2025 Provider Orientation and Training

Information for Oklahoma Medicaid healthcare providers and administrators

Humana Healthy Horizons in Oklahoma is a Medicaid product of Humana Wisconsin Health Organization Insurance Corporation.

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Humana has more than 30 years of experience serving Oklahomans

Humana has proudly served Oklahomans since 1987 and is the only Medicare Advantage (MA) plan working statewide.

We currently serve **more than 278,000** Oklahomans in our Medicare plans, Dual Eligible Special Needs Plans (D-SNPs), TRICARE and prescription drug plans. In addition, Humana Healthy Horizons® in Oklahoma serves 186,000 in the SoonerSelect plan.

100% of Humana's health maintenance organization (HMO) MA members are enrolled in a 4-star-rated plan, including serving Medicaid beneficiaries via our D-SNPs, of which **100% of members are in a 4.5-star-rated plan.**

Humana has **a long history of successful partnerships with Oklahoma healthcare providers** to improve health outcomes. Partnerships include those with OSU Health, OU Health, Ardent Health Services, Mercy, Integris, SSM Health, St. Francis and many more.

Humana's local presence with Medicaid contract brings **over 550 new jobs in Oklahoma**—an estimated $59 million in payroll.

We have **dozens of community partnerships—focused on improving population health and health equity—**that address the specific needs of Oklahoma's Medicaid population.

SoonerSelect program

SoonerSelect is a new health delivery model in Oklahoma that began April 1, 2024.

What is SoonerSelect?
SoonerSelect is a healthcare delivery model used to coordinate health and dental care and improve quality of care. SoonerSelect provides Medicaid health benefits through contracted arrangements among Oklahoma Medicaid agencies, health plans and dental plans.

Members will consist of:

- Children
- Low-income parents
- Pregnant women
- Adults ages 19-64
- American Indian/Alaska Native (AI/AN) members have the option to enroll in a SoonerSelect plan.

More information can be found at **SoonerSelect FAQ for Providers** and by calling the SoonerCare Helpline at **800-987-7767**.

Member eligibility and enrollment

Determination

Oklahoma Health Care Authority (OHCA) determines a member's eligibility and will provide eligibility information to Humana Healthy Horizons.

Newborn coverage

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

Eligibility

If Humana Healthy Horizons members lose Medicaid eligibility but become eligible again within 60 days, they are automatically reenrolled in Humana Healthy Horizons and assigned to the same Primary Care Provider (PCP), if possible.

Open enrollment

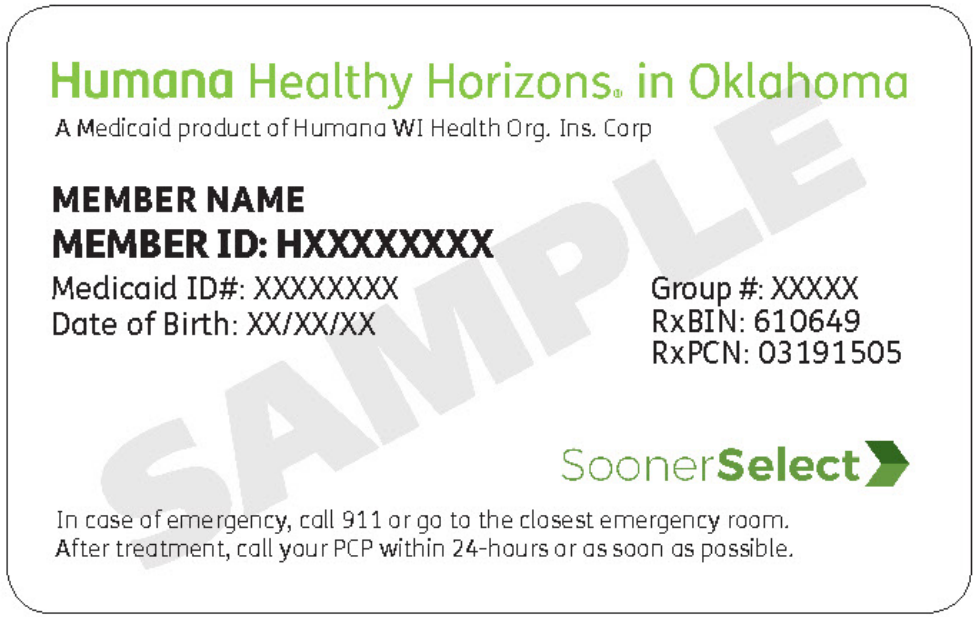
Open enrollment takes place yearly. If a member does not select a managed care organization (MCO) during this period, they will remain with their current MCO. Members have 90 days after open enrollment to change MCOs if they wish.

You can verify member eligibility by signing in to Availity Essentials™ at www.availity.com and navigating to Patient Registration, then selecting Eligibility and Benefits Inquiry.

PCP assignment and changes

- Members choose or are assigned to a PCP on enrollment with Humana Healthy Horizons. PCPs help coordinate healthcare for members and provide additional health options to members for self-care or care from community partners. Members select a PCP from the Humana Healthy Horizons in Oklahoma provider directory. Based on federal protections, AI/AN members can receive care at any Indian Health Care Provider (IHCP), regardless of PCP assignment.
- A PCP is assigned to members if one is listed on the supplemental enrollment file. If a PCP is not on file, members will choose a PCP. If a member does not choose a PCP upon enrollment, a PCP is automatically assigned.
- Humana Healthy Horizon's internal system can identify a member's previous PCP (if applicable) within our participating PCP panel and assist through auto-assignment. Geographic assignment is used when a member has no record of past PCP relationships within the participating Humana Healthy Horizons PCP panel, and our system also ensures that the auto-assigned PCP is age-appropriate for the member.
- Members have the option to change to another participating PCP as often as needed. PCP changes are effective on the first day of the month following the requested change. During the first 30 days of enrollment, members can change PCPs, and we will update our system by the next business day.

Sample ID card



Member rewards

Members have an opportunity to earn rewards for taking healthy actions through Go365® for Humana Healthy Horizons.

Providers can help members obtain rewards by submitting claims on behalf of a member, within 6 months from the date of service but no later than March 15, 2026. This allows members time to redeem the rewards.

Go365 is available to all members who meet the requirements of the program. A full listing of healthy activities that earn rewards can be found in your provider manual.

Members can find additional information on Go365 at **Humana.com/OklahomaGo365**.

Humana Healthy Horizons in Oklahoma deploys a concierge provider services team enabling a transparent and seamless provider experience

Our provider partnerships allow us to deliver high-quality managed care medical and behavioral health services to eligible Oklahoma residents with SoonerSelect coverage.

Dedicated and local support

Every provider will have a dedicated Provider Relations Representative to help conduct business with Humana Healthy Horizons.

Ease of doing business

Our processes are developed to be clear and intuitive. We will educate you on how to submit claims, manage authorizations and more.

Accessible tools and resources

We will help you access Humana Healthy Horizons tools and resources, as well as partner with you to help you thrive in the SoonerSelect program.

Provider support team

Our provider support team is led by our Director of Provider Services

Provider Relations Representatives

- Are local, high-touch representatives regionally assigned by provider type
- Serve as day-to-day, front-line relationship management
- Conduct provider training and education; communicate emerging trends and Humana Healthy Horizons policy updates
- Triage provider inquiries and facilitate resolution
- Conduct ongoing meetings and technical assistance in one-on-one or group settings

Provider Engagement Representatives

- Work with providers to improve quality and value-based payment performance
- Educate and translate available data to identify tangible and impactful interventions to improve quality performance
- Identify population and individual health needs addressable through tailored interventions

Contact information

Provider Services Center
855-223-9868
Monday-Friday,
8 a.m. – 5 p.m., Central time.

