2026

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

Humana Healthy Horizons® in Ohio strives 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 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

Nondiscrimination

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: **Humana's Notice of Non-Discrimination webpage**)

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 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 opportunities 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)
- On-site case management (clinics and facilities)
- Emergency department diversion program
- 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 Monday – Friday, 7 a.m. – 8 p.m., Eastern time. 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) Monday – Friday, 7 a.m. – 8 p.m., Eastern time
24-hour nurse advice line: 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)

Humana Healthy Horizons 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.

Provider disputes

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

Member grievances 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 relations 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:

Email: **OHMedicaidProviderRelations@humana.com**

Provider relations representative assignment map

Provider relations representative assignments by county

Provider resources

Helpful websites

Providers may obtain plan information from our **Humana Healthy Horizons in Ohio provider webpage**. 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
- Provider publications (including the provider manual, Humana Physician News [quarterly updates] and program updates)
- 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 (PA) 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 Ohio Department of Medicaid (ODM)'s Provider Network Management (PNM) system. Please visit the **Ohio Department of Medicaid's Login webpage** to create an account. If you would like more information, please visit the **PNM & Centralized Credentialing website**. 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 are accessible from Availity Essentials. To learn more, call Availity at 800-282-4548 or visit **Availity Essentials**.

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 [ERA] and electronic funds transfer [EFT] enrollment should be submitted)
- View member summaries
- Confirm/remedy overpayment
- Confirm/remedy appeal

Member enrollment and eligibility

Medicaid eligibility

Medicaid eligibility is determined by ODM in the county where the member resides.

ODM provides enrollment 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 member. Although PA for the delivery is not required, the notification of birth is required. Humana Healthy Horizons must notify the County Department of Job and Family Services 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 **Medicaid Notification of Birth Form**

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, the member loses 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 Ohio Department of Job and Family Services (ODJFS) for disenrollment. ODJFS reviews each member disenrollment request 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 3 consecutive appointments, providers can request assistance from the Humana Healthy Horizons Care Management department by emailing **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 3 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 3 documented unsuccessful education attempts.

- A copy of the letter must be sent or faxed to Humana Healthy Horizons in Ohio via the 1 of the following methods:
  - Mail: **Humana Provider Relations**
    Grievances and Appeals 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 1 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 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 and must be in Humana Healthy Horizons' provider network. 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, 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
- 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:

– **Mail: Humana Provider Relations**
  Grievances and Appeals 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 reenrolled 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 (HRA) survey
- Member continuity of care form
- Notice of advance directives
- Notification of privacy protections
- Other preventive health education materials and information

Member ID cards

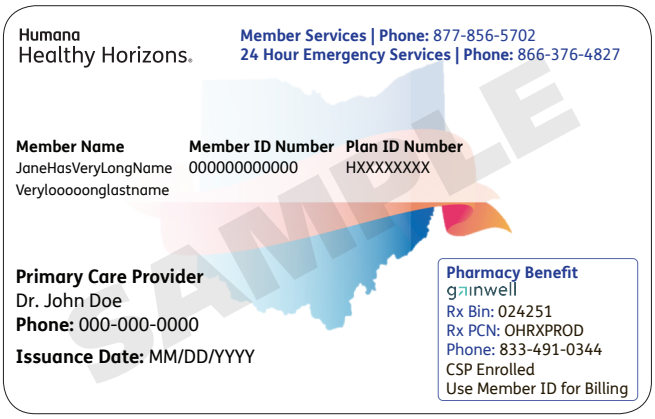
All new Humana Healthy Horizons members receive a Humana Healthy Horizons member ID card. A new card is issued only when the information on the card changes, if a member loses a card or if a member requests an additional card.

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. Providers can verify eligibility at **Availity Essentials**. The ID card contains the following information:

- Member name
- Date of birth: member's date of birth
- Humana Healthy Horizons in Ohio member plan ID number
  - Do not use this number to bill Humana Healthy Horizons (begins with "H").
- Medicaid member ID number: Use this number for Ohio Medicaid member identification on claims submitted to Humana (begins with "number").
- PCP/clinic name: Each member chooses a participating provider to be the member's 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
- Website: Our website contains plan information and access to special functionality, including eligibility verification, claim and PA 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 ODM that a member has lost eligibility retroactively. This occurs occasionally, and in those situations, Humana Healthy Horizons 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.



Humana
Healthy Horizons.

Member Services | Phone: 877-856-5702
24 Hour Emergency Services | Phone: 866-376-4827

Member Name	Member ID Number	Plan ID Number
JaneHasVeryLongName Verylooooonglastname	000000000000	HXXXXXXXX

Primary Care Provider
Dr. John Doe
Phone: 000-000-0000
Issuance Date: MM/DD/YYYY

Pharmacy Benefit
gainwell
Rx Bin: 024251
Rx PCN: OHRXPROD
Phone: 833-491-0344

Use Member ID for Billing

SAMPLE

Member Services | Phone: 877-856-5702
24 Hour Emergency Services | Phone: 866-376-4827

Information for Members
Directions for what to do in an emergency
Please present this card each time before you receive medical care except in an emergency. In case of emergency, call 911 or go to the closest emergency room.
Please visit us at: **Humana.com/HealthyOhio**

Information for Providers
Please verify member eligibility on Date of Service via the ODM provider portal before rendering services.
Payor ID: 61103
Please visit **Humana.com/HealthyOH** for detailed billing instructions or call 877-856-5707 for assistance.
Providers may also call the ODM IHD at 800-686-1516 for assistance.

Ohio Department of Medicaid

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SAMPLE

Humana
Healthy Horizons.

Member Services | Phone: 877-856-5702
24 Hour Emergency Services | Phone: 866-376-4827
OhioRISE Member Service | Phone: 833-711-0773

Member Name	Member ID Number	Plan ID Number	OhioRISE
JaneHasVeryLongName Verylooooonglastname	000000000000	HXXXXXXXX	aetna Aetna Better Health of Ohio **Phone:** 833-711-0773

Primary Care Provider
Dr. John Doe
Phone: 000-000-0000
Issuance Date: MM/DD/YYYY

Pharmacy Benefit
gainwell
Rx Bin: 024251
Rx PCN: OHRXPROD
Phone: 833-491-0344
CSP Enrolled
Use Member ID for Billing

SAMPLE

Member Services | Phone: 877-856-5702
24 Hour Emergency Services | Phone: 866-376-4827
OhioRISE Member Service | Phone: 833-711-0773

Information for Members
Directions for what to do in an emergency
Please present this card each time before you receive medical care except in an emergency. In case of emergency, call 911 or go to the closest emergency room.
Please visit us at: **Humana.com/HealthyOhio**

Information for Providers
Please verify member eligibility on Date of Service via the ODM provider portal before rendering services.
Payor ID: 61103
Please visit **Humana.com/HealthyOH** for detailed billing instructions or call 877-856-5707 for assistance.
Providers may also call the ODM IHD at 800-686-1516 for assistance.
CSP Pharmacy Name: XXXXXXXXXXX
CSP Pharmacy Phone Number: 000-000-0000

OhioRISE
Ohio Department of Medicaid

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SAMPLE

Humana
Healthy Horizons.

