Provider Orientation and Training

Information for Medicaid healthcare providers and administrators

2024

Humana Healthy Horizons® in South Carolina | Healthy Connections

Humana Healthy Horizons in South Carolina is a Medicaid product of Humana Benefit Plan of South Carolina, Inc.

335202SC1023 SCHM652EN

Training topics

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Training topics are based on:

- Humana's contract with the South Carolina Department of Health and Human Services (SCDHHS)
- Humana's policies and procedures

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Humana Healthy Horizons in South Carolina

Humana Healthy Horizons

Humana Healthy Horizons is committed to the SCDHHS approach to improve the health of its members by:

- Defining measurable results that will improve Medicaid managed care organization (MCO) member access and satisfaction
- Maximizing program efficiency, effectiveness and responsiveness
- Reducing operational and service costs

Humana Healthy Horizons focuses on prevention and partnering with local providers to offer integrated care our members need to be healthy. Humana Healthy Horizons is available statewide to eligible members.

Member populations and eligibility

Eligible populations and member eligibility

Eligible populations

Members are eligible to receive Medicaid assistance under one of the following aid categories:

- Temporary Assistance for Needy Families (TANF)
- Supplemental Security Income (SSI)
- Optional coverage for pregnant women and infants
- Dual-eligible members
- Foster care children

Member eligibility

- Medicaid eligibility is determined by SCDHHS.
- Eligibility begins on the first day of each calendar month, including the initial application month.

PCP assignment and reassignment

Members can select a PCP during the enrollment process or one may be automatically assigned.

Automatic assignment process:

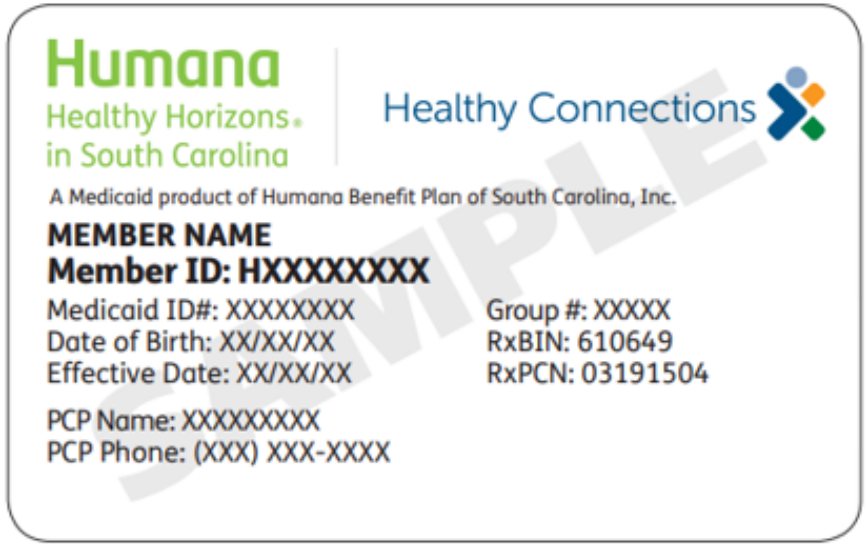
- Assign the member's previous PCP if that PCP is participating with Humana Healthy Horizons.
- Geographic assignment is used when a member has no record of past PCP relationships within the participating Humana Healthy Horizons PCP panel.
- Humana Healthy Horizons' internal editing system also ensures the auto-assigned PCP is age-appropriate for the member.

Members may request reassignment to another PCP for any reason by calling Member Services at **866-432-0001**.

PCPs may request a member's disenrollment from the practice and reassignment to a new PCP under certain circumstances. Please refer to the **provider manual** for details.

Member eligibility–ID cards

- Members will receive an ID card prior to their enrollment date with Humana Healthy Horizons.

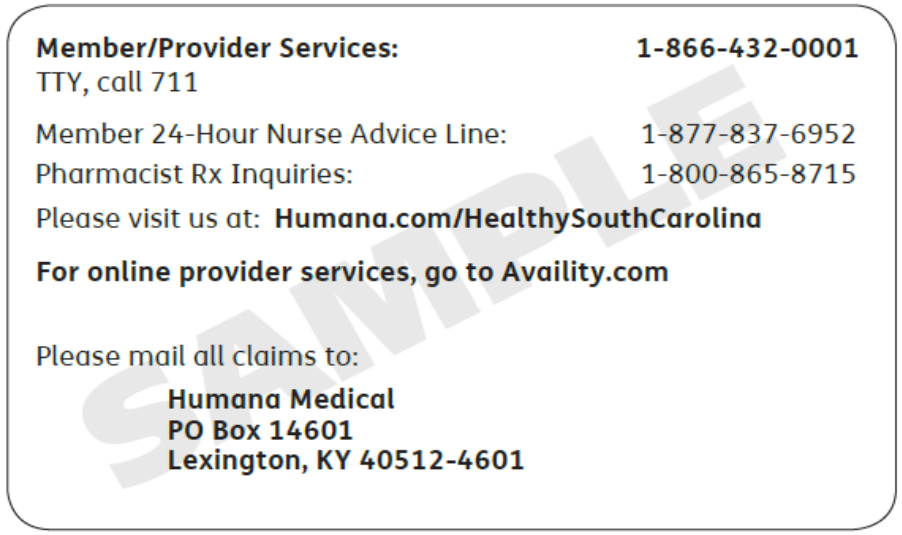


Please note: This PDF meets state/compliance guidelines and is subject to change at any time. Notification will be communicated if compliance guidance changes.

Front of Humana Healthy Horizons member ID card

- Member ID: Humana Unique Member Identification Medicaid ID number–required for all members and used when filing claims
- Effective date: indicates when member becomes eligible for benefits
- RxBIN/RxPCN: needed for pharmacy benefits

Member eligibility–ID cards



Please note: This PDF meets state/compliance guidelines and is subject to change at any time. Notification will be communicated if compliance guidance changes.

