of high-quality care.
- To promote better communication between departments and improve service and satisfaction to members, practitioners, providers and associates.
- To promote improved clinician experience for providers and all clinicians to foster greater member safety, provider satisfaction, and provider retention.

Provider participation in the quality improvement program

Network providers are contractually required to comply with Humana Healthy Horizons' Quality Improvement Program, which includes providing member records for assessing quality of care. In addition, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 Privacy Rule 45 CFR 164.506 and rules and regulations promulgated thereunder (45 CFR Parts 160, 162 and 164) permits a covered entity (provider) to use and disclose protected health information (PHI) to health plans without member authorization for treatment, payment and healthcare operations activities. Healthcare

operations include, but are not limited to, the health plan conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing healthcare costs, care management and care coordination. Providers also must allow Humana Healthy Horizons to use provider performance data.

Humana Healthy Horizons evaluates the effectiveness of the QI Program on an annual basis. Information regarding the QI Program is available on request and includes a description of the QI Program and a report assessing the progress in meeting goals.

An annual report is published which reviews completed and continuing QI activities and addresses the quality of clinical care and service, institutes measures to assess performance in quality of clinical care and quality of service, identifies any corrective actions implemented or corrective actions recommended or in progress, and identifies any modifications to the QI Program. This report is available as a written document.

To receive a written copy of Humana Healthy Horizons' Quality Improvement program and its progress toward goals, call us at **1-877-856-5707**.

Member satisfaction

On an annual basis, Humana Healthy Horizons conducts a member satisfaction survey of a representative sample of members. Satisfaction with access to services, quality, provider communication and shared decision-making is evaluated. The results are compared to Humana Healthy Horizons' performance goals, and improvement action plans are developed to address any areas not meeting the standard.

Clinical practice guidelines

These protocols incorporate relevant, evidence-based medical and behavioral health guidelines from recognized sources such as professional medical associations, voluntary health organizations and National Institutes of Health (NIH) centers and institutions. Humana Healthy Horizons considers the needs of our members when adopting guidelines.

Contracted network providers and Humana Healthy Horizons internal physicians from a cross section of disciplines review and approve adoption of the guidelines and are reviewed quarterly. The guidelines help providers make decisions regarding appropriate healthcare for specific clinical circumstances. We strongly encourage providers to use and consider these guidelines whenever they promote positive outcomes for clients. The provider remains responsible for ultimately determining the applicable treatment for everyone.

The use of these guidelines allows Humana Healthy Horizons to measure the impact of the guidelines on outcomes of care. Humana Healthy Horizons monitors provider implementation of guidelines using claim, pharmacy and utilization data. Areas identified for improvement are tracked and corrective actions are taken as indicated.

Preventive health guidelines and clinical practice guidelines are distributed to all new and existing providers through the following formats:

- Provider manual updates
- Provider communications
- Provider website

Providers also can receive preventive health and clinical practice guidelines through the care management department or their Provider Relations representative. Clinical practice guidelines also are available on our website at **https://provider.humana.com/patient-care/guidelines**.

Healthcare Effectiveness Data and Information Set

Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. HEDIS® includes care coordination measures for members transitioning from a hospital or emergency department to home in which hospitals and providers have additional responsibilities. Humana Healthy Horizons may conduct medical record reviews to validate HEDIS measures. In addition to medical record reviews, information for HEDIS® is gathered administratively via claims, encounters and submitted supplemental data. There are two primary routes for supplemental data:

- Nonstandard supplemental data involves directly submitted, scanned images (e.g., PDF documents) of completed attestation forms and medical records. Nonstandard data also can be accepted electronically via a proprietary Electronic Attestation Form (EAF) or Practitioner Assessment Form (PAF). Submitted nonstandard supplemental data is subject to audit by a team of nurse reviewers before closing a HEDIS® improvement opportunity.

- Standard supplemental data flows directly from one electronic database (e.g., population health system, EMR) to another without manual interpretation. Therefore, standard supplemental data is exempt from audit consideration. Standard supplemental data can be accepted via HEDIS®-specific custom reports extracted directly from the provider's EMR or population health tool and is submitted to Humana Healthy Horizons via either secure email or FTP transmission. Humana Healthy Horizons also accepts lab data files in the same way. Humana Healthy Horizons partners with various EMRs to provide member summaries and detail reports and to automatically retrieve scanned charts.