Member Services | Phone: 877-856-5702
24 Hour Emergency Services | Phone: 866-376-4827
OhioRISE Member Service | Phone: 833-711-0773

Member Name	Member ID Number	Plan ID Number	OhioRISE
JaneHasVeryLongName Verylooooonglastname	000000000000	HXXXXXXXX	aetna Aetna Better Health of Ohio **Phone:** 833-711-0773

Primary Care Provider
Dr. John Doe
Phone: 000-000-0000
Issuance Date: MM/DD/YYYY

Pharmacy Benefit
gainwell
Rx Bin: 024251
Rx PCN: OHRXPROD
Phone: 833-491-0344

Use Member ID for Billing

SAMPLE

Member Services | Phone: 877-856-5702
24 Hour Emergency Services | Phone: 866-376-4827
OhioRISE Member Service | Phone: 833-711-0773

Information for Members
Directions for what to do in an emergency
Please present this card each time before you receive medical care except in an emergency. In case of emergency, call 911 or go to the closest emergency room.
Please visit us at: **Humana.com/HealthyOhio**

Information for Providers
Please verify member eligibility on Date of Service via the ODM provider portal before rendering services.
Payor ID: 61103
Please visit **Humana.com/HealthyOH** for detailed billing instructions or call 877-856-5707 for assistance.
Providers may also call the ODM IHD at 800-686-1516 for assistance.

OhioRISE
Ohio Department of Medicaid

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SAMPLE

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, promote preventive healthcare and 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, non-emergency transportation coordination and benefits. Representatives are available by calling 877-856-5702, Monday – Friday, 7 a.m. – 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 day-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 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])
- Urgent and nonurgent care advice
- Health and 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 experiencing a mental health or addiction crisis and 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 ODM** website.

Visit the **Centers for Medicare & Medicaid Services (CMS)** website.

Visit the **Council for Affordable Quality Healthcare Inc. (CAQH)** provider website.

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**.

Provider engagement council

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

The HUM OH PEC selects a wide array of provider types to participate, including dental and behavioral health providers. Meetings take place no less than semiannually, and attendees can attend in person, by phone or by webinar. The HUM OH PEC discusses various topics that enable Humana Healthy Horizons 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 Healthy Horizons policy and procedures. Humana Healthy Horizons sends providers network bulletins and posts policy notices on our **Communications and network notices** webpage 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), Monday – Friday, 7 a.m. – 8 p.m., Eastern time

Humana Healthy Horizons 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 training

Education

Humana Healthy Horizons conducts an initial educational orientation 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 Healthy Horizons-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 and abuse
- 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**.

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 2 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 sign in to Availity Essentials > Payer Spaces > Humana > Humana Learning Center.

Please note: Humana's separate Compliance Policy and Standards of Conduct documents are available for review and download on our **Addressing fraud, waste and abuse webpage**.

Forms

- **ODM forms webpage**
- **Consent for release of medical information** form
- Hysterectomy, abortion and sterilization forms
  - **Abortion certification** form
  - **Acknowledgement of hysterectomy information** form
  - **Consent for sterilization** form

- Standardized appeal form: **Humana Healthy Horizons Appeals and grievances webpage**
- **SUD Residential Treatment Notification of Admission** form
- **Medicaid Managed Care Provider Addenda**
- **Medicaid Addendum**
- **MCE Out-of-Network and Managed Care-Only Provider Application**
- **Ohio Medicaid Provider Enrollment Agreement**
- Humana Healthy Horizons **Prior authorization resources** webpage

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 are also 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 PHI 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) 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 PNM system and utilized to populate ODM's centralized provider directory. This information for credentialed providers will be transmitted to MCOs on a weekly basis for them to align their directories with the information contained in the PNM.

Delivering high-quality care means recognizing and respecting the diverse cultural, linguistic and social backgrounds of the individuals we serve. Providers are expected to offer services in a culturally and linguistically appropriate manner, ensuring no patient faces barriers due to language, cultural beliefs or social circumstances.

Humana Healthy Horizons is committed to building a provider network that reflects the diversity of our members and ensures all our members have a fair and just opportunity to reach their full health potential. This includes compliance with all applicable federal and state laws and regulations, such as:

- Title VI of the Civil Rights Act of 1964
- The Age Discrimination Act of 1975
- The Americans with Disabilities Act (ADA)
- The Rehabilitation Act of 1973

We recognize that race, ethnicity, language and socioeconomic status significantly influence healthcare experiences and outcomes. Cultural misunderstandings, language barriers and differing health beliefs can contribute to differences in care. Providers play a vital role in bridging these gaps through culturally competent communication and care delivery.

A 2023 workshop hosted by the National Institutes of Health (NIH) and the Agency for Healthcare Research and Quality (AHRQ) emphasized a healthcare workforce reflective of the cultural and linguistic diversity of the communities it serves. The workshop highlighted the importance of understanding cultural foodways, communication styles and social norms in improving care outcomes for underrepresented populations.

Practical tips for providers

To support culturally competent care, providers should:

- Offer language assistance services, including qualified interpreters and translated materials at no cost to patients with limited English proficiency (LEP).
- Collect and use race, ethnicity and language data to identify differences and tailor interventions.
- Participate in cultural competency training to enhance awareness of implicit bias, communication styles and culturally influenced health behaviors.
- Respect cultural health beliefs and practices and incorporate them into care plans when appropriate.
- Use plain language and confirm understanding through teach-back methods, especially during cross-cultural interactions.

Humana Healthy Horizons supports providers with:

- Access to language services
- Training modules on cultural awareness and cultural competence
- Data tools to identify and address gaps in care
- Educational materials from trusted health organizations

Together, we can ensure every member receives respectful, responsive and equitable care regardless of background.

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 Provider Services at 877-856-5707. Humana also offers training material on this topic on our **Provider compliance training materials** webpage.

