

2026

Provider Handbook

Humana Healthy Horizons in Florida

Humana
Healthy Horizons®
in Florida

956607FL0226 FLHMXBVEN

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

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Welcome

Thank you for your participation with Humana Healthy Horizons® in Florida, where our goal is to provide quality services to Medicaid recipients.

This handbook applies to those who provide services to our Humana Healthy Horizons members enrolled in the following plans:

- Managed Medical Assistance (MMA) plan
- Long-term care (LTC) plan
- Comprehensive (combined MMA and LTC) plan
- Serious mental illness (SMI) Specialty plan
- HIV/AIDS specialty plan

Within this handbook, key points are highlighted related to Humana Healthy Horizons' policies and procedures. This handbook serves as an extension of your provider agreement and is intended to inform both you and your staff of requirements for each of the Florida plans, what Humana Healthy Horizons requires of you and what you can expect from us. The guidelines set forth in this handbook are designed to assist you in the provision of caring, responsive service to your patients who are Humana Healthy Horizons members.

You will be notified of updates to this handbook via fax or United States (U.S.) mail. If you require further information about anything covered within this handbook, please reach out to your local provider relations representative or contract specialist.

On behalf of everyone at Humana Healthy Horizons, we look forward to a lasting partnership with you and your team.

About this handbook

This handbook applies to those who provide services to our Humana Healthy Horizons members. Throughout the handbook, all instances of "us," "we" or "our" refers to Humana Healthy Horizons, and all references to "you" or "your" refers to you, the provider contracted with us.

All acronyms used within this provider handbook are defined in the **Acronyms section** of this provider handbook.

Color coding and font variations are used to denote different information throughout this provider handbook as follows:

- **Internal references** to other parts of this provider handbook are denoted in bold dark green font and are linked to the relevant section of the manual.
- **Contact information** is denoted in bold navy font, and detailed information is available at the beginning of each respective chapter.
- **Hyperlinks** to external resources are denoted in bold teal font.

This handbook furnishes you and your office staff with important information concerning Humana Healthy Horizons' policies and procedures, claim submission and adjudication requirements, and other guidelines used to administer our health plans. This handbook replaces and supersedes all previous versions as of Jan. 1, 2026. If you require further information about anything covered within this handbook or want a paper copy of this handbook, which can be obtained at any time upon request, please call Member/Provider Services at **800-477-6931**, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

Except as may otherwise be set forth in your provider contract, you are contractually required to comply with all provisions contained in this handbook. Revisions to this handbook constate revisions to Humana Healthy Horizons' policies and procedures.

Any requirements under applicable law, regulation or guidance that are not expressly set forth in the content of this handbook are incorporated herein by this reference and shall apply to providers and/or Humana Healthy Horizons where applicable. Such laws and regulations, if more stringent, take precedence over the content in this handbook. You are responsible for complying with all applicable laws and regulations.

We may deny payment for any services or supplies for which you failed to comply with Humana Healthy Horizons' policies and procedures.

Handbook updates and changes

Updates to this handbook as permitted by the provider contract are posted on Humana Healthy Horizons' **Florida provider website**. You may be notified of updates to this handbook via fax or U.S. mail.

Acronyms

Acronym	Definition
ABA	Applied behavior analysis
ACIP	Advisory Committee on Immunization Practices
ADA	Americans with Disabilities Act
ADHC	Adult day home care
ADRC	Aging and Disability Resource Center
ADT	Admits, discharges and transfers
AFCH	Adult family care home

Acronym	Definition
AHCA	(Florida) Agency for Health Care Administration
ALF	Assisted living facility
AOR	Appointment of representation
ARNP	Advanced registered nurse practitioner
BA	Behavior analysis
CAQH	Council for Affordable Quality Healthcare
CARES	Comprehensive Assessment and Review for LTC Service
CDC	Centers for Disease Control and Prevention
CE	Continuing education
CHCUP	Child Health Check-up
CHD	County health department
CLIA	Clinical Laboratory Improvement Amendment
CMME	Commercial and Medicare Member Equivalent
CMO	Chief medical officer
CMS	Centers for Medicare & Medicaid Services
CPIO	Community Partnerships to Improve Outcomes
CPT®	Current Procedural Terminology
CSS	Customer service specialist
CVO	Credentialing verification organization
DCF	Department of Children and Families
DDE	Direct data entry
DEA	Drug Enforcement Administration
DME	Durable medical equipment
DOEA	Department of Elder Affairs
DOH	Department of Health
DPNA	Denial of payment for new admissions
D-SNP	Dual Eligible Special Needs Plan
ECFMG	Education Council for Medical Graduates
EFT	Electronic funds transfer
EHR	Electronic health record
EIS	Early intervention services
EOB	Explanation of benefits
EPLS	Excluded parties list system
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
ER	Emergency room
ERA	Electronic remittance advice

Acronym	Definition
EVV	Electronic visit verification
FFS	Fee-for-service
FQHC	Federally qualified health center
FTE	Full-time equivalent
GSA	General Services Administration
HCBS	Home- and community-based services
HCPCS	Healthcare Common Procedure Coding System
HCPR	Humana Clinical Pharmacy Review
HEENT	Head, eyes, ears, nose and throat
HHC	Home healthcare
HHS	Health and Human Services
HIE	Health information exchange
HIT	Health information technology
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HRA	Health risk assessment
ID	Identification
IFSP	Individualized family support plan
LEIE	List of Excluded Individuals and Entities
LTC	Long-term care
MIT	Medication intake team
MMA	Managed medical assistance
MMIS	(Florida) Medicaid Management Information System
MPI	Medicaid Program Integrity
MRDR	Medical record documentation review
MRT	Mobile response team
NCQA	National Committee for Quality Assurance
NICU	Neonatal intensive care unit
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
OB-GYN	Obstetrician gynecologist
OIG	Office of Inspector General
PA	Prior authorization
PAL	Prior authorization list
PCMH	Patient-centered medical home
PCP	Primary care provider

Acronym	Definition
PDL	Preferred drug list
PERS	Personal emergency response system
PIP	Physician Incentive Program
PMAP	Performance measure action plan
PML	Provider Master List
QI	Quality improvement
RHC	Rural health clinic
SAM	System for Award Management
SBIRT	Screening, Brief Intervention and Referral to Treatment
SIU	Special Investigations Unit
SMI	Serious mental illness
SMMC	Statewide Medicaid Managed Care
SNF	Skilled nursing facility
US	United States
UM	Utilization management
URL	Uniform resource locator
VFC	Vaccines for Children (Program)

Chapter 1: Introduction

Contact information

Contact name	Contact information	Hours of operation
Access Behavioral Health (Region A) claims	Address: Access Behavioral Health Attn: Claims Dept 1221 W. Lakeview Avenue Pensacola, FL 32501 Phone: **866-477-6725**	24 hours a day, 7 days a week
Access Behavioral Health Case Management Staff (Region A)	Email: **abhreferral@lifeviewgroup.org**	
AHCA consumer complaint hotline	Phone: **888-419-3456**	Monday through Friday, 8 a.m. to 5 p.m., Eastern time
Availity Essentials™	Phone: **800-282-4548** Website: **Availity Essentials**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Carelon Behavioral Health Claims (Regions B through I)	Address: Carelon Behavioral Health P.O. Box 1870 Hicksville, NY 11802-1870 Phone: **800-397-1630** Email: **BH_CM@carelon.com**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
CenterWell Pharmacy®	Phone: **800-526-1490**	Monday through Friday, 8 a.m. to 6 p.m., Eastern time
Central Abuse Hotline	Phone: **800-96-ABUSE (800-962-2873)**	24 hours a day, 7 days a week

Contact name	Contact information	Hours of operation
Claim submission: LTC/ Comprehensive	Email: **FL_MMA_OB_Referrals@humana.com**	
Claim submission: LTC/ Comprehensive	Address: Humana Healthy Horizons – LTC Attn: Claims Department P.O. Box 14732 Lexington, KY 40512-4732	
Claim submission: MMA/specialty	Address: Humana Healthy Horizons MMA Plan Attn: Claims Department P.O. Box 14601 Lexington, KY 40512-4601	
Clinical Intake Team	Phone: **800-523-0023** Fax: **813-321-7220**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Credentialing	Address (reconsideration requests): Humana Dr. Shoba Srikantan, M.D. Regional Medical Director 101 E. Main Street Louisville, KY 40202 Email (inquiries): **CredentialingInquiries@humana.com**	
Encounter submission	Address: Humana Claims Office P.O. Box 14605 Lexington, KY 40512-4605	
Ethics Helpline	Phone: **877-5 THE KEY (877-584-3539)**	24 hours a day, 7 days a week
Florida Attorney General's Office	Phone: **866-966-7226** **850-414-3990**	Monday through Friday, 8 a.m. to 5 p.m., Eastern time
Florida DCF	Phone: **866-762-2237**	Monday through Friday, 8 a.m. to 5 p.m., Eastern time
Florida Statewide Medicaid Managed Care Help Line	Phone: **877-711-3662**	Monday through Thursday, 8 a.m. to 8 p.m., and Friday, 8 a.m. to 7 p.m., Eastern time
Go365 for Humana Healthy Horizons®	Phone: **888-225-4669 (TTY: 711)**	Monday through Friday, 8 a.m. to 7 p.m., Eastern time

Contact name	Contact information	Hours of operation
Humana Clinical Pharmacy Review (HCPR)	Phone: **800-555-CLIN (800-555-2546)** Fax: **877-486-2621**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Humana Concierge Service for Accessibility	Phone: **877-320-2233**	24 hours a day, 7 days a week
Humana Healthy Horizons Ethics	Email: **ethics@humana.com**	
Humana Healthy Horizons in Florida Coaching Line (weight management, smoking cessation)	Phone: **855-330-8053 (TTY: 711)**	Monday through Friday, 8 a.m. to 6 p.m., Eastern time
Humana Healthy Horizons in Florida MMA case management	Phone: **800-229-9880 (TTY: 711)** Email: **FL_MMA_CM_Referrals@humana.com**	Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time
Medicaid Fair Hearing requests	Address: Agency for Healthcare Administration Medicaid Hearing Unit P.O. Box 7237 Tallahassee, FL 32314-7237 Phone: **877-254-1055 (TTY 866-467-4970)** Fax: **239-338-2642** Email: **MedicaidHearingUnit@ahcamyflorida.com**	Monday through Friday, 8 a.m. to 5 p.m., Eastern time
Member grievance and appeal requests	Address: Humana Healthy Horizons P.O. Box 14546 Lexington, KY 40512-4546	
Member HRA completion	Phone: **800-611-1467**	Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time
Member LTC inquiries	Phone: **888-998-7732**	Monday through Friday, 8 a.m. to 5 p.m., Eastern time

Contact name	Contact information	Hours of operation
Contact name	Contact information	Hours of operation
Member urgent or expedited appeals	Phone: **888-259-6779**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Member/ provider services	Phone: **800-477-6931**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Modivcare	Phone: **866-779-0565**	Monday through Friday, 9 a.m. to 6 p.m., Eastern time
NICU admissions	Phone: **855-391-8655** Email: **NICU@humana.com**	Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time
Overpayment notification	Address: Humana Healthcare Plans P.O. Box 931655 Atlanta, GA 31193-1655	
PCMH program	Email: **FL_Medicaid_PCMH@humana.com**	
Provider complaint submission	Address: Humana Healthy Horizons Provider Correspondence P.O. Box 14601 Lexington, KY 40512-4601	
Provider contracting team	Email: **Humana_FL_Centralized_Provider_Relations@humana.com**	
Provider LTC inquiries	Phone: **888-998-7735**	Monday through Friday, 8 a.m. to 5 p.m., Eastern time
Provider relations	Email: **FLMedicaidPR@humana.com**	
Referrals	Email: **FL_MMA_CM_Referrals@humana.com**	
SIU	Phone: **800-614-4126** Email: **siureferrals@humana.com**	24 hours a day, 7 days a week

About Medicaid

Medicaid provides healthcare coverage for income-eligible children, seniors, disabled adults and pregnant women and includes both capitated health plans and FFS coverage. It is a means-tested program jointly funded by the state and federal governments and managed by the state.

Humana Healthy Horizons in Florida's mission statement

We offer a whole-person approach to delivering healthcare to eligible recipients in Florida aiming to improve the health and well-being of members across the state while helping you provide quality care.

Program description

Medicaid is the largest source of funding for medical and health-related services for people with limited income in the U.S. Medicaid recipients must be U.S. citizens or legal permanent residents, and may include low-income adults, their children and people with certain disabilities. Poverty alone does not necessarily qualify someone for Medicaid.

AHCA is responsible for administering the Medicaid program in the state of Florida and in this capacity administers contracts, monitors health plan performance and provides oversight for all aspects of health plan operations. The state of Florida remains the sole authority for determining Medicaid eligibility and whether recipients are required to enroll in, may volunteer to enroll in, or may not enroll in a Medicaid health plan or are subject to annual enrollment.

Statewide Medicaid Managed Care

House Bill 7101 (creating part IV of Chapter 409, Fla. Stat.) was passed in 2011 by the Florida legislature to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services. This program is referred to as SMMC. By contracting with AHCA to provide services to Medicaid beneficiaries, Humana Healthy Horizons agreed to comply with the provisions of the Medicaid contract which are available online via AHCA's SMMC website, as well as with all applicable agency rules relating to that contract and applicable provisions in the Medicaid Provider General Handbook. The goals of the program are to improve efficiency, improve care coordination, reduce costs and provide a wider range of services particularly for vulnerable populations. Humana Healthy Horizons' obligations pursuant to this contract include, but are not limited to, the following:

- Maintaining a QI program aimed at improving the quality of member outcomes
- Maintaining quality management and UM programs
- Furnishing AHCA with data as required under the contract and as may be required in additional ad hoc requests
- Collecting and submitting encounter data in the format and time frames specified by AHCA

In signing this contract, Humana Healthy Horizons is authorized to take whatever steps necessary to ensure providers are recognized by the state Medicaid program, including its Choice Counseling/ Enrollment Broker contractors, as a participating provider of Humana Healthy Horizons. In addition, Humana Healthy Horizons is responsible for ensuring provider submissions of encounter data are accepted by the Florida MMIS and/or the state's encounter data warehouse.

Programs

Program	Description
MMA plan	The MMA plan is designed to implement a statewide managed care delivery system that will improve outcomes and consumer satisfaction while reducing and controlling costs. The Florida MMA plan has 4 key objectives: • Preserving continuity of care • Requiring sufficient and accurate networks under contract and taking members, allowing recipients to make an informed choice of available plans and the ability to make an appointment • Paying providers promptly and fully to preclude provider cash flow or payroll issues and to give providers ample opportunity to learn and understand the plan's PA procedures • Coordinating with AHCA's contracted enrollment broker, the **Choice Counseling Call Center** The MMA plan is designed to care for all eligible individuals who meet financial and other criteria; qualifications are determined by the state. The program provides Medicaid-covered medical services such as PCP visits, hospital care, prescribed drugs, mental health care and transportation to these services. Most people on Medicaid receive their care from a plan that covers MMA services. MMA plans include the following managed care plans: • Managed Medical Assistance plan • Managed Medical Assistance Plus plan • Select Comprehensive LTC plans • Comprehensive LTC Plus plans Most Medicaid recipients must enroll in the MMA plan. The following individuals are not required to enroll, although they may enroll if they choose: • Medicaid recipients who have other creditable healthcare coverage excluding Medicare • Persons eligible for refugee assistance • Medicaid recipients who are residents of a developmental disability center • Medicaid recipients enrolled in the developmental disabilities HCBS waiver or Medicaid recipients waiting for waiver services

Program	Description
SMI and HIV/AIDS specialty plans	• Included within the MMA umbrella of services, Humana Healthy Horizons offers 2 specialty product plans: • Specialty SMI plan – For those members in 1 or more of the following diagnostic categories: ▪ Psychotic disorders ▪ Bipolar disorder ▪ Major depression ▪ Schizophrenia ▪ Delusional disorder ▪ Obsessive-compulsive disorders – Individuals enrolled must be at least 6 years or older. • Specialty HIV/AIDS plan – Individuals enrolled in the HIV/AIDS specialty plan must be diagnosed with HIV or AIDS. Humana Healthy Horizons offers specialty plans to Medicaid beneficiaries who meet specific criteria based on age, medical condition or diagnosis. Each specialty plan offers additional benefits to eligible members.
LTC plan	The LTC plan is designed for all eligible individuals 18 and older who meet a nursing-home level of care (indicating a functional deficit) and who meet Medicaid financial requirements; both qualifications are determined by the state. The LTC plan provides eligible individuals with access to care in a nursing home or a less restrictive environment in the community. The goal of this program is to prevent or delay institutionalization in nursing facilities and support individuals to maintain stable health while receiving services in their homes and communities. A key goal is to shift LTC members from facility-based care to community-based care. This is achieved through a variety of services, including home-delivered meals, assistance with personal care and case management.

Program	Description
Comprehensive LTC Plus plans	The Humana Healthy Horizons Comprehensive LTC Plus plan includes members who are enrolled in both: • Florida's MMA plans, including HIV/AIDS specialty plan or SMI specialty plans • Florida's LTC plan The Comprehensive LTC Plus plan covers both medical and LTC services. Members enrolled in a Medicare D-SNP are eligible for LTC services from Humana Healthy Horizons' LTC plan. Humana Healthy Horizons' MMA plan provides Medicaid covered medical services like PCP visits, hospital care, prescribed drugs, mental health care and transportation to these services. Most people on Medicaid will receive their care from a plan that covers MMA services. The MMA program includes specialty plans designed for specific populations with unique needs, such as children with special healthcare needs, those with chronic conditions and individuals with serious mental illness. These specialty plans are tailored to address the specific needs of the enrolled members. Humana SMI and HIV/AIDS specialty plans assist with improving the management of members living with serious mental illness and HIV/AIDS, ensuring they receive comprehensive care from a holistic approach to help improve overall health conditions. Humana Healthy Horizons' LTC plan works directly with the state of Florida to provide members with community and/or facility care, with a focus on coordination of the member's primary care through their primary insurance. Humana Healthy Horizons is a statewide contractor for the LTC plan, allowing members to move to any county they choose within the state. Humana Healthy Horizons' goal for this program is to keep members in their homes and provide HHC and community-based services that may prevent or delay long-term placement in a nursing facility. If members require an environment with more supervision or socialization, Humana Healthy Horizons facilitates services in an ALF or an adult family home. We understand some members will require nursing home care. Humana Healthy Horizons will help members transition to this level of care when it is no longer safe to remain in a community setting. Humana Healthy Horizons will facilitate care that meets the individual needs of each member.

Program	Description
	The goals for this program include: • The provision of coordinated LTC across different healthcare settings • The assurance that members have a choice of the best LTC plan for their needs • The creation of LTC plans with the ability to offer additional services • The provision of access to cost-effective, community-based LTC services Humana Healthy Horizons has established guidelines to assist you in understanding the goals of our program. This handbook will provide you with vital information needed to develop and maintain an effective relationship as we work to meet members' needs.

Regions served

Region	Counties
A	Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, Washington
B	Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando
C	Lafayette, Lake, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, Volusia
D	Pasco, Pinellas
E	Hardee, Highlands, Hillsborough, Manatee, Polk
F	Brevard, Orange, Osceola, Seminole
G	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota
H	Indian River, Martin, Okeechobee, Palm Beach, St. Lucie
I	Broward

Compliance and ethics

Humana Healthy Horizons serves a variety of audiences, including 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 legally and ethically. A compliance plan has been established by Humana Healthy Horizons that:

Formalizes Humana Healthy Horizons' commitment to honest communication within the company and 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 reporting of noncompliance with laws and regulations; for fraud, waste and abuse concerns; or with Humana Healthy Horizons policies or professional, ethical or legal standards

Member/provider services

Humana Healthy Horizons' **member/provider services** include dedicated staff who are available to answer your questions.

Provider contract specialists

The Provider Contracting department included information in this handbook with an overview of our operational policies and procedures. As a participating provider, you and your staff have a dedicated contract specialist who will be a key contact.

Provider contracting specialists are responsible for ensuring services are available to our members by obtaining contracts and by providing ongoing community and provider training and education about the Humana Healthy Horizons plan. They also assist our network providers in understanding the terms of our contract and help resolve problems they may encounter.

We encourage you to contact your contract specialist when you have questions, comments or concerns. To locate your local contract specialist, please contact **member/provider services**.

Humana Healthy Horizons provider relations representatives are also available to support you by answering questions you may have pertaining to claims, education, training or onboarding, as well as for any other general inquiries. Our Provider Relations team is based regionally and can meet with you virtually or in person. They are here to help you have the best experience in working with Humana Healthy Horizons. Please reach out to **provider relations**.

Availity Essentials

Humana Healthy Horizons partners with **Availity Essentials™** to allow providers to reference member and claim data for multiple payers using a single sign in. Availity Essentials provides access to: • Certificates of coverage

- Claim submission and status
- Disputes and appeals
- Eligibility and benefits
- ERA/EFT enrollment
- Humana Healthy Horizons-specific applications, resources and news
- Medical record requests

- Member summaries
- Overpayment management
- Plans of care
- Provider directory
- Referrals and authorization information
- Remittance advice
- Status of PA and referral requests

To learn more about **Availity Essentials**, please visit the **Availity Essentials website** or contact them directly.

Provider resources

You can obtain plan information from our **Humana Healthy Horizons in Florida provider website**. This website also includes information related to:

- Claim processing edits
- Clinical practice guidelines
- Compliance training
- Coverage and claims
- Credentialing
- Dental benefits
- Drug list
- Grievances and appeals
- Health programs
- Humana Community Navigator® directory
- In-person, video or telephonic interpretation services
- Language assistance resources
- PA lookup
- PA search tool
- Tutorial library
- Value-based care report

Florida-specific educational resources are also available on the **Humana Healthy Horizons in Florida provider website**. These resources include, but are not limited to:

- Annual training information
- Communications and network notices
- COVID-19 coverage and resources

- Educational materials
- Key information for LTC
- OB-GYN documents and forms
- Pharmacy materials
- Quality resources

Additional resources for providers include our **Making it Easier for Physicians and Other Healthcare Providers resource** and other educational presentations about Humana Healthy Horizons' claims payment policies and processes via **Availity Essentials**.

Providers can also visit our **Humana Healthy Horizons in Florida provider website** (registration not required) to find more important information. These pages provide a variety of informational resources including, but not limited to, Humana's drug list and links to clinical practice guidelines. The following resources are also available:

- **Prior authorization list**: Find a comprehensive list of services and medications outlining which services and plans require PA or notification.
- Prescription tools and resources: Learn more about Humana Healthy Horizons' pharmacy programs by using the **drug list search, pharmacy tools and resources and pharmacy locater**.
- Humana Physician News: Access a quarterly email newsletter for network providers, clinicians and office staff. Humana Physician News the latest news, resources and administrative information to support you in the care of your Humana Healthy Horizons-covered patients. See the latest newsletter and subscribe online by visiting our **Publications** webpage.

Provider directory

The provider directory is a listing of all participating network providers with Humana Healthy Horizons. A copy of this document is available on request from the Provider Contracting department. The **Humana Healthy Horizons provider directory** is also available online for your reference.

Chapter 2: Member eligibility and enrollment

Providers can verify Humana Healthy Horizons member eligibility through Availity Essentials. Member eligibility should be verified before services are rendered.

Contact information pertaining to member eligibility and enrollment

Contact name	Contact information	Hours of operation
Choice Counseling Call Center (enrollment broker)	Phone: **877-711-3662**	Monday through Thursday, 8 a.m. to 8 p.m. and Friday, 8 a.m. to 7 p.m., Eastern time
Florida Department of Children and Families	Phone: **866-762-2237**	Monday through Friday, 8 a.m. to 5 p.m., Eastern time
Member/ provider services	Phone: **800-477-6931**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time

Plan eligibility

Plan type	Eligibility description
MMA plan	The MMA program is designed to care for all eligible individuals who meet financial and medically needy criteria; both qualifications are determined by the state.
LTC plan	Eligibility for enrollment in the LTC plan is based on standards established by DOEA and CARES. Financial eligibility is based on standards established by Florida DCF. Recipients eligible for enrollment must: • Be at least 18 years old and reside in Florida • Be at risk of nursing home placement, meet specific clinical/functional criteria and be able to be safely served with HCBS, as determined by CARES • Be financially eligible, as determined by DCF (Financial eligibility criteria for the program is the same as the Medicaid institutional care plan.) For specific information regarding eligibility criteria, please contact your provider relations representative or contract specialist. If you need help locating your local contract specialist, please call **member/provider services**.
Comprehensive plan	The Humana Healthy Horizons Comprehensive plan includes members who are enrolled in both Florida's MMA plan, which encompasses the HIV/AIDS and the SMI specialty plans, and the LTC plan. The Comprehensive plan can provide MMA and LTC services concurrently. This plan type is not eligible to provide services to members only eligible for MMA; members must be enrolled in both MMA and LTC.
HIV/AIDS specialty plan	Members who are eligible/enrolled in the HIV/AIDS specialty plan must be diagnosed with HIV or AIDS.
SMI specialty plan	Members who are eligible/enrolled in the SMI specialty plan must be at least 6 years or older and have a diagnosis of SMI, typical psychotic disorders, bipolar disorder, major depression, schizophrenia, delusional disorder or obsessive-compulsive disorder.

Verifying member eligibility

Before providing all services (except emergency services), you must verify member eligibility. You should ask members to present an ID card each time services are rendered. If you are not familiar with the member seeking care and cannot verify the person is a Humana Healthy Horizons member, you should ask to see photo ID. Eligibility can be verified through the **Florida Medicaid website** (sign in required) for LTC plans, or through **Availity Essentials** for all other plans.

Member enrollment

DCF is responsible for members' enrollment into the Medicaid plan. Humana Healthy Horizons accepts Medicaid members enrolled by DCF with no restrictions and provides services to Medicaid members who meet eligibility requirements and who live in a region with authorized Humana Healthy Horizon plans.

Newborn PCP assignment

No later than the beginning of the last trimester of gestation, Humana Healthy Horizons will assign a pediatrician or other appropriate PCP to all pregnant members for the care of their newborn babies if the member has not selected a provider for a newborn. If Humana Healthy Horizons selects the PCP and the parent does not want the selected PCP, the parent can request the child be reassigned to another provider by calling **member/provider services**. To select or change the baby's health plan, the member should contact the **Choice Counseling Call Center** as soon as possible. The member must also notify DCF of the birth of the baby by calling the **Florida Department of Children and Families**.