Back of Humana Healthy Horizons member ID card

- Member/provider service number: Toll-free number for questions and information
- Pharmacist Rx inquiries number: Toll-free number for questions and information
- **Availity**: For online provider services
- Claims address to submit paper claims: P.O. Box 14601, Lexington, KY 40512-4601

Member eligibility–State-issued Medicaid ID card

Humana Healthy Horizons provides most of the services delivered by South Carolina Medicaid. Members are encouraged to present their Humana Healthy Horizons plan ID card and South Carolina Medicaid card prior to receiving the following services:

- Dental services
- Targeted Case Management (TCM) services
- Home- and community-based waiver services
- Medicaid Adolescent Pregnancy Prevention Services (MAPPS)
- Developmental Evaluation Services (DECs)

Covered services

Covered services

Humana Healthy Horizons, through its contracted healthcare providers, is required to arrange for the following medically necessary services for each member:*

Abortions (coverage only when rape, incest or pregnancy endangering the woman's life is documented)	Institutional long-term care (LTC) facilities/nursing homes
Ambulance transportation • Transportation for out-of-state medical services	Maternity services
Ancillary medical services	Medication-assisted treatment
Audiological services	Nutritional counseling
Autism spectrum disorder (ASD) services	Pharmacy/prescription drugs
BabyNet services	Physician services
Behavioral health services	Rehabilitative therapies for children — nonhospital based
Chiropractic services	Specialty services such as dermatology, gastroenterology
Communicable disease services	Sterilization services including hysterectomies
Durable medical equipment (DME)	Substance use services
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/well-child visits	Telehealth services
Emergency/post-stabilization services	Therapy services such as occupational, physical and speech language pathology
Family planning services	Transplant and transplant-related services
Home health	Vision services—limited to members 21 and younger
Independent laboratory and X-ray services	
Inpatient and outpatient hospital services	

* See member Certificate of Coverage for full coverage details.

Member costs

Covered medical services are provided at no cost to the member. Except for pharmacy costs, Humana Healthy Horizons waives all copays.

Medicines on the Preferred Drug List (PDL) have a $3.40 copay for drugs for members 19 and older. However, there are no copays for:

- Members younger than 19
- Pregnant women
- Institutionalized individuals (such as persons in a nursing facility or intermediate care facilities for individuals with intellectual disability [ICF/ID])
- Members of a federally recognized Indian tribe are exempt from most copayments. Tribal members are exempt when services are rendered by the Catawba Service Unit in Rock Hill, South Carolina, and when referred to a specialist or other medical provider by the Catawba Service Unit.

EPSDT

- Members eligible for Medicaid EPSDT benefits do not have copayments.
- Children (birth through 18) and adults (19 through the end of the 21st birthday month) eligible for Medicaid's EPSDT program continue to receive vision and dental benefits through EPSDT coverage.
- SCDHHS adopted the Bright Futures/American Academy of Pediatrics periodicity schedule for medical, hearing, vision and other age-appropriate assessments and immunizations. More information on the medical and dental periodicity schedules is available at **AAP Pediatric Periodicity Schedule** and at the **SCDHHS EPSDT provider website**.
- Federal regulation requires that all children receive a blood test for lead at:
  - 12 months and 24 months
  - 36 months and 72 months for children who have not had a previous blood lead screening

EPSDT special services

EPSDT special services include coverage for other medically necessary healthcare, evaluations, diagnostic services, preventive services, rehabilitative services and treatment, or other measures not covered by South Carolina Medicaid, including:

- Preventive, diagnostic or rehabilitative treatment or services that are medically necessary to correct or ameliorate the individual's physical, developmental or behavioral condition
- Medically necessary services regardless of whether those services are covered by South Carolina Medicaid

Medical necessity is determined on a case-by-case basis. EPSDT special services that are subject to medical necessity often require prior authorization. The payer source must consider the child's long-term needs, as well as immediate needs, and account for physical, developmental and/or behavioral aspects of the child's health.

More information regarding EPSDT is available in the **Humana Healthy Horizons in South Carolina Provider Manual** or online at **South Carolina Medicaid Support: Child Members – Humana**.

Telehealth

Virtual visits

For medical and behavioral health services, telehealth, also called telemedicine or virtual visits, is available through select providers. Similar to using FaceTime or Skype, virtual visits involve a member's use of a webcam and screen to talk to a licensed healthcare provider. These virtual visits are private and confidential.

Pharmacy benefit summary

90-day supply

Select maintenance medications are eligible for a 90-day supply at both retail and mail order locations.

PDL

Covered drugs and any applicable prior authorization criteria can be found at **Humana.com/Provider** and **Humana.com/DrugLists**.

Copayment

Medicaid members have a $3.40 copay at network pharmacies. Children and select individuals may be exempt.

Over-the-counter (OTC) benefit

Members have a $10 per month OTC benefit allowance through CenterWell Pharmacy®.

Additional pharmacy benefit information can be found at **Humana.com**.

Drug prior authorization and notification

Get forms at **Humana.com/PA** or call **800-555-CLIN (2546)**. (Monday through Friday, 8 a.m. to 8 p.m., Eastern time).

- Submit requests electronically by going to **Covermymeds.com/EPA/Humana**.
- Submit requests by fax to **877-486-2621**.
- Call Humana Clinical Pharmacy Review (HCPR) at **800-555-CLIN (2546)**.

For drugs delivered/administered in the provider's office, clinic, outpatient or home setting (fee-for-service providers only):

- Obtain forms at **Humana.com/MedPA**.
- Submit a request by fax to **888-447-3430**.

State Pharmacy Lock-In Program (SPLIP)

- This program is designed for individuals who need help managing their use of prescription medications to limit overuse of benefits while providing an appropriate level of care for the member.
- The Lock-In Program is required by SCDHHS.
- Members identified for the Lock-In Program receive written notification from Humana Healthy Horizons in South Carolina, along with the designated lock-in pharmacy's information and the member's right to appeal the plan's decision.
- Members who meet the program criteria are locked into one specific pharmacy location and initially locked in for a total of 24 months.

For additional details regarding SPLIP, including program criteria and exclusions, please refer to the **Humana Healthy Horizons in South Carolina Provider Manual**.