Overview of provider website

Visit **Humana.com/HealthyOK** for additional resources.

- Training calendar
- Provider resource guide
- Provider manual
- Quick reference guides
- Provider Relations Representative contacts and territory map
- Transportation
- Pharmacy
- Dental vendors
- Vision
- Relias (tobacco cessation and other training)
- Training materials

Availity Essentials

Availity Essentials is our provider portal. Through Availity Essentials, you have access to:

- Patient management
- Claims management and status
- Provider engagement
- Authorization and referral management
- Electronic funds transfer (EFT) and electronic remittance advice (ERA) enrollment

Sign in to Availity Essentials at **Availity Essentials** (registration required).

From the Payer Spaces menu, select Humana.

From the Applications tab, select the ERA/EFT Enrollment app. (If you don't see the app, contact your Availity Essentials administrator.)

How to register for Availity Essentials

To access Availity training content, please:

- Sign in to your Availity account
- Select Help & Training
- Select Get Trained to launch the Availity Learning Center

Claim processing

Humana Healthy Horizons will process accurate and complete provider claims in accordance with its normal claims processing procedures, including **claims processing edits**, **claims payment policies** and applicable state and/or federal laws, rules and regulations.

Humana Healthy Horizons pays 90% of all clean claims submitted from healthcare providers within 14 calendar days of the date of receipt.

Humana Healthy Horizons pays 99% of all clean claims from providers within 90 calendar days of the date of receipt.

Humana applies 1.5% prorated monthly interest for any non-timely clean claim adjudicated after 30 days of receipt for electronic claims and 45 days of receipt for paper claims.

All claims must be paid within 12 months of the date of receipt except in cases of retro adjustments, investigations of fraud/abuse or court orders.

Provider reimbursement and rate structures are outlined in the contract between Humana and provider.

For specific information on payment for codes, please refer to the **OHCA website**.

Submitting electronic and paper claims

Here are some commonly used clearinghouses:

- **Availity Essentials**
- **Change Healthcare**
- **TriZetto**
- **SSI Group**

When filing an electronic claim use payer ID 61101.

Paper claims can be submitted on:

- CMS-1500, formerly HCFA 1500 form-AMA universal claim form also known as the National Standard Format (NSF)
- CMS-1450 (UB-04), formerly UB92 form, for facilities

Paper claims mailing address:

Humana Claims Office
P.O. Box 14359
Lexington, KY 40512-4359

Encounter submissions

Humana Healthy Horizons submits 100% of its encounter data including capitated arrangements to OHCA.

Encounter data is submitted in accordance with OHCA accuracy standards of 95% for submitted and accepted encounters.

Humana Healthy Horizons uses the electronic data interchange acknowledgement files to determine if files were successfully loaded and correct and resubmit those that failed within 30 days of the original submission.

Denied encounters will be corrected and resubmitted within 30 calendar days after the initial encounter reporting due date.

Encounter submission and remediation

- Humana Healthy Horizons will submit 100% of its encounter data including, capitated arrangements, to OHCA for services rendered to a member that resulted in a paid, denied, corrected, voided or zero paid claim. We also will submit encounter data in accordance with OHCA accuracy standards of 95% for submitted and accepted encounters.
- Humana Healthy Horizons collects and submits encounter data to OHCA via the Edifecs system compliant with 05010 Health Insurance Portability and Accountability Act of 1996 (HIPAA) transactions. Humana uses a customized version of the Edifecs transaction management platform to manage and monitor encounter submissions and resubmissions. This is a single solution for submitting, tracking and error correcting. Any failed edits/errors, adjustments, and voids are categorized based on Humana defined logic and distributed to the respective areas.
- Humana Healthy Horizons will utilize the electronic data interchange response (acknowledgement) files to determine if files were successfully loaded. Humana will correct and resubmit files that fail to load within 7 days of the original submission attempt.
- We will correct and resubmit previously denied encounter data that can be remedied within 30 calendar days after the initial encounter reporting due date.

Timely filing requirements

Initial claims must be submitted within 6 months from the date of service or discharge.

Corrected claims must be submitted within 12 months from the date of service or discharge.

Claims will not be paid if they have incomplete, incorrect or unclear information.

Overpayments

Healthcare providers must report to Humana Healthy Horizons any service claim overpayments for medical services rendered to Medicaid managed-care plan members, in accordance with the OHCA contract. Regardless of agreement specifics, the provider or subcontractor agrees to submit such claims after the date on which the overpayment was identified, and to notify Humana Healthy Horizons in writing of the reason for the overpayment as required by 42 CFR 438.608.

Refund checks for overpayments can be mailed to:

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

Humana Healthy Horizons reports all overpayments to OHCA Program Integrity. These reports include all unsolicited provider refunds.

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

Balance billing

- State requirements and federal regulations prohibit you from billing Humana members for medically necessary covered services except under very limited circumstances. 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 of 1935.
- Humana monitors this billing policy activity based on complaints of billing from members. Failure to comply with regulations after intervention may result in both criminal charges and termination of your agreement with Humana Healthy Horizons .
- For more information on balance billing, please refer to your **Provider Manual**.

Prior authorizations

Prior authorization (PA)

- Prior authorization (PA) is the process through which healthcare providers obtains approval from the plan as to whether an item, drug or service will be covered.

Requesting authorization

- Visit **Availity Essentials** and complete an authorization request.
- Call **855-223-9868** and follow the menu prompts for authorization requests, depending on your needs.
- Fax your request to **833-558-9712**.

PA forms

- To simplify the PA process, Humana will utilize the state-approved PA forms. You can find these forms at **Humana.com/OKPA**.

List of services requiring PA

- You can find a full list of services requiring PA at **Humana.com/PAL**. Our list is subject to change, and changes will be posted on our website.

Utilization Management

Utilization Management (UM) includes PA, concurrent reviews, discharge planning and other activities such as monitoring initial and ongoing inpatient and outpatient admissions.

UM also reviews covered services based on medical necessity, appropriateness of care and service, and existence of coverage to help maintain the quality and appropriateness of healthcare services provided to Humana Healthy Horizons members.

We place appropriate limits on a service based on criteria applied under the Medicaid state plan and applicable regulations, such as medical necessity.

Second opinions

Members and providers may request a second opinion for surgery or medical services at no cost. The following is criteria that should be used when selecting a provider for a second opinion.

The provider must participate in the Humana Healthy Horizons network. If an in-network provider is not available, Humana Healthy Horizons will arrange for the member to obtain the second opinion from a nonparticipating provider and facilitate the referral process.

Providers must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.

Providers must be in an appropriate specialty area.

Referral process

Humana Healthy Horizons has policies and procedures in place to guide PCP referrals to ensure timely, appropriate care for a member's condition. Humana Healthy Horizons does not require a referral to in-network specialists.