Clear communication

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 for 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 can 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 nonsecure website and member materials
- TTY/TDD services

Members can request a written translation of Humana Healthy Horizons documentation mailed to them. Members should call Member Services at 877-856-5702 (TTY: 711) 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 is also 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 healthcare providers with a lot of respect. These patients may feel uncomfortable questioning providers' 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 the member's 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 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:

- 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:
  - The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered
  - Any information the member needs to decide among all relevant treatment options
  - The risks, benefits and consequences of treatment or nontreatment
  - 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
- To receive information on grievance, appeal and state hearing procedures
- To have access to Humana Healthy Horizons' policies and procedures covering the authorization of services
- 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
- To challenge, on behalf of Humana Healthy Horizons members, the denial of coverage of, or payment for, medical assistance
- 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
- 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 the following 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 by visiting **Availity Essentials**.
- 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 actions taken.
- Complete separate, required training sessions on multiple topics and, when required, submit at an organization-level attestation certifying completion. Additional, related information is in the **Required Training** section of this manual.
- 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 actions 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., National Provider Identifier [NPI] and Ohio Medicaid ID) in ODM's PNM system.
- Notify us if you have questions or need guidance for proper protocol.

PCP 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/GYN). 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 6 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 preventive care
- Recommending referrals to specialists, as required
- Triaging members in accordance with previously stated 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
- providing the same high standards of care and operating hours
- Managing and coordinating the medical and behavioral healthcare needs of members to ensure 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 PA 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 members 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 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 (e.g., e-visits, phone visits, group visits, home visits, alternate location visits or expanded hours in the early mornings, evenings, and weekends).
- CPC must provide access to a PCP with access to the member's medical record within 24 hours of an initial request.
- The practice must make members' clinical information 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 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 they don't provide due to ethical reasons by emailing 1 of the following:

- 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 must also 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. To register for a live provider orientation training, please visit our **Provider training and education sessions** webpage.

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), found on our **Provider training and education sessions** webpage†
- 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 to us annually, on request, to certify 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 functions 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 Healthy Horizons training modules for the topics listed above, as well as an organization-level attestation form, can be accessed online within **Availity Essentials**.

For additional provider training, please visit our **Humana Healthy Horizons in Ohio provider webpage**.

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 the providers' responsibility to ensure they are fully enrolled with Ohio Medicaid. Each provider is required to have an NPI. Humana Healthy Horizons may deny reimbursement for covered services if it determines a 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 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 availability
- 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 Humana Healthy Horizons can refer to them members who make requests to see a provider who shares their race, ethnicity or language.

If you have additional questions, email Humana Healthy Horizons at:

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

Procedure to notify MCO 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 1 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 Member Services at 877-856-5702 (TTY: 711) 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 member's permanent medical record. 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 the member 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 (e.g., 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 ODM's value-based payment (VBP) models, including 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**.

In addition to ODM's VBP models, Humana Healthy Horizons-contracted providers can participate in a variety of VBPs 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 HIEs. HIEs provide 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 an 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**.

Critical incidents and abuse, neglect and exploitation

Critical incident and abuse, neglect and exploitation reporting

Critical incidents include, but are not limited to, abuse (verbal, physical, sexual, psychological or emotional abuse), neglect, exploitation, misappropriation greater than $500, accidental/unnatural death, self-harm or suicide resulting in ER/hospitalization, misuse or unauthorized use of restrictive interventions or seclusions, a medication error resulting in a call or consultation with a poison control center, emergency department visit, urgent care visit, hospitalization, or death, per Ohio Administrative Code 5160-26-14.

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. Report to Humana Healthy Horizons Member Services by calling 877-856-5702 or email **OHMCDCareManagement_BH@humana.com** using the following template to submit information:

- Send an email as High Priority Email to Humana Care Management (CM) with the below information within 2 hours of being notified of the incident.
- Subject Line: "URGENT- Critical Incident"
- In the email include the following information:
  - Member Name
  - Member ID
  - Member date of birth
  - Phone number
  - Type of incident: Select options from OH Medicaid critical incident type.
  - Date of incident
  - Location of incident
  - First and last names of all alleged persons responsible
  - Brief description of incident: Insert what happened, any other parties involved, etc.
  - Name, phone number, email details of reporting associate if follow-up needed
  - Date and time notified of the incident
    - Any action taken for health, safety, and welfare of the individual?
    - Any notification to 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).

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 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 the number on the back of their member ID card or visit the **Humana accessibility support** webpage.

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 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 the individual 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 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 the member's 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 Healthy Horizons, 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

- Obtain direct access to a women'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 women's health specialist.
- Be provided a second opinion from a qualified healthcare professional who participates with Humana Healthy Horizons
  - If such a qualified healthcare 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 provider 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 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).
- 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 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 **Humana Healthy Horizons in Ohio member website**.

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 2025 is $730 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 provider 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**
- 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** 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 PNM 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 submitted through our **Join Our Network** website.

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. Visit this link to see a **sample of the participation agreement**.

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 1 year from the date of the final notification letter, the provider may reapply to Humana Healthy Horizons 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 Healthy Horizons in writing as follows:

1. Submit a request to appeal any denial of participation in writing to **OhioNetworkSpecialist@humana.com**.
2. Attach any additional documented information to the physician requests Humana Healthy Horizons reviews to support the provider's appeal.
3. Include the name and address of the contact person for the provider with the 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 Healthy Horizons.

Please note the provider must submit all documentation and supporting information they wish Humana Healthy Horizons to consider at least 1 day prior to the date of the scheduled meeting to consider the provider's appeal.

On receipt of written request of appeal from a provider, Humana Healthy Horizons schedules a meeting to discuss the appeal. The provider is then sent a letter containing 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 Healthy Horizons' final decision.

Suspension

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

Termination

Humana Healthy Horizons notifies providers of a participation agreement (i.e., contract) termination or nonrenewal 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.

The provider must provide Humana Healthy Horizons with notice according to the terms outlined in the participation agreement regarding any termination or nonrenewal to allow Humana Healthy Horizons 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 Healthy Horizons 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 Provider Services center is available at 877-856-5707, Monday – Friday, 7 a.m. – 8 p.m., Eastern time. 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 Healthy Horizons 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 Healthy Horizons' responsibilities under the 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 Healthy Horizons 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.

The delegation process begins with Humana Healthy Horizons performing a predelegation audit prior to any function being delegated to a prospective entity. After approval and an executed delegation agreement, Humana Healthy Horizons performs an annual audit on an ongoing basis until the delegation agreement is terminated.