Prescriber quick reference guide

Humana Clinical Pharmacy Review (HCPR)

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

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

Humana Medication Intake Team

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

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

General Humana contact information

Claims address	Located on the patient's Humana member ID card
Pharmacy appeals	**Commercial and Medicaid:** Humana Appeals, P.O. Box 14546, Lexington, KY 40512-4546; Fax: **800-949-2961**

CenterWell Pharmacy (formerly Humana Pharmacy)

CenterWell Pharmacy (mail-delivery pharmacy for maintenance medications and durable medical equipment)	Call **800-379-0092** (Fax: **800-379-7617**), Monday through Friday, 8 a.m. to 11 p.m., Eastern time; Saturday, 8 a.m. to 6:30 p.m., Eastern time; CenterWellPharmacy.com
CenterWell Specialty Pharmacy® (mail-delivery pharmacy for specialty medications)	Call **800-486-2668** (Fax: **877-405-7940**), Monday through Friday, 8 a.m. – 8 p.m. Eastern time; Saturday, 8 a.m. to 6 p.m., Eastern time; CenterWellPharmacy/specialty-medications.html

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

Benefits and services

Humana Healthy Horizons offers several benefits and services for Medicaid members, including:

- Care management and behavioral health services for members with chronic health conditions
- Behavioral health services that include a dedicated hotline and crisis intervention
- Local pharmacy support to help members learn about their medication needs and drug safety
- Dental services based on member coverage
- Population health management programs to encourage healthy behaviors and preventive care
- A toll-free phone number for members to speak with a registered nurse about their health concerns 24 hours a day, 7 days a week, at **877-837-6952**

Member services

Humana Healthy Horizons members enjoy a range of support and care services, including:

- Referrals to community resources and/or case management
- Support and education for chronic conditions
- Assistance with finding a PCP
- Access to the grievances and appeals processes
- Support for claims issue resolution
- Help with benefit inquiries
- Access to pharmacy benefits
- Help with prior authorization requests
- Support with interpretation services

Excluded services

The following services continue to be provided and reimbursed by the current Medicaid program and are consistent with the outline and definition of covered services in the Title XIX South Carolina State Medicaid plan:

- Medical (nonambulance) transportation
- Broker-based transportation (routine nonemergency medical transportation)
- Dental services
- TCM services
- Home- and community-based waiver services
- MAPPS family planning services
- DECs
- Sex transition surgery

Payment for these services remains Medicaid fee-for-service. MCOs are responsible for the continuity of care for all Medicaid MCO members by ensuring appropriate service referrals are made for excluded services.

Services not covered

South Carolina Medicaid only pays for services that are medically necessary. Below are some of the services for which South Carolina Medicaid does not pay, including examples of service limitations, exclusions from coverage and moral or religious objections:*

Abortion (unless the mother's life is in danger or in the case of incest or rape)	In vitro fertilization
Braces for teeth, dentures, partials and bridges for members 21 and older	Massage and hypnosis
Cosmetic surgery	Paternity testing
Fans, air conditioning, humidifiers, air purifiers, computers and home repairs	Services from providers who are not South Carolina Medicaid providers
Fertility drugs	*Services not covered (including those listed)
Hearing aids for members 21 and older	Services that are not medically necessary
Hospital stays for treatments that can be delivered outside the hospital	Unauthorized services
	*Exceptions may exist, reach out if uncertain or have questions regarding a service and possible exceptions

Humana Healthy Horizons added benefits

Added benefits

Humana Healthy Horizons in South Carolina offers members extra benefits, tools and services, at no cost to the member, that are not otherwise covered or that exceed limits outlined in the South Carolina plan and the South Carolina Medicaid fee schedules. The following are examples of value-added benefits (VABs); for a full listing, please consult the provider manual.

VAB	Details and limitations
Baby and Me meals	Up to 2 precooked, home-delivered meals are available per day for 10 weeks for pregnant women who are high risk. **Care Manager approval required.**
Breast pumps	Female members can receive 1 non-hospital grade breast pump every 2 years, or 1 rental of a hospital grade breast pump if the baby has an inpatient stay in a neonatal intensive care unit (NICU).
Convertible car seat and portable crib	Pregnant members are contacted once we are notified that the mom is expecting. During the call or through a call to Member Services, pregnant moms can confirm if a car seat or crib is needed prior to delivery. Pregnant members who do not need the crib/car seat prior to delivery are asked to enroll and actively participate in our HumanaBeginnings® care management program and after completion of the prenatal comprehensive assessment can then choose between a crib or a car seat. Upon completion of the postpartum assessment and 1 follow-up call, the member can have the second item (portable crib/car seat). Members who are in need of the crib and car seat prior to delivery will receive the items and also will be contacted for a postpartum assessment along with a follow-up call. This applies per infant, per birth.
Fresh produce box	Up to 4 boxes per year are available for members who are identified as food insecure or diabetic, or who suffer from heart failure or hypertension. **Care manager approval required.**

Added benefits (cont'd.)

VAB	Details and limitations
GED testing	GED test preparation assistance is provided for members 16 and older and includes a bilingual adviser, access to guidance and study materials and unlimited use of practice tests. Test preparation assistance is provided virtually to allow maximum flexibility for members. This also includes test pass guarantee to provide members multiple attempts at passing the test. Members can be ages 16 to 18 if they have a South Carolina Verification of School Withdrawal Form completed by the principal or attendance supervisor of the last school attended. The GED test may be taken at age 19 and up without the South Carolina Verification of School Withdrawal Form.
Haircuts for kids	1 standard haircut, valued at $20, is provided for members in grades K-12 who upload a photo of their school registration form, school ID or class schedule. The redemption period runs from July 2024 through September 2024. Members can upload a photo of their child's school registration form, school ID or class schedule in the Go365® app.
Housing assistance	Members 18 and older may receive up to $750 per member per lifetime to assist with the following housing expenses: • Apartment rent or mortgage payment (late payment notice required) • Utility payment for electric, water, gas or internet (late payment notice required) • Trailer park and lot rent if this is the member's permanent residence (late payment notice required) • Moving expenses via licensed moving company when transitioning from a public housing authority The member must meet the following qualifications; plan approval is required: • Member must complete the Health Risk Assessment (HRA). • Member must not live in a residential facility or nursing facility. **Note:** Funds will not be paid directly to the member. If the bill is in the spouse's name, a marriage certificate may be submitted as proof.

Added benefits (cont'd.)

VAB	Details and limitations
Newborn circumcision	The member is covered from 29 days old through 12 months.
OTC pharmacy allowance	Up to $30 per quarter allowance enables members to purchase products that support commonly occurring conditions such as: • Pain relivers • Diaper rash cream • Cough and cold relief medicine • First aid equipment that does not require a prescription Unused amounts do not roll over to the next quarter.
Post-discharge meals	Up to 14 home-delivered meals are provided following discharge from an inpatient or residential facility. This is limited to 4 discharges per year.

Added benefits (cont'd.)