Member identification card

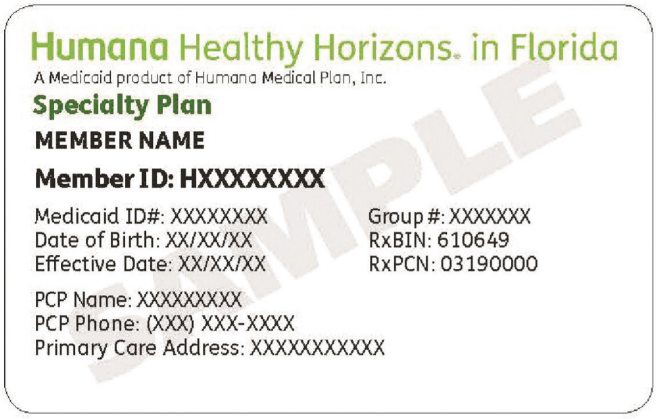
Each member will receive an ID card from Humana Healthy Horizons. The plan type (MMA, LTC, Comprehensive, SMI specialty or HIV/AIDS specialty) with which the member is enrolled is indicated on their member ID card. If the card is lost or stolen, the member may contact **member/provider services**. Alternatively, the member may contact their case manager to obtain a new card. Members also can access their ID card through the **MyHumana website** or mobile app. Sample member ID cards for each plan type in English and Spanish are pictured below.






Humana Healthy Horizons. in Florida
Un producto de Medicaid de Humana Medical Plan, Inc.
Plan Médico
NOMBRE DEL AFILIADO
Número de Identificación del Afiliado: HXXXXXXXX
N.º de Identificación de Medicaid: XXXXXXXX
Fecha de Nacimiento: XX/XX/XX
Fecha de Vigencia: XX/XX/XX
N.º de Grupo: XXXXXXX
RxBIN: 610649
RxPCN: 03190000
Nombre del PCP: XXXXXXXXX
Teléfono del PCP: (XXX) XXX-XXXX
Dirección de Cuidado Primario: XXXXXXXXXXX


Servicios para Afiliados y Servicios de Proveedores
Participantes y No Participantes: 800-477-6931 (TTY: 711)
Consultas sobre Salud del Comportamiento del Afiliado: 888-778-4651
Preguntas sobre Recetas para el Farmacéutico: 844-918-0110
Autorización Previa del Proveedor: 800-523-0023
Consultas sobre Beneficios Dentales: 877-711-3662
Visítenos en es-www.Humana.com/HealthyFlorida
Para servicios para proveedores en línea, visite Availity.com
Envíe todas las reclamaciones por correo postal a:
Humana Medical
P.O. Box 14601
Lexington, KY 40512-4601


Humana Healthy Horizons. in Florida
A Medicaid product of Humana Medical Plan, Inc.
Specialty Plan
MEMBER NAME
Member ID: HXXXXXXXX
Medicaid ID#: XXXXXXXX
Date of Birth: XX/XX/XX
Effective Date: XX/XX/XX
Group #: XXXXXXX
RxBIN: 610649
RxPCN: 03190000
PCP Name: XXXXXXXXX
PCP Phone: (XXX) XXX-XXXX
Primary Care Address: XXXXXXXXXXX


Member &
Par/Non-Par Provider Services: 800-477-6931 (TTY: 711)
Member Behavioral Health Inquiries: 888-778-4651
Pharmacist Rx Inquiries: 844-918-0110
Provider Prior Authorization: 800-523-0023
Dental Benefit Inquiries: 877-711-3662
Please visit us at Humana.com/HealthyFlorida
For online provider services, go to Availity.com
Please mail all claims to:
Humana Medical
P.O. Box 14601
Lexington, KY 40512-4601


Humana Healthy Horizons. in Florida
Un producto de Medicaid de Humana Medical Plan, Inc.
Plan de Especialidad
NOMBRE DEL AFILIADO
Número de Identificación del Afiliado: HXXXXXXXX
N.º de Identificación de Medicaid: XXXXXXXX
Fecha de Nacimiento: XX/XX/XX
Fecha de Vigencia: XX/XX/XX
N.º de Grupo: XXXXXXX
RxBIN: 610649
RxPCN: 03190000
Nombre del PCP: XXXXXXXXX
Teléfono del PCP: (XXX) XXX-XXXX
Dirección de Cuidado Primario: XXXXXXXXXXX


Servicios para Afiliados y Servicios de Proveedores
Participantes y No Participantes: 800-477-6931 (TTY: 711)
Consultas sobre Salud del Comportamiento del Afiliado: 888-778-4651
Preguntas sobre Recetas para el Farmacéutico: 844-918-0110
Autorización Previa del Proveedor: 800-523-0023
Consultas sobre Beneficios Dentales: 877-711-3662
Visítenos en es-www.Humana.com/HealthyFlorida
Para servicios para proveedores en línea, visite Availity.com
Envíe todas las reclamaciones por correo postal a:
Humana Medical
P.O. Box 14601
Lexington, KY 40512-4601


Humana Healthy Horizons. in Florida
A Medicaid product of Humana Medical Plan, Inc.
Comprehensive Plan
MEMBER NAME
Member ID: HXXXXXXXX
Medicaid ID#: XXXXXXXX
Date of Birth: XX/XX/XX
Effective Date: XX/XX/XX
Group #: XXXXXXX
RxBIN: 610649
RxPCN: 03190000
PCP Name: XXXXXXXXX
PCP Phone: (XXX) XXX-XXXX
Primary Care Address: XXXXXXXXXXX


Member &
Par/Non-Par Provider Services: 888-998-7732 (TTY: 711)
Member Behavioral Health Inquiries: 888-778-4651
Pharmacist Rx Inquiries: 844-918-0110
Provider Prior Authorization: 800-523-0023
Provider Long-Term Care Inquiries: 888-998-7735
Dental Benefit Inquiries: 877-711-3662
Please visit us at Humana.com/HealthyFlorida
For online provider services, go to Availity.com
Please mail all claims to:
Managed Medical Assistance
Humana Medical
P.O. Box 14601
Lexington, KY 40512-4601
Long-term care
Humana Long-term care
P.O. Box 14732
Lexington, KY 40512-4732

Humana Healthy Horizons® in Florida

Un producto de Medicaid de Humana Medical Plan, Inc.

Plan Integral

NOMBRE DEL AFILIADO

Número de Identificación del Afiliado: HXXXXXXXX

N.º de Identificación de Medicaid: XXXXXXXX
Fecha de Nacimiento: XX/XX/XX
Fecha de Vigencia: XX/XX/XX

N.º de Grupo: XXXXXXX
RxBIN: 610649
RxPCN: 03190000

Nombre del PCP: XXXXXXXXX
Teléfono del PCP: (XXX) XXX-XXXX
Dirección de Cuidado Primario: XXXXXXXXXXX

Servicios para Afiliados y Servicios de Proveedores Participantes y No Participantes: **888-998-7732 (TTY: 711)**

Consultas sobre Salud del Comportamiento del Afiliado:	888-778-4651
Preguntas sobre Recetas para el Farmacéutico:	844-918-0110
Autorización Previa del Proveedor:	800-523-0023
Consultas sobre Cuidado a Largo Plazo de Proveedores:	888-998-7735
Consultas sobre Beneficios Dentales:	877-711-3662

Visítenos en **es-www.Humana.com/HealthyFlorida**
Para servicios para proveedores en línea, visite Availity.com

Envíe todas las reclamaciones por correo postal a:

Managed Medical Assistance
Humana Medical
P.O. Box 14601
Lexington, KY 40512-4601

Long-term care
Humana Long-term care
P.O. Box 14732
Lexington, KY 40512-4732

Humana Healthy Horizons® in Florida

A Medicaid product of Humana Medical Plan, Inc.

Specialty Comprehensive Plan

MEMBER NAME

Member ID: HXXXXXXXX

Medicaid ID#: XXXXXXXX
Date of Birth: XX/XX/XX
Effective Date: XX/XX/XX

Group #: XXXXXXX
RxBIN: 610649
RxPCN: 03190000

PCP Name: XXXXXXXXX
PCP Phone: (XXX) XXX-XXXX
Primary Care Address: XXXXXXXXXXX

Member & Par/Non-Par Provider Services: **888-998-7732 (TTY: 711)**

Member Behavioral Health Inquiries:	888-778-4651
Pharmacist Rx Inquiries:	844-918-0110
Provider Prior Authorization:	800-523-0023
Provider Long-Term Care Inquiries:	888-998-7735
Dental Benefit Inquiries:	877-711-3662

Please visit us at **Humana.com/HealthyFlorida**
For online provider services, go to Availity.com

Please mail all claims to:

Managed Medical Assistance
Humana Medical
P.O. Box 14601
Lexington, KY 40512-4601

Long-term care
Humana Long-term care
P.O. Box 14732
Lexington, KY 40512-4732

Humana Healthy Horizons® in Florida

Un producto de Medicaid de Humana Medical Plan, Inc.

Plan Integral de Especialidad

NOMBRE DEL AFILIADO

Número de Identificación del Afiliado: HXXXXXXXX

N.º de Identificación de Medicaid: XXXXXXXX
Fecha de Nacimiento: XX/XX/XX
Fecha de Vigencia: XX/XX/XX

N.º de Grupo: XXXXXXX
RxBIN: 610649
RxPCN: 03190000

Nombre del PCP: XXXXXXXXX
Teléfono del PCP: (XXX) XXX-XXXX
Dirección de Cuidado Primario: XXXXXXXXXXX

Servicios para Afiliados y Servicios de Proveedores Participantes y No Participantes: **888-998-7732 (TTY: 711)**

Consultas sobre Salud del Comportamiento del Afiliado:	888-778-4651
Preguntas sobre Recetas para el Farmacéutico:	844-918-0110
Autorización Previa del Proveedor:	800-523-0023
Consultas sobre Cuidado a Largo Plazo de Proveedores:	888-998-7735
Consultas sobre Beneficios Dentales:	877-711-3662

Visítenos en **es-www.Humana.com/HealthyFlorida**
Para servicios para proveedores en línea, visite Availity.com

Envíe todas las reclamaciones por correo postal a:

Managed Medical Assistance
Humana Medical
P.O. Box 14601
Lexington, KY 40512-4601

Long-term care
Humana Long-term care
P.O. Box 14732
Lexington, KY 40512-4732

Humana Healthy Horizons® in Florida

A Medicaid product of Humana Medical Plan, Inc.

Long-term care plan

MEMBER NAME

Member ID: HXXXXXXXX

Medicaid ID: XXXXXXXXXX
Group #: XXXXXXX

Member Long-term care inquiries:	888-998-7732
Provider Long-term care inquiries:	888-998-7735

Please visit us at **Humana.com/HealthyFlorida**
For online provider services, go to Availity.com

For participating and non-participating providers send claims to:

Humana Long-term care
P.O. Box 14732
Lexington, KY 40512-4732

SAMPLE





Member disenrollment

Mandatory members include categories of eligible Medicaid recipients who must be enrolled in a managed care plan. Mandatory members who wish to change plans following an initial 120-day period or after the end of the open enrollment period must have a state-approved, for-cause reason to change plans. AHCA reviews and determines approval of the member's request. More information is available from the enrollment broker by calling the **Choice Counseling Call Center**. Potential forcause reasons for which members may change managed care plans include the following:

- A substantiated marketing or community outreach violation has occurred.
- The managed care plan no longer participates in the region.
- The member does not live in a region where the managed care plan is authorized to provide services, as indicated in the Florida MMIS.
- The member has an active relationship with a provider who is not on the managed care plan's panel but is on the panel of another managed care plan. An active relationship means the member has received services from the provider within the 6 months preceding a disenrollment request.
- The member is excluded from enrollment.
- The member is in the wrong managed care plan as determined by AHCA.
- The member is prevented from participating in the development of the member's treatment plan/ plan of care.
- The member needs related services to be performed concurrently, but not all related services are available within the managed care plan network, or the member's PCP determined that receiving the services separately would subject the member to unnecessary risk.
- The provider is no longer with the managed care plan.
- The state imposed intermediate sanctions on the managed care plan, as specified in 42 CFR 438.702(a)(3).

Chapter 3: Member rights and responsibilities

Contact information pertaining to member rights and responsibilities

Contact name	Contact information	Hours of operation
Consumer complaint hotline (report suspected fraud, waste or abuse in Florida Medicaid)	Phone: **888-419-3456**	Monday through Friday, 8 a.m. to 5 p.m., Eastern time
Florida Attorney General's Office (report suspected fraud, waste or abuse in Florida Medicaid)	Phone: **866-966-7226** OR **850-414-3990**	Monday through Friday, 8 a.m. to 5 p.m., Eastern time
SIU	Phone: **800-614-4126**	Monday through Friday, 8 a.m. to 5 p.m., Eastern time

Member rights and responsibilities

Case managers provide members with information about their rights and responsibilities at the time of enrollment and on an annual basis.

Member rights

Members have the right:

- To be free from all forms of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion
- To request and receive a copy of their medical records and request that they be amended or corrected, as per rules set forth in 45 CFR parts 160 and 164 subparts A and E, and as specified in 45 CFR § 164.524 and 164.526
- To be fully informed in advance of all care and treatment to be provided by the service provider, changes in care or treatment and to receive a copy of their plan of care if they request
- To be fully informed of services available from the service provider and how to access care

- To be fully informed by a provider of health status, unless medically contraindicated
- To be afforded the opportunity to participate in the development of the care plan and to refuse treatment without retribution, while being fully informed of the possible medical consequences of refusal
- To be assured of the confidentiality of records and to approve or refuse the release of information not authorized by law
- To be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs; to have property treated with respect
- To file a grievance without fear of discrimination or reprisal from the service provider
- To voice complaints or appeals about the plan or the care it provides
- To be informed of the state hotline number with hours of operation to obtain information regarding home health agencies
- To be assured that qualified personnel will present proper identification at the time of a visit
- To be served without regard to race, color, creed, sex, age, national origin, ancestry or handicap/disability
- To be advised—before care is initiated—of the cost of services and the extent to which payment may be required by the member
- To receive HCBS in a home-like environment and participate in their communities regardless of their living arrangements
- To direct their care with their own staff and/or providers
- To receive information about the plan, its services, its practitioners and providers, and member rights and responsibilities
- To have a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage
- To make recommendations regarding the organization's member rights and responsibilities policy

General member responsibilities

Members have a responsibility:

- To provide accurate and complete medical and health history information as they understand it
- To participate with the plan of treatment they agreed to, when possible, and make available an informal caregiver to assume primary care, as appropriate
- To understand their health problems and participate in developing mutually agreed-on treatment goals, to the degree possible
- To have a PCP who provides orders (as required) for skilled home-care treatments and services
- To inform the service provider about changes in health status, medications or treatments
- To inform AHCA of any change in financial status that may affect reimbursement for home care

- To have a plan to manage emergencies and to access the plan, if necessary, for safety
- To inform the service provider of the presence of advance directives and provide copies, as appropriate
- To accept services of provider staff, without regard to race, creed, color, religion, national origin, handicap, sex or age
- To report fraud, abuse and overpayment
  - To file a report of suspected fraud, waste or abuse in Florida Medicaid:
    - Call the **Consumer Complaint Hotline**.
    - Call the **Florida Attorney General**.
    - Call the **SIU hotline**.
    - **Complete a form online**.
  - If member-reported fraud results in a fine, penalty or forfeiture of property from a healthcare provider, the member may be eligible for a reward through the Florida Attorney General's Fraud Rewards Program. The reward may be up to 25% of the amount recovered, or a maximum of $500,000 per case (§ 409.9203, Fla. Stat.). Individuals can speak to the **Florida Attorney General's Office** about keeping their identity confidential and protected.

LTC member rights and responsibilities

LTC members have the right:

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- Receive services in a home-like environment regardless of where they live
- Receive information about being involved in their community, setting personal goals and how they can participate in that process
- Be told where, when and how to get the services they need
- To be able to take part in decisions about their healthcare
- To talk openly about the treatment options for their conditions, regardless of cost or benefit
- To choose the programs they participate in and the providers that give them care LTC members have the responsibility:
- To tell their case manager if they want to disenroll from the LTC program
- To agree to and participate in the annual face-to-face assessment, quarterly face-to-face visits and monthly telephone contact with their case manager

Chapter 4: Provider and subcontractor rights and responsibilities

Contact information pertaining to provider and subcontractor rights and responsibilities

Contact name	Contact information	Hours of operation
Clinical Intake Team	Phone: **800-523-0023** Fax: **813-321-7220**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Florida Department of Children and Families	Phone: **866-762-2237**	Monday through Friday, 8 a.m. to 5 p.m., Eastern time
Humana Concierge Service for Accessibility	Phone: **877-320-2233**	24 hours a day, 7 days a week
Humana Healthy Horizons in Florida MMA case management	Phone: **800-229-9880** (TTY: 711) Email: **fl_mma_cm_referrals@humana.com**	Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time
HumanaBeginnings	Phone: **800-322-2758**	Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time
Provider contracting team	Email: **Humana_FL_Centralized_Provider_Relations@humana.com**	

Provider responsibilities

As a Humana Healthy Horizons participating provider, you agree:

- To provide a health screening evaluation, including comprehensive health and developmental history and past medical history assessment
- To provide developmental history behavioral health status
- To conduct a comprehensive unclothed physical examination
- To conduct a developmental assessment
- To conduct a nutritional assessment

- To immunize as required by the appropriate CDC Recommended Childhood Immunization Schedule
- To offer health education, including anticipatory guidance
- To conduct a dental screening, including a direct referral to a dentist for members 3 years or younger, as indicated
- To conduct a vision screening, including objective testing, as required
- To conduct a hearing screening, including objective testing, as required
- To provide diagnosis and treatment utilizing a trauma-informed care approach
- To provide referral to a specialist as needed and follow-up as appropriate
- To cooperate with QI activities to improve the quality of care and services and member experience
- To understand and agree that provider performance data can be used by Humana Healthy Horizons

Primary care provider responsibilities

For children/adolescents who have abnormal levels of lead after the PCP preforms a blood-lead screening, the PCP should provide case management follow-up services, as required in Chapter 2 of the **Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook** (downloads a PDF.

Screening for lead poisoning is a required component of a health screening. Humana Healthy Horizons requires all providers to screen all enrolled children for lead poisoning at 12 and 24 months. In addition, children between the ages of 12 months and 72 months must receive a blood-lead screening test if there is no record of previous testing.

The PCP should provide additional diagnostic and treatment services determined to be medically necessary to a child diagnosed with an elevated blood-lead level. The PCP should recommend, but not require, the use of paper filter tests as part of the lead screening requirement.

- The PCP should inform members of all required testing/screenings in accordance with the periodicity schedule specified on AHCA's **Medicaid Well Child Visits website**. The PCP should contact members to encourage them to obtain health assessments and preventive care.
- The PCP (or OB-GYN for pregnant members) should refer members to appropriate service providers within 4 weeks of the examination for further assessment and treatment of conditions found during the examination.
- The PCP may provide fluoride treatment for children and adolescents even if the health plan does not provide dental coverage.
- The PCP should offer scheduling assistance and transportation to members to assist them to keep medical appointments.

The well-child program includes a system of screening and treatment maintenance that supports the member, as well as supplying CHCUP training to medical care providers.

PCPs should report on 95% minimum of members for health-related social needs using an AHCAapproved screening tool and record the identified International Classification of Diseases, 10th edition (ICD-10) codes (Z55-Z65) in member's EHR.

PCPs also must participate in Humana Healthy Horizons' holistic, integrated care model, in which behavioral and physical healthcare providers collaborate and consult to provide a comprehensive person-centered care model. This holistic model ensures there is active coordination of care to ensure the best member outcomes. As part of this model, education related to behavioral health integration is available. Coordination with behavioral health providers and Humana Healthy Horizons is key to this model of care.

Humana Healthy Horizons providers are strongly encouraged to:

- Provide after-hours availability to improve access to care
- Offer telemedicine appointments to improve access to care
- Consider obtaining PCMH certification
- Utilize the educational resources provided by Humana Healthy Horizons

Provider training

As a Humana Healthy Horizons provider, you are required to complete all necessary training identified in your contract during your initial Humana Healthy Horizons orientation. All training must be completed within the first 30 calendar days of your Medicaid contract. You also must ensure your affiliated participating providers and staff members are trained on mandatory compliance materials.

As part of the training requirements, you must complete training on the following topics:

- **Provider orientation**
- **Fraud, waste and abuse**
- **Cultural humility, health equity and implicit bias**
- **Health, safety and welfare**

You are required to complete compliance and fraud, waste and abuse training, as well as implement specific controls for the prevention and detection of potential or suspected fraud and abuse, as required by § 6032 of the Federal Deficit Reduction Act of 2005. Providers and authorized users can access these online training modules 24 hours a day, 7 days a week via **Availity Essentials**. Sign in to Availity Essentials using your existing user ID and password. If you do not already have access to Availity Essentials, your organization's administrator may create a new user for this purpose. Within Availity Essentials, the administrator should:

1. Select Payer Spaces Humana Humana Learning Center.
2. Select the category: Compliance trainings.
3. Search for the current year training by state (for any states in which you are contracted).

For additional provider training, please see the **compliance training materials section** of the Humana Healthy Horizons in Florida website.

Additional education and training are available to you on our **Humana Healthy Horizons in Florida website** and through our CE program for medical and nonmedical network providers via Relias—a web-based CE library. With more than 300 modules to choose from and more than 500 hours of CE credits available, the training modules in Relias provide integrated information to support comprehensive care and address unique member needs. Relias offers courses designed to help you succeed in the emerging value-based healthcare delivery system.

Humana Healthy Horizons also created a resource guide to support providers, clinicians and care teams to screen and address the social health needs of members. This resource guide is available to network providers on the **compliance training materials section** of the Humana Healthy Horizons in Florida website and is designed to help network providers:

- Understand the impacts of unmet health needs
- Screen members using evidence-based tools
- Support the discussion of SDOH with members and provide member-specific resources and support
- Offer guidance to members, document and code for monitoring, and follow up with resource referrals to improve health outcomes

Humana Healthy Horizons supports providers in offering language services and additional training to practitioners on provisioning language services.

Specialized provider education for treating members with HIV, AIDS and serious mental illness

You are required to complete formal training and verify completion of training in the use of evidencebased assessment tools, instruments and techniques for identifying individuals with unmet health needs. The training and screening tool is available in our online **guide to addressing social determinants of health in patients**. Additional training on topics including SMI and HIV is available via Relias to help you treat affected Humana Healthy Horizons members.

Access to care

Humana Healthy Horizons adopted service standards regarding the availability of participating provider services. You are expected to maintain these standards as outlined in your contract.

Participating PCPs and specialists are required to ensure adequate accessibility for healthcare 24 hours a day, 7 days a week. An after-hours telephone number must be available to members (voicemail is not permitted). The member should have access to care for PCP services, and the PCP (or OB-GYN for pregnant members) should submit referrals to the plan so the member can see specialists for medical and behavioral healthcare services on a timely basis.

Appointments for urgent medical or behavioral healthcare services must be offered as follows:

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

The PCP (and/or OB-GYN for pregnant members) must provide or arrange for coverage of services, consultation or approval for referrals 24 hours a day, 7 days a week by Medicaid-enrolled providers who accept Medicaid reimbursement. This coverage must consist of an answering service, call forwarding, provider call coverage or other customary means approved by AHCA. The chosen method of 24 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 must arrange for coverage of primary care services during absences due to vacation, illness or other situations that require the PCP to be unable to provide services. A Medicaid-eligible PCP must provide coverage.

A PCP must submit referrals when necessary for members to see specialists for care. Referrals can be submitted or requested through the **clinical intake team** by phone or fax, or via **Availity Essentials**. When necessary, OB-GYNs may submit referrals to specialists on behalf of their pregnant members.

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

Electronic visit verification systems

In compliance with the 21st Century CURES Act, you are required to utilize EVV to electronically monitor, track and confirm services provided in the home setting.

Demographic changes

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

Notify your contract specialist immediately of changes, including:

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

Notifying Humana Healthy Horizons of these changes ensures your information is properly listed in the provider directory and all payments made are properly reported to the Internal Revenue Service. Failure to comply with this section could lead to a delay in payments.

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

Provider compliance with the Americans with Disabilities Act

All Humana Healthy Horizons-contracted healthcare providers must comply with ADA, as well as all applicable state and/or federal laws, rules and regulations. More details are available in your Humana Healthy Horizons provider agreement in the section titled Compliance with Regulatory Requirements.

Humana Healthy Horizons develops person-centered care plans that take members' special and unique needs into account. If you are seeing a Humana Healthy Horizons member who requires interpretive services, you can contact the **Humana Concierge Service for Accessibility**. Members requiring interpretation services can call the number on the back of their member ID cards, the **Humana Concierge Service for Accessibility**, or access interpretation services via Humana Healthy Horizons' **accessibility support website**.

Immunizations

As part of Humana Healthy Horizons' focus on preventive health, all infants and children should receive recommended immunizations and screenings. Additionally, as detailed under section 1905(r)(1)(B)(iii) of the Social Security Act, you should deliver appropriate immunizations according to age and health history as part of the VFC program.

The VFC program provides vaccines at no charge to providers, eliminating the need to refer children to CHDs for immunizations and risk loss of continuity of care. Humana Healthy Horizons is enrolled as a data partner with **Florida State Health Online Tracking System (SHOTS)**.

Please note the following:

- Healthcare providers can verify their participation in the VFC program on the **Florida Health website**.
- Providers must maintain an adequate vaccine inventory. Useful information about this process is available in this return/waste guide on the **Florida State Health Online Tracking System (SHOTS)** website.
- Humana Healthy Horizons may reimburse the cost of the vaccine and an administration fee for Medicaid-eligible recipients 0 to 18 years old who receive vaccines not available through the VFC program.
- Guidelines on how providers bill for vaccines and vaccination administration can be found in the **prescribed drugs immunization fee schedule**.
- Providers must cooperate with all requests for member immunization records from any local or federal agency, including the Florida DCF.

Immunizations should be provided in accordance with the **Recommended Childhood Immunization Schedule for the US** or when medically necessary for the member's health, as determined by the provider.

Immunizations (vaccines) for adults ages 19 years and older are covered as recommended by the ACIP. For more information on these recommendations, please visit the **CDC ACIP website**.

Screening for health-related social needs

PCPs must conduct screening of at least 95% of members for health-related social needs using an AHCA-approved screening tool and record the identified ICD-10 codes in Table 8 (Z55-Z65) in the member's EHR.