Members are permitted to self-refer, at minimum, to the following services:

- Behavioral health services, including SUD treatment
- Vision services
- Emergency services
- Family planning services and supplies
- Prenatal care
- Department of health providers, including mobile clinics
- Services provided by Indian healthcare providers to American Indian/Alaska Native members

Female members

- Humana Healthy Horizons covers services when the PCP is not a woman's health specialist. The plan will provide the member with direct access to a women's health specialist within the provider network for covered routine and preventive women's healthcare services.
- Woman's health services is open access for in-network providers. When members are identified as having a gap related to women's healthcare, they receive education related to their benefits and the plan helps them find a woman's health specialist, schedule an appointment and, if needed, provide transportation to the provider's office.
- Humana Healthy Horizons includes information on how to access services in the **Member Handbook** and **Provider Manual** and on the plan's website. Members can obtain assistance in using the provider look-up tool by calling Member Services at **855-223-9868**. Humana Healthy Horizons covers out-of-network services when the plan's provider network is unable to provide them and also those provided in a bordering state.

Family planning services

Members, including adolescents, may receive family planning services and related supplies from appropriate Medicaid family planning providers regardless of network status. Referrals and PAs are not required. Services include:

- Comprehensive medical history and physical exam, including anticipatory guidance and education related to the member's reproductive health needs and contraceptive counseling
- Laboratory tests for the detection of certain sexually transmitted infections, cancerous or precancerous conditions and determination of pregnancy
- Annual supply of chosen contraceptive
- Insertion and removal of contraceptive devices
- Sterilization procedures: vasectomy and tubal ligations–payment is not made for sterilization procedures for members younger than 21
- Additional visits for members experiencing difficulty with their contraceptive method or having concerns with their reproductive health

Transition of care

Humana Healthy Horizons honors previously approved authorizations for 90 days from the day prior to the member's enrollment date.

During this period, PAs will not be denied if the provider is not in network, and payments to the nonparticipating providers will be made.

Humana Healthy Horizons will allow members to continue an existing relationship with ~~a~~ nonparticipating provider during this period until the member can be transferred to a participating provider without impeding the services needed to maintain the member's health.

A listing of special conditions covered under continuity of care can be found in our provider manual at **Humana.com/OKDocuments**.

Credentialing and recredentialing

Humana Healthy Horizons will transition to a Credentials Verification Organization (CVO) for credentialing and recredentialing by July 1, 2025, as required by OHCA. Until the CVO is implemented, Humana Healthy Horizons will only consider OHCA's provider enrollment status when making determinations for network participation for the Humana Healthy Horizons provider population. Humana will continue to monitor that providers remain in good standing with federal and state entities.

Network providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria.

Providers must:

- Be eligible for participation in the SoonerSelect program
- Have a unique Oklahoma SoonerSelect provider number in accordance with OHCA guidelines
- Be credentialed prior to participating in the Humana Healthy Horizons network and treating members
- Be in good standing with Medicare and Medicaid, federal, state and local agencies

Network enrollment requests will be processed within 60 days.

Further details regarding credentialing/recredentialing requirements can be found in the Humana Healthy Horizons in Oklahoma provider manual at **Humana.com/HealthyOK**.

Types of providers within the scope of credentialing, recredentialing or assessment

Physical health providers

- Nurse practitioners
- Medical doctors (M.D.)
- Doctor of Osteopathic Medicine (D.O.)
- Oral surgeons
- Chiropractors
- Podiatrists
- Dentists
- Optometrists
- Pharmacists
- Physician assistants
- Other medical practitioners who are licensed, certified or registered by the state to practice independently within the scope of state regulations
- Certain individuals that render service and are not required to be licensed or certified

Licensed behavioral health providers

- Psychiatrists:
  - M.D.
  - D.O.
- Psychologists
- Licensed behavioral health professionals
- Board certified behavior analysts
- Licensed practical counselors
- Licensed marriage and family therapists
- Licensed clinical addiction counselors
- BH–Advanced practice registered nurses
- BH–Clinical nurse specialists
- Certain individuals that render service and are not required to be licensed or certified
- Licensed clinical social workers

School-based services

Credentialed by Oklahoma State Department of Education (OSDE)

- Behavioral health providers
- Physical/occupational/speech therapy providers
- Physical/occupational/speech therapy assistant providers
- Speech fellows or those who are currently in school to receive certification
- School-based paraprofessionals

Non licensed providers

As permitted by service and provider qualifications:

- Certain individuals that render services and are not required to be licensed or certified

Organizations within the scope of credentialing and recredentialing

Physical health

- Ambulatory surgery centers
- Dialysis centers/end stage renal disease
- Durable medical equipment/medical supply centers
- Federally Qualified Health Centers
- Free-standing birth centers
- Health departments
- Hearing aide dealers
- Home health agencies
- Hospice
- Hospitals
- Laboratories
- Outpatient physical therapy and speech pathology facilities
- Pathology facilities
- Pharmacies
- Portable X-ray suppliers
- Public health agencies
- Rehabilitation facilities
- Rural Health Clinics
- School corporations
- Skilled nursing facilities/extended care
- Transportation providers

Behavioral health

- Organizations providing behavioral health or substance use services in the following settings:
  - Ambulatory
  - Inpatient
  - Residential

Contractual demographic changes

We should be notified 30 days prior of changes such as:

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

You can notify us by:

Phone

- **855-223-9868**

Email

- Medical providers:
  OKProviderDevelopment@humana.com
- Behavioral health providers:
  OKBHMedicaid@humana.com

*Data displayed within the online directory will reflect the most current information reported to OHCA.

Provider rights

Healthcare providers who contract with Humana Healthy Horizons to furnish services to the member shall be assured of the following rights:

- To advise and advocate on behalf of members, including the right to file a grievance or appeal on behalf of a member as the member's authorized representative
- To review, upon request, information submitted to support their credentialing application to the Humana Credentialing department
  - Humana keeps all submitted information locked and confidential.
  - Access to electronic credentialing information is password-protected and limited to staff that requires access for business purposes.
- To be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of the provider's license or certification under applicable state law, solely on the basis of that license or certification

Humana, our subcontractors, and participating providers shall, upon request, make available any and all administrative, financial and medical records relating to the delivery of items or services for which state or federal monies are expended, unless otherwise provided by law. Any audit of a participating provider that is a pharmacy shall comply with the requirements of 59 O.S. § 356.2.

Provider responsibilities

To comply with the requirements of accrediting and regulatory agencies, Humana Healthy Horizons has adopted certain responsibilities for participating providers. You have responsibilities to:

- Provide all covered services that are within the normal scope and in accordance with your licenses and/or certifications
- Have a National Provider Identifier (NPI), to the extent such provider is not an atypical provider as defined by the Centers for Medicare & Medicaid Services (CMS)
- Meet applicable appointment waiting time standards and after-hours coverage requirements
- Abide by members' rights and responsibilities per the contract
- Display notices of members' rights to grievances, appeals and state hearings in public areas of your facility in accordance with all state requirements
- Provide physical access, reasonable accommodations and accessible equipment for members with physical or mental disabilities
- Accommodate interpreters
- Hold members harmless except for any applicable copayment amounts allowed by the Oklahoma Health Care Authority (OHCA)
- Render emergency services without the requirement of prior authorization
- Keep member information confidential
- Comply with necessary and authorized member communications, movement and/or reassignment
- Maintain an adequate system for recording services and all other commonly accepted information elements, including but not limited to, charges, dates and records necessary for evaluation of the quality, appropriateness and timeliness of services performed
- Maintain all records related to services provided to members for a 10-year period