VAB	Details and limitations
Smartphone services	1 free smartphone is provided through the federal Lifeline program, per household. Members who are under 18 will need a parent or guardian to sign up. This benefit covers the following per lifetime: 1 phone; 1 charger; 1 set of instructions; unlimited talk, text and high-speed data; and training for the member and his/her caregiver at the first case manager orientation visit if you are enrolled in care management. The member must make 1 phone call or send 1 text message every month to keep the benefit. The member may qualify for enhanced benefits through the Affordable Connectivity Program (ACP) that provides unlimited minutes, 10GB hotspot capacity and unlimited data. You can opt into this benefit by contacting SafeLink at **800-SAFELINK** or online at **SafeLink**. Benefits are subject to change by the Federal Communications Commission under the Lifeline program.
Sports physical	1 sports physical is offered per year for members ages 6 to 18.

Added benefits * (cont'd.)

VAB	Details and limitations
Tobacco cessation program	The tobacco cessation program is focused on tobacco and vaping cessation coaching for members ages 12 and older. The program is designed as a 6-month engagement for a total of 8 coaching calls, but the member has 12 months to complete the program if needed. Humana's tobacco and vaping cessation health coaching program offers support for both OTC and prescription nicotine replacement therapy (NRT).
Vision services	Comprehensive vision exams are offered every year (12 months) for members 21 and older. 1 set of eyeglasses (lenses and frames) or contacts is offered every two 2 years.* * Luxury frames are not allowed.
Waiving copays (medical and behavioral health)	No copays are required for members 19 and older for medical and behavioral health services
Weight management program	The weight management coaching program delivers weight management intervention for members who are 12 and older. Upon receiving physician clearance, members can complete 6 weight management coaching sessions with a health coach, including approximately 1 call per month for a period of 6 months.
Youth academic support	Members in grades K-12 can access online tutoring services for 2 hours per week.
Youth development and recreation	Members 18 and younger can receive reimbursement of up to $250 annually for participation in activities such as: • The "Y" • Boys and Girls Club programming • Swim lessons • Computer coding classes • Music lessons

Added benefits (cont'd.)

Go365 for Humana Healthy Horizons® is a wellness program that offers members the opportunity to earn rewards for taking healthy actions. Most of the rewards are earned by Humana's receipt of the provider's claim services rendered. Humana Healthy Horizons recommends that all providers submit their claims on behalf of a member no later than Dec. 31, 2024. This allows members time to redeem their reward(s). Members can qualify to earn rewards by completing one or more of the following healthy activities:

Healthy activity	Reward
Breast cancer screening	Annual $25 reward for female members 40 and older who obtain a mammogram.
Cervical cancer screening	Annual $25 reward for female members 21 and older who obtain a Pap test.
Colorectal cancer screening	Annual $25 reward for members 45 and older who obtain a colorectal cancer screening as recommended by their PCP.
Chlamydia screening	An annual $25 reward is offered to female members who obtain a chlamydia screening when sexually active and as recommended by their healthcare provider.
COVID-19 vaccine	An annual $25 reward is offered to members 5 and older who upload a picture/file of their completed COVID-19 vaccine card, 1 per year. Members who were vaccinated prior to enrollment with the Humana plan may upload their vaccination card within 90 days of enrollment to receive the reward. New members who were not vaccinated prior to enrollment with Humana have 90 days from completion of vaccination to upload the vaccination card to receive the reward.
Diabetic retinal eye exam	An annual $25 reward is offered to diabetic members 18 and older who complete a retinal eye exam.
Diabetic screening	An annual $25 reward is offered to diabetic members 18 and older who obtain a screening with their PCP for HbA1c and blood pressure.
Digital onboarding	A one-time $25 reward is offered for downloading Humana's mobile Go365 app and completing the registration.

Rewards are not transferrable to other managed care plans or other programs. Rewards are nontransferable and have no cash value. E-gift cards may not be used for tobacco, alcohol, firearms, lottery tickets and other items that do not support a healthy lifestyle.

Added benefits (cont'd.)

Healthy Activity	Reward
Flu vaccine	Annual $25 reward for members who receive an annual flu vaccine from their provider, pharmacy or self-reporting if they received a vaccine from another source.
Follow-up after high-intensity care for substance use disorder	$25 reward for members who received follow-up care within 30 days of an inpatient hospital discharge, residential treatment or detoxification visit for a diagnosis of substance use disorder.
Follow-up after hospitalization for mental illness	$25 reward for members who received follow-up care within 30 days after a hospital discharge for a diagnosis of select mental illness or intentional self-harm.
HRA completion	One-time $25 reward for completing the HRA.
HPV vaccine	One-time $25 reward for members who receive 2 doses of the HPV vaccine between their 9th and 13th birthday.
Level of Care video	Annual $10 reward for members 19 and older upon watching a short educational video about when to access the emergency room (ER).
Notification of pregnancy (NOP)	$25 reward when pregnant members notify Humana of pregnancy prior to delivery, once per pregnancy.
Postpartum visit	$25 reward for all postpartum females who complete 1 postpartum visit within 7 to 84 days after delivery, once per pregnancy.

Rewards are not transferrable to other managed care plans or other programs. Rewards are nontransferable and have no cash value. E-gift cards may not be used for tobacco, alcohol, firearms, lottery tickets and other items that do not support a healthy lifestyle.

Added benefits (cont'd.)

Healthy activity	Reward
Prenatal visit	Pregnant members can earn $10 per prenatal visit, up to 10 prenatal visits, for a total of up to $100, once per pregnancy.
Tobacco cessation program	Members 12 and older who enroll in the tobacco cessation program will have 2 opportunities to earn rewards: • $25 reward for completing 2 calls within 45 days of enrollment in the program • $25 reward for completing the full program

Rewards are not transferrable to other managed care plans or other programs. Rewards are nontransferable and have no cash value. E-gift cards may not be used for tobacco, alcohol, firearms, lottery tickets and other items that do not support a healthy lifestyle.

Added benefits (cont'd.)

Healthy activity	Reward
Weight management program	Members 12 and older who enroll in the weight management program will have 2 opportunities to earn rewards: • $25 reward for completing a well-being checkup • $25 reward for completing the program
Well-child visits (0-15 months)	Up to $120 in rewards is offered to members who complete routine well-child visits. Members can receive $20 in rewards per visit with a 6-visit limit.
Well-child visits (16-30 months)	Up to $30 in rewards is offered to members who complete routine well-child visits. Members can receive $15 per visit with a 2-visit limit.
Wellness visits	An annual $25 reward is offered to members 3 and older for completing an annual wellness visit.