Hysterectomies, sterilizations and abortions

For hysterectomies, sterilizations and abortions, providers must acquire a signed form from the member when required by state or federal law and submit it with the claim for processing per state guidelines. If a form is not required, medical records supporting the exception must be submitted with the claim. Required forms can be found at the following links and must be on file before claims are paid:

- **State of Florida Abortion Certification Form**
- **Consent for Sterilization form**
- **Hysterectomy Consent Form**
- **Exception to Hysterectomy Acknowledgment Requirement Form**

Healthy Start services

Humana Healthy Horizons partnered with Healthy Start. The Healthy Start program includes targeted support services that address identified risks. The range of free and voluntary Healthy Start services available to pregnant women, infants and children up to age 3 include:

- Childbirth, breastfeeding and car seat education classes
- Comprehensive assessment of service needs considering family and community resources
- Home visits to provide education and support for breastfeeding, baby weight checks, parenting, immunization information and safe sleep
- Ongoing coordination to assure access to needed services and support to help families attain their goals
- Developmental screening, psychosocial assessments, nutritional education, smoking cessation counseling or referrals as needed

Humana Healthy Horizons refers members to Healthy Start for these services when identified utilizing the Healthy Start Assessment Tool. The tool is used to determine eligibility for enrollment in Healthy Start's Care Coordination Program and is completed by the OB-GYN at the initial visit. Eligibility is based on identified risk factors that may affect the health of the pregnancy. The goal of the program is to mitigate those risk factors. If a member exhibits criteria (e.g., homelessness, history of abuse), the member is automatically enrolled, regardless of the assessment tool score.

If you are treating members who are pregnant, you should offer Florida's Healthy Start prenatal risk screening to each pregnant member as part of the first prenatal visit. Providers conducting such screening must use the **DOH prenatal risk form** (Form DH 3134), which can be obtained from the local CHD. A copy of the completed screening form should be kept in the member's medical record, and another copy should be provided to the member. Within 10 business days of completion, the provider must submit the screening form to the CHD in the county in which the prenatal screen was completed. Providers must document the member's preterm delivery risk assessment within the member's medical record no later than the 28th week.

Referrals to Healthy Start

Pregnant members or infants who do not score high enough to be eligible for Healthy Start care coordination may be referred for services, regardless of their score on the Healthy Start risk screen, in the following ways:

- If the referral is made at the same time the Healthy Start risk screen is administered, you may indicate on the risk screening form that the member or infant is invited to participate based on factors other than score.
- If the determination is made after risk screening, you may refer the member or infant directly to the Healthy Start care coordinator based on assessment of actual or potential factors associated with high risk, such as HIV, hepatitis, hepatitis B, substance use or domestic violence.

Humana Healthy Horizons providers should refer all pregnant, breastfeeding and postpartum women, infants, and children up to age 5 to the local WIC office using the following guidance:

- Participating providers of Humana Healthy Horizons should provide:
  - A completed Florida WIC program medical referral form with the current height or length and weight (taken within 60 calendar days of the WIC appointment)
  - Hemoglobin or hematocrit test results
  - Documentation of all identified medical/nutritional problems
- For subsequent WIC certifications, providers should coordinate with the local WIC office to provide the above referral data from the most recent CHCUP.
- Each time the participating provider completes a WIC referral form, the provider should give a copy of the WIC referral form to the member and retain a copy in the member's medical record.

Florida Healthy Start Infant Postnatal Risk Screening Instrument

Participating hospitals and birthing centers should complete the **Florida Healthy Start Infant Postnatal Risk Screening Instrument** (Form DH 3135) with the Certificate of Live Birth and transmit both documents to the CHD in the county in which the infant was born within 5 business days of completion. Copies of this form should be maintained by the provider, included in the member's medical record and furnished to the member.

Provider responsibilities for high-risk pregnancies

If you determine a member's pregnancy is high-risk, you must ensure the obstetrical care during labor and delivery includes preparation by all attendants for symptomatic evaluation and the member progresses through the final stages of labor and immediately receives postpartum care. You must notify Humana Healthy Horizons immediately of a member's pregnancy, which can be identified through medical history, examination, testing, claims or otherwise.

HIV counseling and testing

If you are a practitioner attending women for prenatal care, you must provide all women of childbearing age HIV counseling and offer them HIV testing.

- In accordance with Florida law, you should offer all pregnant members counseling and HIV testing at the initial prenatal care visit and again at 28 and 32 weeks.
- You must attempt to obtain a signed objection if a pregnant member declines an HIV test.
- All pregnant women who are infected with HIV should be counseled and offered the latest antiretroviral regimen recommended by the U.S. Department of HHS.
- You must screen all pregnant members receiving prenatal care for the hepatitis B surface antigen (HBsAg) during the first prenatal visit.

- You must perform a second HBsAg test between 28 and 32 weeks of pregnancy for all pregnant members who tested negative at the first prenatal visit and are considered high-risk for hepatitis B infection. This test should be performed at the same time other routine prenatal screening is ordered.
- All HBsAg-positive women should be reported to the local CHD and to Healthy Start, regardless of their Healthy Start screening score.
- You should ensure that infants born to HBsAg-positive members receive hepatitis B immune globulin (HBIG) and the hepatitis B vaccine once they are physiologically stable, preferably within 12 hours of birth, and you should complete the hepatitis B vaccine series according to the recommended vaccine schedule established by the Recommended Childhood Immunization Schedule for the U.S.
- You should test infants born to HBsAg-positive members for HBsAg and hepatitis B surface antibodies (anti-HBs) 6 months after the completion of the vaccine series to monitor the success or failure of the therapy.
- You must report a positive HBsAg result for any child 24 months or younger to the local CHD within 24 hours of receipt of the positive test results.
- You should ensure that infants born to members who are HBsAg-positive are referred to Healthy Start, regardless of their Healthy Start screening score.

You should report to the perinatal hepatitis B prevention coordinator at the local CHD all prenatal or postpartum members who test HBsAg-positive. You should also report said member's infant and contacts to the perinatal hepatitis B prevention coordinator at the local CHD.

You should report the following information about the mother:

- Name
- Date of birth
- Race
- Ethnicity
- Address
- Contacts
- Laboratory test performed
- Date the sample was collected
- Due date or estimated date of conception
- Whether the member received prenatal care and immunization dates for infant and contacts

Providers should use the **Practitioner Disease Report Form** (DH Form 2136) for reporting purposes. For more information, please review the U.S. Department of HHS Public Health Service Task Force report entitled **Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the US.**

PCPs must maintain all documentation of Healthy Start screenings, assessments, findings and referrals in the member's medical records.

Notification of member pregnancy

You are required to immediately notify Humana Healthy Horizons of a member's pregnancy by **HumanaBeginnings**, whether identified through medical history, examination, testing, claims or otherwise.

If a member becomes pregnant while enrolled with Humana Healthy Horizons, the member is requested to contact Humana Healthy Horizons' obstetrics case manager through **HumanaBeginnings**. The member should choose a Humana Healthy Horizons OB-GYN or midwife for care and make an appointment to see this healthcare provider as soon as possible. The member must also notify the **Florida Department of Children and Families** about the pregnancy.

Quality of care for pregnant members

You should provide the most appropriate and highest level of quality care for pregnant members, including but not limited to the following:

- Prenatal care
  - Require a pregnancy test and a nursing assessment with referrals to a provider, physician assistant or ARNP for comprehensive evaluation.
- Required case management through the gestational period according to the needs of the member – Require necessary referrals and follow-up.
  - Schedule return prenatal visits at least every 4 weeks until the 32nd week, every 2 weeks until the 36th week and every week thereafter until delivery unless the member's condition requires more frequent visits.
  - Contact members who fail to keep their prenatal appointments as soon as possible and arrange for their continued prenatal care.
  - Assist members in making delivery arrangements, if necessary.
  - Ensure all pregnant members are screened for tobacco use and make smoking cessation counseling and appropriate treatment as needed available to the pregnant members.
- Nutritional assessment/counseling—You should supply nutritional assessment and counseling to all pregnant members. In addition, you are expected to:
  - Ensure the provision of safe and adequate nutrition for infants by promoting breastfeeding and the use of breast milk substitutes.
  - Offer a mid-level nutrition assessment.
  - Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse or physician following the nutrition assessment.
  - Document the nutrition care plan in the medical record by the person providing counseling.
- Postpartum care
  - Provide a postpartum examination for all members within 6 weeks of delivery.

- Ensure members are supplied with voluntary family planning information, including a discussion of all methods of contraception (please see the **family planning services section of this provider handbook**).
- Ensure the continuing care of newborns is provided through the CHCUP program component and documented in the child's medical record (please see the **well-child visits section of this provider handbook**).

Newborn care

Humana Healthy Horizons wants to ensure that providers supply the highest level of care for newborns, beginning immediately after birth. In addition, providers should provide the following:

- All necessary and immediate referral needs in consultation from a specialty physician; includes administering the Healthy Start (postnatal) infant screen
- Newborn screening services in accordance with § 383.14, Fla. Stat., which outlines the required laboratory screening process to test for metabolic, hereditary and congenital disorders known to result in significant impairment of health or intellect
  - These required laboratory tests must be processed through the State Public Health Laboratory.
  - Humana Healthy Horizons reimburses for these screenings at the established Medicaid rate.

Screening members for domestic violence, alcohol and substance use, and smoking cessation

PCPs should screen members for signs of domestic violence and should offer referral services to applicable domestic violence prevention community agencies.

PCPs and OB-GYNs should screen members for signs of tobacco, alcohol and substance use as a part of prevention evaluation at the following times:

- On initial contact with member
- During routine physical examinations
- During initial prenatal contact
- When the member shows evidence of serious overutilization of medical, surgical, trauma or emergency services
- When documentation of ER visits suggests the need

Screening Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based approach to identify problematic use, reduce excessive use of substances and treat substance use disorders. SBIRT training is available online via **AHCA's SBIRT website**. In addition, participating providers are encouraged to use SBIRT codes for screening (H0049) and brief intervention (H0050). Members who meet one of the indicators may be referred to an appropriate participating behavioral health provider or to Humana Healthy Horizons to enroll in the substance use program by contacting **Humana Healthy Horizons in Florida MMA case management**.

Community partnerships to improve outcomes (CPIOs)

CPIOs are community-based partnerships which Humana Healthy Horizons develops to provide services and supports for members in priority areas. These include:

- Birth outcomes
- Mental health of children and adolescents
- Health-related social needs

In addition, Humana Healthy Horizons partners with CPIOs in the priority areas of chronic diseases, mental health and HCBS.

Humana Healthy Horizons may cosponsor training, provided the training meets the provider training requirements. Services can be offered in collaboration with agencies such as early intervention programs, Healthy Start coalitions and local school districts.

Providers must document referrals to community programs in the member's medical record and follow up on the member's receipt of services from community programs.

The programs should be targeted toward teen members but should be open to all members, regardless of age, gender, pregnancy status or parental consent.

Smoking cessation

- You are required to conduct regularly scheduled smoking cessation programs as an option for all your Humana Healthy Horizons-covered patients or make a good faith effort to involve members in existing community smoking cessation programs.
- Smoking cessation counseling must be available to all Humana Healthy Horizons-covered patients.
- For additional education and resources on smoking cessation, please visit **TobaccoFreeFlorida's website** and **Humana Healthy Horizons' tobacco cessation website**.

Substance use

- Providers are required to offer targeted Humana Healthy Horizons-covered patients either community- or plan-sponsored substance use cessation programs.

Quality improvement requirements

Providers must agree to comply with quality assurance, quality investigation and peer review process, QI, accreditation, risk management, utilization review, UM, clinical trial, and other administrative policies and procedures established and revised by Humana Healthy Horizons.

We have processes available to help facilitate the exchange of data to support monitoring of select performance measures. We encourage providers to explore these options.

Humana Healthy Horizons monitors, measures and evaluates provider quality using identified standards, appropriateness of care and service delivery (or the failure to provide care or deliver services) to members, including members enrolled in specialty plans, via the following means:

Measure	Description
Medical record audits	Medical record audits are reviews of medical records to evaluate patterns of complaints regarding poor quality of service, poor quality outcomes and adherence to member record documentation standards.
Peer reviews	Peer reviews are reviews of the provider's practice methods, patterns and appropriateness of care.
Performance improvement projects (PIP)	Performance improvement projects include ongoing measurements and interventions that are designed to significantly improve the quality of care and service delivery, sustained over time, in both clinical care and nonclinical care areas. These projects are implemented to have a favorable effect on member health outcomes and satisfaction.
Performance measures	Performance measures include claims data collected on member outcomes as defined by the Healthcare Effectiveness Data and Information Set (HEDIS®) or otherwise defined by AHCA.
Surveys	Survey measures assess member satisfaction with the quality of care received. Surveys include the Consumer Assessment of Health Plans Survey (CAHPS®).

Community outreach and provider-based marketing and activities

Humana Healthy Horizons providers must remain aware of and in compliance with the following requirements:

- You may display health-plan-specific materials in your own offices. You are permitted to make available and/or distribute Humana Healthy Horizons marketing materials as long as you and/or your facility distribute or make available marketing materials for all managed care plans with which you participate.
- If you agree to make available and/or distribute Humana Healthy Horizons marketing materials, you should do so knowing you must accept future requests from other plans with whom you participate.
- You also are permitted to display posters or other materials in common areas such as the waiting room.
- LTC facilities are permitted to provide materials in admission packets announcing all contractual relationships with managed care plans.

- You may not orally or in writing compare benefits or provider networks among health plans, other than to confirm whether providers participate in a health plan's network. If you can assist a recipient in an objective assessment of their needs and potential options to meet those needs, you may do so. You may engage in discussions with members should a member seek advice. However, you must remain neutral when assisting with enrollment decisions.
- You may announce new or continuing affiliations with Humana Healthy Horizons through general advertising (e.g., radio, television, websites).
- You may make new affiliation announcements within the first 30 days of the new provider agreement.
- You may provide members a list of health plans with whom you are contracted.
- You may cosponsor events, such as health fairs, and advertise with the health plan in indirect ways, such as television, radio, posters, flyers and print advertisements.
- You cannot furnish lists of your Medicaid-covered patients to Humana Healthy Horizons or any other entity.
- You cannot furnish other health plans' membership lists to Humana Healthy Horizons, nor can you assist with health plan enrollment.
- For Humana Healthy Horizons, you may distribute information about non-health-plan-specific healthcare services and the provision of health, welfare and social services by the state of Florida or local communities as long as inquiries from prospective members are referred to the member services section of the health plan or AHCA's choice counselor/enrollment broker.
- You may refer your members to other sources of information, such as the managed care plan, the enrollment broker or the local Medicaid area office. You also may share information with members from the AHCA or CMS website.

You must not:

- Offer marketing/appointment forms
- Make phone calls or direct, urge or attempt to persuade members to enroll in a health plan with a particular managed care organization based on financial or any other interests you may have
- Mail marketing materials on behalf of a particular plan
- Offer anything of value to induce recipients/members to select you as their provider
- Offer inducements to persuade recipients to enroll in a particular plan
- Conduct health screenings as a marketing activity
- Accept compensation directly or indirectly from any managed care plan for marketing activities
- Distribute marketing materials within an exam room setting
- Furnish lists of your Medicaid-covered patients or the membership of any managed care plan to a managed care plan

Florida Medicaid provider number

All providers and healthcare professionals must be confirmed active on the **AHCA portal** on the PML. Healthcare professionals must be listed as **Enrollment** or **Limited Enrollment** in the Enrollment Type column and as **Active (A)** in the Current Medicaid Enrollment Status column. You must be eligible for participation in the Medicaid program to provide services to Medicaid recipients. If you are currently suspended or involuntarily terminated from the Florida Medicaid program whether by contract or sanction, other than for purposes of inactivity, you are not considered an eligible Medicaid provider. Once actively enrolled, you are issued a unique Florida Medicaid provider number. To comply with reporting requirements, Humana Healthy Horizons submits an electronic data file representing its credentialed and contracted provider network each week. Proper Medicaid enrollment is critical because incorrect enrollment affects the way a healthcare provider or provider group is identified by AHCA and its Choice Counselors, as well as how they are listed on the **find a doctor website**, Humana Healthy Horizons' online provider directory.

Indications of proper provider or healthcare professional enrollment include:

- Active listing on the PML on the **AHCA portal**
- Active (A) listing in the current Medicaid Enrollment Status column
- Accurate NPI listing related to attending, billing, ordering, prescribing, referring and rendering providers (not applicable to atypical providers) affiliated with the correct Medicaid ID
- Listing with all active service and/or billing locations, provider type and provider specialty codes associated with its respective NPI and Medicaid ID

You must bill with the information exactly as it is listed in the AHCA PML. If claims are received with provider information that does not match the applicable active PML record, claims may be rejected, denied or subject for recoupment if paid in error.

Please note: CMS defines atypical providers as providers who do not provide healthcare. Atypical providers must have an active Medicaid ID or claims may be rejected, denied or subject to recoupment.

AHCA's Provider Enrollment area is available to assist healthcare professionals with enrollment issues, including change of address, change of ownership and reenrollment issues via the **AHCA portal**. Guidelines regarding how healthcare professionals should enroll with Medicaid can be found in Chapter 2 of the **AHCA Provider Enrollment Policy**.

Emergency service responsibilities

You are required to ensure adequate accessibility for healthcare 24 hours a day, 7 days a week. Humana Healthy Horizons members should contact their PCP if they experience an emergency but should go to the closest ER or any other emergency setting if they have any of the following:

- Heavy blood loss
- Heart attack

- Severe cuts requiring stitches
- Loss of consciousness
- Poisoning
- Severe chest pains
- Loss of breath
- Broken bones

Members are instructed to call their PCP as soon as possible when they are in a hospital or have received emergency care. When a member arrives at a hospital seeking emergency services and care, the determination that an emergency medical condition exists is made, for the purposes of treatment, by a provider of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a hospital physician. See § 409.9128, Fla. Sta., § 409.901, Fla. Stat. and § 641.513, Fla. Stat.

If the ER provider treating the member determines the visit is not an emergency, the member is given the choice to stay and receive medical treatment or follow up with their PCP.

If the member's PCP responds to the hospital's notification, and the hospital provider and the PCP discuss the appropriate care and treatment of the member, the managed care plan may have a member of the hospital staff with whom it has a participating provider contract participate in the treatment of the member within the scope of the provider's hospital staff privileges.

If the member is treated for an emergency and the treating doctor recommends treatment after the member is stabilized, the member is instructed to contact their Humana Healthy Horizons PCP.

Members who are away from home and have an emergency are instructed to go to the nearest ER or any emergency setting of their choice. In such situations, members should contact their PCP as soon as possible.

Reporting requirements

The Humana Healthy Horizons PCP agrees to prepare and submit all reports and clinical information required by Humana Healthy Horizons, as required by their Humana Healthy Horizons agreement, including well-child visit program reporting if applicable, and in compliance with state and federal requirements.

Release due to ethical reasons

Humana Healthy Horizons has no moral or religious objections for providing any covered services. However, you are not required to perform any treatment or procedure that is contrary to your conscience, religious beliefs or ethical principles, in accordance with 45 C.F.R. 88. Humana Healthy Horizons informs members you do not cover the requested service and instructs the member how to access the requested service from another provider.

Member transfer-for-cause requests

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

Please note: Members have the right to participate in decisions regarding their health, including the right to refuse treatment.

Requested transfers for cause cannot be based on:

- Member inability to pay for services
- Medical or mental health reasons
- Member refusal of treatment

This process does not apply to members who:

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

Members cannot be transferred until the effective date of an approved transfer. Until then, the assigned provider is responsible for the member's care. You may not take steps to transfer the member prior to obtaining transfer-for-cause approval from Humana Healthy Horizons.

Please note: Please follow these steps unless your request meets the escalated exception criteria listed in the escalated exceptions section of this provider handbook.

To initiate a request to transfer a member for cause:

- Conduct a verbal discussion with the member/caregiver at the time of the first incident and at every subsequent incident, and outline provider behavior expectations of member/caregiver behavior during office visits and phone conversations. You should document each conversation in the member's record.
- If the member/caregiver continues to be disruptive, unruly, abusive or uncooperative after verbally provided education, send a written communication that outlines provider expectations of member/caregiver behavior during office visits and phone conversations. You should document and retain a copy of the written communication in the member's record.
- If unruly, abusive or uncooperative member/caregiver behavior continues after receipt of the written provider communication, you may submit a **Humana Provider-initiated Transfer Request** form by email to the **provider contracting team**.

The provider contracting team reviews the submitted form and supporting documentation to ensure they are complete and accurate. A contract specialist logs and submits the request to the clinical medical director for review and determination.

- **If the medical director approves the request to transfer**, the enrollment team contacts the member/caregiver 3 times to assist with choosing another PCP. If outreach is unsuccessful, the member is automatically reassigned to another PCP and sent a transfer notice. The member then receives a new Humana Healthy Horizons ID card in the mail that includes their new PCP's contact information.
  - Once the member is transferred, the provider contracting team notifies the requesting provider and closes the request.
  - On request, you must send the member's medical records to the newly selected provider for the purpose of continuity of care at no charge to Humana Healthy Horizons, the member or the requesting party.
- **If the medical director does not approve the transfer-for-cause request**, the reason for denial is given to the provider contracting team. The provider contracting team either notifies the requesting provider and requests additional details as applicable or closes out the request.

Escalated exceptions

If the situation between the member/caregiver and the provider intensifies to the point of law enforcement involvement, the provider may submit an escalated exception request to the provider contracting team. The request must include:

- An incident description
- All available police reports

The provider contracting team then escalates the request to the clinical medical director and engagement team to immediately transfer the member to another provider. A notice is sent informing the member of the change.

Once the member is transferred, the provider contracting team notifies the requesting provider and closes the request. The member receives a new Humana Healthy Horizons ID card in the mail that includes the new provider's contact information.

Cultural competency

Humana Healthy Horizons providers are expected to provide services in a culturally competent manner which includes, but is not limited to, removing all language barriers to service and accommodating the special needs of the ethnic, cultural and social circumstances of each member. Providers also must meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care including, but not limited to, those explicit in Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the ADA and the Rehabilitation Act of 1973.

Humana Healthy Horizons recognizes cultural differences and the influence that race, ethnicity, language and socioeconomic status have on the member's healthcare experience and health outcomes. Humana Healthy Horizons is committed to developing strategies that eliminate health disparities while addressing gaps in care. Racial and ethnic disparities in health and healthcare are well documented. The COVID-19 pandemic highlighted these inequities, which are rooted in structural and systemic racism. Data across 64 measures show significant differences in health outcomes and access to care between people of color and their White counterparts[1]. The Commonwealth Fund 2024 State Health Disparities Report found that Black members received worse care than White members on 52% of quality measures in 2023[2].

Communication is paramount in delivering effective care. Achieving mutual understanding may be difficult during cross-cultural interaction between members and their providers. Some disparities may be attributed to miscommunication between members and their providers, language barriers, cultural norms, and beliefs and attitudes that determine healthcare-seeking behaviors. Providers can address racial and ethnic gaps in healthcare with an awareness of cultural needs and make efforts to improve communication with diverse members.

Humana Healthy Horizons offers several initiatives to deliver services to all members regardless of ethnicity, socioeconomic status, culture or primary language, including language assistance services, race and ethnicity data collection and analysis, internal staff training, and resources offered in Spanish. Other initiatives provide you with additional resources and materials including tools from health-related organizations that support awareness of gaps in care and information on culturally competent care.

To request a printed copy of Humana's Cultural Competency Plan at no charge, please contact **member/provider services**, your provider relations representative or your contract specialist.

Termination of provider contract

Every Humana Healthy Horizons provider has the right to terminate their contract with Humana Healthy Horizons' plan. To terminate your contract, you must submit your request in writing to your contract specialist and provide 90 calendar days' notice.