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

- Ability to perform the delegated functions
- Compliance with accreditation organization standards, state and federal rules, laws and regulations, Humana Healthy Horizons 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)

Humana Healthy Horizons continues to monitor all delegated entities through the collection of periodic reporting outlined. The delegate must submit all required reporting for all delegated functions as outlined within the contract and related addenda or attachments. 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, accreditation standards 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 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 additional corrective measures including immediate suspension or revocation of all or any portion of the functions and activities delegated or withholding a portion of the reimbursement or payment under the contract agreement.

Humana Healthy Horizons 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 to 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.

Delegation 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 that 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.
- Use Humana Healthy Horizons member templates for all member communications. Delegate must implement any updates to templates within 30 calendar days of notification of updates from Humana Healthy Horizons.
- Comply with requirements to issue member denial and approval letters in the member's preferred language if required by state laws, rules or regulations.

Utilization management delegation requirements

Delegation of utilization management (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 or concurrently (including urgent/emergent).

UM 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 accreditation 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.
- Formally review, revise, date and sign policies and procedures annually. Effective dates should be present on policies or on a policy master list.
- Agree not to have a more stringent PAL than the **Humana Healthy Horizons PAL**. If the delegate is delegated for both UM and claims payment, the delegate may develop their own PAL. However, the delegate's PAL may not be more stringent than the Humana Healthy 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 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, but not limited to, hospital reportable incidents, 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 the member, facility and provider of a decision on concurrent determination.
- Use Humana Healthy Horizons' step-therapy PAL when implementing a step-therapy regimen.
- Notify the member, facility and provider of a decision on an initial determination.
- Maintain documentation of pertinent clinical information gathered to support the determination.
- Understand that all UM files and supporting documentation are the property of Humana Healthy Horizons. 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

Population health management delegation

All delegates performing population health management (PHM) must conduct PHM activities in accordance with NCQA accreditation standards, including:

- 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 (DM) is a multidisciplinary, continuum-based approach to healthcare delivery that proactively identifies populations with, or at risk for, established medical conditions.

Claims delegation requirements

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 or deny any 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.

All delegates performing claims processing functions must comply with and meet 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 make correct claims determinations and 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 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 shall supply staff and systems required to provide claim and encounter data to Humana Healthy Horizons as required by state and federal rules, regulations and Humana Healthy Horizons. Refer to the Process Integration Agreement for details.
- 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.

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 nonparticipating physician, practitioner, hospital and other healthcare professional provider claim payment and payment denial disputes or requests for reconsiderations.

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 these medical situations may occur from time to time and will address them 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**.

Humana Healthy Horizons is required to provide its 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 nonquantitative 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 (FQHCs), rural health clinics (RHCs) and outpatient health facilities (OHFs)
- 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, pediatric recovery center services, and Family Connects 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, Diagnostic 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 services

Behavioral health services, including services for the treatment of mental health and/or substance use concerns, are covered services for Humana Healthy Horizons members. Humana Healthy Horizons recognizes 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 and therapy services (individual, group and family therapy)
- A broad range of high-intensity services for both behavioral health and substance use disorders, typically offered by community behavioral health centers (CBHCs), including:
  - Peer support services
  - Care management/care coordination services (community psychiatric support treatment, therapeutic behavioral services, psychosocial rehabilitation, substance use disorder case management)
  - Mental health day treatment
  - Substance use disorder intensive outpatient programming
  - Substance use disorder partial hospitalization
  - Crisis services
  - Substance use disorder residential treatment
  - Long- and short-term, hospital-based inpatient stays

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.

Screening and evaluation

Humana Healthy Horizons requires providers 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.

Providers 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 providers on how to screen for and identify behavioral health disorders, Humana Healthy Horizons' behavioral health services referral process, and clinical coordination requirements for such services. Humana Healthy Horizons also includes coordination and quality-of-care training, education on the OhioRISE program for multisystem 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 is also 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 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
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	To support safe practices for our expectant members, members who actively participate in our HumanaBeginnings Care Management program (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. We deliver these items with educational content on proper use and installation.
Dental services	1 dental cleaning annually for members 21 and older
Financial literacy coaching	Up to 6 life coaching sessions for money management and budgeting Age 16 and older are eligible.

Value-added benefit	Details and limitations
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 the 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.
Healthy food produce box	Up to 4 produce boxes containing nutritious food that meets medical dietary guidelines and educational materials that include recipes tailored to the member's condition. To be eligible for this benefit, members must have a qualifying chronic condition, be able to prepare their own meals and actively participate in care management. All ages.
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 annually for housing-related expenses such as rent, utility payments, and moving expenses. The benefit can be used towards: • 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 this is a member's permanent residence (late payment notice required) • Moving expenses via a licensed moving company when transitioning from a public housing authority
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.
Sports physical	1 sports physical per year. Age limit: 6–18 years

Value-added benefit	Details and limitations
Tobacco and vaping cessation coaching	The tobacco cessation benefit 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. Members can also earn rewards for participating in coaching through the Go365 for Humana Healthy Horizons® wellness and rewards program. 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. Behavioral health/SUD members must be actively engaged in one of the following courses of treatment: • Outpatient and residential behavioral health 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 behavioral health facility

Value-added benefit	Details and limitations
Transportation continued	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 provider appointments)
Weight management coaching	Weight management coaching delivers weight management intervention for members 12 and older. After completing enrollment, the member participates in 6 virtual weight-management coaching sessions with a health coach; approximately 1 call per month for a period of 6 months. Members can also earn rewards for participating in coaching through the Go365 for Humana Healthy Horizons wellness and rewards program.
Vision services	For members 21-59: • 1 eye exam per year • Up to $200 allowance for 1 set of glasses (frames and lenses) or contacts (not both) during the plan year • Member pays any cost more than $200
Youth development and recreation	Members can receive reimbursement of up to $250 annually for participation in activities such as: • YMCA • Swim lessons • Computer coding classes • Music lessons Age limit: 4 to 18 years

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 rewards are earned when Humana Healthy Horizons receives 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 of the following plan year. This allows the member time to redeem the reward. Members have 90 days from one plan year to another, assuming they remain continuously enrolled, to redeem their rewards.