Rewards are not transferrable to other managed care plans or other programs. Rewards are nontransferable and have no cash value. E-gift cards may not be used for tobacco, alcohol, firearms, lottery tickets and other items that do not support a healthy lifestyle.

Contracting and credentialing

Contracting process

To be eligible for participation in the Humana Healthy Horizons provider network, a provider must be actively enrolled in the South Carolina Medicaid program. Humana Healthy Horizons works with the following networks to provide vision, pharmacy and hearing services. To request participation, please contact the appropriate network below:

Coverage type	Network	Contact
Medical	Humana Healthy Horizons	**866-432-0001** **SCProviderUpdates@humana.com**
Behavioral health	Humana Behavioral Health Network (HBHN)	**SCBHMedicaid@humana.com**
Pharmacy	Humana Pharmacy Solutions® (HPS)	**PharmacyContracting@humana.com**

Contracting process

Please include the following information when reaching out to medical/physical health provider relations at **SCProviderUpdates@humana.com** or behavioral health provider relations at **SCBHMedicaid@humana.com**:

- Provider/practice/facility name
- Service address with phone, fax and email information
- Mailing address, if different than service address
- Tax Identification Number (TIN)
- Specialty
- Medicaid provider number (with corresponding registered provider specialty code and provider type code)
- NPI
- Type of contract (e.g., individual, group, facility)
- Council for Affordable Quality Healthcare (CAQH®) number

After receipt and review of your request, a Humana HBHN provider contracting representative will contact you.

Contractual and demographic changes

As a contracted provider, notifying Humana Healthy Horizons of legal and demographic changes is required and ensures provider directory and claim processing accuracy. Please note: Contracted providers are required to notify Humana of changes to their TIN.

Notification of changes should be sent to:

- Medical providers – **SCProviderUpdates@humana.com**
- Behavioral health providers – **SCBHMedicaid@humana.com**

Use a standard roster or Humana Healthy Horizons form for the following changes:

- New providers added to group
- Providers leaving group
- Service address changes (e.g., new location, phone, fax)
- Access to public transportation
- Standard hours of operation and after hours
- Billing address updates
- Credentialing updates
- Panel status
- Languages spoken in office

Please refer to your agreement or contact your provider representative for any additional contracting questions.

Credentialing

- Providers must be credentialed prior to participating in the Humana Healthy Horizons network and treating members.
- Humana participates with CAQH, as applicable by provider type.
  - To aid with credentialing and recredentialing activities, please maintain your CAQH application to ensure it is complete and current.
- Recredentialing occurs at least every 3 years. Some circumstances require shorter recredentialing cycles.
  - Humana Healthy Horizons leverages applications available via CAQH during the recredentialing cycle, as applicable by provider type.
  - If we are not able to access your CAQH application, CAQH does not support your provider type or the supporting documentation available via CAQH is expired or incomplete, providers will receive a request to provide the necessary documentation prior to the 36-month anniversary date of the last credentialing cycle.
- Healthcare providers must be screened by and enrolled as qualified Medicaid providers with SCDHHS prior to being considered for network participation.
- In addition to being in good standing with Medicare and federal, state and local agencies, healthcare providers must not appear on the Excluded Providers List published by SCDHHS.

Further details regarding Humana Healthy Horizons' credentialing/recredentialing requirements can be found in the **Humana Healthy Horizons in South Carolina Provider Manual**.

Provider and member rights and responsibilities

Humana Healthy Horizons-contracted healthcare providers have a responsibility to respect our members' rights. Our members are informed of their rights and responsibilities via the member handbook.

Detailed information on provider and member rights and responsibilities can be found in the **Humana Healthy Horizons in South Carolina Provider Manual**.

Clinical

Health services and Utilization Management

Utilization Management (UM) helps maintain the quality and appropriateness of healthcare services provided to Humana Healthy Horizons members.

- Provides concurrent review and discharge planning
- Promotes effective level of care based on member's individual needs
- Refers to appropriate Humana Healthy Horizons programs

UM

Front-end review:

- Reviews inpatient admissions for medical necessity using evidence-based clinical criteria during preauthorization or on notification of admission
- Begins discharge planning upon notification of admission

Concurrent review:

- Completes discharge planning assessments on members with inpatient admission
- Conducts medical-necessity reviews using evidence-based clinical criteria for members with continued inpatient stays
- Collaborates with member's healthcare team to maximize member's benefits and resources and identifies member's anticipated discharge planning needs
- Conducts medical-necessity reviews using evidence-based clinical criteria for post-acute level-of-care requests in collaboration with medical director
- Identifies and refers members to internal Humana Healthy Horizons case management/disease management programs, as appropriate

Referrals

PCPs serve as the entry point into the healthcare system for the member. The PCP is responsible for providing primary care, coordinating care with specialty providers, authorizing hospital services and maintaining continuity of care.

PCPs should screen their patients regularly for behavioral health disorders, including substance use disorders.

If PCPs need assistance locating appropriate behavioral health providers for members, Humana Healthy Horizons' care management team can assist you and the patient by emailing a referral to **SCMCDCareManagement@humana.com**.

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

Exceptions to this policy apply to members eligible for participation in the Lock-In Program.

Referrals (cont'd.)

Providers are encouraged to implement Screening, Brief Intervention and Referral to Treatment (SBIRT) best practices for all members who may be affected by a substance use disorder:

- Screening – Use a standard screening tool to assess risks for patients.
- Brief Intervention – Use clinical expertise to engage patients in a conversation about how risky behaviors are affecting them and develop the patients' interest in treatment.
- Referral to Treatment – Refer patients to treatment professionals who specialize in behavioral health or substance use disorder treatment.

For more information on how to use SBIRT in your practice, please visit **https://www.samhsa.gov/sbirt**.

Prior authorizations

- Humana Healthy Horizons requires prior authorization for certain services to facilitate care coordination and to confirm the services are being provided according to South Carolina coverage policies.
- Member eligibility is verified when a prior authorization is issued; however, treating providers must confirm eligibility on the date of service. Humana Healthy Horizons is not able to pay claims for services provided to ineligible members.
- Prior authorizations are required for specific services and medications. Please see the Pharmacy section of this presentation for details on drug prior authorizations.
- Physicians and other healthcare providers should review the South Carolina Medicaid Prior Authorization List online at **Humana.com/PAL**.
- Prior authorization for services, including EPSDT services, must be obtained prior to the date of service to determine medical necessity of the request. The provider authorization form can be found online at **Humana.com/HealthySC/PriorAuth**.