Provider responsibilities (cont'd)

To comply with the requirements of accrediting and regulatory agencies, Humana Healthy Horizons has adopted certain responsibilities for participating providers. You have responsibilities to:

- Make all member medical records or other service records available for any quality reviews that may be conducted by Humana, OHCA or its designated agent(s) during and after the term of the provider agreement
- Furnish and maintain member health records with professional standards
- Connect to the state health information exchange (HIE) for the purpose of bidirectional health data exchange, if you do not have a certified electronic health record (EHR) use the state HIE provider portal to query patient data for enhanced patient care
- Sign a participation agreement with the state HIE and sign up for direct secure messaging services and portal access if you do not have EHR

- Sign a participation agreement with the state HIE within 1 month of contract signing
- Allow authorized representatives of OHCA and other state or federal agencies reasonable access to facilities and records for audit purposes during and after the term of the provider agreement
- Release to Humana any information necessary to monitor provider performance on an ongoing and periodic basis
- Send electronic patient even notifications of a member's admission, discharge and/or transfer to the state HIE(applicable to network hospitals, long-term care facilities and emergency departments)
- Submit all reports, clinical information and encounter data required by Humana and OHCA timely

Provider responsibilities (cont'd)

To comply with the requirements of accrediting and regulatory agencies, Humana Healthy Horizons has adopted certain responsibilities for participating providers. You have responsibilities to:

- Participate and cooperate in internal and external quality management or quality improvement activities
- Follow the standards for medical necessity as required under the contract and the regulatory rules
- Complete all annual required training
- Implement and provide a tobacco-free campus in accordance with the standards of the tobacco-free policy of the state of Oklahoma 63 O. S. § 1-1523 and Executive Order 2013-43, making an effort to communicate the tobacco-free campus in signage and other communications associated with the organization

Primary care provider (PCP) responsibilities

In addition to the provider responsibilities in the previous section of this training, PCPs also have the following responsibilities:

- Delivering primary care services and follow-up care
- Utilizing and practicing evidence-based medicine and clinical decision supports
- Screening members for behavioral health disorders and conditions
- Making referrals for specialty care, behavioral health services and other covered services and, when applicable, working with Humana to allow members to directly access a specialist as appropriate for a member's condition and identified needs
- Ensuring there is a process for following up on referrals for members made to specialists
- Maintaining a current medical record for the member
- Using health information technology to support care delivery
- Providing care coordination in accordance with the member's care plan, as applicable based on the Contractor's Risk Stratification Level Framework and in cooperation with the member's care manager
- Ensuring coordination and continuity of care with providers, including but not limited to specialists and behavioral health providers
- Engaging active participation by the member and the member's family, authorized representative or personal support, when appropriate, in healthcare decision-making, feedback and care plan development
- Providing access to medical care 24 hours a day, 7 days a week, either directly or through coverage arrangements made with other providers, clinics and/or local hospitals
- Providing enhanced access to care, including extended office hours outside normal business hours and facilitating use of open scheduling and same-day appointments where possible
- Participating in continuous quality improvement and voluntary performance measures established by the contractor and/or OHCA

Behavioral health provider responsibilities

In addition to the provider responsibilities in the previous sections of this training, behavioral health providers also have the following responsibilities:

- Scheduling the member receiving inpatient psychiatric services for outpatient follow-up care prior to discharge from the inpatient setting, with the outpatient treatment occurring within 7 calendar days from the date of discharge
- Participating providers providing treatment to pregnant members who are intravenous drug users and all other pregnant substance users within 24 hours of assessment

Conditions of participation

Providers are required to meet all state and federal participation requirements, including, but not limited to, background screening compliance. Conditions of your participation are continuously monitored.

Required status notifications

- Being named in a medical malpractice suit
- Involuntary changes in:
  - Hospital privileges
  - Licensure
  - Board certification
- An event reportable to the National Practitioner Data Bank
- Sanctions or complaints:
  - Federal
  - State
  - Local

Provider complaint system

If you are not satisfied with Humana Healthy Horizons' policies and procedures or a decision made by Humana Healthy Horizons that does not impact the provision of services to members, you can file a provider complaint.

Humana Healthy Horizons' provider complaint system consists of 2 steps: reconsiderations and formal appeals.

1. Reconsideration: This is the first step in the provider complaint system. A reconsideration represents your initial request for an investigation into a denied claim, Humana Healthy Horizons' policies and procedures, findings of a provider payment integrity audit or the termination of a provider agreement. Most issues are resolved at the reconsideration step.
2. Formal appeal: This is the second step in the process. If you disagree with the outcome of the reconsideration, you may request an additional review known as a formal appeal.

Provider complaint system: reconsiderations

Reconsideration:

If your reconsideration request is regarding a denied claim, you have 6 months from receiving written notification to submit a reconsideration.

For all other reasons, you are allowed 15 calendar days to submit a request for reconsideration.

Reconsideration requests will be:

- Resolved within 30 calendar days of receipt of the request
- Followed up with a resolution letter to you within 5 calendar days of resolution

A reconsideration request may be filed using any of these methods:

In person: Please reach out to your Provider Relations Representative

For claims:

Phone: 855-223-9868

For dissatisfaction with policies and procedures, Provider Payment Integrity audit findings or provider contract agreement terminations, please contact your Provider Relations Representative

Online:

Provider claim reconsiderations about finalized claims may be submitted online via Availity Essentials.

- To begin, sign in at **Availity Essentials**, use the Claim Status tool to locate the claim and select the “Dispute Claim” button.
- Then go to the request in the Appeals worklist (located under Claims & Payments) to supply needed information and documentation and submit the request to Humana.
- Status and high-level Humana determination for claim disputes submitted online can be viewed in the Appeals worklist.

You also can submit reconsideration requests in writing via mail using the following address:

Claims:

Humana
Reconsideration Request
PO Box 14359
Lexington, KY 40512-4359

All other reasons:

Humana Healthy Horizons in Oklahoma
Oklahoma Tower
210 Park Ave., Box 43
Oklahoma City, OK 73102

Humana email address: OKMedicaidProviderRelations@humana.com

Provider complaint system: formal appeals

Formal appeal:

Dissatisfied with the determination of the reconsideration request related to policies and procedures, Provider Payment Integrity audit findings or provider contract agreement terminations?

You may request a formal review referred to as a formal appeal.

- All appeals are reviewed by an independent panel with professionals knowledgeable about the policy, legal and clinical issues involved in the matter subject to the appeal. The panel also includes individuals who were not involved in any previous consideration of the matter. All information and material submitted by the provider that bears directly upon an issue involved in the matter is considered in the formal appeal.

You may submit a written appeal within 30 calendar days of the date on the determination letter for the reconsideration request.

Humana Healthy Horizons will review and provide a determination within 30 calendar days.

Process for filing a formal claim appeal:

- A provider's request for reconsideration is required before requesting a formal appeal.
- Providers or their authorized representative have the option to submit a formal appeal following the reconsideration process. The provider must submit any documentation from the reconsideration request when submitting a formal appeal.
- If the appeal is on behalf of a member, written authorization from the member or the member's legal representative must be submitted, along with all required documents, prior to beginning the process. The appeal will be processed under the member's name. Please refer to the Grievance and Appeals section of the Provider Manual for additional information.
- A resolution letter will be mailed within 5 calendar days of determination of the appeal.