Go365 for Humana Healthy Horizons is available to all members who meet the requirements of the program. Members can qualify to earn rewards by completing 1 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 PCP
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 all female members who obtain a chlamydia screening when sexually active and as recommended by their healthcare provider
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 18 and older who complete a retinal eye exam
Diabetic screening	Annual $30 reward for diabetic members 18 and older who obtain a screening with their PCP for HbA1c
Digital onboarding	One-time $5 reward for downloading the Go365 for Humana Healthy Horizons app and updating communication preferences
Flu vaccine	Annual $20 reward for members who receive an annual flu vaccine from their provider or pharmacy, or the member can self-report after receiving the vaccine from another source
Follow-up after high-intensity care for substance use disorder	Annual $25 reward for members who receive follow-up care within 30 days of an inpatient hospital discharge, residential treatment or detoxification visit for a diagnosis of substance use disorder, 1 per year maximum

Healthy activity	Reward
Follow-up after hospitalization for mental illness	Annual $25 reward for members who complete a follow-up visit within 30 days of discharge for behavioral health diagnosis, 1 per year maximum
HRA completion	Annual $30 reward for completing an HRA
Human papillomavirus (HPV) vaccine	One-time $30 reward for members ages 9 to 13 who receive 2 doses of the HPV vaccine
Postpartum visit	$50 reward for postpartum members who complete 1 postpartum visit 7 to 84 days after delivery. Available to members once per pregnancy.
Prenatal visit	Pregnant members earn $10 per prenatal visit, up to 10 prenatal visits, up to $100. Available to pregnant members once per pregnancy.
Tobacco and vaping cessation coaching	Members 12 and older who enroll in coaching 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 12 and older who enroll in weight management coaching have 2 opportunities to earn rewards: • $15 reward for completing enrollment • $15 reward for completing the program
Well-child visits (0–15 months)	Up to $60 in rewards for members who complete routine well-child visits. Members receive $10 in rewards per visit for up to 6 visits.
Well-child visits (16–30 months)	Up to $20 in rewards for members who complete routine well-child visits. Members receive $10 in rewards per visit for up to 2 visits.

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 unified 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 authorization, for all Ohio Medicaid individuals.

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 877-856-5702 (TTY: 711), Monday – Friday, 7 a.m. – 8 p.m., Eastern time.

Coordinated services program

The 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 required to 1 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
- Reside in a long-term care facility
- Receive 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 IP hospitals. Humana Healthy Horizons does not require referrals from PCPs to see participating specialists; however, PA 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 network. If not, PA 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 or 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 nonemergent medical transportation vendor MTM Health by calling 855-739-5986. Members can also call the Medicaid transportation coordinator at the local county ODJFS office for trips less than 30 miles. The main phone number for each county ODJFS is included in a list available on ODM's **ODJFS website** and selecting "County Directory." Members can also call Member Services for transportation assistance at 877-856-5702 (TTY: 711), Monday – Friday, 7 a.m. – 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 nonambulatory 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.

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 nonparticipating 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 patient-centered medical home 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, are 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:
  - Preapproved by a plan provider or representative
  - Not preapproved 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 preapproval of further post-stabilization care services
- Administered to maintain, improve or resolve the member's stabilized condition without PA 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 preapproval within 1 hour
  - Could not be contacted
  - Representative and the treating provider 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 preapproved, ends when:

- A Humana Healthy Horizons-contracted 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, Diagnostic and Treatment and Healthchek

Healthchek is Ohio's EPSDT benefit. EPSDT is a federally mandated program 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 Programs & Initiatives** website. 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 development) 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 risky behaviors, and safety)
- Referral for further evaluation, diagnosis and treatment
- Routine screening for postpartum depression, which 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 that are subject to medical necessity often require PA.

Consideration by the payer source must be given to the child's long-term needs, not only immediate needs, and consider all health aspects such as physical, developmental, behavioral, etc.

EPSDT exam frequency

The Humana Healthy Horizons 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 AAP schedule, please visit the **AAP website**.

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 ages 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**.

Immunizations

Immunizations are an important part of preventive care for children and should be administered during well-child and Healthchek exams as needed. Humana Healthy Horizons endorses the same childhood immunization schedule recommended by the Centers for Disease Control and Prevention (CDC) and approved by the Advisory Committee on Immunization Practices (ACIP), the CDC's **Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger**; the Bright Futures/AAP medical periodicity schedule, available at **Recommendations for Preventive Pediatric Health Care**; and the American Academy of Family Physicians (AAFP). The AAP's schedule is updated annually, and current updates can be found on the **AAP website**.

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 Medicaid website**

Additional information on Healthchek can be found at the **ODM Medicaid Healthchek Program website**.

Optimization of pregnancy outcomes: Ohio Perinatal Quality Collaborative

Ohio Perinatal Quality Collaborative (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 by visiting the **OPQC website**.

Perinatal Risk Assessment Communication

The Perinatal 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. 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**.

Physicians can find the official ODM PRAF 2.0 online by visiting **ODM's Resources for Providers webpage**.

Benefit manager

DentaQuest

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

For more information, please call DentaQuest's Ohio Provider Relations at 833-615-0432 or email **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 Humana Routine Vision Care Services Line at 844-744-3888 or sign in to **EyeMed's Provider Portal** (called inFocus).

Tivity

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 **WholeHealth Living's provider portal**.

Noncovered 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 the member is 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 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 1 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 authorization 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 Healthy Horizons' 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 Healthy Horizons 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 case management services
- Dedicating specially trained staff to handle claims quickly and efficiently

For further assistance with transplant services, please call 866-421-5663, Monday – Friday, 8 a.m. – 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 found on our **Ohio Medicaid: Grievances and appeals webpage**
- Writing a letter that includes the following information:
  - Member name
  - Member ID number from the front of the Humana Healthy Horizons ID card
  - Member address and phone number
  - Explanation of the issue

Written grievances:

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

Fax the form or letter to 800-949-2961

Humana Healthy Horizons acknowledges 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 claim-related grievances

If the member requests it, or if we need additional information to make a decision and receiving that information is in the member's best interest, we may extend the grievance time frame by up to 14 calendar days. If we extend the time frame, we will notify the member orally and in writing. If the member disagrees with the extension of the resolution time frame, the member may file a grievance.

Negative actions are not taken against a member who files a grievance or a provider who 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 the member's authorized representative. Appeals must be filed within 60 calendar days of 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 ID number from the front of the Humana Healthy Horizons ID card
  - Member address and phone number
  - Any information that will help explain the reason for the appeal
  - Any supporting records or documentation

Mail the form or letter to
Humana Healthy Horizons in Ohio
Grievances 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 appeal within 3 business days of the day we receive the request.

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

If the member or appointed representative feels 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 quickly as needed based on the member's health. If the member requests it, or if we need additional information to make a decision and receiving that information is in the member's best interest, we may extend the standard appeal time frame by up to 14 calendar days. If we extend the time frame, we will make reasonable efforts to provide the member or their authorized representative with prompt oral notice of the delay. Humana Healthy Horizons also sends written notice of the reason for the decision to extend the time frame within 2 calendar days. If the member disagrees with the extension of the resolution time frame, the member may file a grievance.