Prior authorizations for medical procedures

Prior authorization for healthcare services can be obtained by contacting the UM department online or phone:

- Visit **Availity Essentials**
- Call **866-432-0001** and follow the menu prompts for authorization requests, depending on your need
- Fax the request to **833-441-0950**

Online authorizations

Online submission

- Fast and easy entry of authorizations through Availity Essentials
- Express entry feature
- Real-time responses
- Ability to add attachments
- Quick-print feature

Online management

- Access to last 18 months of authorization history
- Ability to update authorizations
- Status updates on submitted authorizations

Sign in to Availity Essentials

Prior authorization—What should be included in the request?

When requesting authorization, please provide the following information:

- Member/patient name and Humana Healthy Horizons member ID number
- Provider name, NPI, TIN and contact information for ordering/servicing providers and facilities
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits or units of service requested, if applicable
- Reason for referring to an out-of-plan provider, if applicable
- Clinical information to support the medical necessity of the service, including a current treatment plan and assessments, if applicable
- Admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs, if the request is for inpatient admission for elective, urgent or emergency care
- Date of surgery, surgeon and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment, all appropriate clinical review and anticipated discharge needs, if inpatient surgery is planned
- Date of surgery, surgeon and facility, diagnosis and procedure planned and anticipated discharge needs, if the request is for outpatient surgery

Prior authorization—Determination time frames

Standard determination

- Notice of decision is provided as expeditiously as the member's health condition requires but no later than 14 calendar days following receipt of the request for service.

Expedited determination

- When a provider indicates, or Humana Healthy Horizons determines, that following the standard time frame could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function, Humana Healthy Horizons will complete an expedited authorization decision within 72 hours and provide notice as expeditiously as the member's health condition requires. Please specify if you believe the request should be expedited.

Retrospective review

Humana Healthy Horizons only allows for a retrospective authorization submission after the date of service when a prior authorization is required but not obtained in the following circumstances:

- The service is directly related to another service for which prior approval was obtained, and the service already was performed.
- The new service was not needed at the time the original prior-authorized service was performed.
- The need for the new service was determined at the performance of the original prior-authorized service.
- Humana Healthy Horizons-covered patients are determined to be retroactively eligible for Medicaid. (Retroactive Medicaid coverage is defined as a period of time up to 3 months prior to the application month.)
- Exception: An authorization obtained prior to a member transitioning from another MCO to Humana Healthy Horizons will be upheld for the remainder of that prior authorization approval time period.

Retrospective review

Please fax retro-authorization requests to **833-441-0950**. The following documentation must be included:

- Patient name and Humana Healthy Horizons member ID number
- Authorization number of the previously authorized service for the related request, if applicable
- All supporting documentation related to the service

Members with special healthcare needs

When a new/transitioning member is actively receiving medically necessary covered services from the previous MCO:

- Humana Healthy Horizons provides continuation/coordination of medically necessary covered services for up to 90 calendar days or until the member may be reasonably transferred without disruption, whichever is first.
- Humana Healthy Horizons may require prior authorization for continuation of the services beyond 90 calendar days; however, under these circumstances, authorization is not denied solely on the basis that the provider is not contracted with Humana.

Transitioning during pregnancy

- **First trimester:** Humana Healthy Horizons covers the costs of continued medically necessary prenatal care, delivery and postnatal care services without prior authorization and, regardless of the provider's contract status, until Humana Healthy Horizons can safely transfer the member to a network provider without impeding service delivery.
- **Second and third trimesters:** Humana Healthy Horizons covers the costs of continued access to the prenatal care provider (even if the provider is not contracted) for 60 calendar days postpartum, provided the member remains covered through Humana Healthy Horizons, or referral to a safety-net provider if the member's eligibility terminates before the end of the postpartum period.

Transitioning during pregnancy (cont'd.)

Medically necessary services covered by the previous MCO in addition to, or other than, prenatal services:

- Humana Healthy Horizons temporarily covers the costs of continuation of such medically necessary services.
- After 90 days, Humana Healthy Horizons may require prior authorization for continuation of services, but authorization is not denied at that point solely due to a provider's contract status.
- Humana Healthy Horizons may continue services uninterrupted for up to 90 calendar days or until the member may be reasonably transferred without disruption, whichever is less.

Access to care requirements

- Providers must offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, even if the provider serves only Medicaid managed care members.
- Providers are required to ensure all services included in the contract are made available 24 hours a day, 7 days a week when medically necessary.
- Providers must maintain formalized relationships with other PCPs to refer members for after-hours care, during certain days, for certain services and other reasons to extend the hours of services of their practice.
- An after-hours telephone number must be provided to all members. The after-hours number must connect the member to an answering service, a call center or a recording that directs the caller to another number to reach you or your designated medical provider for answering calls.
- Members should be triaged and provided appointments for care within the time frames listed on the following slide.

Access to care requirements (cont'd.)

Primary care providers

Patients with:	Should be seen:
Emergency needs	Immediately on presentation
Urgent care needs	Within 48 hours of a request
Routine care needs	Within 4 to 6 weeks of member's request
Walk-in members with nonurgent needs	Should be seen if possible or scheduled for an appointment consistent with written scheduling procedures

Non-PCP specialists

Patients with:	Should be seen:
Emergency needs	Immediately upon referral
Urgent care needs	Within 48 hours of referral or notification from PCP
Routine care needs	Within 4 weeks and a maximum of 12 weeks for unique specialists

Access to care requirements (cont’d.)

Behavioral health providers

Patients with:	Should be seen:
Emergency care needs	Immediately on receiving referral for emergent visit
Urgent care needs	Within 48 hours of referral or notification from PCP
Routine office visit	Within 4 weeks of member's request and a maximum of 12 weeks for unique specialists

Interpretation/translation services

All providers are required to abide by federal and state regulations related to sections 504 and 508 of the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA), Executive Order 13166 and Section 1557 of the Affordable Care Act (ACA), in the provision of effective communication, including in-person or video-remote interpretation for deaf and hard-of-hearing patients and over-the-phone interpretation with a minimum 150 languages available for non-English speakers.

Such services are provided at no cost to the member, per federal law.

Preventive health service and clinical practice guidelines

These clinical treatment protocols are systematically developed statements that help providers and members make decisions regarding appropriate healthcare for specific clinical circumstances or for specific age ranges. We strongly encourage providers to consider and use these guidelines whenever they promote positive health outcomes for their patients.