1 N dugga, N., Hill, L., & Artiga, S. Key data on health and health care by race and ethnicity. Kaiser Family Foundation (June 11, 2024). **https://www.kff.org/key-data-on-health-and-healthcare-by-race-and-ethnicity/?entry=executive-summary-introduction**

2 The Commonwealth Fund. Advancing racial equity in U.S. health care. The Commonwealth Fund 2024 State Health Disparities Report (April 18, 2024). **https://www.commonwealthfund.org/publications/fund-reports/2024/apr/advancing-racial-equity-us-health-care**

Chapter 5: Covered services

Contact information pertaining to provider and subcontractor rights and responsibilities

Contact name	Contact information	Hours of operation
Access Behavioral Health (Region A)	Address (claims): Access Behavioral Health Attn: Claims Dept 1221 W. Lakeview Avenue Pensacola, FL 32501 Phone (claims): **850-469-3631** Phone (provider inquiries, referral and authorization support): **866-477-6725** Email (provider inquiries): **abhinfo@lifeviewgroup.com** Email (referral and authorization support): **abhreferral@lifeviewgroup.com** Email (claims): **abhbilling@lifeviewgroup.org** Email (grievances and appeals): **ABHQualityDepartment@lifeviewgroup.org**	24 hours a day, 7 days a week Provider inquiries: Monday through Friday, 9 a.m. to 6 p.m., Eastern time Referral and authorization support: Monday through Friday 8 a.m. to 5 p.m., Eastern time
Apalachee Center MRT	Serves Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor and Wakulla counties Phone: **800-342-0774**	24 hours a day, 7 days a week
Behavioral analysis services (general questions and support)	Email: **ABA@humana.com**	

Contact name	Contact information	Hours of operation
Behavioral analysis services (Regions A through E)	Phone (Kiesa Arrington): **901-232-7247** Email (Kiesa Arrington): **karrington@humana.com**	Monday through Friday, 8 a.m. to 5 p.m., Eastern time
Behavioral analysis services (Regions F through I)	Phone (Elba Martinez): **754-230-7899** Email (Elba Martinez): **emartinez1@humana.com**	Monday through Friday, 8 a.m. to 5 p.m., Eastern time
Carelon Behavioral Health Claims (Regions B through I)	Address (claims): Carelon Behavioral Health P.O. Box 1870 Hicksville, NY 11802-1870 Address (grievances and appeals): Carelon Behavioral Health P.O. Box 1872 Hicksville, NY 11802-1872 Phone (provider inquiries): **800-397-1630** (provider inquiries): **providerrelationsFL@carelon.com** Email (referral support): **BH_CM@carelon.com**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Go365 for Humana Healthy Horizons	Phone: **888-225-4669 (TTY: 711)**	Monday through Friday, 8 a.m. to 7 p.m., Eastern time
Humana Concierge Service for Accessibility	Phone: **877-320-2233**	24 hours a day, 7 days a week
Humana Healthy Horizons in Florida coaching line (weight management, smoking cessation)	Phone: **855-330-8053 (TTY: 711)**	Monday through Friday, 8 a.m. to 6 p.m., Eastern time
Humana Healthy Horizons in Florida MMA case management	Phone: **800-229-9880** (TTY: 711) Email: **FL_MMA_CM_Referrals@humana.com**	Monday through Friday 8:30 a.m. to 5 p.m., Eastern time
HumanaBeginnings	Phone: **800-322-2758**, extension 1394119	Monday through Friday 8:30 a.m. to 5 p.m., Eastern time
Lakeview Center MRT	Serves Escambia, Santa Rosa, Okaloosa and Walton counties Phone: **866-517-7766**	24 hours a day, 7 days a week

Contact name	Contact information	Hours of operation
Life Management Center MRT	Serves Bay, Calhoun, Gulf, Home, Jackson and Washington counties Phone: **850-522-4485**	24 hours a day, 7 days a week
Member HRA completion	Phone: **800-611-1467**	Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time
Member/ provider services	Phone: **800-477-6931**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Modivcare	Phone: **866-779-0565**	Monday through Friday, 9 a.m. to 6 p.m., Eastern time

General services

Through our contracted providers, Humana Healthy Horizons is required to arrange for the following medically necessary services for each member:

Covered service	Covered service	Covered service
Allergy services	Clinical services	Orthopedic services
Ambulatory surgical centers	Community mental health services	Optometric and vision services
ARNP services	CHD services	Pain management services
Anesthesia services	Dental services	Personal care for members with AIDS
Assistive care services	Dialysis services	Physician assistant services
BA services	DME and medical supplies	Podiatry services
Behavioral health, including:	EIS	Prescribed drug services
• **Ambulatory detox services**	Emergency behavioral health services	Primary care case management services
• **Community-based wraparound services**	Emergency services	Primary care services
• **Crisis stabilization units and class III/IV freestanding psychiatric hospitals**	Evaluation and management services	Private duty nursing
• **Detox or addictions receiving facilities**	Family planning services and supplies	Radiology and nuclear medicine services
• **Drop-in center**	FQHC services	Prosthetics and orthotics
• **Family training and counseling**	Gastrointestinal services	Regional perinatal intensive care center
• **Infant mental health pre/post-testing**	Genitourinary services	Reproductive services
• **Mobile crisis assessment and intervention**	Healthy Start services for pregnant members	Respiratory services—systems and therapy
• **Mental health partial hospitalization**	Hearing services	RHC services
• **Respite care**	Home health services and nursing care	SNF
• **Self-help/peer services**	Hospital services—inpatient and outpatient Imaging services	Speech-language pathology services
• **Substance use intensive outpatient program**	Immunizations	Specialty provider services
• **Substance use short-term residential treatment**	Laboratory services	Sitewide inpatient psychiatric program
Behavioral health services—inpatient and outpatient Birth center services	Licensed midwife services	Targeted case management
Cardiovascular services	Massage therapy for members with AIDS	Therapy services (occupational, physical, respiratory and speech)
Child health services targeted case management	Medical foster care	Transplant services
Chiropractic services	Mental health targeted case management	Transportation services
	Medication management services	Well-child visits
	Nursing facility services Oral and maxillofacial surgery services	X-ray services, including portable X-rays

In providing covered services to Medicaid members, you are required to adhere to applicable provisions in the Florida Medicaid Coverage and Limitations Handbook, as well as all state and federal laws pertaining to the provision of such services.

Out-of-network care for services not available

Humana Healthy Horizons arranges out-of-network care if we are unable to provide members with necessary covered services within our network. Additionally, we arrange for a second opinion if a network healthcare provider is not available. Payment is coordinated with the out-of-network provider to confirm that any cost to the member is not greater than it would be if the service were provided in network.

Expanded benefits

Expanded benefits are services offered by Humana Healthy Horizons and approved in writing by AHCA. Expanded benefits are those services or benefits not otherwise covered or that exceed limits outlined in the Medicaid State Plan handbook, the Florida Medicaid Coverage and Limitations handbook, and Florida Medicaid Fee Schedules. These services exceed the amount, duration and scope of the covered services listed in this chapter of the provider handbook. In instances when an expanded benefit is also a Medicaid covered service, Humana Healthy Horizons administers the benefit in accordance with all applicable service standards, the Florida Medicaid State Plan, and all Medicaid coverage and limitations. Expanded benefits do not have copays. Members of Humana

Healthy Horizons have specific enhanced benefits; please refer to the Expanded Benefits Provider Resource Guide located on the **Humana Healthy Horizons in Florida provider website** or within the Florida Medicaid Handbook for benefit descriptions and details which are included on the **Florida Medicaid web portal**.

Copayments for MMA, HIV, SMI and LTC base benefits for members 21 and older are waived as an expanded benefit. You must not charge copayments to members for covered services.

Humana Healthy Horizons' Healthy Behaviors program

Healthy Behaviors programs offered by Humana Healthy Horizons encourage and reward behaviors designed to improve the member's overall health. Members can earn rewards while participating in these programs. Programs administered by Humana Healthy Horizons comply with all applicable laws, including fraud and abuse laws, that fall within the purview of the U.S. Department of HHS OIG.

Go365 for Humana Healthy Horizons in Florida

Available at no extra cost to members, Humana Healthy Horizons in Florida offers its members Go365 for Humana Healthy Horizons which is designed to help our members live and age well. Please share this information with your Humana Healthy Horizons-covered patients who can benefit from these programs. Encourage your patients to enroll and participate in eligible programs.

To earn rewards, members must:

- Download the Go365 for Humana Healthy Horizons app from iTunes/Apple Shop or Google Play on a mobile device.
- Create an account to access and engage in the program.
- If they are 18 and older, register to create a Go365 account. They must have their Medicaid Member ID.
- If they are younger than 18, have a parent or guardian register on their behalf to participate and engage with the program. The person completing the registration process on behalf of a minor must have the minor's Medicaid Member ID.

If the member has a **MyHumana account**, the member can use the same sign-in information to access Go365 for Humana Healthy Horizons after they download the app.

For each eligible Go365 for Humana Healthy Horizons activity completed, members can earn rewards and redeem the rewards for gift cards in the Go365 in-app mall. To earn rewards, members must be enrolled in one of the following:

- MMA plan
- Comprehensive (MMA and LTC) plan
- SMI or HIV/AIDS specialty plan

Rewards earned through Go365 for Humana Healthy Horizons have no cash value and must be earned and redeemed prior to the reward expiration date.

Call **Go365 for Humana Healthy Horizons** to learn more about rewardable activities.

Activity	Criteria	Reward
Annual well visit	Complete an annual wellness visit with a PCP. Applies to members 18 and older.	$20 in rewards, once per year, upon receipt of claim
Cervical cancer screening	Receive a cervical cancer screening as part of a routine Pap test. Applies to female members 21 and older. Members have open access for OB-GYN visits and do not require a referral from a PCP.	$20 in rewards, once per year, upon receipt of claim
Colorectal cancer screening	Receive a colorectal cancer screening as recommended by a PCP. Applies to members 45 and older. Provider-written order (i.e., referral) may be required for colorectal cancer screening. Members should check with their PCP.	$20 in rewards, once per year, upon receipt of claim

Activity	Criteria	Reward
Health Risk Assessment (HRA)	The HRA can be completed in 1 of 4 ways: • Complete in the Go365 for Humana Healthy Horizons app. • Fill out and send back the HRA in the envelope from the member's welcome kit. • Call **member HRA completion**. • Create a **MyHumana account** and complete and submit the HRA online (via desktop only). Applies to all members.	$20 in rewards if completed within the first 90 days of enrollment. $10 in rewards if completed after the first 90 days of enrollment. 1 reward per new enrollment
HumanaBeginnings	Pregnant members can enroll and complete the HumanaBeginnings program. Includes a prenatal component and/or postpartum component. Applies to pregnant females 13 and older. To learn more and enroll, contact **HumanaBeginnings**.	$20 in rewards, once per year, per pregnancy
Mammogram cancer screening	Receive a mammogram. Applies to female members 40 and older. High-risk members 40 and younger are also eligible for rewards. Provider-written order (i.e., referral) may be required for mammogram screening. Members should check with their PCP or OB/GYN.	$20 in rewards, once per year, upon receipt of claim
Postpartum visit	Complete 1 postpartum visit with a provider within 7 to 84 days of delivery. Available to all pregnant female members. **Please note: Members do not have to enroll in and complete the HumanaBeginnings program to earn rewards for prenatal and/or postpartum visits with their OB-GYN**	$15 in rewards once per year, per pregnancy, upon receipt of claim
Prenatal visit	Complete a prenatal visit during the first trimester or within 42 days of enrollment with Humana Healthy Horizons. Available to all pregnant female members. **Please note: Members do not have to enroll and complete the HumanaBeginnings program to earn rewards for prenatal and/or postpartum visits with their OB-GYN**	$15 in rewards once per year, per pregnancy, upon receipt of claim

Activity	Criteria	Reward
Substance use disorder counseling	Members work with a substance abuse counselor over the phone to get help with substance use. $15 for enrolling and completing 3 sessions within 3 months of the first session $15 for completing 3 additional sessions (6 sessions total) within 6 months of enrolling And/or: $20 for active participation in an outpatient program for 28-30 days Available to members 18 years and older. Members can enroll by calling **Humana Healthy Horizons in Florida MMA case management**.	Up to $50 in rewards once per member per year
Tobacco and vaping cessation program	Members work with a coach over the phone to quit smoking or vaping. $25 for completing 2 calls within 45 days of enrolling in coaching $25 for completing 6 more calls (8 total) within 12 months of enrolling in coaching To enroll, members should contact the **Humana Healthy Horizons in Florida Coaching Line** (select option 1). Applies to members 12 and older. Parent/guardian consent required for members 12 to 17. Nicotine replacement therapy is available to members 18 and older. **Please note: The intention is for members to complete the tobacco cessation program in 7 months but allows up to 12 months to complete 8 sessions**	Up to $50 in rewards, once per member per year

Activity	Criteria	Reward
Weight management program	Members work with a coach over the phone to reach or keep a healthy weight. $10 for enrolling and submitting a PCP form $30 for completing coaching, 6 calls total, within 12 months of enrolling To enroll, members should contact the **Humana Healthy Horizons in Florida Coaching Line** (select option 2). Applies to all members 12 and older. Parent/guardian consent required for members 12 to 17. **Please note: The intention is for members to complete the weight management program in 6 months but allows up to 12 months to complete 6 sessions**	Up to $40 in rewards once per member per year
Well-child visit	Complete a wellness visit with a pediatrician. Applies to members newborn to 17.	$20 in rewards once per year, upon receipt of claim

How to redeem rewards

After completing any of the healthy activities listed above, members can:

- Download the Go365 for Humana Healthy Horizons app. Members should choose the app that includes Humana Healthy Horizons in the app title.
- Add eligible minors to their account.
- Find available rewards in the Go365 for Humana Healthy Horizons app.
- Access the Go365 Mall in the app.
- Redeem their rewards for e-gift cards.

Please contact **Go365 for Humana Healthy Horizons** or visit the **Go365 website** for more information.

Federal Lifeline program

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. Members receive 1 free smartphone per household. For additional information, contact **member/provider services**.

Inpatient coverage

For members 21 and older, up to 45 calendar days of inpatient coverage are covered. Additional days are covered for emergencies. PA and other limits may apply.

For members newborn through the last day of the month of their 21st birthday, Humana Healthy Horizons provides up to 365 days of health-related inpatient care, including behavioral health, each year. PA may apply.

Behavior analysis services

Applied BA is an evidence-based approach that helps individuals experiencing developmental delay or autism spectrum disorders improve their quality of life. Medicaid-covered BA services are highly structured interventions, strategies and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.

BA services are covered for members 21 and younger and are assessed for medical necessity by a qualified practitioner. A comprehensive diagnostic evaluation completed by a qualified licensed practitioner is required for a member to receive BA services. For PA information and submission requirements, please refer to Humana Healthy Horizons' authorization guidelines on our **provider prior authorization notification lists website** and **prior authorization search tool website**. Services must be medically necessary, not duplicative of another service and meet the criteria as specified in the **Florida AHCA Medicaid Behavior Analysis Coverage Policy**.

> **Please note:** Please note that BA claims are to be submitted directly to Humana Healthy Horizons for payment and processing. For all other behavioral health services, Humana Healthy Horizons partners with Access Behavioral Health in Region A and Carelon Behavioral Health in Regions B through I.

If you need to make behavioral health referrals, please refer to the appropriate behavioral health provider partner based on the member's home address and region. Please work with our care managers and behavioral health provider partners for all consultations and integrated care.

For additional information related to referral guidelines, accepted rendering provider specialties, behavior assessments, behavior plans, clinical criteria and more, please refer to the **provider prior authorization notification lists website**.

Once PA is granted, Humana Healthy Horizons case management conducts regularly scheduled care conferences with members who are receiving BA services, including their families and providers.

For specialized provider relations assistance, please reach out to us as specified below:

- For general questions and support, please email **behavioral analysis services (general questions and support)**.
- Providers in regions A through E should contact **behavioral analysis services (regions A through E)**.
- Providers in regions F through I should contact **behavioral analysis services (regions F through I)**.

For other helpful information, including specialized billing guidance, please see the **behavior analysis provider quick guide** located on the **Humana Healthy Horizons in Florida provider website**.

Behavioral health services

Emergency behavioral health services

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

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

Carelon Behavioral Health

Providers and members in regions B through I can contact Carelon Behavioral Health Claims (regions B through I), one of Humana Healthy Horizons' behavioral health providers.

Authorization support can be reached through the contact number located on the back of the member's card.

Relevant Carelon websites

- **Behavioral health provider contact information**
- **About Carelon behavioral health**
- **Behavioral health provider resources**
- **Behavioral health provider toolkit**
- **Behavioral health medical necessity criteria**
- **Behavioral health clinical practice guidelines**

Access Behavioral Health

Providers and members in region A should contact Access Behavioral Health, one of Humana Healthy Horizons' behavioral health providers.

The 988 suicide and crisis lifeline is available for members in crisis.

Region A MRTs provide intervention and support and are available to respond within 60 minutes via telephone triage or in person.

- Members in Escambia, Santa Rosa, Okaloosa and Walton counties can contact the **Lakeview Center MRT**.
- Members in Bay, Calhoun, Gulf, Homes, Jackson and Washington counties can contact the **Life Management Center MRT**.
- Members in Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor and Wakulla counties can contact the **Apalachee Center MRT**.

Relevant Access Behavioral Health websites

- **Access Behavioral Health website**
- **Provider resources**
- **Provider handbook**

Treatment for psychiatric and emotional disorders includes the following services:

- Children's behavioral healthcare services
- Counseling
- Day treatment services
- Evaluation and testing services
- Rehabilitation services
- Therapy and treatment services

For emergency mental healthcare within or outside the service area, please instruct members to go to the closest hospital ER or any other recommended emergency setting. Members should contact their PCP first if they are unsure whether they are experiencing an emergency. Emergency mental health conditions include:

- The member is a danger to themselves or others.
- The member is unable to carry out actions of daily life due to functional harm.
- The member is experiencing serious harm to the body that may cause death.

In addition, Humana Healthy Horizons and the mental healthcare provider shall ensure:

- The member has a follow-up appointment within 7 calendar days of discharge.
- All required prescriptions are authorized at the time of discharge.
- Coordination of care, including the following:
  - Discharge planning begins at admission and is designed for early identification of medical and/or psychosocial issues requiring post-hospital intervention.
  - Discharge plans from behavioral health inpatient admissions are monitored to ensure they incorporate the member's needs for continuity in existing behavioral health therapeutic relationships.
  - Behavioral healthcare providers should assign a mental health targeted case manager to oversee the member's care to ensure a smooth transition to a lower level of care.
  - The concurrent review clinician works with the attending provider, hospital discharge planner, family members, guardians, ancillary providers and/or community resources to coordinate care and postdischarge services to facilitate a smooth transfer of the member to the appropriate level of care.
  - An inpatient review nurse may refer an inpatient member with identified complex discharge needs to transitional case management for in-facility outreach.

Transplant services

Medically necessary transplants and related services are covered. PA and other limits may apply. Please see **Humana's transplant services website**.

Family planning services

AHCA requires family planning services be furnished on a voluntary and confidential basis. Humana Healthy Horizons provides family planning services to help members make comprehensive and informed decisions about family size and/or spacing of births.

The following services are provided:

- Planning and referral
- Education and counseling
- Initial examination
- Diagnostic procedures
- Routine laboratory studies
- Contraceptive drugs and supplies
- Follow-up care in accordance with the **Adopted Rules Service-Specific Policies website**

This information should be documented in the member's medical record to meet the contractual requirement. Humana Healthy Horizons or AHCA may audit medical records to confirm compliance with this contractual clause.

Members can choose from any Medicaid provider for family planning services. Prior approval is not required.

> **Please note:** The above content is informational only and does not constitute clinical advice or recommendations. This information is not intended to interfere with or prohibit clinical decisions made by prescribers or communication between prescribers and members regarding clinical care and all available options.

Clinical trials

Humana Healthy Horizons covers any item or service provided to a member, including members enrolled in a specialty plan, participating in a qualifying clinical trial to the extent that the item or service would otherwise be covered for the member when not participating in the qualifying clinical trial. This includes any item or service provided to prevent, diagnose, monitor or treat complications resulting from participation.

Treatment adherence services in the HIV/AIDS specialty plan

Humana Healthy Horizons recognizes the management of chronic disease conditions involves more than addressing the disease process. In recognition of this fact, Humana Healthy Horizons provides a holistic, interdisciplinary structure designed to consider the individual's physical, behavioral and social conditions, along with comorbid diagnoses, and facilitates treatment adherence. The intent of the HIV/AIDS specialty program is to assist members and their caregivers in meeting their personally identified health improvement goals. In addition to addressing and increasing a member's knowledge of their disease process and treatment plan, the HIV/AIDS specialty program assists members in the development of improved health-related behaviors and coping skills while providing them with needed support and resources. The program uses a multifaceted approach to achieve the best possible therapeutic outcomes based on assessment of members' needs, ongoing care monitoring, evaluation, and tailored member and practitioner interventions.

Assessment and reassessment of the acuity level and service needs of each member includes:

- Planning care for treatment of HIV/AIDS that is tailored to the individual member and is in agreement with evidenced-based guidelines for treatment of the specialty population
- Coordinating care through all levels of practitioner care (primary care to specialist)
- Monitoring compliance with scheduled appointments, laboratory results and medication adherence
- Intervening to avoid unnecessary use of emergency departments, inpatient care and other acute care services
- Educating members in better management of their health issues, including the principles of recovery and resiliency
- Linking members to community or other support services

Well-child visits

Medicaid well-child visit

The Medicaid well-child visit, also called a child health checkup, is a regularly scheduled comprehensive, preventive health screening service for children from birth through age 20. Wellchild visits are performed according to a periodic schedule to facilitate routine health screenings for children to identify and correct medical conditions before the conditions become more serious and potentially disabling. The well-child visit is part of Florida's EPSDT program.

A well-child visit includes the following:

- Comprehensive health and developmental history, including assessment of:
  - Past medical history
  - Developmental history
  - Behavioral health status
- Nutritional assessment
- Developmental assessment

- Comprehensive unclothed physical examination
- Dental screening including dental referral (when required)
- Vision screening including objective testing (when required)
- Hearing screening including objective testing (when required)
- Laboratory tests including blood lead testing (when required)
- Appropriate immunizations
- Health education and anticipatory guidance
- Diagnosis and treatment
- Referral and follow up, as appropriate

Pursuant to § 409.975(5), Fla. Stat. (2023), Humana Healthy Horizons must achieve a well-child visit screening rate of at least 80% for those members who are continuously enrolled for at least 8 months during the federal fiscal year (October 1 to September 30). This screening compliance rate is based on the CHCUP screening data reported by the PCP and due to AHCA by July 1 following the end of each federal fiscal year.

Humana Healthy Horizons adopts annual screening and participation goals to achieve at least an

80% well-child visit screening and participation rate. For each federal fiscal year that the Humana Healthy Horizons provider network does not meet the 80% screening and participation rate, Humana Healthy Horizons must submit quarterly updates in the PMAP to AHCA.

Child blood-lead screenings

Federal regulations require children receive a blood-lead screening test at 12 and 24 months. Children aged 36 to 72 months who have not previously been screened should also be screened. Humana Healthy Horizons recommends that healthcare providers use a verbal lead-screening questionnaire to assess the risk of elevated levels in children aged 6 months to 6 years old. In accordance with CDC guidelines and recommendations, children whose blood-lead levels are found to be 3.5 mcg/dL or greater (by venous sampling) should be treated and managed according to the provider's discretion. Follow-up visits should include identification of possible sources of lead, appropriate treatment and periodic repeat testing.

Emergency and nonemergency transportation

For emergency transportation services, call 911.

If a Humana Healthy Horizons member needs a ride to a healthcare appointment that is not an emergency or to a pharmacy following a provider visit, the member should call **ModivCare** at least 24 hours before the appointment time.

Assistive care services

Assistive care services are an integrated set of 24-hour services only for eligible Medicaid members 18 and older. The assistive care service is a covered service in the SMMC program under both the LTC and MMA programs.

Telemedicine

Humana Healthy Horizons reimburses providers for telemedicine services that use interactive telecommunications equipment including, at a minimum, audio equipment permitting twoway communication between a member and provider. Telemedicine is defined as the practice of healthcare delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis or treatment. This applies to any person or entity prescribing or reviewing a request for Florida Medicaid services and to all providers of Florida Medicaid services that are enrolled in or registered with the Florida Medicaid program.

Humana Healthy Horizons does not reimburse the following:

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

For reimbursement, Humana Healthy Horizons requests providers who bill for telemedicine services to report the place of service code that would have been reported had the service been furnished in person. Florida Medicaid Telehealth Billing Guide providers must include the modifier GT or 95 on their CMS 1500 claim form. As an example, if the patient would have been seen in the office, the claim should be submitted with POS 11 and a modifier GT or 95. Out-of-state healthcare providers not licensed in Florida should contact the appropriate regulatory board at the Florida Department of Health for more information on telemedicine registration.

Providers who offer and/or facilitate telemedicine services in their practices must remain aware of the state guidelines to ensure they are informed of their responsibilities, requirements and criteria for telemedicine. Offering these services may include a review of the practice by Humana Healthy Horizons' legal designee to ensure all considerations for the practice of telemedicine have been met.

If you are approved by Humana Healthy Horizons to provide services through telemedicine, you must implement telemedicine fraud and abuse protocols that address:

- Authentication and authorization of users
- Authentication of the origin of the information
- The prevention of unauthorized access to the system or information
- System security, including the integrity of information that is collected, program integrity and system integrity
- Maintenance of documentation about system and information usage

Providers offering these services to members with Medicaid coverage must address each of the following requirements:

- Telecommunication equipment and telemedicine operations meet the technical safeguards required by 45 CFR 164.312, where applicable.

- Administration of telemedicine services complies with the Health Insurance Portability and Accountability Act (HIPAA) and other state and federal laws pertaining to member privacy.
- Telemedicine services provided are documented in the member's medical/case record.
- Telemedicine services are offered to the member as a choice of whether to access services through faceto- face or telemedicine encounters. This must be documented in the member's medical/ case records.
- Telemedicine services must be performed by licensed practitioners within the scope of their practice.

  Please note: Humana Healthy Horizons does not reimburse for the costs or fees of any of the equipment necessary to provide services through telemedicine, including telecommunication equipment and services.

Providers are encouraged to contact their provider relations representative if they are offering or plan to offer these services to patients covered by Humana Healthy Horizons. If you have questions, please email your **provider relations representative**.

For more information, please refer to our **Telemedicine Quick Guide**.

Many telehealth platforms do not allow for an interpreter to participate. If this is the case with your telehealth platform, please call the **Humana Concierge Service for Accessibility**, to utilize Humana Healthy Horizons' secure doxy portal with the member, provider and interpreter. Please keep in mind that when using telemedicine with a disabled member, nothing can be downloaded to the member's phone.

Humana Healthy Horizons Comprehensive plan covered services

The Humana Healthy Horizons Comprehensive plan provides coverage for members who are enrolled in both the LTC and MMA programs. LTC coverage is limited to those services authorized in writing by the member's case manager and in accordance with the **Adopted Rules Service-Specific Policies website**. Covered services include:

Service	Description
Adult day care	The adult day care service provides Humana Healthy Horizons members with supervision, socialization and therapeutic activities in an outpatient setting and provides caregivers with respite. Meals are included as part of this service when the member is at the center during mealtimes. Adult day care health services include, but are not limited to, the following: • Basic health monitoring, including glucose level checks • Cognitive exercises • Coordination of transportation • Hands-on assistance with personal care, such as toileting, eating, ambulating and grooming • Lunch and snacks • Medication administration and management • Physical exercises • Referral to physical therapy screening (conducted on-site) • Supervised, recreational activities at least 80% of the day • Vital signs monitoring
Assisted living facility	The ALF service provides members with an alternative living arrangement where there is access to 24-hour staff in a home-like environment for members. Meals, personal care and housekeeping services are provided by the staff, and the facility may be used for respite care. The ALF provides members with the following services as indicated in each individual provider contract: • 24-hour access to staff • 3 meals per day, plus snacks • Alarmed doors or locked unit • Bathing assistance • Dementia care • Emergency/disaster planning • Escort to dining room • Housekeeping • Incontinence management • Incontinence supplies • Medication management • Nutritional supplements • Personal hygiene items • Personal laundry and linen service • Transportation or coordination of transportation • Utilities

Service	Description
Assistive care	Assistive care offers 24-hour services for members in ALFs, AFCHs and residential treatment facilities. Services include: • 24-hour access to staff • 3 meals per day, plus snacks • Assistance with ambulation • Assistance with eating • Assistance with transferring • Dementia care • Dressing and grooming • Emergency/disaster planning • Escort services • Housekeeping • Incontinence management • Medication management • Personal laundry and linen services • Transportation • Utilities • Wander guard
Behavioral management	The behavioral management service provides behavioral healthcare services to help address mental health or substance use needs of LTC members. These services are used to maximize reduction of the member's disability and restoration to the member's best functional level.