Providers can file an appeal in writing to:

Humana Healthy Horizons in Oklahoma
Provider Appeals
Oklahoma Tower
210 Park Ave., Box 43
Oklahoma City, OK 73102

Or via email: **OKMedicaidProviderRelations@humana.com**

Provider complaint system

Administrative appeal

In the event you have completed the formal appeal process and remain dissatisfied with Humana's determination, you have the option to request an administrative appeal within 30 calendar days of the date of the appeal determination.

You have the right to be represented by counsel at the administrative appeal. Your request should include decisions from all reconsiderations and formal appeals. Humana will supply OHCA with all relevant information within 15 days of receiving the Administrative Appeal request.

Mail administrative appeal requests to:

Docket Clerk, OHCA Office of Hearings & Appeals
P.O. Drawer 18497
Oklahoma City, OK 73154-0497

Accessibility and availability standards and methods of identifying compliance

Providers must offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service if the provider serves only Medicaid managed care members.

Participating PCP 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's provider network must meet OHCA's time and distance standards and members should have access to care for PCP services and referrals to specialists for medical and behavioral health services available on a timely basis.

Humana will monitor providers to ensure compliance with timely access requirements through audits and surveys and take corrective action for failure to comply.

Appointment time standards

Provider type	Appointment time standards
Adult PCP **Pediatric PCP**	• Not to exceed 30 days from date of the Humana Healthy Horizons member's request for routine appointment • Within 72 hours for nonurgent sick visits • Within 24 hours for urgent care • Each PCP allowing for at least some same-day appointments to meet acute care needs
OB-GYN	• Not to exceed 30 days from date of the Humana Healthy Horizons member's request for routine appointment • Within 72 hours for non-urgent sick visits • Within 24 hours for urgent care **Maternity care:** • First trimester – Not to exceed 14 calendar days • Second trimester – Not to exceed 7 calendar days • Third trimester – Not to exceed 3 business days
Adult and pediatric mental health Adult and pediatric substance use	• Not to exceed 30 days from date of the Humana Healthy Horizons member's request for routine appointment • Within 7 days of residential care and hospitalization • Within 24 hours for urgent care

Member rights and responsibilities

- Humana Healthy Horizons contracted providers have a responsibility to respect our member's rights.
- Members are informed of their rights and responsibilities in the member handbook.
- Detailed information on provider and member rights and responsibilities can be found in the Provider Manual on our website at **Humana.com/HealthyOK**.

Grievances and appeals

Grievances

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

Appeals

Members or their authorized representatives can file an oral or written appeal request within 60 days of the date on the adverse benefit determination. Members can request assistance from Member Services at **855-223-9868**.

Member grievances and appeals contact information

Mail
Humana Grievance and Appeal Department
P.O. Box 14163
Lexington, KY 40512- 4163

Member Services
Member Services **855-223-9868 (TTY: 711)**,
Monday – Friday, 8 a.m. – 5 p.m.,
Central time.

Additional training
Humana.com/OKDocuments

Grievances and appeals continued

Grievances

- We will resolve the member's grievance as quickly as the member's health condition requires.
- Grievances concerning a member's request for disenrollment will be resolved within 10 days from the date of receipt.
- Grievances regarding all other matters will be resolved within 30 days from the date we receive the request.

Appeals

- We will resolve appeals as quickly as the member's health condition requires.
- Standard appeals will be resolved no later than 30 days from the date we receive the request.
- If the member's life, physical or mental health, or ability to attain, maintain or regain maximum function would be at risk following the standard appeal time frame, an expedited appeal can be requested.
- Expedited appeals will be resolved within 72 hours of receipt.
- We may extend the appeal timeframe by up to 14 days if we need more information and extending the timeframe is beneficial to the member.

Continuation of benefits

While the state fair hearing or appeal is pending, we will continue paying for the member's benefits if all the following conditions are met:

- The appeal involves the termination, suspension or reduction of previously authorized services
- The services were ordered by an authorized provider
- The period covered by the original authorization has not yet expired

If the member receives a continuation or reinstatement of benefits while the appeal or state fair hearing is pending, we will continue the benefits until one of the following occurs:

- The member withdraws the appeal or state fair hearing request
- A state fair hearing officer issues a decision that is adverse to the member

If the appeal or state fair hearing is not decided in the member's favor, the member may be liable for the cost of services received while the appeal was pending.

Medicaid state fair hearing

If the appeal decision is not fully in the member's favor, the member or the member's authorized representative can appeal to Oklahoma Health Care Authority by requesting a state fair hearing. Medicaid state fair hearing requests must be filed within 120 days from the date on Humana Healthy Horizons' appeal decision letter.

Mail state fair hearing requests to:
Oklahoma Health Care Authority, Grievance Docket Clerk
P.O. Drawer 18497
Oklahoma City, OK 73154-0497

Critical incident reporting

When a member is in the care of a behavioral health inpatient, residential or crisis stabilization unit, critical incidents can include, but are not limited to, the following, in accordance with OAC 317:30-5-95.39:

- Suicide death
- Non suicide death
- Death cause unknown
- Homicide
- Homicide attempt with significant medical intervention
- Suicide attempt with significant medical intervention
- Allegation of physical, sexual, verbal abuse or neglect
- Accidental injury with significant medical intervention
- Use of restraints/seclusion (isolation)
- AWOL or absence from a mental health facility without permission
- Treatment complications (medication errors and adverse medication reaction) requiring significant medical intervention

Critical incident reporting timeline

- Psychiatric Residential Treatment Facility (PTRF) providers are required to report adverse or critical incidents to Humana Healthy Horizons, the OHCA Behavioral Health Unit and Oklahoma Department of Human Services (OKDHS) by phone no later than 5 p.m. on the business day following a serious occurrence.
- In the case of a minor, the PTRF provider also must notify the member's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence.
- PTRF providers shall immediately (not to exceed 24 hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members.
- PTRF providers shall conduct an internal critical incident investigation and submit a report on the investigation as soon as possible, based on the severity of the critical incident and no later than 3 days from the serious occurrence to Humana, the OHCA Behavioral Health Unit and Oklahoma DHS and the member's parent(s) or legal guardian(s).
- Humana will review the PTRF provider's report and follow up with the participating provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable time frames.

Humana Healthy Horizons Provider Services:
855-223-9868

OHCA Behavioral Health Unit**:**
800-522-9054

Reporting potential cases of abuse, neglect and exploitation of members

Abuse, neglect or exploitation must be reported in accordance with state law.

- Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (OKDHS) hotline, at **800-522-3511**.
- Suspected abuse, neglect or exploitation of a vulnerable adult should be immediately reported to the nearest DHS county office, municipal or county law enforcement authorities. Or, if the report occurs after normal business hours, call the OKDHS hotline.
- Healthcare professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity should promptly make a report to the nearest law enforcement agency.

Important phone numbers:

Humana Healthy Horizons Provider Services: **855-223-9868**
Oklahoma Department of Human Services: **405-522-5050**

Advance directives

Providers have the responsibility to discuss advance medical directives with adult members who are 18 or older and who are of sound mind at the first medical appointment.

The discussion should subsequently be charted in the permanent medical record of the member.

A copy of the advance directive should be included in the member's medical record inclusive of other mental health directives.

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

Providers must inform members that complaints concerning advance directive requirements can be filed with the Oklahoma State Department of Health per 42 CFR 489.102(a)(4).