Humana Healthy Horizons uses the guidelines to measure the impact of quality care and monitors provider implementation of guidelines, analyzing claim, pharmacy and utilization data.

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

- Provider manual updates at **Humana.com/HealthySC**
- Provider website at:
  - **Humana.com/provider/medical-resources/clinical/guidelines**
  - **Humana.com/provider/medical-resources/clinical/behavioral-health-guidelines**

Care management overview

Care management:
Humana Healthy Horizons manages and coordinates care for members with special healthcare needs who require ongoing care management/chronic condition management. Outreach frequency is determined by individual member needs, preferences and risk level.

Humana Healthy Horizons includes the following steps in its care management:

- Identifies members through referrals from on-site/telephonic UM nurses, PCPs, specialists, member self-referral, health needs assessment, predictive model algorithms, post-discharge assessments, etc.
- Obtains members' permission/agreement to participate (Members may opt out at any time.)
- Completes a comprehensive assessment incorporating physical and behavioral health as well as social determinants of health (SDOH)
- Identifies key people on members' interdisciplinary care team and engages the PCP
- Creates an individualized comprehensive care plan with the member and works toward identified goals
- Makes available the individualized care plan to providers by contacting Humana Healthy Horizons

Care management functions

Humana Healthy Horizons also:

- Identifies triggers for ER visit/admission and partners with members and their healthcare providers to prevent/reduce ER visits and unplanned inpatient admissions
- Addresses Health Effectiveness Data and Information Set (HEDIS®) measures for members' gap reports or alerts on file*
- Refers to internal and external programs and community resources as needed (e.g., maternal health program, smoking cessation, food pantry resources, etc.)
- Coordinates and participates in interdisciplinary team meetings to identify the best course of action for improved outcomes based upon member needs
- Educates members on disease process, self-care VABs, such as vision and dental coverage
- Supports and reinforces medical provider instructions and facilitates appointment scheduling and attendance post-discharge to support members transitioning from inpatient to home or community setting

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

Discharge supports

Case management:
When inpatient discharge notes indicate need for a Medicaid member, Humana Healthy Horizons' case management collaborates with multiple areas to coordinate care.

- Referrals from UM nurses following discharge, PCPs, specialists, self-referral, internal/external programs, community partners, etc.
- Educates members on disease process, self-care and value-added services
- Completes post-discharge or post-ER visit telephonic outreach within three days of discharge (when applicable)
- Identifies gaps in care, addresses post-discharge needs and assists in making follow-up appointment(s) with PCP and specialists

Case management tools

To support our population health initiatives, providers are encouraged to refer members with a need identified through your evaluation process to our care management program by sending an email to **SCMCDCareManagement@humana.com** with "Case Management Referral" in the subject line. Providers should encourage members to utilize Humana Healthy Horizons' population health tools:

- Go365: Humana's wellness and rewards program, Go365 incorporates practices of behavioral economics and encourages members to complete healthy activities, including preventive exams and the completion of the health risk assessment (HRA). The custom Medicaid Go365 mobile app provides an experience designed to specifically meet the needs of our South Carolina Medicaid members. On completion of key activities, participants can earn and redeem gift cards to popular retailers, such as Walmart, CVS and Amazon, which are delivered to the member via email or mail.
- Milliman Care Guides provide access to evidenced-based knowledge and education in multiple care settings. Our care managers have in-depth training to maximize these tools and provide our members with disease-specific education and resources to maintain and improve their health.
- KidsHealth®: A library of video modules and written content on pediatric behavioral health (BH) and physical health conditions. KidsHealth content is designed to be accessible and readable by children, adolescents and adults, enabling younger members to play a role in the self-management of their condition.
- Healthwise®: Provides disease-specific education and self-management support in an easy-to-read format. It is available across priority conditions and follows current clinical practice guidelines. Our care managers use the Healthwise database to deliver condition-specific content to our members.
- NLM Search: Provides link to Medline Plus. Our Care Managers are able to send educational information provided from Medline Plus.

Chronic condition management

Goal

Empower members with chronic conditions through education and development of self-management skills that foster treatment plan compliance and better health outcomes.

Overview

- Participation is voluntary and members may opt out at any time.
- Referrals come from claims data, on-site/telephonic nurses after discharge, PCPs, self-referral, internal/external programs, community partners, etc.
- Assessment includes health history, cognitive/psychological/depression screening, medication review and diet compliance.
- Creates an individualized education plan based on member needs.
- Case manager coordinates care to meet identified needs and works with member to set agreed-upon contact frequency and cadence.
- Educates members about disease process, self-care and value-added benefits, such as vision and dental coverage. Refers to internal and external programs and community resources as needed (e.g., maternal health program, smoking cessation, food pantry resources, etc.).
- More information is available at **Humana.com/HealthySC**.

Member incentive programs

- Member incentive programs are healthy behavior programs designed to help members live a healthier lifestyle and maintain health.
- For incentive details, please see the Humana Healthy Horizons in South Carolina Added Benefits slide in this presentation.
- Members can call the Humana Healthy Horizons Member Services phone number on the back of their ID card to learn how to enroll in incentive programs and find out more.

Maternal health and transition programs

HumanaBeginnings

All pregnant members are eligible to join our maternity case management program, HumanaBeginnings. Through this program, our members receive registered nurse-led maternity case management services that are tailored to their acuity level.

- HumanaBeginnings assists members with the following:
  - Development of and adherence to treatment plans for high-risk members
  - Resources and support for substance use disorders or mental health concerns
  - Referrals to community-based programs and resources
- Manages prenatal and postpartum members from onset of pregnancy up to 8 weeks postpartum or eligibility loss
- Facilitates care coordination with internal and external programs

Claims processing

Electronic claim submission

Claims clearinghouses*

Availity	**Availity.com**
Change Healthcare	**ChangeHealthcare.com**
TriZetto	**TriZettoProvider.com**
McKesson	**McKesson.com**
SSI Group	**TheSSIGroup.com**

* Some clearinghouses and vendors charge a service fee. Contact the clearinghouse for more information.