Service	Description
Consumable medical supplies	The consumable medical supplies service provides members and caregivers with supplies that assist in meeting members' needs. Items include incontinence supplies and diabetic supplies not covered by Medicare. These services do not include personal toiletries, over-thecounter medications or household items. Consumable medical supplies also include adult disposable diapers, tubes of ointment, cotton balls and alcohol for use of injections, medicated bandages, gauze and tape, colostomy and catheter supplies, and other consumable supplies. Supplies covered under home health service, personal toiletries and household items, such as detergents, bleach, paper towels or prescription drugs, are not included. These services require written authorization from the member's Humana Healthy Horizons Comprehensive plan case manager. Supplies are delivered to the member's home, and the member or caregiver signs an itemized receipt. Members must work with their case manager to make changes to an order. Nutritional supplements require both a provider's prescription and PA from the Humana Healthy Horizons Comprehensive plan case manager. Members authorized to live in a contracted facility receive this service directly from the facility.
Durable medical equipment	DME is medical equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful in the absence of illness or injury, and is appropriate for use in the member's home. Medicare and Medicaid acute-care programs cover most DME that Humana Healthy Horizons Comprehensive plan members need. Items needed by Humana Healthy Horizons Comprehensive plan members that are not covered by Medicare require PA from the member's Humana Healthy Horizons Comprehensive plan case manager.
Home accessibility adaptation services	The home accessibility adaptation services benefit provides Humana Healthy Horizons members with home modifications that promote safety. This includes the installation of the following to accommodate the medical equipment and supplies necessary for the member's welfare: • Grab bars • Ramps and widening of doors • Modification of bathroom facilities These services exclude home modifications that may be considered home improvements. All services must be provided in accordance with applicable state and local building codes. Members or caregivers will be contacted within 2 business days of receipt of authorization from the Humana Healthy Horizons Comprehensive plan case manager to schedule an appointment.

Service	Description
Home healthcare	Providers contracted with the Humana Healthy Horizons Comprehensive plan must adhere to the following procedures when providing services: • Humana Healthy Horizons reserves the right to determine the plan of care for its members and sends a request of specific services and frequency to meet the member's needs. • Services may be provided in a member's home or an ALF on an hourly or per-visit fee as authorized by Humana Healthy Horizons. • After a case manager's initiation of care coordination with a home health provider, the provider has 2 hours to inform the plan if they can staff the case. After notification from the provider that they are unable to staff services for the member, the case manager counsels the member on which providers are available and seeks coordination with the new provider of a member's choice. • HHC staff are required to have AHCA's designated form signed by the Humana Healthy Horizons member verifying that the services were provided at the time of each visit, including the date and time of service and direct care staff who provided the service. • In compliance with the 21st Century CURES Act, providers are required to utilize EVV to electronically monitor, track and confirm services provided in the home setting. • If a Humana Healthy Horizons Comprehensive plan member is entitled to Medicare home health benefits, these benefits are utilized prior to services being authorized under your contract with the Humana Healthy Horizons Comprehensive plan. • Missed visits are to be documented with EVV and reported within a 3-hour window from when services are to be rendered. Home health services are authorized by the member's case manager on a weekly basis (Sunday through Saturday). PA is required by the case manager to provide services that exceed the number of hours authorized in a day or in a week. The only variation that is allowable without PA is a switch in the days of services within the same week, with PA of the member. If the schedule change is permanent, you should inform the member's case manager of the change. Please see the **home health services table in this provider handbook** for more details.

Service	Description
Home-delivered meals	The home-delivered meal service provides nutritionally sound meals to members who are unable to shop or cook. Meals are delivered to the home hot, cold, frozen, dried or canned, with a satisfactory storage life. Each meal is designed to provide a third of the recommended dietary allowance for caloric intake. A signature must be obtained from the member or caregiver on meal delivery. Members can coordinate changes to their meal delivery through their case manager.
Hospice	The hospice benefit provides forms of palliative medical care and services designed to meet the physical, social, psychological, emotional and spiritual needs of terminally ill members and their families. Case managers coordinate hospice care with members enrolled in Medicare hospice services. If a Humana Healthy Horizons member requires any hospice service traditionally covered by Medicaid, PA may be required from the case manager. Humana Healthy Horizons members can be simultaneously enrolled in the Humana Healthy Horizons Comprehensive plan and hospice. Medicaid hospice services require prior approval from Humana Healthy Horizons. Dual-eligible members may enroll in Medicare hospice. The case manager assists to coordinate services. Members or their representatives are required to contact the member's Humana Healthy Horizons Comprehensive plan case manager before enrolling in a hospice program.
Nutritional assessment/risk reduction	The nutritional assessment/risk reduction service provides Humana Healthy Horizons members with nutrition assessment, hands-on care, and guidance for members and their caregivers. Nutritional assessments are provided by dietitians, usually from a home health agency. Humana Healthy Horizons reserves the right to determine the plan of care for its members and sends a request for specific services and frequency to meet a member's needs. Services may be provided in a member's home or through ALFs on a 15-minute increment fee as authorized by Humana Healthy Horizons.

Service	Description
Personal emergency response system	PERS service includes the installation and service of an electronic device that enables members at high risk of institutionalization to secure help in an emergency. A PERS is connected to the member's phone and programmed to signal a response center once the help button is activated. The member also may wear a portable help button to allow for mobility. PERS services generally are limited to those members who live alone or are alone for a significant part of the day and who would otherwise require extensive supervision. Humana Healthy Horizons Comprehensive plan members should be trained on the use and monthly testing of the unit after installation and notify Humana Healthy Horizons via telephone or fax if the member utilizes the system. Medical alert system must be installed within 5 business days of receiving written authorization from a Humana Healthy Horizons Comprehensive plan case manager.
Quality enhancements	Quality enhancement includes education and/or community-based services that are coordinated by a Humana Healthy Horizons case manager to address concerns related to safety in the home and fall prevention, disease management, education on end-of-life issues, advance directives and domestic violence.
Skilled nursing facility services	SNF services are coordinated with a member's acute-care coverage. If members are dually eligible for Medicare and Medicaid, the Humana Healthy Horizons Comprehensive plan is responsible for coinsurance per the Medicaid crossover guidelines. Claims must be submitted with the Medicare EOB. SNF staff are expected to inform Humana Healthy Horizons Comprehensive plan staff of changes or concerns identified while providing services to members to ensure member needs are being met. Notification must be provided within 24 hours of a significant change in a member's healthcare needs. Providers should inform Humana Healthy Horizons Comprehensive plan staff of changes or concerns they identify while providing services to members to ensure the member's needs are met. This includes notification when a member is admitted to a hospital and/or moves into a Medicare or Medicaid hospice program. Medicaid hospice services require PA from Humana Healthy Horizons. Please see the **SNF services table in this provider handbook** for more details.

Service	Description
Transportation	All Humana Healthy Horizons Comprehensive plans contract with ALFs require the ALF to coordinate transportation for members. Humana Healthy Horizons Comprehensive plan members are eligible for transportation trips to LTC-covered services as authorized by Humana Healthy Horizons. Please contact the member's case manager for authorization approval. Humana Healthy Horizons members use their health plan ID card for all covered transportation services, including emergency transportation. Transportation for nonmedical appointments is offered but requires PA. Please contact the member's assigned Humana Healthy Horizons case manager for more details.

Home health services

Service	Description
Adult companion	Companions can perform tasks, such as meal preparation, laundry and shopping, while providing socialization for the Humana Healthy Horizons member. This includes light housekeeping tasks incidental to the care and supervision of the member. Services do not include hands-on nursing care or bathing assistance.
Family training	This service provides training to family members to promote safety while caring for the Humana Healthy Horizons member. This includes education regarding diabetes management, transferring an individual and how to use safety equipment properly.
Homemaker services	This service provides members with assistance with general household activities that include meal preparation, laundry and light housekeeping.
Occupational therapy	This service provides members with treatment to restore, improve or maintain impaired function regarding daily living tasks (e.g., using a fork, using a shower chair or cooking from a wheelchair).
Personal care	This service provides members with assistance with bathing, dressing, eating, personal hygiene and other activities of daily living. A personal care worker can do incidental housekeeping, such as making beds and cleaning up areas where they have performed services.
Physical therapy	This service provides members with treatment to restore, improve or maintain impaired function in regard to ambulation and mobility such as walking, transferring, or using a walker or wheelchair.
Respite care	This service provides caregivers with relief for short periods of time. Respite care may be provided by a home health agency, assisted living community or an SNF. Respite care is not a substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist.

SNF services

Service	Description
Custodial care	Humana Healthy Horizons members requiring the custodial care service must be assessed, and Humana Healthy Horizons must determine that the member can no longer live in a less restrictive setting. Members who receive approval for placement in a contracted SNF for custodial care are required to pay the facility a member responsibility amount based on their income, which is determined by DCF.
Respite care	Respite care provides caregivers with relief for short periods of time and may be provided by an SNF. Respite care is not a substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist.

Chapter 6: Case management

Contact information pertaining to case management

Contact name	Contact information	Hours of operation
Community management	Phone: **813-392-5303 (TTY: 711)**	Monday through Friday, 8 a.m. to 4:30 p.m., Eastern time
Humana Healthy Horizons in Florida MMA case management	Phone: **800-229-9880** (TTY: 711) Email: **FL_MMA_CM_Referrals@ humana.com**	Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time
HumanaBeginnings	Phone: **800-322-2758**	Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time
Member HRA completion	Phone: **800-611-1467**	Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time
Member/ provider services	Phone: **800-477-6931**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
NICU admissions	Phone: **855-391-8655** Email: **NICU@humana.com**	Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time

Complex case management

Complex case management is a service provided to Medicaid recipients by Humana Healthy Horizons nurses specially trained in case management. Their specialized focus is on members with complex medical needs. Management is designed to meet the medical and psychosocial needs of the member and varies depending on situation and severity. A multidisciplinary team approach is utilized to ensure the member needs are met and all efforts are made to improve and optimize member overall health and well-being. The case management program is optional, excluding those members in LTC case management. To refer Medicaid recipients and verify program eligibility, please contact Humana **Healthy Horizons in Florida MMA case management**.

Authorization of LTC services by case managers

If a member requires services, a case manager issues authorization for medically necessary covered services to a participating provider. Humana Healthy Horizons case managers assess the member's needs prior to ordering services.

Procedures for authorization of LTC services

After determining a member requires services from a facility or company, the case management team contacts the provider to inquire if the services can be provided and provides authorization. Authorization is valid for the time specified or otherwise indicated on the authorization notice. If dates of services are not established, the provider's staff is responsible for following up with the plan with the date that services begin.

- If a member must stop services for a short period of time (e.g., due to a hospitalization), the case management team faxes updated authorization to the provider.
- If a member no longer requires services from the provider, the case management team faxes a termination of services authorization notice to the provider.
- If a member requires an increase or decrease in services, the case management team faxes an updated authorization notice to the provider.

If you have questions or concerns about a member, please contact the member's Humana Healthy Horizons case manager.

Role of case managers

The role of case managers includes utilizing a person-centered care approach to develop a member's personal goals and preferences during the care planning process. Case managers perform assessment visits with members, which are centered around conducting a comprehensive assessment of the member's needs and current supports to develop a person-centered care plan. Members are encouraged to include anyone they would like present in the care planning process, during which the case manager discusses the member's needs, preferences and goals.

Case managers also assist the member with defining personal goals and aspirations, such as going back to school, enjoying a trip with friends, taking part in a dinner outing with family or acquiring desired living arrangements. In coordination with the case manager, the member and the member's authorized representative are required to develop, at a minimum, 2 goals specific to the member's situation and needs, as identified in the comprehensive assessment. Additionally, they work collaboratively to identify a personal goal that focuses on the member's well-being and things that help them feel motivated or happy. The case manager, member and the member's authorized representative also may develop a care goal that focuses on the member's medical or physical health.

The care goal reflects a current issue and/or barrier found during the comprehensive assessment. Care goals are required for members who wish to transition to a different living environment. Member goals are documented in the plan of care. Goals are prioritized by numeric rank. Priorities reflect the member's and caregiver's input, preferences and importance to the member. The case

manager assesses and documents the member's current ability to contribute towards the goal, how the member prefers to participate in the activity, potential challenges towards the member's achievement of the goal and resources available to assist member with meeting the goal in the plan of care. The case manager also documents the member's progress toward meeting the member's established goals after each contact with the member.

Humana Healthy Horizons case managers are available to work with members to coordinate referrals to community- based organizations and other services provided through interagency agreements.

Case management/care coordination services for members with HIV/AIDS

Humana Healthy Horizons' HIV/AIDS Specialty program oversees the case management for Medicaid recipients appropriate to the needs of persons meeting the HIV/AIDS Specialty product eligibility criteria. Humana Healthy Horizons' HIV/AIDS Specialty program works to improve the health outcomes for people with HIV and AIDS. The purpose of this specialized HIV/AIDS Specialty program is to assess needs/issues, develop goals and implement interventions for members who have complex medical needs/issues related to specific disease processes, high utilization of services, intensive health needs and/or who consistently access high level-of-care services. Humana Healthy Horizons' HIV/AIDS Specialty program is a member-focused program in which nurses help members learn how to control their disease by providing education, support, community resources and communication with their PCP and other specialists.

Humana Healthy Horizons' HIV/AIDS Specialty case manager is a licensed nurse with skills to classify, assess, monitor, evaluate and instruct members; to intervene when needed; and to document goals and outcomes for each member. Members eligible to enroll in Humana Healthy Horizons' HIV/AIDS Specialty program consist of those mandatory and voluntary members diagnosed with HIV or AIDS.

The HIV/AIDS Specialty program is intended to provide support and encouragement for members to speak with their healthcare practitioners about symptoms, conditions and treatment options specific to their needs. Humana Healthy Horizons informs practitioners about services offered to members with HIV/AIDS and how to use the HIV/AIDS Specialty program through this provider handbook, the **Humana Healthy Horizons provider education and training website**, provider updates and the new provider orientation. The HIV/AIDS Specialty program team works collaboratively with Humana Healthy Horizons, its network clinicians and licensed professionals to improve disease state outcomes and maximize individual member functioning. Components of the HIV/AIDS Specialty program include provider education on evidence-based clinical guidelines and telephonic and face-to-face member education with care coordination.

Case management/care coordination services for members with SMI

Humana Healthy Horizons' Serious Mental Illness (SMI) Case Management Program is a comprehensive and specialized service designed to oversee case management for Humana Healthy Horizons members who are living with severe and persistent mental health conditions. The goal of Humana Healthy Horizons' SMI Case Management Program is to improve the health outcomes for members with SMI by mitigating disease progression, reducing complications, preventing comorbidities, reducing potentially preventable events, improving quality of life and achieving cost savings to the member, Humana Healthy Horizons and the state. Your role in case management and care coordination services for members with SMI involves contributing to person-centered care plans, participating in multidisciplinary care teams, partnering with community-based organizations (including community mental health centers) and collaborating with Humana Healthy Horizons case managers.

In addition to community mental health centers, Humana Healthy Horizons collaborates with other community providers and resources to help support our members, including those enrolled in the SMI Specialty Plan, to ensure comprehensive treatment planning that address the member's medical and behavioral health needs.

For members enrolled in the SMI Specialty Plan, Humana Healthy Horizons collaborates with community mental health centers, behavioral health providers and other community resources to ensure appropriate and comprehensive treatment planning that address the member's medical and behavioral health needs.

Integrating medical and behavioral health services

Humana Healthy Horizons' approach to integrating behavioral health services and primary care includes the development of targeted partnerships, programs supporting provider mentorship, provider reimbursement and tailored provider training.

Evidence-based programs for children with intense behaviors

Humana Healthy Horizons partners with DCF to offer the following evidence-based programs for children with intense behaviors, when medically necessary:

- Homebuilders
- Motivational interviewing
- Multisystemic therapy
- Parent-child interaction therapy
- Functional family therapy
- Parents as teachers
- Brief strategic family therapy

- Healthy families
- Nurse family partnership

Medicaid chronic disease management program

The Medicaid chronic disease management program provided by Humana Healthy Horizons pursues the following goals:

- Improving member understanding and assisting self-management of their disease with education and support while following their PCP's plan of care
- Helping members maintain optimal disease management and mitigating potential comorbidities using interventions to influence behavioral changes
- Increasing member compliance and disease-specific knowledge with their plan of care via mailed materials, recommended websites and newsletters
- Ensuring timely medical/psychological visits and appropriate utilization of access to care, including the use of HHC services
- Locating and facilitating the use of community-based resources that meet members' medical, psychological and social needs
- Developing routine reporting and feedback loops that may include communications with members, providers, health plans and ancillary providers via telephonic contact and secure fax progress notes
- Providing proactive health promotion education to increase awareness of the health risks associated with certain personal behaviors and lifestyles
- Evaluating clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall population health of disease management program members

For LTC, Humana Healthy Horizons offers chronic disease management program interventions for the chronic conditions listed below: • Cancer and cancer prevention

- Chronic obstructive pulmonary disease (COPD)
- Dementia and Alzheimer's
- Depression and depression prevention (including suicide prevention)
- Diabetes and diabetes prevention
- End-of-life issues/advance directives
- HIV/AIDS and HIV prevention
- Hypertension

Chronic disease management case managers with a nursing license are selected based on demonstrated skills in classifying, assessing, monitoring, evaluating, instructing, intervening and documenting goals and outcomes of MMA members with:

- Anxiety disorders
- Asthma

- Attention deficit hyperactivity disorder (ADHD)
- Bipolar disorder
- Cancer and cancer prevention
- Cardiovascular disease
- Chronic kidney disease
- COPD
- Dementia
- Depression and depression prevention (including suicide prevention)
- Diabetes and diabetes prevention
- End stage renal disease (ESRD)
- HIV/AIDS
- Hypertension
- Osteoporosis
- Parkinson's disease
- Sickle cell disease
- Substance use disorders

Member eligibility is based on diagnosis of 1 or more of these diseases. The disease management program provides services including but not limited to the following:

- Evaluating member needs affecting control of their disease such as physical limitations, mental health effects, transportation difficulties and environmental needs
- Developing self-management goals and plans of care considering members' health history, psychosocial assessment, providers' plan of care and member needs
- Educating members about their diagnosis and potential treatment modalities
- Referring members to internal and external programs
- Supporting members and providers regarding diagnosis, plans of care and other health-related concerns
- Educating and assisting members about reaching disease-specific diet and exercise goals
- Educating members about recommended health checks

Members may contact their provider to request a disease management program referral, or they may call **Humana Healthy Horizons in Florida MMA case management** to self-refer. Referrals also are generated by claims data, on-site and telephonic nurses after discharge, PCPs, internal and external programs, and community partners. To obtain more information about the program, refer a member, provide feedback or file a complaint for disease management, please contact **Humana Healthy Horizons in Florida MMA case management**.

Enrollment and disenrollment from this program are voluntary.

Community resources

Humana Healthy Horizons Community Navigator

Our **Humana Healthy Horizons Community Navigator®** powered by FindHelp connects members and caregivers in need with local community programs and services including our Humana Healthy Horizons CPIO. Our navigator is a tool that makes it easy for people with social needs to find community resources. These programs provide help with food resources, utility services, housing support, education, jobs and more.

Humana Healthy Horizons community resource team

The Humana Healthy Horizons community resource team helps connect members and caregivers with health-related social needs to community resource programs and supports including our Humana Healthy Horizons CPIO. These programs and services provide help with food resources, utility services, housing support, education, jobs and more. Contact **community management** for more information.

Chapter 7: Provider complaints

Contact information pertaining to provider complaints

Contact name	Contact information	Hours of operation
Capitol Bridge	Florida's independent dispute resolution organization Phone: **800-889-0549** Email: **FLCDR@capitolbridge.com**	Monday through Friday, 8:30 a.m. to 9:30 p.m., and Saturday 8:30 a.m. to 5 p.m., Eastern time
Member/ provider services	Phone: **800-477-6931**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Overpayment notification	Address: Humana Healthcare Plans P.O. Box 931655 Atlanta, GA 31193-1655	
Provider complaint submission	Address: Humana Healthy Horizons Provider Correspondence P.O. Box 4601 Lexington, KY 40512-4601	

Filing provider complaints

All inquiries and complaints should be directed to **member/provider services** or your provider relations representative or contract specialist. Based on the type of issue or complaint, your inquiry is reviewed by a Humana Healthy Horizons associate with the designated authority to resolve your issue or complaint.

A provider complaint may be filed verbally or in writing.

Verbal complaint	Written complaint
A Humana Healthy Horizons customer service specialist (CSS) receives the initial call and attempts to resolve any issues or concerns at the time of the call If the provider requests to file a complaint, the CSS will immediately log the details in the database, document the verbal acknowledgement given to the provider and transfer the complaint to the provider complaint resolution team After the CSS receives a complaint that does not involve claims, the provider complaint resolution team thoroughly investigates each complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying the plan's written policies and procedures The provider complaint resolution team contacts the provider and/or provider's office to research and resolve the issue within 90 calendar days of receipt Every 30 calendar days, a written status report is sent to the provider until the issue is resolved A written notice of the disposition and the basis of the resolution is sent to the provider within 3 business days of resolution	Providers can submit written complaints to provider complaint submission. Providers have 45 calendar days to file a written complaint for issues that are not related to claims.

Provider complaint Q&A

Time frames for filing a claims complaint or reconsideration are listed in the table that follows.

Question	Answer
How do I submit a complaint?	Written complaints can be submitted via mail to **provider complaint submission**. Verbal complaints can be submitted by calling **member/providerservices**.
What is the time frame for complaint submission?	Claims-related complaints must be submitted within 90 calendar days of the date of the final determination of the primary payer. Complaints unrelated to claims must be submitted within 45 calendar days of the date the issue occurred.

Question	Answer
What communication can be expected?	Written complaints: • Acknowledgement letter sent within 3 business days of receipt of the complaint • Status letters sent on the 30th day and every 30 calendar days until resolved • Disposition letter, within 3 business days of resolution Verbal complaints: • Verbal acknowledgement at the time of receipt of the call • Status letters, sent on the 30th day and every 30 calendar days until resolved • Disposition letter, within 3 business days of resolution
What is the resolution time frame?	Claims-related complaints: Within 60 calendar days of receipt of the complaint, unless the claim is under active review by a mediator, arbitrator or third-party dispute entity Complaints unrelated to claims: Within 90 calendar days of complaint receipt
What is the time frame for overpayment claim submissions?	Providers must report to Humana Healthy Horizons when they have received an overpayment within 60 calendar days of the date on which the overpayment was identified and must notify Humana in writing of the reason for the overpayment as required by 42 CFR 438.608(d)(2), to be mailed to **overpayment notification**.

Chapter 8: Member grievance and appeal

Contact information pertaining to member grievance and appeal

Contact name	Contact information	Hours of operation
Medicaid Fair Hearing requests	Address: Agency for Healthcare Administration Medicaid Hearing Unit P.O. Box 7237 Tallahassee, FL 32314-7237 Phone: **877-254-1055 (TTY: 866-467-4970)** Fax: **239-338-2642** Email: **MedicaidHearingUnit@ahcamyflorida.com**	Monday through Friday, 8 a.m. to 5 p.m., Eastern time
Member grievance and appeal requests	Address: Humana Healthy Horizons P.O. Box 14546 Lexington, KY 40512-4546	
Member urgent or expedited appeals	Phone: **888-259-6779**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Member/ provider services	Phone: **800-477-6931**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time

Member grievance and appeal overview

Member grievance and appeal procedures are set forth in the Humana Healthy Horizons Member Handbook. These procedures are included here for your convenience to better assist Humana Healthy Horizons members in this process. Please contact your contract specialist if you have questions about the member grievance and appeal process.

Humana Healthy Horizons representatives handle all member grievances and appeals. A special set of records is kept with the reason, date and results of each grievance and appeal. Humana Healthy Horizons keeps these records in its central office.

Term	Definition
Complaint	Any oral or written expression of dissatisfaction by a member submitted to Humana Healthy Horizons or to a state agency and resolved by close of business the following business day
Grievance	An expression of dissatisfaction about any matter other than an adverse benefit determination
Appeal	A formal request from a member to seek a review of an adverse benefit determination made by Humana Healthy Horizons pursuant to 42 CFR 438.400(b)
Medicaid Fair Hearing	An administrative hearing conducted by AHCA to review an action taken by Humana Healthy Horizons that limits, denies or stops a requested service
AOR	An AOR is a form signed by the member allowing someone to act on their behalf during the grievance or appeal process. The member can appoint a relative, friend, advocate, attorney or a provider to act on the member's behalf.
Expedited appeal process	The process by which the appeal of Humana Healthy Horizons' adverse benefit determination is accelerated when the standard time frame for resolution of the appeal could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function.
Notice of adverse benefit determination	Humana Healthy Horizons gives the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested or currently authorized under the fee-for-service (FFS) delivery system or from the member's immediate former managed care plan at the time of the member's transition into Humana Healthy Horizons. Humana Healthy Horizons provides the member with a written notice of adverse benefit determination for any service authorization decisions using the template provided by AHCA.

Member complaints

A complaint is a subcomponent of the member grievance system. Possible subjects for complaints include, but are not limited to:

- The quality of care provided
- The quality of services provided

- Aspects of interpersonal relationships such as the rudeness of a provider or a Humana Healthy Horizons employee
- Failure to respect the member's rights
- Managed care plan administration
- Claim practices
- Provision of services that relate to the quality of care rendered by a provider pursuant to Humana Healthy Horizons' contract

If a member calls with a complaint and it remains unresolved by the close of business the next day, Humana Healthy Horizons will automatically initiate the grievance process.

Submitting a member grievance or appeal

Filing a grievance

Members may file a grievance at any time when they are dissatisfied with Humana Healthy Horizons or any aspect of their care. A member may file an appeal if the member disagrees with an adverse benefit decision. Members can file a complaint, grievance or appeal by contacting **member/provider services**. Questions and concerns about grievances can also be addressed via **member/provider services**.

Members calling on weekends or holidays or after hours for an urgent/expedited appeal are asked to leave a voicemail. The member will receive a call back from Humana Healthy Horizons by the end of the following day to address the expedited appeal.

Members can mail written grievance or appeal requests to **member grievance and appeal requests**. Members may also request assistance from **member/provider services** when completing the grievance and appeal request form.

All Humana Healthy Horizons member grievances and appeals are considered. Members may have someone represent them during the grievance or appeal process, either a provider or an authorized representative, with written consent.