- All member records shall contain documentation that the member was provided with written information concerning the member's rights regarding advance directives (written instructions for living will or power of attorney), including whether the member has executed an advance directive. 42 CFR 489.102(a)(2) and OAC 317:30-3-13(a), 63 OS 3101.4.D
- Humana Healthy Horizons and its providers will not condition the provision of care or otherwise discriminate against a member based on whether or not the member has executed an advance directive. (42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(F); 42 CFR 489.102(3), OAC 317:30-3-13(a)(4).

Revocation of advance directive may happen at any time by the member, without regard to their medical or mental health, in accordance with 63 O.S. § 3101.6, and the following:

- If the member is pregnant and the provider is aware, the pregnant patient is to be provided with life-sustaining treatment unless the patient has specifically authorized to withhold treatment during pregnancy, pursuant to 63 O.S. § 3101.8.
- If a provider is unable or unwilling to provide care as per the advance directive (63 O.S. § 3101.9), Humana will process the information. The provider will transfer care of patient to another provider to comply with medical decisions of the patient. The original provider must comply with the member's advance directive during the transfer process, if the member may die, unless the provider is physically or legally unable to provide without thereby denying the same treatment to another patient.
- An advance directive from another state is valid to the extent that it does not exceed authorizations allowed under Oklahoma laws. It must have been executed by the individual to which the directive applies, and it must specifically authorize withholding/withdrawal of artificial nutrition/hydration and be signed, pursuant to 63 O.S. § 3101.14.

Behavioral health

As a Humana Healthy Horizons healthcare provider, you can take advantage of Relias—a web-based continuing education library.

Relias offers more than 300 modules to choose from and over 575 continuing education credits, in addition to behavioral health training. Relias' training modules provide integrated information to support comprehensive care and address unique patient needs.

Relias offers courses designed to help you succeed in the emerging value-based healthcare delivery system.

Through Relias, you can explore training such as:

Overview of behavioral health screening tools: This course will provide a review of some of the most widely used behavioral health screening tools currently available to support collaborative care.

Screening and brief interventions for substance use issues: This course will discuss the core components of the Screening, Brief Intervention and Referral to Treatment (SBIRT) model and the most common screening tools used. It also will discuss how the basic philosophy, principles and techniques of motivational interviewing and stages of change apply to SBIRT.

Integration of primary and behavioral healthcare: This course covers a variety of ways behavioral healthcare professionals can function effectively in an integrated care environment.

Collaborative care in primary care: management of depression: The goal of this course is to provide nursing professionals, provider assistants and providers with an overview of the collaborative (interdisciplinary) approach to the management of patients with depression and chronic illness.

Collaborative care in primary care: substance misuse: The goal of this course is to educate providers, provider assistants and nurses in all healthcare settings on how to address substance use problems in the context of collaborative care.

How to access the Relias library

- Visit the **Relias website** or sign in to your **Availity Essentials™** account.
- Select Humana under the Payer Spaces tab.
- Select the Resources tab.
- Select Relias Training.

For more information, please contact your Provider Relations Representative.

Behavioral health referral process

PCPs could encounter a member that also needs behavioral health services during their visit. Should a member be identified as such:

- The PCP may refer the member to **Humana.com/FindADoctor** to utilize the provider directory.

Our provider directory will allow members to search by specialty or condition to find the appropriate provider for their needs.

Providers and/or members also can connect with a care manager by calling **855-223-9868** for assistance with their behavioral health needs.

Please note: Members are eligible to self-refer to behavioral health services, including substance use disorder (SUD) treatment.

Behavioral health provider coordination

Humana's providers are required to coordinate care for members who experience behavioral health conditions that require ongoing care.

PCPs are required to:

- Provide basic behavioral health services to members to include:
  - Screening for mental health and substance use issues during routine and emergency 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 nonduplicitous care to the member.
- Obtain the necessary signed release of information for sharing personal health information including compliance with 42CFR Part II requirements around behavioral health and SUD.

Behavioral health provider coordination continued

Behavioral health providers are required to:

- Notify the PCP when a member initiates behavioral health services with the provider.
- Obtain the signed release of information for sharing personal health information in compliance with 42CFR Part II requirements around behavioral health and SUD prior to sharing information with the PCP.
- Provide initial and summary reports to the PCP (after receiving the 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.

Care management

Humana Healthy Horizons coordinates care and population health services for our members.

The care plan will be person-centered and holistic with services that address the member's physical care, behavioral health and community and social support needs.

Care management supports members by:

- Reducing admission and readmission risks
- Managing anticipatory transitions
- Reducing emergency room (ER) visits for nonurgent needs
- Engaging noncompliant members
- Reinforcing medical instructions
- Assessing social determinants of health (SDOH)

Care management participation and referrals

Humana Healthy Horizons encourages providers to participate in the development of the patients' comprehensive care plan.

Member care plans and health risk assessments are viewable, with member consent, on **Availity Essentials**.

Providers can contact Humana Healthy Horizons to refer members needing care management assistance:

- Call **855-223-9868**
- Email **OKMCDCareManagement@humana.com**
- Fax **877-473-0056**

If a member needs access to a car, wheelchair van, stretcher services or nonmedical transportation:

- Call ModivCare at **877-718-4213**.
  - To cancel a ride, please make every effort to call at least 24 hours in advance.

We offer individualized member education and support for many conditions and needs, including assistance with housing and accessing community support.

Care management

Humana Healthy Horizons uses a holistic and fully integrated health management program using a multidisciplinary team to ensure the best and most comprehensive care for our members.

This approach supports members by:

- Reducing admission and readmission risks
- Reducing emergency room (ER) visits for nonurgent needs
- Managing anticipatory transitions
- Engaging noncompliant members
- Reinforcing medical instructions
- Assessing SDOH

Care management programs include:

- Transitional care management
- Chronic condition management
- Neonatal intensive care unit (NICU) case management
- Transplant care management
- A maternity program, HumanaBeginnings®

Oklahoma care management operating model roles

Care manager – (physical and behavioral health) adult and pediatrics

- Supports engaged members based on the primary need (behavioral health or physical health)
- Performs member outreach, assessment completion and care plan and/or service plan development
- Supports members with all care coordination needs
- Assists in discharge planning and post-discharge outreach for assigned members to include medication reconciliation
- Collaborates with community health workers (CHWs), housing specialists and other internal and external agencies for SDOH needs
- Assists members aging out of childhood programs into the adult Medicaid program
- Participates/leads multidisciplinary team
- Assists in value-added benefits (VAB) coordination for members

Maternity care management

- Supports pregnant members through 6 weeks postpartum
- Performs member outreach, assessment completion and care plan development
- Supports members with identified comorbidities outside of their maternal needs to improve outcomes and decrease utilization
- Ensures members receive appropriate and timely prenatal care to achieve healthy delivery with a 6-week postpartum visit
- Collaborates with CHWs and housing specialists for SDOH needs
- Participates/leads multidisciplinary teams
- Assists in VAB coordination for members

Transition coordinator

- Collaborates with the UM team regarding discharge planning for members admitted to a facility and not assigned a primary care manager
- Completes the transition planning assessment for inpatient members and the post-discharge assessment when members are discharged and not assigned a primary care manager
- Documents/updates members' medication with discharge outreach
- Provides members with the care plan upon discharge
- Collaborates with UM for members transitioning in and out of SoonerSelect to ensure continuity of care
- Collaborates with CHWs, housing specialists and other internal and external agencies for SDOH needs
- Participates in multidisciplinary teams meetings
- Assists in VAB coordination for members