External quality reviews

ODM retains an external quality review organization (EQRO) for an annual external and independent review of the quality, outcomes, timeliness of, and access to services provided by Humana Healthy Horizons, including medical record reviews for Humana Healthy Horizons members. Participating providers are expected to partner with Humana Healthy Horizons on any EQRO activities.

Patient safety to include quality of care and quality of service

Humana Healthy Horizons supports implementation of a complete range of patient safety activities. These activities include medical record legibility and documentation standards, communication and coordination of care across the healthcare network, utilization of evidence-based clinical guidelines to reduce practice variations, tracking and trending adverse events/quality of care issues and grievances related to safety and quality of care.

Patient safety is also addressed through adherence to clinical guidelines that target preventable conditions. Preventive services include:

- Regular checkups for adults and children
- Prenatal care for pregnant women
- Well-baby care
- Immunizations for children, adolescents and adults
- Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, sexually transmitted diseases, PAP smears and mammograms

Preventive guidelines address prevention and/or early detection interventions and recommended frequency and conditions under which interventions are required.

Prevention activities are based on reasonable scientific evidence, best practices and member needs.

Prevention activities include distribution of information, encouragement to use screening tools and ongoing monitoring and measuring of outcomes. While Humana Healthy Horizons implements activities to identify interventions, the support and activities of families, friends, providers and the community have a significant impact on prevention.

Quality improvement requirements

Humana Healthy Horizons monitors and evaluates provider quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to members using the following methods:

- Performance improvement projects (PIPs) – Ongoing measurements and interventions which seek to demonstrate significant improvement to the quality of care and service delivery sustained over time, in both clinical care and nonclinical care areas, that have a favorable effect on health outcomes and member satisfaction.
- Member medical record reviews – Medical record reviews to evaluate documentation patterns of providers and adherence to member medical record documentation standards. Medical records also may be requested when investigating complaints of poor quality, service or clinical outcomes. Your contract with Humana Healthy Horizons requires that you furnish member medical records to us for this purpose. Member medical record reviews are a permitted disclosure of a member's PHI, in accordance with HIPAA. The record reviewers protect member information from unauthorized disclosure as set forth in the Contract and ensure all HIPAA guidelines are enforced.

Access standards

Providers must offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid managed care members. Participating PCPs and medical/behavioral health specialists are required to ensure adequate accessibility for healthcare 24 hours a day, 7 days a week when medically necessary. An after-hours PCP telephone number must be available to members. Voicemail is not permitted. Humana Healthy Horizons in Ohio's provider network must meet ODM's access standards as follows:

Type of visit	Description	Minimum standard
Emergency service	Services needed to evaluate, treat, or stabilize an emergency medical condition.	24 hours, 7 days/week
Urgent care (includes medical, behavioral health, and dental services)	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include but are not limited to sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain, and severe, non-resolving headache. Includes acute illness or substance dependence that impacts the ability to function, but does not present imminent danger.	Within 24 hours, 7 days/week
Behavioral health, non-life-threatening emergency	A non-life-threatening situation in which a member exhibits extreme emotional disturbance or behavioral distress, has a compromised ability to function, or is otherwise agitated and unable to be calmed.	Within 6 hours
Behavioral health routine care	Requests for routine mental health or substance-use treatment from behavioral health providers.	Within 10 business days or 14 calendar days, whichever is earlier
CANS initial assessment	Assessment for the purposes of OhioRISE eligibility	Within 72 hours of identification
ASAM residential services	Initial screening, assessment and referral to treatment	Within 48 hours of request
ASAM medically managed intensive inpatient services – 4	Services needed to treat and stabilize a member's behavioral health condition.	24 hours, 7 days/week
Primary care appointment	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and Pap tests.	Within 30 calendar days
Non-urgent sick primary care	Care provided for a non-urgent illness or injury with current symptoms.	Within 3 calendar days
Prenatal care – First or second trimester	Care provided to a member while the member is pregnant to keep member and baby healthy; includes checkups and prenatal testing.	First appointment within 7 calendar days; follow up appointments no more than 14 calendar days after request
Prenatal care – Third trimester or high-risk pregnancy		Within 3 calendar days
Specialty care appointment	Care provided for a non-emergent/non-urgent illness or injury requiring consultation, diagnosis, and/or treatment from a specialist.	Within 6 weeks
Dental appointment	Non emergent/non urgent dental services, including routine and preventive care.	Within 6 weeks of request

These appointment availability standards do not replace the access requirements established by ODM for comprehensive primary care (CPC) practices.