The grievance or appeal request should include the following:

- The member's name, address, telephone number and ID number
- Facts and details about the issue
- What action would resolve the grievance or appeal
- The member's signature
- Date

Florida Medicaid grievance first-level review

Humana Healthy Horizons members have the right to submit a written or verbal grievance. The grievance process may take up to 30 calendar days. Humana Healthy Horizons resolves the member's grievance as quickly as the member's health condition requires. A grievance outcome letter is sent to the Humana Healthy Horizons member within 30 calendar days of the date the grievance is received.

Humana Healthy Horizons members can request an extension of 14 calendar days, if needed. Humana Healthy Horizons may also request an extension if additional information is needed and the extension is in the member's best interest. Humana Healthy Horizons sends notice of the extension to the member with details regarding any needed information and how the member's best interest is served by the additional time.

Florida Medicaid grievance first-level review Q&A

Question	Answer
In what manner may the grievance be submitted?	Verbally or in writing
What is the time frame to submit the grievance?	Unlimited
Is an AOR required?	Yes, unless the request is filed by the member
Is an acknowledgment of the grievance required?	Yes, within 5 business days of receipt
What is the resolution time frame?	No later than 30 calendar days after receipt

Filing an appeal

Humana Healthy Horizons members must file their appeal either verbally or in writing within 60 calendar days of the date on the notice of adverse benefit determination. The date of the oral request is considered the date of receipt.

Humana Healthy Horizons resolves the appeal as quickly as the member's health condition requires. A letter explaining the outcome of the appeal is sent to the member within 30 calendar days from the date Humana Healthy Horizons receives the request. Members can request an extension of 14 calendar days, if needed. Humana Healthy Horizons can also request an extension if additional information is needed and the extension is in the member's best interest.

Humana Healthy Horizons informs the member of any extra time needed to make a decision, what additional information is needed and why it is in the member's best interest.

Filing an appeal Q&A

Question	Answer
In what manner may the appeal be submitted?	Verbally or in writing
What is the time frame to submit the appeal?	Within 60 calendar days from the date of the notice of adverse benefit determination

Question	Answer
Question	Answer
Is an AOR required?	Yes, unless the request is filed by the member
Is an acknowledgment of the appeal required?	Yes, within 5 business days of the appeal receipt
What is the decision notification method?	Written
What is the decision time frame?	Appeal determinations will be rendered as expeditiously as the member's health condition requires but no later than 30 calendar days from receipt, whether received verbally or in writing.

Expedited appeal first-level review

Humana Healthy Horizons members have the right to request an expedited verbal or written appeal. If there is a problem that puts the member's life or health in danger, the member or the member's authorized representative can file an urgent or expedited appeal, which is resolved within 48 hours. When making an appeal, the member or member's authorized representative must let Humana Healthy Horizons know it is an urgent or expedited appeal. An urgent or expedited appeal may be requested by calling **member urgent or expedited appeals**. If Humana Healthy Horizons determines an expedited process is not required, the appeal is processed within the standard resolution time frame.

Humana Healthy Horizons does not discriminate against providers or take punitive action against a provider who requests an expedited resolution or supports a member's appeal.

Expedited appeal first-level review Q&A

Question	Answer
In what manner may the expedited/urgent appeal be submitted?	Verbally or in writing
What is the time frame to submit the expedited/urgent appeal?	Within 60 calendar days of the date of the notice of adverse benefit determination
Is an AOR required?	Yes, unless the request is filed by the member
Is an acknowledgment of the expedited/urgent appeal required?	Yes, prompt oral acknowledgment is provided following receipt of the appeal
What is the decision time frame?	As expeditiously as the member's health condition requires, not to exceed 48 hours after receipt, whether the request was submitted verbally or in writing

Medicaid Fair Hearings

If a member is not happy with Humana Healthy Horizons' appeal decision, the member can request a Medicaid Fair Hearing orally or in writing. A member may only seek a Medicaid Fair Hearing after exhausting Humana Healthy Horizons' internal appeal process. The Humana Healthy Horizons member has 120 calendar days from the date on the appeal resolution letter to request a Medicaid Fair Hearing. More information about **Medicaid Fair Hearings** is available online on the **AHCA portal**.

A member, the member's authorized representative or a provider acting on behalf of the member with the member's written consent can submit a request for a Medicaid Fair Hearing by contacting **Medicaid Fair Hearing requests**.

Continuation of benefits

Humana Healthy Horizons members have the right to request to continue receiving benefits during an appeal or a Medicaid Fair Hearing. Members can request continued benefits by calling **member/provider services**. The member has the right to review the case before and during the appeal process.

While the Medicaid Fair Hearing or appeal is pending, Humana Healthy Horizons continues paying the member's benefits if all the following conditions are met:

- The member or the member's authorized representative filed the appeal or Medicaid Fair Hearing request within 10 calendar days of the date on the notice of action, or on or before the intended effective date of the action, whichever is later
- The member or the member's authorized representative requests continuation of benefits
- 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 appeal or Medicaid Fair Fearing decision is not in the member's favor, the member may be required to pay for services rendered during this time.

Chapter 9: Credentialing and recredentialing

Contact information pertaining to credentialing

Contact name	Contact information	Hours of operation
Credentialing	Address (reconsideration requests): Humana Dr. Shoba Srikantan, M.D. Regional Medical Director 101 E. Main Street Louisville, KY 40202 Email (inquiries): **CredentialingInquiries@humana.com**	
Member/ provider services	Phone: **800-477-6931**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time

Organizational credentialing and recredentialing

The organizational providers to be credentialed and recredentialed include, but are not limited to, the following:

- Behavioral health facilities providing mental health or substance use services in an inpatient, residential or ambulatory setting
- Diabetes education
- Dialysis centers
- FQHCs
- Free-standing ambulatory surgery centers
- Free-standing birthing centers
- Home health agencies
- Hospice providers
- Hospitals
- Pharmacies

- Physical, occupational therapy and speech-language pathology (PT/OT/SLP) facilities • Portable X-ray suppliers
- Rehabilitation hospitals (including outpatient locations)
- RHCs
- SNFs
- Urgent care clinics

When credentialing organizational providers, Humana Healthy Horizons assesses the following elements:

- Completion of a signed and dated application; signature not more than 180 business days old
- Organization is in good standing with:
  - Medicaid agencies
  - Medicare program
  - HHS-OIG
  - GSA (formerly EPLS)
- Organization has been reviewed and approved by an accrediting or certification body
  - If not accredited or certified, a site survey was conducted by a state agency
  - If not accredited, certified or surveyed by a state agency, Humana Healthy Horizons conducts a site survey
- Copy of facility's state license, as applicable
- CLIA certificates are current, as applicable
- Active and valid Florida Medicaid ID number
- NPI, as verifiable via the National Plan and Provider Enumerator System
- Disclosure of ownership

Providers are informed of the credentials committee's decision within 60 business days of the committee meeting. Recredentialing occurs at least every 3 years. Some circumstances require shorter recredentialing cycles.

Humana Healthy Horizons Network Operations/Credentialing collects Florida Medicaid numbers for all Medicaid-contracted providers at initial credentialing. Medicaid numbers are loaded into the credentialing system.

Effective June 1, 2026, providers contracted with Humana Healthy Horizons who join an in-network group not delegated for credentialing will have a network effective date 30 days after the day Humana Healthy Horizons receives notification and a clean credentialing application, if applicable. Claims submitted for members seen before the network effective date will generally be paid at an out-of-network rate.

CAQH application

Humana Healthy Horizons is a participating organization with CAQH, a nonprofit alliance of leading health plans, networks and trade associations. A catalyst for positive change, CAQH members collectively develop and implement administrative solutions that produce meaningful, concrete benefits for physicians, allied health professionals, their staff, members and plans. Humana Healthy Horizons requires use of CAQH ProView® for gathering credentialing information for all network providers.

Be sure to include your CAQH provider ID number when submitting credentialing documents. It is essential that all documents are complete and current. Please include copies of the following documents:

- Current malpractice insurance face sheet
- A current DEA certificate
  - All buprenorphine prescribers must have an "X" DEA number.
- Explanation of any lapse in work history of 6 or more months
- CLIA certificate, as applicable
- ECFMG, if you have a foreign medical degree
- If you are acting as a PCP, attestation that your total member load is not more than 3,000 members
- Disclosure of ownership, as applicable

Failure to submit a complete application may result in a delay in Humana Healthy Horizons' ability to complete or begin the credentialing process. You can confirm Humana Healthy Horizons' access to your credentialing application by completing the following steps:

1. Sign in to the **CAQH website** utilizing your individual account information.
2. Select the Authorization Tab.
3. Confirm Humana Healthy Horizons is listed as an authorized health plan.
   a. If Humana Healthy Horizons is not listed as an authorized health plan, please select the authorized box to add the plan to your profile.

Credentialing committee

The credentialing committee is overseen by a Humana Healthy Horizons CMO and is responsible for making determinations for all credentialing and recredentialing decisions. The credentials committee meets monthly and is comprised of participating providers in both primary care and specialty disciplines, including behavioral health, pharmacy and midlevel practitioners. The credentialing committee has the responsibility to establish and adopt, as necessary, criteria for provider participation and termination. The committee also directs credentialing procedures, including provider participation, denial and termination. Failure of an applicant to adequately respond to a request for assistance may result in termination of the application process.

Initial credentialing

Providers seeking participation with Humana Healthy Horizons must complete an application with required documentation and a signed contract. You are required to maintain active status with licensure and insurance coverage and provide proper documentation annually as documents expire. It is also required that Humana Healthy Horizons be immediately notified of changes in your licensure, status of insurance coverage, disciplinary actions and/or ownership.

Humana Healthy Horizons' credentialing review includes, but is not limited to, the following criteria:

- Completion of a signed and dated application, signature not older than 180 calendar days
- Copy of current provider's medical license or occupational or facility license as applicable to provider type, or authority to do business, including documentation of provider qualification as outlined by the governing agency
- No revocation, moratorium or suspension of license
- A satisfactory level II background check pursuant to guidelines for all treating providers not currently enrolled in Medicaid's FFS program
- Employer background screening affidavit of compliance with § 435.05(3) Fla. Stat.
- Medicaid ID number or Medicaid provider registration number for enrollment by state Medicaid program for compliance with data submission
  - Humana Healthy Horizons takes necessary steps to ensure that a provider's business is recognized by the state Medicaid program, including its enrollment broker, as a participating provider. It also takes the steps necessary to ensure that a provider's submission of encounter data is accepted by Florida's MMIS and/or the state's encounter data warehouse.
- Certificate of insurance
  - Proof of general liability, professional liability (as applicable)
  - Proof of workers' compensation (as applicable)
  - Humana Healthy Horizons comprehensive plan listed as notify agent or certificate holder on the certificate of insurance
- Licensure inspection/AHCA survey as applicable
- W-9 indicating taxpayer identification number
- Disclosure of ownership addendum
- NPI
- CLIA certification, as applicable
- Provider Abuse, Neglect & Exploitation Questionnaire

Site visits

HCBS setting assessments—National Network Operations/Credentialing Operations verifies that ALFs, AFCHs and adult day home cares (ADHCs) meet the requirement for offering a home-like environment and community inclusion characteristics as defined by the state of Florida. The AHCA prescribed **HCBS Setting Assessment Tool** is available online.

Other site visits are performed as deemed necessary. When credentialing and recredentialing a nursing facility provider, Credentialing Operations reviews the facility's performance using the measures as provided on the **CMS nursing home compare website**.

Recredentialing

Network providers, including practitioners, organizational providers and LTC providers, are recredentialed at least every 3 years. As part of the recredentialing process, Humana Healthy Horizons considers information regarding performance to include complaints, safety and quality issues collected through the QI program. Additionally, information regarding adverse actions is collected from the NPDB, Medicare and Medicaid sanctions list, CMS Preclusion list, the HHS/OIG and GSA (formerly EPLS), and limitations on licensure. A notification is sent to the provider for reverification of credentialing. All network providers must submit updated documents as they expire. Failure to provide updated documentation may delay payment. A provider's agreement may be terminated at any time if it is determined the credentialing requirements are no longer being met or the provider fails to complete the recredentialing process.

Provider rights in the credentialing process

Providers have the right to review, on request, information submitted to support their credentialing application to the Humana Healthy Horizons credentialing department. Humana Healthy Horizons 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.

Providers have the right to correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the credentialing department prior to presentation to the credentialing committee. If information obtained during the credentialing or recredentialing process varies substantially from the application, the provider is notified and given the opportunity to correct information prior to presentation to the credentialing committee.

Providers have the right to be informed of the status of their credentialing or recredentialing application on written request to the credentialing department.

Provider responsibilities in the credentialing process

Humana Healthy Horizons providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. Humana Healthy Horizons initiates immediate action in the event participation criteria are no longer met. You are required to inform Humana Healthy Horizons

of changes in status, including, but not limited to, being named in a medical malpractice suit, involuntary changes in hospital privileges, changes in licensure or board certification, the occurrence of an event reportable to the NPDB, imposition of federal, state or local sanctions, or complaints.

Disclosure of ownership addendum for participation with Humana health plans

Humana Healthy Horizons Network Operations/Credentialing Operations collects full and accurate disclosure of any financial or ownership interest the provider, or any principal, partner or major shareholder thereof, may hold in any other Medicaid provider or healthcare-related entity or any other entity that is licensed by the state to provide health or residential care and treatment to persons.

Minority recruitment and retention plan

Humana Healthy Horizons makes every effort to recruit and retain providers of all ethnicities to support the cultural preferences of its members. Humana Healthy Horizons provider networks are open to review new provider participation, assuming provider willingness to accept contractual requirements, contractual rates, and satisfy all credentialing and regulatory requirements. Humana Healthy Horizons reviews and accommodates all provider nomination requests, when appropriate, from both members and providers to ensure all providers are equally represented in Humana Healthy Horizons' provider network.

As part of this process, Humana Healthy Horizons collects and publishes spoken languages in **Find a Doctor**, Humana's online provider directory. Please be sure to accurately indicate all languages spoken in your office on your Humana Healthy Horizons recredentialing application and/or CAQH application, or contact your provider relations representative to request updates.

Humana Healthy Horizons gathers information on the languages in which healthcare providers are fluent, particularly concerning their ability to communicate medical care effectively. This includes details about language services offered through the practice. Additionally, Humana Healthy Horizons gathers data on race, language skills and ethnicity of providers. Providing this information is entirely voluntary.

Practitioner office site evaluation tool

Network Operations, or an agent thereof, performs periodic office site reviews on all Medicaidcontracted PCPs and OB- GYNs using the Humana Site Visit Tool. Verification includes ensuring the statewide consumer call center telephone number, summary of Florida members' bill of rights and responsibilities, and consumer assistance notice are posted in the office. Credentialing verifies site visits are completed at initial credentialing and recredentialing.

Medicaid attestation for PCPs

Network Operations/Credentialing Operations collects a signed Medicaid attestation from all Medicaid-contracted PCPs stating the total active member load is no more than 3,000 members per PCP.

Level II background screening

Credentialing performs a satisfactory Level II background check, pursuant to §.409.907, Fla. Stat., for all treating providers not currently enrolled in Medicaid's FFS program. Credentialing may verify the provider's Medicaid eligibility through the AHCA electronic background screening clearinghouses, more information about which can be found on the **AHCA website**.

Sanctions and exclusions

Humana Healthy Horizons does not contract with providers who have a record of illegal conduct as identified in § 435.04, Fla. Stat. Credentialing reports providers suspended or terminated from Humana Healthy Horizons to the appropriate authorities (e.g., NPDB, OIG, GSA and the state licensing board).

Credentialing conducts regular license monitoring for all Medicaid-contracted providers to verify active licensure. Credentialing reviews sanction information for any individual/entity identified below:

- **Online list of excluded individuals and entities maintained by OIG**
- **Online list of state Medicaid agency sanctions**
- **Online list of GSA exclusions**

Delegation of credentialing/recredentialing

Humana Healthy Horizons only enters into agreements to delegate credentialing and recredentialing if the entity that wants to be delegated or their CVO is accredited by NCQA or adheres to NCQA standards and successfully passes a predelegation audit demonstrating compliance with NCQA and federal and state standards and requirements. A predelegation audit must be completed prior to entering into a delegated agreement. All preassessment evaluations are performed using the most current NCQA and regulatory requirements. At minimum, the following items are included in the review:

- Credentialing and recredentialing policies and procedures
- Credentialing and recredentialing committee meeting minutes
- Credentialing and recredentialing file review

Delegates must be in good standing with Medicaid and CMS. Reporting will be required from the delegated entity, which is defined in an agreement between both parties.

Reconsideration of credentialing/recredentialing decisions

Humana Healthy Horizons' credentials committee may deny a provider's request for participation based on credentialing criteria. The credentials committee notifies you of a denial that is based on credentialing criteria and provides the opportunity to request reconsideration of the decision within 30 calendar days of the notification. Reconsideration opportunities are available to you if you are

affected by an adverse determination. To submit a reconsideration request, submit the request to the senior medical director in writing and include any additional supporting documentation. Mail the reconsideration request to **credentialing**.

Applying providers do not have appeal rights. However, you may submit additional documents to **credentialing** for reconsideration by the credentialing committee. After reconsideration, the credentialing committee may affirm, modify or reverse its initial decision. Humana Healthy Horizons notifies you in writing of the credentialing committee's reconsideration decision within 60 calendar days.

Reconsideration denials are final unless the decision is based on quality criteria, in which case you have the right to request a Medicaid Fair Hearing. Providers who have been denied are eligible for reapply for network participation once they meet the minimum credentialing criteria.

ARNP and physician assistant services

Humana Healthy Horizons covers services rendered by ARNPs and physician assistants. Services may be rendered in the provider's office, the member's home, a hospital, a nursing facility or other approved place of service as necessary to treat a particular injury, illness or disease.

ARNPs are licensed and work in collaboration with practitioners pursuant to Chapter 464, Fla. Stat. according to protocol, to provide diagnostic and interventional member care.

Physician assistants are certified to provide diagnostic and therapeutic member care and be fully licensed as a physician assistant as defined in Chapter 458 or 459, Fla. Stat. The services must be provided in collaboration with a practitioner licensed pursuant to Chapter 458 or 459, Fla. Stat.

Humana Healthy Horizons complies with provisions of the Medicaid Physician Practitioner Services Coverage and Limitations Handbook available via the **Florida Medicaid web portal**. In no instance will the limitations or exclusions imposed by Humana Healthy Horizons be more stringent than those in the Medicaid Physician Practitioner Services Coverage and Limitations Handbook available via the **Florida Medicaid web portal**.

In accordance with Section 1932(b)(7) of the Social Security Act (as enabled by Section 4704(a) of the 1997 Balanced Budget Act), Humana Healthy Horizons provides adequate assurances that it has the capacity to serve the expected Medicaid enrollment in that service area.

PCP member panels

Total member load for an FTE PCP cannot be greater than 3,000 active members for all healthcare entities and lines of business.

A full-time PCP in the Humana Healthy Horizons MMA plan may not have more than 2,400 CMME members enrolled in their panel. A Medicare member is equivalent to 3 non-Medicare members (1:3 ratio). A physician extender may increase the panel enrollment by an additional 1,200 CMME members.

The minimum standards for PCPs must be met to ensure adequate accessibility to all primary care services for all enrolled recipients of all ages. One FTE PCP is required per 1,500 HMO Medicaid members. The ratio may be increased by 750 HMO Medicaid members for every one physician extender (ARNP or physician assistant).

Provider monitoring

Humana Healthy Horizons monitors provider sanctions, monitors complaints and quality issues between credentialing cycles, and ensures corrective actions are taken to address occurrences of poor quality. Ongoing monitoring and appropriate interventions, including removal from the network, are implemented by collecting and reviewing the following information within 30 calendar days of its release:

- Medicare and Medicaid sanctions and exclusions, including AHCA Public Record Search available online
- LEIE/OIG
- EPLS/SAM
- Sanctions or limitations on licensure
- Complaints
- Identified adverse events

NPI

NPI is a unique government-issued standard 10-digit alphanumeric identifier mandated by HIPAA. Humana Healthy Horizons requires participating providers comply with this mandate, as appropriate. Please refer to the **CMS website** for additional information and assistance with applying for an NPI.

Florida Medicaid provider number

Training program compliance

You are expected to adhere to all training programs identified by the contract and Humana Healthy Horizons as compliance-based training. This includes agreement and assurance that all affiliated participating providers and staff members are trained on the identified compliance material.

As part of the training requirements, you must complete annual compliance training on the following topics:

- Humana Healthy Horizons provider orientation training
- Compliance and fraud, waste and abuse
- Cultural competency
- Health, safety and welfare (abuse, neglect and exploitation)

All new providers also receive Humana Healthy Horizons' provider orientation.

Providers also must complete annual required training on compliance and fraud, waste and abuse to ensure specific controls are in place for the prevention and detection of potential or suspected fraud and abuse, as required by § 6032 of the Federal Deficit Reduction Act of 2005.

Your contract specialist is available to provide an initial orientation within 30 calendar days of completion of the credentialing process. This orientation reviews Humana Healthy Horizons policies and procedures. These personalized meetings are scheduled at your convenience and include staff you would like to attend. Additional educational training can be scheduled any time by contacting your contract specialist.

Participating agreement standards

By signing a Humana Healthy Horizons contract, you are required to comply with all applicable federal and state laws and licensing requirements. Providers are required to maintain back-up procedures for absent employees to ensure services are not interrupted. Humana Healthy Horizons may exercise its options to terminate a participating provider from the provider network with the appropriate notice.

Chapter 10: Pharmacy

Contact information pertaining to pharmacy services

Contact name	Contact information	Hours of operation
CenterWell Pharmacy	Phone: **800-526-1490**	Monday through Friday, 8 a.m. to 6 p.m., Eastern time
Humana Clinical Pharmacy Review	Phone: **800-555-CLIN (800-555-2546)** Fax: **877-486-2621**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Humana Medication Intake team	Phone: **866-461-7273** Fax: **888-447-3430**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Member/ provider services	Phone: **800-477-6931**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time

Humana Healthy Horizons pharmacy network

If newly enrolled Humana Healthy Horizons members are using a pharmacy that is not in the Humana Healthy Horizons network, Humana Healthy Horizons continues to process their prescriptions for 90 calendar days during the continuity-of-care period. Prior to the end of the continuity-of-care 90-day time frame, Humana Healthy Horizons and its providers should educate members on how to access their drug benefit through Humana Healthy Horizons' participating pharmacy provider network.

Drug coverage

Humana Healthy Horizons and other health plans in the state are required to use a uniform PDL and UM, which are developed by AHCA. The PDL includes some preferred brands, as well as preferred diabetic supplies such as CGM (continuous glucose monitoring) devices, blood glucose test strips, lancets, meters, syringes, etc.

Utilization management

The PDL identifies covered drugs and associated drug UM requirements, such as PA, quantity limits, age limits, etc.

- **PA:** The medication must be reviewed using a criteria-based approval process prior to a coverage decision.
- **Drug safety limits:** Drug safety limits facilitate the appropriate, approved label use of various classes of medications (e.g., drug-to-drug interactions, opioid limits, therapeutic duplication).
- **Quantity limits:** AHCA implemented quantity limits for various classes of drugs to facilitate the appropriate, approved label use of these agents to help members obtain the optimal dose required for treating their conditions. If a member's medical condition warrants an additional quantity, the pharmacist should ask the prescriber to submit a request to HCPR.
- **Age limits:** AHCA implemented age limits for various classes of drugs to facilitate the appropriate, approved label use of these agents to help members receive age-appropriate care. If a member's medical condition warrants an exception to an age limit, the pharmacist should ask the prescriber to submit a request to HCPR.

You can review the **PDL online**.

Coverage limitations

The following is a list of noncovered (i.e., excluded from the Medicaid benefit) drugs and/or categories:

- Agents used for anorexia, weight gain or weight loss
- Agents used to promote fertility
- Agents used for cosmetic purposes or hair growth
- Drugs for the treatment of erectile dysfunction
- Drug Efficacy Study Implementation (DESI) drugs or drugs that were determined to be identical, similar or related
- Investigational or experimental drugs
- Agents prescribed for any indication that is not medically accepted
- Agents used for the symptomatic relief of cough and colds

PDL updates

Humana Healthy Horizons may add or remove drugs on the PDL throughout the year as directed by AHCA. We also may change our UM requirements for covered drugs. Examples include:

- Elect to require or not require PA
- Elect to change the quantity limits
- Add or change step therapy restrictions

- Add new guidance or clinical guidelines for a drug from the Food and Drug Administration (FDA)
- Add a generic drug new to the market

Please review the current formulary prior to writing a prescription to determine if the drug is covered. The PDL is updated regularly. The **current PDL** can be viewed online. To view current medical and pharmacy coverage policies, please view our **medical and pharmacy coverage policies online**.

Medications administered in the provider setting

Humana Healthy Horizons covers medications administered in a provider setting, such as a provider office, hospital outpatient department, clinic, dialysis center or infusion center. PA requirements exist for many injectables. Humana Healthy Horizons may add or remove drugs on the PAL throughout the year as directed by AHCA. The **current PAL** is available online. Medicaid providers may:

- Obtain forms on our **prior authorization for professionally administered drugs webpage**.
- Submit requests by:
  - Online (preferred) via **CoverMyMeds**
  - Fax the **Humana medication intake team**
  - Call the **Humana medication intake team**
- View the **provider prior authorization and notification lists**

Coverage determinations and exceptions

Providers may request coverage determinations, including medication PA, step therapy, quantity limits and formulary exceptions, via the following methods:

- Obtain forms on our **prior authorization for professionally administered drugs webpage**.
- Submit requests electronically via **CoverMyMeds**
- Submit requests by fax to **Humana Clinical Pharmacy Review (HCPR)**
- Call **Humana Clinical Pharmacy Review (HCPR)**

The coverage determination decision is based on medical necessity and is communicated within 24 hours of receipt of the request from the prescriber.

Over-the-counter program

Humana Healthy Horizons also offers an over-the-counter (OTC) program through **CenterWell Pharmacy**. This benefit is obtained exclusively through CenterWell Pharmacy.

The OTC program provides a maximum benefit of $50 per household per month for OTC items provided through CenterWell Pharmacy. There is no charge for shipping, and orders are shipped to the member's home by UPS Inc. or the U.S. Postal Service. Please allow 10 to 14 business days from when the order is received.

The OTC order form is available on request. More details are available in the **member handbook**.

Counterfeit-proof prescription pads

All Humana Healthy Horizons-participating prescribers are required to utilize a counterfeit-proof prescription pad.