Tribal liaison

- Tribal Government Liaison collaborates with the care manager and UM team to ensure specialized support for tribal members

Oklahoma care management operating model roles (cont'd)

Community health worker

- Supports in the field locating and engaging unable to contact members who stratify as high utilization/complex needs
- Refers high utilizers and/or complex members to CM.
- Connects members to community support programs and Humana community events to provide education on CM services
- Utilizes FindHelp.org to identify and refer to community resources
- In the field, can attend appointments with member as needed
- Participates in multidisciplinary team (MDT) meetings
- Assists in VAB coordination for member

SDOH coordinator

- Support members telephonically with short term needs (< 60 days) and low to medium risk level with primary SDOH needs
- Refers to CM for ongoing needs that require long-term support (> 60 days)
- Connects members to community support programs and Humana Healthy Horizons community events to provide education on CM services
- Utilizes FindHelp to identify and refer to community resources
- Assists in VAB coordination for member

Housing specialist

- Supports members with SDOH specific to housing
- Assists members in applying for state specific housing programs
- Utilizes FindHelp to identify and refer to community resources
- Participates in MDTs as needed
- Assists in VAB coordination for member

Care manager support assistant

- Nonclinical support for CM administrative needs
- Supports member mailing needs and member phone number research as needed
- Distributes referrals from manual reports, shared mailboxes and work queues
- Guides members/families by facilitating interaction with resources for the care and well-being of members
- Assists in VAB coordination for member

Risk stratification model

Member movement based on need and clinical judgement

Complex care management

Members are of the highest need and require the most focused attention. These members have multiple or complex conditions (behavioral or physical health) that require intensive management and coordination or have significant barriers to self-management that might lead to unplanned hospitalization.

High-risk members

Members require the most focused attention to support their clinical care needs. High-risk members receive weekly contacts to review plans of care and quarterly reassessment for changing needs. Case managers focus on implementing members' plan of care, preventing institutionalization and other adverse outcomes, and supporting members in self-managing their care goals.

Medium-risk members

These members typically demonstrate rising risk and need-focused attention to support their clinical care needs. Conditions require a moderate amount of coordination of care, given the complexity of members' physical, behavioral or social needs. Care plans are developed based on individual needs and include treatment plans as appropriate.

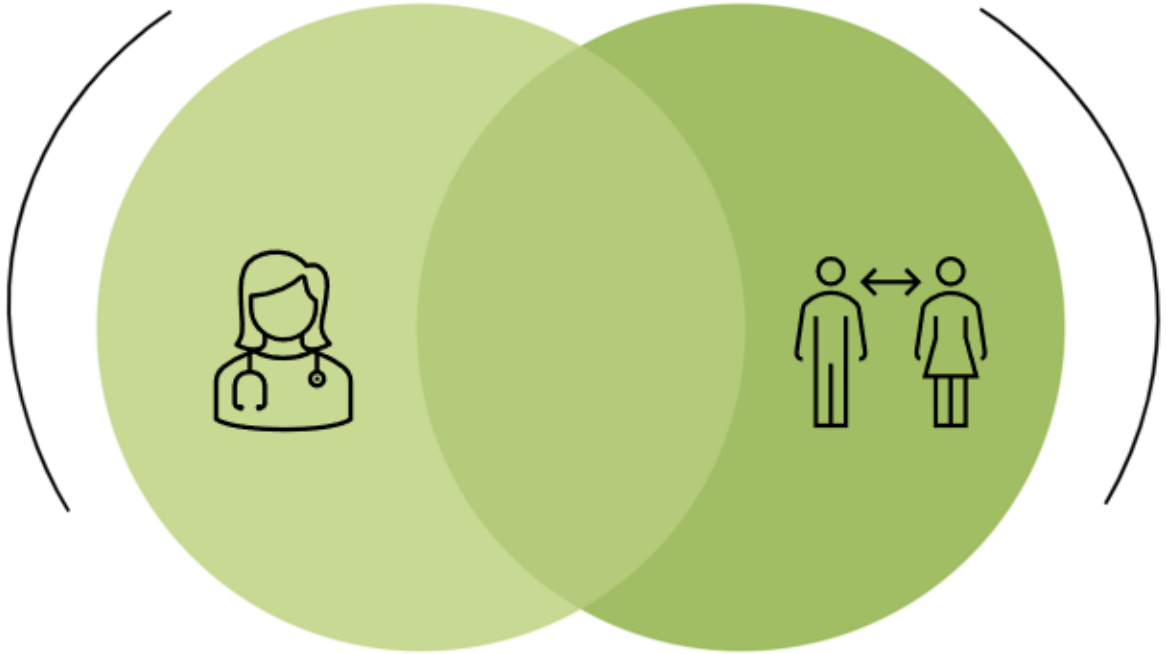
Low-risk members

These members typically demonstrate conditions indicating emerging needs or vulnerabilities best suited by assistance from a nonlicensed care coordinator for short-term support aiming to help them address their needs and move to the wellness and prevention level. We also target members to support wellness and emergent needs to help them maintain an optimal level of health, which may include healthy children and adults (vaccinations, well visits, healthy lifestyle.

Wellness and prevention

Humana Healthy Horizons supports members in wellness to maintain an optimal level of health. Wellness and prevention programs are available to all active Humana Healthy Horizons members and include incentives for vaccinations, well visits, healthy lifestyle education and more.

Care management team capabilities



Care management (primarily telephonic)

Care coordinators, case managers, care managers and care coaches are often used interchangeably.

Care management supporting roles

- SDOH–telephonic
- Transition – telephonic
- CHWs–face-to-face
- Case manager support assistants – telephonic

Early and Periodic Screening, Diagnostic and Treatment

- Early and Periodic screening, Diagnostic and Treatment (EPSDT) is a federally mandated program developed for Medicaid recipients from birth through the end of the month of their 21st birthday.

- All Humana Healthy Horizons members in this age range should receive age-recommended EPSDT preventive exams, health screenings and EPSDT special services to address health issues as soon as identified or suspected. EPSDT benefits are available at no cost to members.

- The EPSDT program aims to offer comprehensive preventive healthcare services at scheduled age intervals. These visits identify health issues early, covering physical and mental health, and growth and development, allowing for prompt testing, evaluation and/or treatment when needed.

Fraud, waste and abuse definitions

Fraud

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

Waste

- The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program; generally, not considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse

- Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes eligibility and member practices that result in unnecessary cost to the Medicaid program.

Cultural and linguistic competency

Cultural humility and competency in healthcare acknowledge and recognize the distinctions and unique differences of care level needs that center on diverse values, beliefs and behaviors, inclusive to tailoring to meet patients' social, cultural and linguistic needs.

Participating providers are expected to provide services in a culturally sensitive and competent manner inclusive of, removing language barriers to services and accommodating special needs relating to the ethnic, cultural and social circumstances of the patient.

Services should be delivered in a culturally aware manner fostering a connection to the broader context, considering factors such as race, culture and gender of Medicaid managed care members.

Understand your patients' needs and preferences:

- Ask your patients their communication preference (e.g., explain by talking, using a model, making a drawing or demonstrating how to do something).
- You may find your patient wants you to share information in a variety of ways.
- How does your patient prefer you to offer materials (e.g., print, video or audio format)?
- Make sure that multimedia decision aids (videos, DVDs, CDs, audiotapes), other health resources for treatment and other intervention materials reflect the diversity of the patients you serve.