Humana Healthy Horizons determines within 1 business day of the appeal request whether the expedition criteria is met. We make reasonable efforts to provide 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 will 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.

The member or someone that the member chooses 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 records, 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.

Negative actions will not be taken against:

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

State hearings

Members, or their appointed representatives, also have the right to ask for a state hearing from ODJFS Bureau of State Hearings or local county OCDJFS after Humana Healthy Horizons completes its appeal process. Requests must be made within 90 calendar days of the date on the Humana Healthy Horizons appeal decision letter.

To request a state hearing:

- 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
- 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 state hearing process when all of the following conditions are met:

- The member requests an appeal or state 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, suspended or terminated
- The authorization period has not expired

Member benefits continue until 1 of the following occurs:

- The original authorization period for services has ended
- The member fails to request a state hearing within 15 calendar days of the date on the appeal decision letter
- The member withdraws the appeal or state hearing request
- The bureau of state hearings issues a decision that is not in the member's favor

If the appeal or state 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 state 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 (LTSS) 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 PA, 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

Healthcare providers should review the Ohio Medicaid prior authorization list online on our **Provider prior authorization and notification lists webpage**. 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 PA requests, including physician-administered drug requests and associated attachments, through **Availity Essentials** via 1 of the following methods:

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

For both of the above methods, select the following payer descriptions:

- Humana (medical)
- Humana behavioral health

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

Humana Healthy Horizons does not require PA for observation level of care.

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

Inpatient facility providers please note, Humana Healthy Horizons cannot complete medical necessity reviews without supporting documentation. To avoid denial 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 Thursday – Saturday without clinical documentation may result in denial 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, MCG Guidelines, American Society of Addiction Medicine (ASAM) and Humana clinical 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 PA 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 PA 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. Authorization is 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 and 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 at 877-856-5707.

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** for members to receive out-of-network services.
- If the out-of-network provider is not an active provider in ODM's PNM 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

Humana Healthy Horizons processes standard authorization requests based on the member's health condition and ensures a decision is made within 7 days of receiving the request.

Concurrent determination

Notice of decision as expeditiously as the member's health condition requires, but no later than 3 calendar days from the date of request.

Expedited/Urgent/inpatient 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 processes expedited authorization requests based

on the urgency of the member's health condition and ensures a decision is made within 48 hours of receiving the request. 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 provider reviewer, please email **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) is the review process conducted by an independent, external medical review entity indicated by a provider who disagrees with Humana Healthy Horizons' 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 preservice, concurrent or retrospective authorization requests) based on medical necessity
- A Humana Healthy Horizons claim payment denial, limitation, reduction, suspension or termination based on medical necessity
- 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 10 calendar days or within 30 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 appeal 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 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. 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 or state hearing, or the timeliness of appeal and/or state hearing resolutions.

Once the provider submits the EMR request, the provider does 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 performs its review and issues a decision within 30 calendar days for a standard request and 3 business days for an expedited request.

- 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.

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 Guidelines, American Society of Addiction Medicine (ASAM) Level of Care Adolescent Guidelines and American Society of Addiction Medicine Patient Placement Criteria
- Humana Healthy Horizons 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 provider's medical expertise; they are to provide guidance to providers related to medically appropriate care and treatment. Providers can access clinical criteria or clinical rationale used in UM determinations online, at the point of care, at **Clinical Coverage Policies for Ohio Medicaid Providers | Humana**, the Provider newsletter, **Provider Publications**, or upon request by calling 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 UM staff with any UM questions. For medical health inquiries, call 877-856-5707 or email **OHMCDUM@humana.com**. For 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 – Friday, 8 a.m. – 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 first priority. Provider reviewers from Humana Healthy Horizons are available to discuss individual cases with attending providers 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 the 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 authorization

If the member has PA approved before transition, Humana Healthy Horizons must honor PA 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 the member's current provider to a network provider.
- 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, PA requests and associated attachments through **Availity Essentials**.

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 Provider Master File. Humana Healthy Horizons is instructed by ODM not to accept changes from providers in their own systems that are inconsistent with PNM system data 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**.

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 Healthy Horizons rejects all claims submitted in this manner.

Paper claim submissions are prohibited.

Claim submissions

Claims must be submitted within 365 days of the date of service or discharge date. Corrected claims must be submitted within 365 days of the date of service or 180 days of 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 codes
- HIPAA-compliant Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes 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 prior authorization.
- NPI: Please refer to the location of provider NPI, TIN and member ID number section.
- Federal TIN or provider Social Security number: Every provider practice (e.g., legal business entity) has a different TIN.
- Billing and rendering taxonomy codes that match the ODM Master Provider List (MPL)
- Billing and rendering addresses that match the ODM MPL
- Signature of provider or supplier: The provider's complete name should be included. If we already have the provider'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.

FQHCs and 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 file a timely 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 untimely filing.

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

Claims status

You can track the progress of submitted claims at any time through **Availity Essentials**. 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 numbers and date
- Procedure/diagnostic
- Claim payment date
- Remittance advice

Claim 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 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 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 **https://www.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
- 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 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 or 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 call Humana Healthy Horizons at 877-856-5707 or contact 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 in to **Availity Essentials** (registration required).
2. From the Payer Spaces menu, select Humana.
3. From the Applications tab, select the ERA/EFT Enrollment app. (If you don't see the app, contact your Availity administrator to discuss your need for the tool.)

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:

- 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

To learn more, call 800-282-4548 or visit **Availity Essentials**. For information regarding electronic claim submission, contact your local Provider Relations representative, visit **our main provider webpage** and choose "Coverage and Claims" then "Claim submissions."

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.

Healthcare providers may also submit manual claims and associated attachments through Availity Essentials. Paper claim submissions are prohibited. Humana's payer ID is 61103 for fee-for-service claims.

Please note: Humana's traditional payer ID for fee-for-service claims, 61101, cannot be used to submit Humana Healthy Horizons Ohio claims. Humana Healthy Horizons 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	800-282-4548
Trizetto	800-556-2231
Optum	800-792-5256
SSI Group	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:

- Decrease the need for medical record review during Healthcare Effectiveness Data and Information Set (HEDIS®) audits
- Are critical to future implementation of Medicaid risk adjustments
- Help 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 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 code sets:

- HCPCS which includes
  - 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 Administration**
- 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 are also typically available in various media from vendors licensed to publish them.