Hernandez Settlement Agreement requirements

Humana Healthy Horizons ensures all participating pharmacy locations provide notice to a member when payment is denied for a prescription, in compliance with the Settlement Agreement to Hernandez, et al v. Medows (case number 02-20964 CivGold/Simonton) (HSA). An HSA situation arises when a member attempts to fill a prescription at a participating pharmacy location and is unable to receive the prescription as a result of:

- An unreasonable delay in filling the prescription
- A denial of the prescription
- The reduction of a prescribed good or service
- The expiration of a prescription

Humana Healthy Horizons maintains a log of all correspondence and communications from members relating to the HSA ombudsman process. Humana Healthy Horizons submits the ombudsman log report quarterly to AHCA.

Prescribing psychotropic medication to a child

Florida statute requires that providers have express and informed consent from a child's parent or legal guardian to prescribe a psychotropic (psychotherapeutic) medication to a child in the Medicaid program; a child is defined as an individual from birth until the individual's 13th birthday.

Psychotropic medications include:

- Antipsychotics
- Antidepressants
- Antianxiety medications
- Mood stabilizers

Anticonvulsants and ADHD medications (stimulants and nonstimulants) are not included at this time.

You must document the consent in the child's medical record and provide the pharmacy with a signed attestation of this documentation with the prescription. This attestation must be completed and presented to the pharmacy with every new prescription. A new prescription means every time a new prescription number is assigned and includes all new prescriptions including same drug/same dose prescriptions for continuing therapy. This does not replace PA requirements for medications not included on the PDL or previously authorized antipsychotics for children and adolescents from birth through 17 years old.

Prescriptions may be phoned in or emailed for these medications when the child is younger than 13. The pharmacist should obtain a completed consent form from the prescriber or guardian via fax or mail prior to dispensing.

For additional information, including a list of generic names of medications subject to the informed consent and a link to a variety of consent forms allowed, please visit the **behavioral health medication management resources website**.

Chapter 11: Utilization management

Contact information pertaining to utilization management

Contact name	Contact information	Hours of operation
Access Behavioral Health authorization support	Region A behavioral health authorization Phone: **866-477-6727** Email: **abhreferral@lifeviewgroup.org**	24 hours a day, 7 days a week
Authorization line	Phone: **866-856-8974**	24 hours a day, 7 days a week
Carelon authorization support	Regions B through I behavioral health authorization Phone: **800-397-1630** Email: **bh_cm@carelon.com**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Clinical intake team	Phone: **800-523-0023** Fax: **813-321-7220**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
HCPR	Phone: **800-555-CLIN (800-555-2546)** Fax: **877-486-2621**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Humana Medication Intake team	Phone: **866-461-7273** Fax: **888-447-3430**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
HumanaBeginnings	Phone: **800-322-2758**, extension 1500290 for HumanaBeginnings	Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time
Member/ provider services	Phone: **800-477-6931**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time

Contact name	Contact information	Hours of operation
NICU admissions	Phone: **855-391-8655** Email: **NICU@humana.com**	Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time
Utilization management	Phone: **800-223-6447**	

Utilization management program overview

Humana Healthy Horizons seeks to ensure its members receive the right medical care from the right provider at the right time. Humana Healthy Horizons works with practitioners and providers to deliver services that are correct and medically needed for a member's medical condition. UM decisionmaking at Humana Healthy Horizons is based only on appropriateness of care and service and existence of coverage.

- Humana Healthy Horizons does not specifically reward practitioners or other individuals for issuing denials of coverage.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

If you have questions or concerns related to UM, Humana Healthy Horizons staff are available by contacting the **clinical intake team**. Providers may also obtain copies of criteria used to make UM decisions by contacting **utilization management**. Language assistance is available at no cost. Clinical rationale or criteria used in making adverse UM determinations are available upon request by contacting **utilization management**.

Relevant definitions

	Referral	Prior authorization
Definition	A referral is a request for services from the PCP to another provider.	Prior authorization (i.e., preauthorization, precertification, preadmission) is a process through which Humana Healthy Horizons requires a healthcare provider to obtain advance plan approval to cover an item or service.
Scope	All specialist visits require a referral.	Any service or treatment

	Referral	Prior authorization
Exclusions	Exclusions: • OB-GYN • Dental or vision anesthesia services not covered under the applicable dental/vision vendor • Certain pediatric services related to testing, treating or screening conditions such as EIS or EPSDT cases do not require a referral.	The Humana Healthy Horizons PAL details the items, services and medications that require PA before services are provided or administered. You must obtain PA when requesting an item or service that is on the PAL.
Submission method	Submit through **Availity Essentials**.	Submit through **Humana Healthy Horizons' PA search tool website**. Submit via fax to the **clinical intake team**. Call the **authorization line**. Refer to the **provider prior authorization notification lists**.

Prior authorization and notification procedures

You must determine whether PA or notification is required with respect to medical services rendered to any Humana Healthy Horizons member. To make this determination, you must review Humana Healthy Horizons' **provider prior authorization notification** lists, which detail medical services that require PA. You may also contact **member/provider services** for assistance in locating these lists.

Please note: Precertification, preadmission, preauthorization and notification requirements all refer to the same process of prior authorization.

Humana Healthy Horizons updates these lists periodically and notifies providers of revisions in accordance with the time frame specified in the provider agreement. The **prior authorization search tool** is available online or by contacting **member/provider services**.

Obtaining PA and submitting notification

Participating providers can obtain PA and notification of determination through a variety of channels, including:

- **Availity Essentials**
- **Prior authorization notification lists webpage**
- Calling the **authorization line**

CMS mandate requires the NPI is included for authorization. As a result, your NPI is required on authorization requests submitted to Humana Healthy Horizons as of Dec. 9, 2023. This requirement applies to authorization submissions and inquiries (Inquiry 278 per AHCA) for all providers (requesting/

referring provider, rendering/treating provider and rendering/treating facility) and lines of business, except atypical providers. Submissions that do not have an NPI and a Medicaid ID number will be returned for resubmission.

Specialists servicing members in regions G–I are required to coordinate with the member's PCP in order for the member to submit authorization on the member's behalf.

For hospital admission, the provider must use Availity Essentials or call the number listed on the back of the member's ID card. The following information is required for each hospital admission:

- Member's name
- Member's ID number, name and date of birth
- Date of actual or proposed admission
- Date of proposed procedure
- Bed type: inpatient or outpatient
- NPI of treatment facility or hospital
- Applicable ICD-10 diagnosis code
- Caller's telephone number
- Attending physician's telephone number

For urgent PA or notification, you should call the **clinical intake team**. Be sure to have your NPI available.

Humana Healthy Horizons reviews and submits a determination on all requests for PA of any medically necessary service to members 21 or younger when the service is not listed in the servicespecific Florida Medicaid Coverage and Limitations Handbook, Florida Medicaid Coverage Policy or the associated Florida Medicaid fee schedule; is not a covered service of the plan; or the amount, frequency or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.

Reconsiderations

The reconsideration process is defined as the process Humana Healthy Horizons follows to review additional clinical documentation from providers to determine if a denial or partial denial should be overturned and approved based on medical necessity criteria. If the service requested is denied or partially denied, you may request reconsideration of the denial determination. Providers who request reconsideration must submit additional information to Humana Healthy Horizons (via phone, fax, web, etc.,) within 10 business days of the date of the denial or partial denial determination to facilitate the reconsideration process.

Humana Healthy Horizons reviews all new clinical information received for reconsideration requests and renders a decision based on the new documentation. If the reconsideration is received with no new clinical information or beyond the 10 business-day submission requirement, the original decision stands. The member or member's authorized representative may choose to file an appeal through the grievances and appeals process, more information about which is available in the **member grievance and appeal section of this provider handbook**

Medical necessity

The medical or allied care, goods or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
- Be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member's needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker or the provider

The fact that a provider has prescribed, recommended or approved medical or allied care, goods or services does not in itself make such care, goods or services medically necessary or a medical necessity or a covered service. Medical necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

Referrals to Humana Healthy Horizons LTC/Comprehensive plan

If an individual believes they may qualify to participate in the program, the individual or the individual's representative must contact the local ADRC office to apply for the Humana Healthy Horizons Comprehensive plan. As a provider, if you decide to assist the individual with the application process, you must obtain the individual's consent and document it using **the Authorization for the Use and Disclosure of Protected Health Information form**. The individual or the provider is welcome to contact Humana Healthy Horizons for program information at any time. To locate an ADRC office in your area, please **refer to this website**.

Care coordination for new Humana Healthy Horizons members

Coordination of care occurs for new Humana Healthy Horizons members transitioning into the plan. In the event a new member is receiving a previously authorized ongoing course of treatment with any provider, Humana Healthy Horizons covers the costs of continuation of such course of treatment without any form of authorization and without regard to whether such services are performed by participating or nonparticipating providers. Providers are reimbursed by Humana Healthy Horizons at the rate they received for services immediately prior to the Humana Healthy Horizons member transitioning for a minimum of 90 calendar days and up to 120 days.

Humana Healthy Horizons covers MMA services until the member's PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the member's treatment.

The continuity of care period for members who transition to Humana Healthy Horizons as part of the implementation phase is up to 120 calendar days after the member's effective date of enrollment, which would be Feb. 1, 2025. For members who transition to Humana Healthy Horizons after the Feb. 1, 2025 implementation phase, the continuity of care period is 90 calendar days.

Providers should continue servicing Humana Healthy Horizons members during the member's continuity of care period, either 120 days or 90 days respectively, for any services that were previously authorized or prescheduled prior to the member's effective date of enrollment with Humana Healthy Horizons, regardless of whether the provider is participating in Humana Healthy Horizons' network.

Providers should keep previously scheduled appointments with new members during the transition.

The following services may extend beyond the continuity of care period with the member's current provider:

- Prenatal and postpartum care
- Radiation and/or chemotherapy services (for the current round of treatment)
- Transplant services (through the first year post-transplant)

If the services were arranged prior to enrollment with the plan, written documentation includes the following:

- Behavioral health services
- Prescriptions (including prescriptions at nonparticipating pharmacies)
- Prior existing orders
- Provider appointments (e.g., dental appointments, surgeries)

Although no additional authorization is needed for any ongoing treatment, written documentation for the provision of continued services may be needed for proper payment of the provided services.

Through the following process, Humana Healthy Horizons ensures transitioning members still receive care even if Humana Healthy Horizons is not contracted with the member's current provider:

- Assign the member a new case manager
- Continue the member's care plan as-is for at least 90 calendar days and up to 120 calendar days
- Contract with nonparticipating providers if at all possible
- Coordinate and build relationships with providers
- Determine unmet needs and put necessary services in place
- Emphasize the member's comfort and safety while addressing unmet needs
- Ensure there are no disruptions in care
- Identify members who desire to transition to another setting (provide continuity of care)
- Reassess and update the personalized plan of care

Out-of-network/noncontracted services

An out-of-network provider is a provider who is not directly contracted with the Humana Healthy Horizons plan. Humana Healthy Horizons is not responsible for payment of services provided by an out-of-network provider without written PA.

Noncontracted services are services not defined on Schedule B of your contract. Humana Healthy Horizons is not responsible for payment of noncontracted services. If you or your staff identifies a service that a member may require that is not listed in your contract, please contact Humana Healthy Horizons **authorization line** and the utilization management team will evaluate the member's needs to determine if the service can be authorized by Humana Healthy Horizons.

Chapter 12: Quality

Contact information pertaining to quality

Contact name	Contact information	Hours of operation
PCMH program	Email: **FL_Medicaid_PCMH@humana.com**	

Accreditation

Humana Healthy Horizons holds a strong commitment to quality. We demonstrate our commitment through programs based on national standards, when applicable. Humana holds accreditation from the NCQA for our Medicaid lines of business.

Quality improvement program

The QI program includes clinical care, preventive care and member services. More information is available on the **Humana Healthy Horizons in Florida website**.

Humana Healthy Horizons has a comprehensive QI program that encompasses clinical care, preventive care, population health management and the health plan's administrative functions. It is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable medical and behavioral health care and services. Strategies are identified and activities implemented in response to findings using a continuous QI methodology.

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 through QI requirements outlined throughout this provider handbook. Member records should be kept in compliance with the **medical records section of this provider handbook**

Patient-centered medical home

Patient-centered medical home (PCMH) is a transformative model of care that strengthens the provider-member relationship by replacing episodic care with coordinated care and fostering greater accountability for both members and providers. PCMH practices are expected to provide evidence-based services to members and integrate care with specialty and subspecialty practices. The medical home is required to adhere to the following tenets:

Enhance access and continuity	Accommodate member needs with access and advice during and after regular office hours; give members and their families information about their medical home; and provide members with team-based care.
Identify and manage member populations	Collect and use data for population management.
Plan and manage care	Use evidence-based guidelines for preventive, acute and chronic case management, including medication and mental health management.
Provide self-care support and community resources	Assist members and their families in self-care management with information, tools and resources.
Track and coordinate care	Track and coordinate tests, referrals and transitions of care.
Measure and improve performance	Use performance and member experience data for continuous QI.

Humana Healthy Horizons' PCMH program works to empower members as they interact with their PCPs and healthcare delivery teams (e.g., family, therapist, specialist, diagnostic center, hospital and laboratory). The PCMH program focuses on a team-based approach to healthcare delivery. Open communications between the healthcare team and member allow for the member to be more actively involved in healthcare decisions with a potential for better health outcomes and costeffective treatment of ongoing health conditions.

PCPs who are interested in the PCMH program, certification requirements and benefits should contact the Humana Healthy Horizons PCMH program.

According to AHRQ, a PCMH program includes the following functions that transform traditional primary care into advanced primary care:

Comprehensive care	A team that guides members through the healthcare delivery system; includes physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators and care coordinators.
Member-centered care	The member is primary in the relationship and drives decisions that influence their health. Physicians provide education and establish a plan of care.

Coordinated care	The PCP communicates with the healthcare delivery team and manages coordination of care.
Accessible services	The member's access-to-care preferences are important. Shorter wait times, urgent needs, after-hours and around-the-clock access, as well as openness to different types of communication besides the telephone are taken into consideration by the provider.
Quality and safety	The PCP uses evidence-based medicine and clinical decision-support tools to guide the member and healthcare delivery.

Provider quality bonus

The quality bonus program aims to promote QI and recognize providers that demonstrate high levels of performance for select performance measures by providing additional financial compensation.

Eligibility for PCP quality bonus:

- PCP must have a current contract with Humana in good standing.
- PCP must have an open panel for Medicaid line of business.
- PCP must have at least 50 attributed patients with Humana Healthy Horizons coverage.

MMA Physician Incentive Program

The MMA PIP's (MPIP) aim is to promote quality of care for Medicaid recipients and recognize those providers who demonstrate high levels of performance for selected criteria. The MPIP provides the opportunity for designated provider types to earn enhanced payments equivalent to the appropriate Medicare FFS rate as established by AHCA based on the achievement of key access and quality measures. To learn more about this program, you can review the program information on the **AHCA website**. For additional questions, including whether you qualify, please contact your contract specialist.

Provider satisfaction survey

Humana Healthy Horizons conducts an annual provider satisfaction survey that includes questions to evaluate provider satisfaction with our services, such as claims, communications, UM and provider services. We encourage you to participate and respond to the survey as the results are analyzed and used to develop provider-related QI initiatives.

Medical records

Standards for member records

Member records must comply with the following standards:

- Include the member's identifying information, including name, member ID number, date of birth, gender and legal guardianship (if any)
- Include information related to the member's use of tobacco, alcohol, drugs or substances
- Include summaries of all emergency services and care and hospital discharges with appropriate, medically indicated follow-up
- Reflect the primary language spoken by the member and any translation needs required
- Identify members who need communication assistance in the delivery of healthcare services
- Include copies of any completed consent or attestation forms used by Humana Healthy Horizons or the court order for prescribed psychotherapeutic medication for a child younger than 13 years
- 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 information on Chapter 765, Fla. Stat., and whether the member has executed an advance directive, per 42 CFR 438.3(j)(3)
  - Neither Humana Healthy Horizons, nor any of its providers must require, as a condition of treatment, the member to execute or waive an advance directive, per 42 CFR 438.3(j)(1)-(2), 42 CFR 422.128(b)(1)(ii)(H) and 42 CFR 489.102(a)(5).
- For OB-GYN provider records, must include a copy of the completed screening instrument in the member record
  - A copy is also provided to the member. Documentation of preterm delivery risk assessments must be included in the member record by the 28th week.

Annual medical record documentation review

The purpose of the MRDR is to ensure Humana Healthy Horizons' compliance with maintenance of a member record for each member in accordance with AHCA contract FP059, 42 CFR 431 and 42 CFR 456. Member records should include documents related to the quality, quantity, appropriateness and timeliness of services performed under this contract.

For each Medicaid recipient, you should maintain detailed and legible medical records that include the following:

Member identification	Each page in the medical record must contain identifying information, including name, member ID, date of birth, gender, and parent or legal guardianship (if applicable).
Provider identification	The author must be identified for all entries (including dictation) and each entry authenticated as complete and accurate. Authentication may include signatures or initials.

Date of service/ entry date	All entries must be signed and dated within 2 business days of the date and time of service, or otherwise authenticated by signature, written initials, computer entry or electronic signature. Rubber stamped signatures must be initialed.
Legibility	The medical record must be legible to someone other than the writer.
Problem list	Significant illnesses and medical conditions are indicated on the problem list.
Allergies	The presence or absence of allergies (no known allergies or NKA) must be documented in a uniform location on the medical record. Medication allergies and other adverse reactions must be listed if present.
Past medical history	For members seen 3 or more times, past medical history should be easily identifiable and include details regarding serious accidents, operations, illnesses and familial/hereditary diseases, and a summary of significant surgical procedures, past and current diagnoses or problems, allergies, adverse reactions to drugs, and current medications.
Physical exam (complete)	All body systems should be reviewed within 2 years of the first clinical encounter, including HEENT, teeth, neck, heart, lungs, and neurological and musculoskeletal systems. Height, weight, blood pressure and temperature must be documented on the initial visit.
History and physical	Subjective and objective information regarding presenting complaints should be obtained and noted.
Working diagnosis	The working diagnosis (i.e., the provider's medical impression) should be consistent with findings.
Plan/treatment	Documentation of plan of action and treatment should be consistent with diagnoses and include all prescribed or provided services, medications and supplies. Such services must include, but are not limited to, family-planning services, preventive services and services for the treatment of sexually transmitted diseases. In addition, all entries must include the disposition, recommendations, member instructions, evidence of any followup and outcome of services.
Records	Reports should be filed in the medical record and initialed by the PCP to signify review. Past medical records and hospital records (e.g., operative and pathology reports, admission and discharge summaries, consultations and ER reports) should be filed in the medical record. Examples include: consultation, discharge summaries, ER reports
Referrals	Reports should be filed in the medical record and initialed by the PCP to signify review. Past medical records and hospital records (e.g., operative and pathology reports, admission and discharge summaries, consultations and ER reports) should be filed in the medical record. Examples include consultation or therapy.

Tobacco	For members seen 3 or more times, a notation concerning tobacco use must be present.
Alcohol	For members seen 3 or more times, a notation concerning alcohol use must be present.
Substance use	For members seen 3 or more times, a notation concerning substance use must be present.
Immunization record	A current record of immunizations should appear in the member chart.
Advance directives	For members 21 and older, records should contain evidence members were asked if they have an advance directive (written directions about healthcare decisions) with a yes or no response documented. If the response is yes, a copy of the advance directive must be included in the medical record and should indicate that neither the managed care plan nor any of its providers must, as a condition of treatment, require the member to execute or waive an advance directive.
Prescribed medication	All current medications, including dose and date of initial prescription or refills, should be present in the medical record and include copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child younger than 13.
Primary language	Use of the member's primary language should be documented, along with any communication assistance provided.
Obstetrical providers	Healthy Start records should include a copy of the completed screening instrument and documentation a copy was provided to the member. Records should include documentation of preterm delivery risk assessments by the 28th week of pregnancy.

Humana Healthy Horizons and providers are responsible for coordination of care for new members transitioning to Humana Healthy Horizons or another plan or delivery system and must assist with obtaining the member's medical/case records. This should be done within 30 days.

Confidentiality of medical records

For each medical record, you must have a policy to ensure the confidentiality of medical records, including confidentiality of a minor's consultation, examination and treatment for a sexually transmissible disease.

The member or authorized representative must sign and date a release form before any clinical/medical case records can be released to another party. Clinical/medical case record release must occur in a manner consistent with state and federal law.

You must ensure compliance with the privacy and security provisions of HIPAA and 42 CFR, Part 431, Subpart F.

Humana Healthy Horizons and providers agree to maintain the confidentiality of information contained in the records of the provider regarding healthcare services rendered to members as

required by state or federal law, rule or regulation, including, without limitation, 42 CFR, Part 431, Subpart F, 42 CFR § 438.224, and HIPAA privacy and security requirements in 45 CFR Parts 160 and 164.

Right to review records

Authorized state and federal agencies and their authorized representatives may audit or examine provider records.

This examination includes all records these agencies find necessary to determine whether Florida Medicaid payment amounts were or are due. This requirement applies to the provider's records and records for which the provider is the custodian. You must give authorized state and federal agencies and their authorized representatives access to all Florida Medicaid recipient records and any other information that cannot be separated from Florida Medicaid-related records.

You must send, at your expense, legible copies of all Florida Medicaid-related information to authorized state and federal agencies or their authorized representatives on request.

All records must be provided regardless of the media format on which the original records are retained by the provider at the time of the request. All medical records may be reproduced electronically or as paper copies as authorized by the requestor.

You must maintain complete and accurate fiscal, medical, social and other administrative records for medical services rendered to Medicaid managed care plan members and as are necessary to document the quality, appropriateness and timeliness of services performed under this agreement and in compliance with applicable state and federal laws, rules and regulations and the AHCA contract. Such records must specifically include pertinent books, financial records, medical/case records and records of financial transactions.

You must agree to maintain and retain these records for a period of 10 years following the termination of Humana Healthy Horizons' contract with AHCA.

In addition to record retention requirements for practitioner or provider licensure, subcontractors are required to retain, as applicable, the following information in accordance with 42 CFR 438.3.(u): • Member grievance and appeal records (42 CFR 438.416)

- Base data (42 CFR 438.5(c))
- Medical loss ratio (MLR) reports (42 CFR 438.8(k))
- Data, information and documentation (42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608 and 42 CFR 438.610)

This information must be retained for a period not less than 10 years from the close of the contract and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by Humana Healthy Horizons if the subcontract is continuous (42 CFR 438.3(h)).

Florida Health Information Exchange

The Office of HIE and Policy Analysis produces statutorily mandated reports, administers the Medicaid EHR Incentive program, provides governance of the Florida HIE, and provides research and analytic support to AHCA.

- The **Florida Health Information Network website** provides information and resources relating to AHCA's initiatives for HIT and HIE.
- Details about services, as well as the latest news and events relating to the Florida HIE initiative and information on becoming a participant, can be found on the **Florida HIE website**.
- Provider case studies and testimonials can also be found on the **Florida HIE website**.

Early notification system

AHCA collaborates with hospitals throughout Florida to provide real-time notifications of all ADTs. The system relies on member panels submitted by health plans and providers. Humana Healthy Horizons works with providers for PCP notification and member outreach, including:

- Sending a daily report to providers of their members' previous-day ER encounters, admissions and discharges
- Reaching out to high-utilizing members to close gaps and engage in case management
- Encouraging providers to focus on reaching out and closing gaps with members with lower utilization

Humana Healthy Horizons recommends providers continue the following effective strategy of notification and education to members:

- Immediate outreach to the member and facilitation of PCP follow-up within 3 days of an ER visit
- Education regarding the right place of treatment
- Identifying and addressing barriers to care (including health-related social needs) to foster the PCP/ member relationship
- Referrals to other internal programs (e.g., case management and social work)

Humana Healthy Horizons recommends that providers continue the following effective strategy of notification and education to PCPs:

- Immediate notification of member's ER visit, including chief complaint
- PCP follow-up appointment scheduled within 3 days of member's ER visit

Preventive and clinical practice guidelines

These protocols incorporate relevant, evidence-based medical and behavioral health guidelines from recognized sources, including professional medical associations, voluntary health organizations, and NIH Centers and Institutes. They help providers make decisions regarding appropriate healthcare for specific clinical circumstances. We strongly encourage providers to use these guidelines and to consider these guidelines whenever promoting positive outcomes for clients. The provider remains responsible for ultimately determining the applicable treatment for each individual.

Use of these guidelines allows Humana Healthy Horizons to measure their impact on care outcomes. Humana Healthy Horizons monitors provider guideline implementation through claim, pharmacy and utilization data.

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

- Provider handbook updates
- Provider newsletters
- Provider website

You also can receive preventive health and clinical practice guidelines through the Case Management department or your provider relations representative. Preventive guidelines and clinical practice guidelines also are available on the **Humana Healthy Horizons in Florida provider website**.

Humana Healthy Horizons requires providers to provide care for members with HIV, AIDS and SMI in accordance with the most recent clinical practice guidelines for the treatment of these conditions. PCPs should use approved assessment instruments for treatment of specialty conditions to include HIV, AIDS and SMI. See the **Humana Healthy Horizons in Florida provider website** for additional information about approved assessment instruments.

Chapter 13: Claims and encounters

Contact information pertaining to claims

Contact name	Contact information	Hours of operation
Availity Essentials	Phone: **800-282-4548** Website: **Availity Essentials**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Change Healthcare	Phone: **800-792-5256** Website: **Change Healthcare**	
Claim submission: LTC/ comprehensive	Address: Humana Healthy Horizons – LTC Attn: Claims Department P.O. Box 14732 Lexington, KY 40512-4732	
Claim submission: MMA/ specialty	Address: Humana Healthy Horizons MMA Plan Attn: Claims Department P.O. Box 14601 Lexington, KY 40512-4601	
Encounter submission	Address: Humana Claims Office P.O. Box 14605 Lexington, KY 40512-4605	
Member/ provider services	Phone: **800-477-6931**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Overpayment notification	Address: Humana Healthcare Plans P.O. Box 931655 Atlanta, GA 31193-1655	

Contact name	Contact information	Hours of operation
Provider complaint submission	Address: Humana Healthy Horizons Provider Correspondence P.O. Box 14601 Lexington, KY 40512-4601	
SSI Group	Phone: **800-820-4774** Website: **SSI Group**	
Trizetto	Phone: **800-556-2231** Website: **TriZetto**	Monday through Friday, 8 a.m. to 7 p.m., Eastern time
WayStar	Phone: **877-494-7633** Website: **WayStar**	

Humana Healthy Horizons maintains and complies with HIPAA standards for the submission and adjudication of claims. This section provides information regarding our submission and payment process. If you have questions or would like training regarding submitting claims, please contact your contract specialist.