When possible, offer decision aids, treatment summaries and educational materials that have specific, culturally relevant descriptions of risks and benefits of treatment options. The best decision aids meet cultural and health literacy or plain language standards.

Cultural and linguistic competency (cont'd)

How to interact with patients across cultures and underserved communities

Keep an open mind. Remember that each patient has a unique set of beliefs and values, and your patient may not share yours.

Be aware of your own culture and how that may affect how you communicate with your patients.

In addition to completing the required Humana Cultural Competency training, attend cultural competency training at your organization or through a continuing education program that offers insightful training on the diverse populations your state serves.

Ask patients about their concerns regarding their health condition, (e.g., "What do you think caused the problem? What is your understanding about the sickness? Why do you think it started when it did?"). This information will allow you to make the most of your interactions during shared decision making. Recognize and understand that the meaning or value of health prevention, intervention and treatment varies among cultures, specifically for behavioral health.

American Indian/Alaska Native — cultural competency

Humana Healthy Horizons has supports in place to assist Indian Health Care Providers (IHCPs) navigate Medicaid managed care.

- IHCPs can contact their assigned Provider Relations Representative with questions about Humana or Medicaid; questions about how managed care operates; questions regarding members' benefits, such as transportation or behavioral health services; to request help with accessing our extensive training and education materials; or for any other help they may need.

- Our Tribal Government Liaison conducts outreach to the American Indian/Alaska Native (AI/AN) communities and serves as the Point of Contact to Indian Health Service/Tribal Governments/Urban Indian (I/T/Us). The TGL consults, identifies and addresses questions and concerns. Our Tribal concierge unit is a local, one-stop shop for questions and assistance specifically related to AI/AN health issues. It is comprised of subject matter experts.

American Indians/Alaska Natives cultural competency

In comparison to people who are white, people who are AI/AN often face limited opportunities for higher education, which can decrease quality of life and increase the incidence of chronic health conditions.

16.3% of AIs and ANs older than 25 have at least a bachelor's degree, compared to 40.0% of whites.[1]

AIs and ANs report experiencing serious psychological distress 2.5 times more frequently than the general population over a 30-day period.[2]

AIs and ANs generally prefer to seek mental health services from an IHCP traditional healers of their choice.

Living in rural/reservation areas can limit access to primary and specialty care.

AIs/ANs have a life expectancy of 71.3 years for women and 64.6 for men, compared to whites at 80 for women and 75.1 years for men.[1]

1. "American Indian/Alaska Native Health." U.S. Department of Health and Human Services, Office of Minority Health, last accessed Nov. 4, 2024, https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62
2. "Behavioral Health," Indian Health Service The Federal Health Program for American Indians and Alaska Natives, last accessed Nov. 4, 2024, (https://www.ihs.gov/newsroom/factsheets/behavioralhealth/

Health equity

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Differences in access, treatment and outcomes between individuals are often referred to as inequities or disparities.

- Achieving this requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, overcome economic, social and other obstacles to health and healthcare and eliminate preventable health disparities.
- Healthcare providers have a role to play in healthcare systems and communities to remediate inequities.

Humana’s quality assessment and performance improvement program

Clinical care + **Preventive care** + **Population health management** + **Administrative functions**

Our quality assessment and performance improvement (QAPI) program works to:

- Monitor systemwide 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

QAPI program activities include:

- Clinical indicators or outcome monitoring
- Quality of care complaints
- Utilization metrics
- Quality studies
- Healthcare Effectiveness Data and Information Set (HEDIS®)*
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) results
- Medical record audits

*HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)

Humana's QAPI program

Clinical practice guidelines:

These protocols incorporate 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.

Providers ultimately remain responsible for determining the applicable treatment for every individual.

Preventive health and clinical practice guidelines are distributed through:

- Provider manual updates
- Provider newsletters
- Provider website **Clinical Practice Guidelines for Healthcare Providers – Humana**.

Medical record documentation reviews (MRDRs):

Humana Healthy Horizon's medical records standards are in accordance with OHCA requirements. Records need to be maintained for a minimum of 10 years. For minors, records will be maintained during the period of minority plus a minimum of 10 years after the age of majority (19 years old).

MRDRs are conducted on a regular basis to monitor compliance with medical record standards.

A full listing of the medical record elements can be found in your provider manual.

Humana’s QAPI program continued

HEDIS measures:

HEDIS is a tool used by more than 90% of America’s health plans to measure performance on important dimensions of care and service.

Humana Healthy Horizons may conduct medical record reviews to validate HEDIS measures. In addition to medical record reviews, information for HEDIS is gathered administratively via claims, encounters and submitted supplemental data.

Humana Healthy Horizons also reviews other performance measures in accordance with the CMS child and adult core sets and other state-specific performance measures.

Member satisfaction:

Humana conducts an annual 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’s performance goals, and improvement action plans are developed to address any areas not meeting the standard.

Provider profiling helps assess provider effectiveness and efficiency.

This methodology is developed as part of the QAPI program and is reviewed annually to identify and review the measures used for profiling providers.

Provider profiling activities include:

- Developing and using provider-specific reports that include a multidimensional assessment of performance using clinical, administrative and member satisfaction indicators that are accurate, measurable and relevant to the enrolled population.
- Establishing benchmarks and goals for performance.
- Providing feedback to individual participating providers regarding the results of their performance and the overall performance of the Humana Healthy Horizons provider network. To supplement those reports and feedback, we meet with practices on a regular basis to review data related to performance measures and work with providers to identify opportunities for improvement.

Provider participation in QAPI program

It is a contractual requirement for providers to comply with Humana's QAPI program, which includes providing member records for assessing quality of care and external quality review organization activities.

- Providers also must allow Humana to use provider performance data.
- Our QAPI program effectiveness is evaluated annually.
- Information regarding the QAPI program is available upon request.

To receive a written copy of Humana's QAPI program and its progress toward goals:

Email:

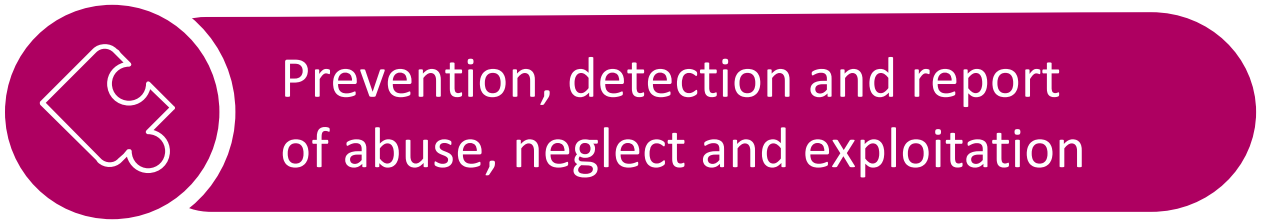
OklahomaMedicaidQuality@humana.com

Call the Provider Services Center:

855-223-9868 (TTY: 711), Monday – Friday, 8 a.m. – 5 p.m., Central time.

Required training and annual compliance

Visit **Humana.com/HealthyOK** for direct links to this training and information on how to complete the annual training and required attestation.



Humana
Healthy Horizons®
in Oklahoma

SoonerSelect