Please note: Humana Healthy Horizons requires HIPAA-compliant codes on 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 NPI and TIN 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.

In accordance with Administrative Code rule 5160-1-17, all providers with an available taxonomy are required to have an 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 an 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
- Home health physical therapies G0151
- Home health occupational therapies G0152
- Home health speech language pathology therapies G0153
- Home health nursing, Registered nurse (RN) G0299
- Home health nursing, Licensed practical nurse (LPN) G0300
- RN & LPN private duty nursing T1000
- Registered nurse assessment T1001
- Registered nurse consultation T1001 with U9 modifier

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 the EVV Provider Hotline at 855-805-3505 for immediate support.

Out-of-network claims

Humana Healthy Horizons established guidelines for payments to out-of-network providers for preauthorized medically necessary services. These services are reimbursed at no less than 90% 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. Out-of-network claims are subject to the following:

- Providers enrolled with ODM, but nonparticipating with Humana Healthy Horizons
- Nonparticipating provider will be paid at default rate of 90%
  - All services billed by an independent laboratory, enrolled as a Provider Type 80, will be reimbursed at 60% of the Ohio Medicaid allowable rate.
  - Codes G0480, G0481, G0483 and G0659 will be reimbursed at a $30 flat rate.
  - If nonparticipating providers want more than the default rate, they will need to work with their provider engagement representative.

Claim processing guidelines

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 of 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

Sterilization:

ODM Sterilization Consent Form (English)

ODM Sterilization Form (Spanish)

Hysterectomy:

ODM Acknowledgement of Hysterectomy Information (English)

ODM Acknowledgement of Hysterectomy Information (Spanish)

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 Healthy Horizons 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**, using 837P for professional claims or 837I for institutional claims. For more information on HIPAA X12 837 Health Care Claim transactions, please visit the **Washington Publishing Company (WPC) website**.

Code editing and payment policies

Humana Healthy Horizons processes accurate and complete provider claims in accordance with Humana Healthy Horizon's normal claims processing procedures, including, but not limited to, **claims processing edits**, **claims payment policies**, and applicable state and/or federal laws, rules and regulations. See the coverage and claims section of the **Humana provider webpage** 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 is dependent upon the factors reported on each claim. Accordingly, it is not feasible to provide an exhaustive description of the claims processing procedures, but examples of the most commonly used factors are:

- The complexity of a service
- Whether a service is 1 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:
  - 2 or more surgeries performed the same day
  - 2 or more endoscopic procedures performed the same day
  - 2 or more therapy services performed the same day
- Whether a cosurgeon, assistant surgeon, surgical assistant or any other provider who is billing independently is involved
- When a claim includes more than 1 claim line, whether any service is part of, or incidental to, the primary service that was provided, or if these services cannot be performed together
- Whether the service is reasonably expected to be provided for the diagnosis reported

- Whether a service was performed specifically for the member
- Whether services can be billed as a complete set of services under 1 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 such as the following, including any successors of the same:

- ODM 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
- AMA's CPT and associated AMA publications and services
- CMS' HCPCS and associated CMS publications and services
- ICD
- American Hospital Association's (AHA) Coding Clinic Guidelines
- Uniform Billing Editor
- American Psychiatric Association's (APA) 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 1 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. Providers can access additional information at our **Humana provider webpage**.

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 to be 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 on our **claims processing webpage**.

Suspension of provider payments

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

Coordination of benefits

Humana Healthy Horizons 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 can also 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:

1. 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.
2. Humana Healthy Horizons sends out a notice to each affected provider that recoupment of payment will occur for the claims identified in the recoupment letter. The provider is allowed 30 calendar days from receipt of the letter to respond to the notice.
3. 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 payments 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 reconsideration, ranging from general questions about a claim to a provider's disagreement 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**
- Verbally by calling 877-856-5707, Monday – Friday, 7 a.m. – 8 p.m., Eastern time
- 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 Healthy Horizons staff member (e.g., care manager, nurse)
- Via a Humana Healthy Horizons office

Claims Dispute FAQ Topic	Response
What is the time frame for a provider to submit a claim 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 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.

The information in the submission should include:

- Name of person calling, submitting or speaking, including phone number and/or email address
- Provider/facility TIN
- Provider/facility name
- Member ID and name
- Claims numbers
- Authorization/referral numbers
- 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 SDOH issues. We recognize 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. You can call the Humana Healthy Horizon care coordination team at 877-856-5702 or email **OHMCDCareManagement@humana.com**.

This coordination is enhanced through data-sharing via our provider portal, support through our provider communication lines, and participation in multidisciplinary 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.

Humana Healthy Horizons offers chronic condition management programs for behavioral health and physical health. 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. You can reach HumanaBeginnings by email at **OHMCDMaternity@humana.com** or by calling 877-856-5702.

All Humana Healthy Horizons care coordination and care management programs are voluntary and free of charge. Members can 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 can submit referrals for member evaluations for OhioRISE to **OHMCDOhioRISE@humana.com**. Humana Healthy Horizons' care coordination staff reaches out to the member and the member's family

to coordinate a timely CANS assessment needed to determine OhioRISE eligibility. An individual enrolled in the OhioRISE program keeps managed care enrollment for the individual's physical health benefit. Humana Healthy Horizons collaborates with the member's OhioRISE care team and participates 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 experience behavioral health conditions that require ongoing care.

PCPs are required to:

- Provide basic behavioral health services to members including:
  - 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 disorders

Behavioral health providers are required to:

- Notify the 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 disorders.
- Provide initial and summary reports to the PCP 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 of 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 SDOH 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 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 who 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

If you believe you have a Humana Healthy Horizons-covered patient with chronic conditions who 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 the PCP for untreated physical health concerns to better coordinate care between behavioral health providers, PCPs and specialists.

Services

- Care guide support for low-risk members with behavioral or physical health conditions
- Care management for moderate-risk members with behavioral or physical health conditions
- Intensive care management for high-risk members with behavioral or physical health conditions
- Complex care management for members with complex condition needs with behavioral or physical health conditions
- Transitional care management
- HumanaBeginnings maternity program
- Chronic condition management program
- SDOH support access

High-risk members

Members in complex care management are of the highest need members 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 the member's care goals.