Claim submission

All claims should be submitted to the Humana Healthy Horizons within 6 months of the date of service, discharge from an inpatient setting, or the date the provider was furnished with the correct name and address of the managed care plan.

When Humana Healthy Horizons is the secondary payer and the primary payer is an entity other than Medicare, Humana Healthy Horizons requires you to submit the claim to us within 90 calendar days of the final determination of the primary payer, in accordance with the **Medicaid Provider General Handbook**.

When Humana Healthy Horizons is the secondary payer and the primary payer is Medicare, Humana Healthy Horizons requires you to submit the claim to us in accordance with timelines established in the **Medicaid Provider General Handbook**. Humana Healthy Horizons cannot deny Medicare crossover claims solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds 3 years.

The Humana Healthy Horizons LTC plan does not deny claims submitted by a nonparticipating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds 365 calendar days. Claims that are incomplete, illegible or missing identifiable information may delay payment or could result in a denial of payment.

For more information on claim submission, please visit the Humana Healthy Horizons **claim submission informational website**.

Electronic claims

Humana Healthy Horizons can receive electronic claims submission. Acceptable formats include X12 5010 837 institutional, professional and dental formats. Humana Healthy Horizons also allows for DDE through **Availity Essentials**.

When filing an electronic claim, you should use payer ID 61115 for LTC claims, 61101 for FFS MMA claims and 61102 for MMA encounter claims.

For questions about enrolling in electronic claims submissions, please contact Availity Essentials by calling **800-282-4548**, Monday through Friday, 8 a.m. to 8 p.m., Eastern time or visit **Availity Essentials**.

Paper claims

Paper claims should be submitted to the address listed on the back of the member's ID card, to **claim submission: LTC/comprehensive** or to **claim submission: MMA/specialty**.

Claim payment inquiries and complaints

For claim payment inquiries, complaints, or if there is a factual disagreement with a response, please contact **member/provider services** or reach out to your contract specialist. Paper claims can be mailed to **provider complaint submission**.

Reimbursement for Medicare dual-eligible members

In addition to the claim payment provisions outlined in your provider agreement, Humana Healthy Horizons reimburses providers for Medicare deductibles and coinsurance payments for Medicare dualeligible members according to the lesser of the following:

- Rate negotiated with the provider
- Reimbursement amount as stipulated in § 409.908 Fla. Stat.

Commonly used clearinghouses

Availity Essentials is the Humana Healthy Horizons preferred claims clearinghouse. However, providers may use other clearinghouses, such as **WayStar**, **TriZetto**, **Optum** or the **SSI Group**.

Encounter submissions

AHCA requires Humana Healthy Horizons to submit 100% of encounters that we pay, and 95% must pass through the state system. For us to comply with this requirement, providers must be registered and bill with the appropriate information. This applies to both FFS and capitated/delegated providers.

Encounters and claims identify members who receive services. This is important because it:

- Decreases the need for medical record review during HEDIS reviews
- Is critical for the future world of Medicaid Risk Adjustment

- Helps identify members receiving preventive screenings
- Decreases members appearing in gap reports

Sanctions for noncompliance can include liquidated damages and even enrollment freezes.

Procedure and diagnosis codes

Federal law establishes various standards for all covered transactions under HIPAA, including electronic medical claims. Those standards currently include the following 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 (CMS)**
- National Drug Codes (NDC), available from the **US Food and Drug Administration**
- ICD-10-CM, available from the **Centers for Disease Control and Prevention**
- International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS), available from the **Centers for Medicare & Medicaid Services**

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

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

Claims payments

Payments due as a result of covered services rendered to Humana Healthy Horizons members are made on or before 90 calendar days after all properly documented invoices and/or claims and any documentation necessary for Humana Healthy Horizons to process such claims are received by Humana Healthy Horizons and in accordance with the reimbursement terms and conditions of the agreement and payment rates.

Humana Healthy Horizons provider claim payments are accompanied by an itemized accounting of the individual claims in the payment including, but not limited to, the member's name, the date of service, the procedure code, service units, reimbursement amount and identification of Humana Healthy Horizons.

Humana Healthy Horizons does not pay, directly or indirectly, a provider as an inducement to reduce or limit medically necessary services to a member. Humana Healthy Horizons-operated provider incentive plans do not provide incentives, monetary or otherwise, for the withholding of medically necessary care.

Third-party liability

Humana Healthy Horizons assumes full responsibility for collections in the event of third-party liability.

Claims and encounter submission protocols and standards

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

	Medical claims		Behavioral health claims	Encounters
MMA	Humana Healthy Horizons MMA Plan Attn: Claims Department P.O. Box 14601 Lexington, KY 40512-4601	**Region A**	Access Behavioral Health Attn: Claims Dept. 1221 W. Lakeview Ave. Pensacola, FL 32501	Humana Claims Office P.O. Box 14605 Lexington, KY 405124605
LTC	Humana Healthy Horizons–LTC Attn: Claims Department P.O. Box 14732 Lexington, KY 40512-4732	**Regions B–I**	Carelon Behavioral Health P.O. Box 1870 Hicksville, NY 118021870	

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

- 61101 for medical claims
- 61102 for encounter claims
- 61115 for LTC claims

For additional information regarding electronic claim submission, contact your contract specialist, visit the **claim submission informational website** or visit **Availity Essentials**.

Claim payment inquiries and complaints

For claim payment inquiries or complaints, please contact **member/provider services** or your contract specialist.

Submit written complaints to **provider complaint submission**.

If there is a factual disagreement with the response received using the above methods to resolve the issue, send an email with detailed information about the issue including the resolution response you received along with the assigned reference number for the case to **FLMedicaidResolution@humana.com**.

If a complaint/appeal results in an unfavorable decision and all Humana Healthy Horizons provider complaint/appeal processes have been exhausted, you may request a review of their original appeal (at the provider's expense) by **Capitol Bridge**, the state's independent dispute resolution organization.

Common submission errors and how to avoid them

Common reasons for rejected or denied claims include the following:

- Member not found
- Insured subscriber not found
- Member birthdate on the claim does not match that found in the Humana Healthy Horizons database
- Missing or incorrect information
- Providers submitting with incorrect NPI/ZIP code/taxonomy/address/NPI type
- Missing provider NPI/ZIP code/taxonomy
- Providers submitting encounters with zero-dollar values
- Rendering provider data missing for provider organizations
- Invalid HCPCS code submitted
- No authorization or referral found
- Billing/rendering/attending NPIs not enrolled/registered for Medicaid with AHCA You can avoid these common errors by doing the following:
- Confirming that member information received and submitted is accurate
- Ensuring that all required claim form fields are complete and accurate
- Obtaining proper authorization and/or referrals for services rendered
- Ensuring you have a valid Medicaid ID for the billing/rendering/attending providers and that the NPIs and taxonomies submitted on claims exactly match the applicable active PML record
- Ensuring submitted charges on claims are more than zero dollars (i.e., must submit billed charges)

Clean claims

CMS developed claim forms that record the information needed to process and generate provider reimbursement. The required elements of the claim must be complete, legible and accurate for the claim to be considered clean. A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for

medical necessity, pursuant to 42 CFR 447.45. The **Humana ASC X12 implementation guide** outlines all the information for the fields Humana Healthy Horizons requires providers to submit a clean claim.

Providers can submit a clean claim by providing the required data elements on the standard claim forms along with any attachments and additional information. Inpatient and facility claims should be submitted on the UB-04 form, and individual professional claims should be submitted on the CMS-1500 form.

The **Humana HIPAA Companion Guides** detail all information required by Humana Healthy Horizons for providers to submit a clean claim.

For instructions on submitting a claim using the CMS-1500 form, please review the **Florida Medicaid Provider Reimbursement Handbook, CMS-1500**. For instructions on submitting a claim using the UB-04 form, please review the AHCA Provider Reimbursement Handbook for UB-04 forms on the **AHCA website**.

Timely filing

Providers are required to file timely claims/encounters for all services rendered to Medicaid members. Timely filing is an essential component of Humana Healthy Horizons' HEDIS reporting and ultimately affects how a managed care plan and its providers are measured in member preventive care and screening compliance.

Providers must submit all claims and, if capitated, encounter data for medical services rendered to Humana Healthy Horizons members. Providers must submit claims within 6 months of the date of service or 30 calendar days of the date of service to Humana Healthy Horizons for encounter data. First-time facility claims must be received within 6 months to be considered timely.

The encounter data submission standards required to support encounter data collection and submission are defined by AHCA in the **Medicaid Companion Guides** on the AHCA portal, pharmacy payer specifications and this section. In addition, AHCA posts encounter data reporting requirements on the **Medicaid Companion Guides** website via its AHCA portal and **Adopted Rules website**.

Code editing and payment policies

Humana Healthy Horizons processes accurate and complete provider claims in accordance with Humana Healthy Horizons' 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 Healthy Horizons provider website** 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 one of multiple same-day services such that the cost of the service to the provider is less than if the service had been provided on a different day. For example:
  - 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:

- AHCA 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 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) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services
- Food and Drug Administration (FDA) guidance
- Medical and surgical specialty societies and associations
- Industry-standard UM criteria and/or care guidelines
- Our medical and pharmacy coverage policies
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published, peer-reviewed literature

Changes to any one of the sources may lead Humana Healthy Horizons to modify current claims processing procedures 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 on the **Humana Healthy Horizons provider website**.

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 complaints section of this provider handbook**

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 providerpreventable 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.

Claims overpayments

You must report all claim overpayments for medical services rendered to Humana Healthy Horizons members. You are expected to submit such claims within 60 calendar days of the date on which the overpayment was identified. You also are required to notify Humana Healthy Horizons in writing of the reason for the overpayment as required by 42 CFR 438.608(d)(2). The notification should be mailed to **overpayment notification**.

Payment suspension

Humana Healthy Horizons pays nursing facility providers in compliance with 42 CFR 488.417 and enforces all DPNA issued by CMS.

ERAs and EFTs

You may register to have your Humana Healthy Horizons ERA and payments/EFTs paid up to 7 calendar days faster. The ERA/EFT enrollment process is outlined on the Humana Healthy Horizons **electronic claims payment website** and in the **Get Paid Faster guide**.

Crossover claims

You are only required to submit your claims once to CMS for processing and are no longer required to submit secondary claims to Humana Healthy Horizons. CMS automatically forwards claims for members who are dually eligible for both Medicare and Medicaid coverage.

Please note: If you submit a claim for a dually eligible member that CMS already has forwarded to Humana Healthy Horizons, the provider-submitted claim is denied as a duplicate.

Incentive plan disclosure requirements

Providers agree to disclose to Humana Healthy Horizons within a reasonable time frame not to exceed 30 calendar days information required for Humana Healthy Horizons to comply with all applicable state and federal laws, rules and regulations for such requests, all of the terms and conditions of any payment arrangement that constitutes a provider incentive plan, as defined by CMS, and/or any state or federal law between a provider and other providers. This disclosure must be in the form of a certification or other form as required by CMS and/or AHCA, by the provider, and should contain information necessary for Humana Healthy Horizons to comply with applicable state and federal laws, rules and regulations as requested by Humana Healthy Horizons.

Providers also agree to disclose to Humana Healthy Horizons within a reasonable time frame not to exceed 30 calendar days, within 35 calendar days of a request by AHCA or DHHS, the provider's ownership; any significant business transactions between the provider and any wholly owned supplier or subcontractor during the 5-year period ending on the date of the request; and the identity of any owner, agent or managing employee of the provider convicted of a crime relating to any program under Medicare, Medicaid or the Title XX services program.

Special provisions for Native Americans

Humana Healthy Horizons does not impose enrollment fees, premiums or similar charges on Native Americans served by a Native American healthcare provider; Native American Health Service, a Native American tribe, Tribal Organization or Urban Indian Organization; or through referral under contract health services, in accordance with the American Recovery and Reinvestment Act of 2009.

Well-child visits information and screening codes

CPT preventive medicine service codes are used for well-child visit services. In some cases, modifiers are required to uniquely identify the service provided. Both the procedure code and modifiers must be included with the claim to receive proper reimbursement. Only those modifiers listed herein are allowed when billing these services.

Humana Healthy Horizons ensures its managed Medicaid members receive these checkups, so it is critical these checkups are billed correctly.

Please note: You are permitted to bill a sick visit in addition to the well-child visit and receive reimbursement for both.

Nonparticipating provider reimbursement

Members may receive medically necessary services and treatment by an out-of-network provider (nonparticipating provider) when a participating provider is not available to provide the medically necessary care. A nonparticipating provider does not have a contract agreement with Humana Healthy Horizons.

Out-of-Network Claims

Absent a controlling legal requirement or Letter of Agreement, reimbursement to nonparticipating providers is limited to the lesser of:

- The amount specified by Humana in the authorization request form for the specific service; or
- 100% of the applicable Medicaid fee schedule.

A valid Medicaid ID is required for all providers—whether located in Florida or out of state—as a condition of payment.

Well-child visit age or description	Well-child visit ICD10 codes	New patient CPT codes	Established patient CPT codes
Neonatal exam	N/A	99460, 99461, 99463	N/A
2 to 4 calendar days for newborns discharged less than 48 hours after delivery	N/A	99460, 99461, 99463	N/A
By 1 month	N/A	99381	99391
2 months	N/A	99381	99391
4 months	N/A	99381	99391
6 months	N/A	99381	99391
9 months	N/A	99381	99391
12 months	N/A	99382	99392
15 months	N/A	99382	99392
18 months	N/A	99382	99392
2 years to younger than 5 years	N/A	99382	99392
5 years to younger than 12 years	N/A	99383	99393
12 years to younger than 18 years	N/A	99384	99394
18 years to younger than 21 years	N/A	99385 EP	99395 EP

Well-child visit age or description	Well-child visit ICD10 codes	New patient CPT codes	Established patient CPT codes
Encounter for health supervision and care of other healthy infant and child	Z76.2	99202–99205	99213–99215
Encounter for routine child health exam with abnormal findings	Z00.121	99202–99205	99213–99215
Encounter for routine child health exam without abnormal findings	Z00.129	99202–99205	99213–99215
Health exam for newborn younger than 8 days old	Z00.110	99202–99205	99213–99215
Health exam for newborns 8 to 28 days old	Z00.111	99202–99205	99213–99215
Encounter for general adult medical exam without/with abnormal findings	Z00.00-01	99202–99205	99213–99215
Encounter for exam for admission to educational institution	Z02.0	99202–99205	99213–99215
Encounter for pre-employment exam	Z02.1	99202–99205	99213–99215
Encounter for exam for admission to residential institution	Z02.2	99202–99205	99213–99215
Encounter for exam for recruitment to armed forces	Z02.3	99202–99205	99213–99215
Encounter for exam for driving license	Z02.4	99202–99205	99213–99215
Encounter for exam for participation in sport	Z02.5	99202–99205	99213–99215

Please note: The child may enter the periodic schedule at any time. For example, if a child has an initial screening at age 4, then the next periodic screening is performed at age 5.

Chapter 14: Fraud, waste and abuse

Contact information pertaining to fraud, waste and abuse

Contact name	Contact information	Hours of operation
AHCA consumer complaint hotline	Phone: **888-419-3456**	Monday through Friday, 8 a.m. to 5 p.m., Eastern time
Availity Essentials	Phone: **800-282-4548** Website: **Availity Essentials**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Change Healthcare	Phone: **800-792-5256** Website: **Change Healthcare**	
Ethics Help Line	Phone: 877-5 THE KEY (**877-584-3539**) Email: **ethics@humana.com**	24 hours a day, 7 days a week
Florida Attorney General's Office	Phone: **866-966-7226** or **850-414-3990**	N/A
Humana Healthy Horizons SIU Hotline	Phone: **800-614-4126**	24 hours a day, 7 days a week
Member/ Provider Services	Phone: **800-477-6931 (TTY: 711)**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
MPI administrator	Phone: **850-412-4600**	N/A
Reporting FWA	Fax: **920-339-3613**	N/A
SIU	Email: **siureferrals@humana.com**	N/A

Fraud, waste and abuse policy

You must incorporate a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse. You understand and agree to educate your employees about 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 fraud, waste and abuse.

Humana Healthy Horizons and AHCA must be immediately notified if you or your staff:

- Are aware of any provider that may be billing inappropriately, including falsifying diagnosis codes and/or CPT codes, or billing for services not rendered
- Are aware of a member intentionally permitting others to use their member ID card to obtain services or supplies from the plan or any authorized plan provider
- Are suspicious that someone is using another member's ID card
- Have evidence that a member knowingly provided fraudulent information on their enrollment form that materially affects the member's eligibility in the plan

You may provide the above information via an anonymous phone call to the Humana Healthy Horizons Fraud Hotline at **800-614-4126**, 24 hours a day, 7 days a week. All information will be kept confidential. Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Humana Healthy Horizons ensures there is no retaliation against callers because Humana Healthy Horizons has a zero-tolerance policy for retaliation or retribution against any person who reports suspected misconduct. More information can be found on the Humana Healthy Horizons **fraud, waste and abuse website**.

You also may contact:

Contact Name	Contact Information	Hours of Operation
AHCA consumer complaint hotline (toll- free)	Phone: **888-419-3456**	Monday through Friday, 8 a.m. to 5 p.m., Eastern time
AHCA online reporting form	**AHCA complaint form**	
Ethics Help Line	Phone: 877-5-THE-KEY (**877-584-3539**)	24 hours a day, 7 days a week
State of Florida general hotline	Phone: **866-966-7226**	
Humana Healthy Horizons ethics	Email: **ethics@humana.com** Website: **Secure reporting portal**	
Humana Healthy Horizons Member/ Provider Services	Phone: **800-477-6931**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
SIU	Hotline: **800-614-4126** Email: **siureferrals@humana.com**	24 hours a day, 7 days a week

If a member reported suspected fraud and the report results in a fine, penalty or forfeiture of property from a healthcare provider, the member may be eligible for a reward through the Attorney General's **Fraud Fighter Reward Program**. The reward may be up to 25% of the amount recovered or a maximum of $500,000 per case (§ 409.9203, Fla. Stat.). Individuals can speak with the Attorney General's Office about keeping their identity confidential and protected by calling toll free at **866-966-7226** or **850-414-3990**.

Chapter 15: Health, safety and welfare

Contact information pertaining to health, safety and welfare

Contact name	Contact information	Hours of operation
Central abuse hotline	Phone: **800-96-ABUSE (800-962-2873)**	24 hours a day, 7 days a week
Member/ Provider Services	Phone: **800-477-6931 (TTY: 711)**	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Risk management administration	Email: **RiskManagementAdministration@humana.com**	N/A

Health, safety and welfare

You are required to report adverse incidents to AHCA immediately but not more than 24 hours after. Suspected cases of abuse, neglect and/or exploitation must be reported to Florida Adult Protective Services, which has the responsibility for investigating allegations of abuse and neglect of elders and individuals with disabilities, including but not limited to:

Incident Type	Description
Abuse	Nonaccidental infliction of physical and/or emotional harm
Physical abuse	The infliction of physical pain or injury on an older person
Sexual abuse	Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an adult with disabilities; touching, fondling, sexual threats, sexually inappropriate remarks or any other sexual activity with an older person when the older person is unable to understand, unwilling to consent, threatened or physically forced to engage in sexual activity
Psychological abuse	Includes, but is not limited to, name calling, intimidation, yelling and swearing; may also include ridicule, coercion and threats

Incident Type	Description
Emotional abuse	Verbal assaults, threats of maltreatment, harassment or intimidation intended to compel the older person to engage in conduct from which they wish and have a right to abstain, or to refrain from conduct in which the older person wishes and has a right to engage
Neglect	Repeated conduct or a single incident of carelessness that results or could reasonably be expected to result in serious physical or psychological/ emotional injury or substantial risk of death (this includes self-neglect and passive neglect)
Exploitation	Illegal use of assets or resources of an adult with disabilities; it includes, but is not limited to, misappropriation of assets or resources of the alleged victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion or in any manner contrary to law
Human trafficking	Transporting, soliciting, recruiting, harboring, providing, or obtaining of another person for transport for the purposes of forced labor, domestic servitude or sexual exploitation using force, fraud and/or coercion

Reporting critical incidents

Critical incidents must be reported to Humana Healthy Horizons case management within 24 hours of the incident. A critical incident is defined as an adverse or critical event that negatively impacts the health, safety or welfare of a member. Critical incidents may include events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing members, or major medication incidents. ALFs and SNFs must report abuse, neglect or exploitation incidents to Humana Healthy Horizons. Critical incidents involving abuse, neglect or exploitation also must be reported by the provider to Florida Adult Protective Services.

You are expected to work with Humana Healthy Horizons case management to resolve all identified critical incidents involving Humana Healthy Horizons members in a timely manner and support the safety and well-being of our members.

Adverse incident reporting

The Humana Healthy Horizons risk management program includes adverse incident reporting and a management system for critical events that negatively impact the health, safety or welfare of Humana Healthy Horizons members. An adverse incident can include death, wrong surgical procedure, wrong site or wrong member, and surgical procedure to remove foreign objects remaining from a surgical procedure.

If you identify an adverse incident, you should:

- Report the adverse incident to the appropriate entity (police, adult protective services, etc.).
- Call 911 if the member is in immediate danger.

- Report the adverse incident within 24 hours to Humana Healthy Horizons and Florida DCF.
- Report suspected abuse, neglect and exploitation of a member immediately in accordance with § 39-201 and Chapter 415, Fla. Stat.
- Complete the **AHCA Critical Incident online report** or download and submit the **Critical Incident Individual Report form** to Humana Healthy Horizons' risk management team via email within 24 hours of being advised of the incident at **RiskManagementAdministration@humana.com**.

Physical indicators of abuse, neglect and exploitation

Physical indicators of abuse, neglect and exploitation include but are not limited to the following:

Indicator	Description
Unexplained bruises or welts	• On face, lips, mouth, torso, back, buttocks, thigh in various stages of healing • Reflecting shape of article used to inflict (electric cord or belt buckle) in several different surface areas
Unexplained fractures	• Skull, nose and/or facial structure fractures, in various stages of healing • Multiple or spiral fractures
Unexplained burns	• Cigar or cigarette burns, especially on palms, legs, arms, back or soles of feet • Immersion burns (sock-like or glove-like shapes on feet or hands, or a doughnut-shape on buttocks that indicate that the victim was held down in hot liquid) • Patterned like objects (electric burner, etc.)
Unexplained lacerations	• Mouth, lips, gums, eye or to external genitalia
Sexual abuse	• Difficulty in walking/sitting • Torn, shredded or bloody undergarments • Bruises or bleeding in external genitalia, vaginal or anal areas • Venereal disease • Pregnancy

Indicator	Description
Other	• Severe or constant pain • Obvious illness that requires medical or dental attention • Emaciated (so that individual can hardly move or so thin bones protrude) • Unusual lumps, bumps or protrusions under the skin • Hair thin as though pulled out, bald spots • Scars • Lack of clothing • Same clothing all the time • Fleas, lice on individual • Rash, impetigo, eczema • Unkempt, dirty • Hair matted, tangled or uncombed

Behavioral indicators of abuse, neglect and exploitation

Indicator	Description
Destructive behavior of victim	• Assaults others • Destroys belongings of others or themselves • Threatens self-harm or suicide • Inappropriately displays rage in public • Steals without an apparent need for the things stolen • Demonstrates recent or sudden changes in behavior or attitudes
Other behavior of victim	• Is afraid of being alone • Is suspicious of other people and extremely afraid others will harm them • Shows symptoms of withdrawal, severe hopelessness, helplessness • Moves from place to place constantly • Is frightened of caregiver • Is overly quiet, passive, timid • Denies problems exist

Indicator	Description
Behavior or family or caregiver	• Exhibits marital or family discord • Exhibits displays of striking, shoving, beating, name-calling, scapegoating • Appears to be hostile, secretive, frustrated, show little concern, poor self-control, blames adult, appear impatient, appear irresponsible • Denies problems exist • Has experienced recent family crisis • Demonstrates inability to handle stress • Has experienced recent loss of spouse, family member or close friend • Has experienced alcohol abuse or drug use by family • Withholds food, medication • Isolates individual from others in the household • Displays lack of physical, facial or eye contact with individual • Changes doctor frequently without specific cause • Has history of similar incidents • Displays resentment, jealousy • Holds unrealistic expectations of individual

Human trafficking indicators

Possible indicators of human trafficking include, but are not limited to, the following:

- A scripted or inconsistent history
- Unwilling or hesitant to answer questions about the injury or illness
- Accompanied by an individual who does not let the member speak for themselves, refuses to let the member have privacy or who interprets for them
- Evidence of controlling or dominating relationships (excessive concerns about pleasing a family member, romantic partner or employer)
- Demonstrates fearful or nervous behavior or avoids eye contact
- Resistant to assistance or demonstrates hostile behavior
- Unable to provide their address
- Not aware of their location, the current date or time
- Not in possession of their identification documents

- Not in control of their own money
- Not being paid or wages are withheld

You are required to report adverse incidents to AHCA immediately, but no later than 24 hours from the incident. Reporting must include information detailing the member's identity, incident description and outcomes, including current member status.

It is your responsibility to ensure that abuse, neglect and exploitation training occurs, and that necessary training documentation is maintained for employees that have contact with plan members. You may be requested to make such documentation available.

You may consider using the **Adult Abuse, Neglect, and Exploitation Guide for Professionals** available online as a training tool.

Suspected elder abuse, neglect or exploitation may be reported to the central abuse hotline at 800-96-ABUSE (**800-962-2873**), 24 hours a day, 7 days a week or via the online **reporter portal**.

When reporting suspected or confirmed abuse, neglect or exploitation, please report the following information (if available):

- Victim's name, address or location, approximate age, race and gender
- Physical, mental or behavioral indications that the victim is infirmed or disabled
- Signs or indication of harm or injury or potential harm or injury (physical description or behavioral changes)
- Relationship of the alleged person responsible to the victim, if possible (if the relationship is unknown, a report is still submitted if the other reporting criteria are met).

Humana Healthy Horizons may be required to ensure that all direct care providers have knowledge of and attest that they maintain compliance with staff training relative to abuse, neglect and exploitation.