Type of visit	Description	Minimum standard
24/7 and same-day access to care	Practice offers at least 1 alternative to traditional office visits to increase access to the patient care team and clinicians in ways that best meet the needs of the population. This may include e-visits, phone visits, group visits, home visits, alternate location visits or expanded hours in the early mornings, evenings and weekends. A practice must offer access to a PCP with access to the member's medical record within 24 hours of an initial request. The practice also must make a member's clinical information available through paper or electronic records, telephone consultation to on-call staff, external facilities and other clinicians outside the practice when the office is closed.	

PCP after-hours availability

The PCP provides, or arranges for, coverage of services, consultation or approval for referrals 24 hours a day, 7 days a week by Medicaid-enrolled providers who accept Medicaid reimbursement. This coverage must consist of an answering service, call forwarding, provider call coverage or other customary means approved by the agency. The chosen method of 24 hours a day, 7 days a week 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 arranges 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.

Preventive and clinical practice guidelines

Preventive health guidelines and clinical practice guidelines are distributed to all new and existing providers via the following formats:

- Humana's provider website at **Provider.humana.com/patient-care/guidelines**
- Provider manual updates
- Provider communications

The protocols:

- Incorporate relevant, evidence-based medical and behavioral health guidelines from recognized sources, such as professional medical associations, voluntary health organizations and NIH centers and institutes
- Help providers make decisions regarding appropriate healthcare for specific clinical circumstances

We strongly encourage providers to use these guidelines to promote positive outcomes for their Humana Healthy Horizons-patients. The provider ultimately remains responsible for determining the applicable treatment for each individual.

The use of these guidelines allows Humana Healthy Horizons to measure the impact of the guidelines on outcomes of care. Humana Healthy Horizons monitors provider implementation of guidelines through the use of claim, pharmacy and utilization data. Areas identified for improvement are tracked and corrective actions are taken as indicated.

Fraud, waste and abuse policy

Providers must incorporate a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse and subsequent correction of identified fraud or abuse into their policy and procedures. Contracted providers agree to educate their employees about:

- The requirement to report suspected or detected fraud, waste or abuse (FWA)
- How to make a report of the above
- The False Claims Act's prohibition on submitting false or fraudulent claims for payment, penalties for false claims and statements, whistleblower protections and each person's responsibility to prevent and detect FWA.

Humana Healthy Horizons and Ohio Department of Medicaid should be notified immediately if a physician/provider or their office staff:

- Is aware of any physician/provider that may be billing inappropriately, e.g., falsifying diagnosis codes and/or procedure codes, or billing for services not rendered;
- Is aware of a member intentionally permitting others to use their member ID card to obtain services or supplies from the plan or any network provider;

- Is suspicious that someone is using another member's ID card;
- Has evidence that a member knowingly provided fraudulent information on their enrollment form that materially affects the member's eligibility.

Providers may provide the above information via an anonymous phone call to Humana's Fraud Hotline at **800-614-4126**. All information is kept confidential. Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Humana ensures no retaliation against callers as Humana has a zero-tolerance policy for retaliation or retribution against any person who reports suspected misconduct.

Providers also may contact Humana at **800-4HUMANA (800-448-6262)** or use the following contacts:

- Special Investigations Unit (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** or **Special Investigations Referral Form**

Providers also may contact ODM by calling **614-466-0722** or online by visiting ODM's Medicaid Fraud webpage at **https://medicaid.ohio.gov/stakeholders-and-partners/helpfullinks/reporting-suspected-medicaid-fraud.**

Ohio Attorney General's Office Medicaid Fraud Control Unit (MFCU) by phone at **800-282-0515** or online at Ohio Attorney General's Medicaid fraud reporting website at **https://www.ohioattorneygeneral.gov/About-AG/Service-Divisions/** Health-Care-Fraud/Report-Medicaid-Fraud and the Ohio Auditor of State (AOS) by phone at 866-FRAUD-OH **(866-372-8364)** or by email at **fraudohio@ohioauditor.gov**.