Prenatal care management

HumanaBeginnings provides perinatal and neonatal care management. Nurses are available to help manage any pregnant members, including those with 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 2 sources for notification of pregnancy:

- Report of Pregnancy (ROP)—This is an early pregnancy notification submitted only once by any non-obstetrical services provider that initially identifies a member is pregnant. Provider types include:
  - Local health departments (LHDs)
  - PCPs
  - Emergency department providers
  - Community clinics
  - Ohio Equity Institute (OEI) Community Based Organizations

- Perinatal Risk Assessment Form (PRAF)—This is 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, providers can:

- Ensure pregnant members maintain Medicaid eligibility without disruption in coverage, resulting in prompt provider payment for services throughout the member's pregnancy.
- Streamline communications among multiple entities, facilitating connection of pregnant members to needed services 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.
- Provide an automatic referral to ODH Home Visiting and Women, Infant and Children (WIC)
- Submit additional PRAFs to report a change in condition or needs.

  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.

Submitting the e-PRAF using NurtureOhio

1. User will need to establish an Ohio ID account to access the PNM system.
2. With PNM access, next step will be to register within the **NurtureOhio website**.
3. Instructions for completion and submission of PRAF can be found on ODM's website at **PRAF 2.0 Provider User Manual | Medicaid**.
4. If you need assistance, please email ODM 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 Medicaid forms website**.

Claim 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.

Ensuring prompt care

All pregnant members with Medicaid coverage should be linked to needed services on their very first prenatal visit. An online e-PRAF submission ensures:

- Medicaid coverage for the member and baby without disruption through the immediate postpartum period

- 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' 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 them to care for the infants at home. They engage families during and after the baby's hospital stay. Case managers work closely with providers and hospital staff to coordinate care during the infant's stay in the hospital and after discharge. They 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, Monday – Friday, 8:30 a.m. – 5 p.m., Eastern time.

Population health module

The population health module helps PCPs monitor the clinical measures identified and executed for their assigned members. Providers can access the population health module by signing in to **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 members' assessments, care plans, authorization requests, 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 potential use or abuse of drugs is monitored and member claims are reviewed for potential assignment to a designated pharmacy. Please visit Coordinated Services Program at **https://medicaid.ohio.gov/stakeholders-and-partners/phm/csp** for additional information.

Health education

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 beneficiary.

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, 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
- Advance 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 1 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 1 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 findings
- 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) addressed from previous visits
- Plan of treatment, including:
  - Medication history, medications prescribed, including 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 OB-GYN 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 the provider's services are regularly performed.
- Agree to comply with Humana Healthy Horizons' quality assurance, quality improvement, accreditation, risk management, utilization review, UM, 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 if the provider 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, 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, NPIs, 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 the provider's 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 providers 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**.)
- 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 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 and, at no cost for Humana Healthy Horizons and all its authorized vendors acting on behalf of Humana Healthy Horizons, to access member clinical information, including, but not limited to, medical records for all payer responsibilities, including, but not limited to, case management, UM, claims review, and audit and claims adjudication.
- Transfer copies of medical records for the purpose of continuity of care to other Humana Healthy Horizons providers on request and at no charge to Humana Healthy Horizons, 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 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.
- Agree 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. You can access these documents by visiting our **Provider compliance training materials webpage**.
- 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 actions 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 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:

- Is identified in the Ohio Medicaid state plan
- 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
- Has a negative consequence for the beneficiary
- Is auditable
- 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
- 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 will 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 to succeed in their schools, homes and communities. This support is provided through care coordination and specialized services that are provided in home or in the young person's community.

Individuals 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 caregivers 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 performs 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 PA 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 the **Medical and Pharmacy Coverage Policies webpage**.

For more information about the SPBM or PPAC initiatives, please email **MedicaidSPBM@medicaid.ohio.gov** or visit **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 cultural competency and encompasses clinical care, preventive care, population health management and Humana Healthy Horizons' 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 differences 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' QI Program, which includes providing member records for assessing quality of care. In addition, the HIPAA Privacy Rule 45 CFR 164.506 and rules and regulations promulgated thereunder (45 CFR Parts 160, 162 and 164) permit 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' QI Program and its progress toward goals, call us at 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 providers 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 **Clinical practice guidelines website**.

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 supplemental data submitted. There are 2 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 can also 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 secure file transfer protocol (SFTP) 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 members
- Well-baby care
- Immunizations for children, adolescents and adults
- Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, sexually transmitted diseases, Pap tests, and mammograms

Preventive guidelines address prevention and/or early detection interventions and recommend 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 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 are conducted 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' 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 nonemergent 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.	24 hours, 7 days/week within 48 hours of request

Type of visit	Description	Minimum standard
Behavioral health, non-life-threatening emergency	A non-life-threatening situation in which a member is exhibiting 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/ inpatient services—3: 3.1, 3.5, 3.7	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 6 weeks
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 future baby healthy, such as 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 maternal care (CMC) or 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 state Medicaid 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 **Clinical practice guidelines provider website**
- 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 suspected or detected FWA
- 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

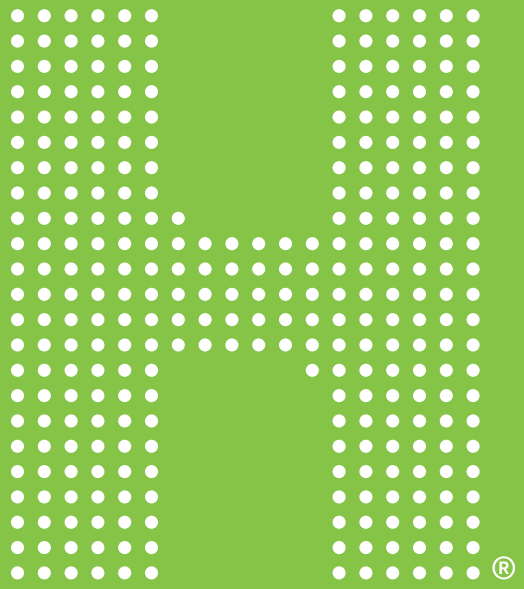
Humana Healthy Horizons and ODM should be notified immediately if a provider or their office staff:

- Is aware of any provider who 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 someone is using another member's ID card
- Has evidence 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 can also call Humana at 877-856-5707 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: **Ethics online reporting** or **Special Investigations Referral Form**

Providers can also contact ODM by calling 614-466-0722 or online by visiting **ODM's Medicaid Fraud webpage**.

You can contact The Ohio Attorney General's Office Medicaid Fraud Control Unit (MFCU) by phone at 800-282-0515 or online at the **Ohio Attorney General's Medicaid fraud reporting website**. You can contact the Ohio Auditor of State (AOS) by phone at 866-FRAUD-OH (866-372-8364) or by email at **fraudohio@ohioauditor.gov**.