Resources	Humana payer IDs
• Go to **Humana.com/ClaimResources** • Choose “Claims and encounter submission”	• 61101 for fee-for-service claims • 61102 for encounter claims

Importance of encounter submissions in Medicaid

Encounters identify members who received services and:

- Decrease the need for medical record review during HEDIS audits
- Are critical to future implementation of Medicaid risk adjustment
- Help identify members receiving preventive screenings and decrease members listed in gaps-in-care reports

Paper claim submission

Paper claims mailing address:
Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Paper encounters mailing address:
Humana Encounters
P.O. Box 14605
Lexington, KY 40512-4605

How to avoid claims submission errors

Common reasons for rejection or denial:

- Providers submitting an incorrect NPI/ZIP code/taxonomy code
- Encounters missing NPI/ZIP code/taxonomy code
- Providers submitting encounters without a billing/ rendering/referring/ordering NPI or one that is not enrolled/registered for Medicaid with SCDHHS
- Providers submitting encounters with zero-dollar billed charges
- Providers submitting with a claim form (1500/UB04) that is not appropriate for their registered provider type
- Providers not submitting the correct encounter payer ID

How to avoid these errors:

- Confirm the provider information submitted exactly matches the provider information as it is registered with SCDHHS and in accordance with the services provided (e.g., NPI, Medicaid number, taxonomy code, ZIP code + 4, provider specialty code, provider type code).
- Ensure that billing/rendering/referring/ordering NPIs on the claim are correct and are enrolled/registered with Medicaid.
- If provider has a one-to-one NPI/taxonomy code on the state's Master Provider List, a taxonomy code is **not** required on the claim.
- Ensure billed amounts are not zero dollars (e.g., providers must submit billed charges).

Timely filing

- Claims, including corrected claims, must be submitted within 365 calendar days of the date of service or discharge.
- Delegated encounter claims should be filed with the plan within 5 calendar days from the date of adjudication by the delegate.
- Timely claims filing and HEDIS:
  - Providers are required to file their claims/encounters in a timely manner for all services rendered to members. Timely filing is an essential component reflected in Humana Healthy Horizons' HEDIS reporting and ultimately can affect how a plan and its providers are measured in member preventive care and screening compliance.

Visit **Humana.com/MakingItEasier** for more information on claims and payment processes.

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

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

Receive HIPAA-compliant ERA transactions.*

Get paid up to 7 days faster than via mail.

Have remittances sent to your clearinghouse or view them online.

Reduce the risk of lost or stolen checks.

Reduce paper mail and time spent on manual processes.

Learn more, including how to enroll, at **Humana.com/ePaymentInfo**.

* HIPAA stands for Health Insurance Portability and Accountability Act of 1996.

Additional assistance with ERA/EFT setup

Contact us if your organization needs:

Payments deposited in more than one bank account

Separate remittance information for different providers or facilities

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

You can call Humana Healthy Horizons Provider Services at **866-432-0001** or Availity at **800-282-4548**.

Balance billing

Per Humana Healthy Horizons in South Carolina Provider Manual:

- **Services that are not medically necessary:** The provider agrees that, in the event of a denial of payment for services rendered to members determined by Humana Healthy Horizons not to be medically necessary, the provider shall not bill, charge, seek payment nor have any recourse against the member for such services.

The Humana Healthy Horizons in South Carolina Provider Manual and other provider communications can be found at **Humana.com/HealthySC**.

Visit **Humana.com/MakingItEasier** for more information on claims and payment processes.

Electronic health records

EHRs

An EHR is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users. While an EHR does contain the medical and treatment histories of patients, an EHR system is built to go beyond standard clinical data collected in a provider's office and can be inclusive of a broader view of a patient's care.

EHRs (cont'd.)

Advantages of EHRs:

EHRs and the ability to exchange health information electronically can help you provide higher quality and safer care for patients while creating tangible enhancements for your organization. EHRs help providers better manage care for patients and improve healthcare by:

- Providing accurate, up-to-date and complete information about patients at the point of care
- Enabling quick access to patient records for more coordinated, efficient care
- Sharing electronic information securely with payers, patients and other clinicians
- Helping providers more effectively diagnose patients, reduce Medicaid errors and provide safer care

EHRs (cont'd.)

Advantages of EHRs:

- Improving payer, patient and provider interaction and communication, as well as healthcare convenience
- Enabling safer, more reliable prescribing
- Promoting legible, complete documentation and accurate, streamlined coding and billing
- Enhancing privacy and security of patient data
- Improving productivity

Member grievances and appeals and provider disputes

Provider education

- Find member grievances and appeals information in the Humana Healthy Horizons in South Carolina Member Handbook and Provider Manual; both can be found at **Humana.com/HealthySC**.
- Humana Healthy Horizons has a no-wrong-door policy for submission:
  - A member or their authorized representative can submit an appeal request verbally, in writing or online.
  - Member appeals are handled in accordance with South Carolina regulations.
- For more information, talk to your provider engagement representative.

What happens when Humana Healthy Horizons receives a grievance

- Humana Healthy Horizons acknowledges the receipt of each grievance to the individual filing the grievance within 5 business days.
- The investigation and final resolution for grievances are completed within 90 calendar days.

What happens when Humana Healthy Horizons receives an appeal

- Humana Healthy Horizons acknowledges the receipt of each appeal within 5 business days.
- For all standard appeals, Humana Healthy Horizons provides written notice of resolution within 30 calendar days.
- If additional information and time to resolve the appeal are needed, and it is in the member's best interest for us to receive that information, Humana Healthy Horizons will request a 14-calendar day extension to resolve the matter.

Expedited appeal

- A member or their authorized representative may request an expedited appeal. Expedited appeals are resolved within 72 hours of receipt of the request.
- If additional information and time to resolve the appeal are needed, and it is in the member's best interest for us to receive that information, Humana Healthy Horizons will request a 14-calendar day extension to resolve the appeal.

State fair hearing

- An authorized representative, including a provider, may request an appeal, file a grievance or request a state fair hearing on behalf of a member, with the member's written consent. However, providers cannot request continuation of benefits.
- If a member or authorized representative has exhausted Humana’s appeal process, a state fair hearing may be requested no later than 120 calendar days from the date of the notice of resolution.

Provider disputes

Humana Healthy Horizons investigates provider disputes within the framework of its written policies and procedures, while also applying necessary statutory, regulatory, contractual and provider contract provisions.

- Disputes must be received within 30 calendar days from the receipt of notice of an adverse action.
- A status letter is sent within 30 days of receipt of a provider dispute. Humana Healthy Horizons and/or the provider can request an additional 15 calendar days if additional information and time are needed to resolve the dispute.

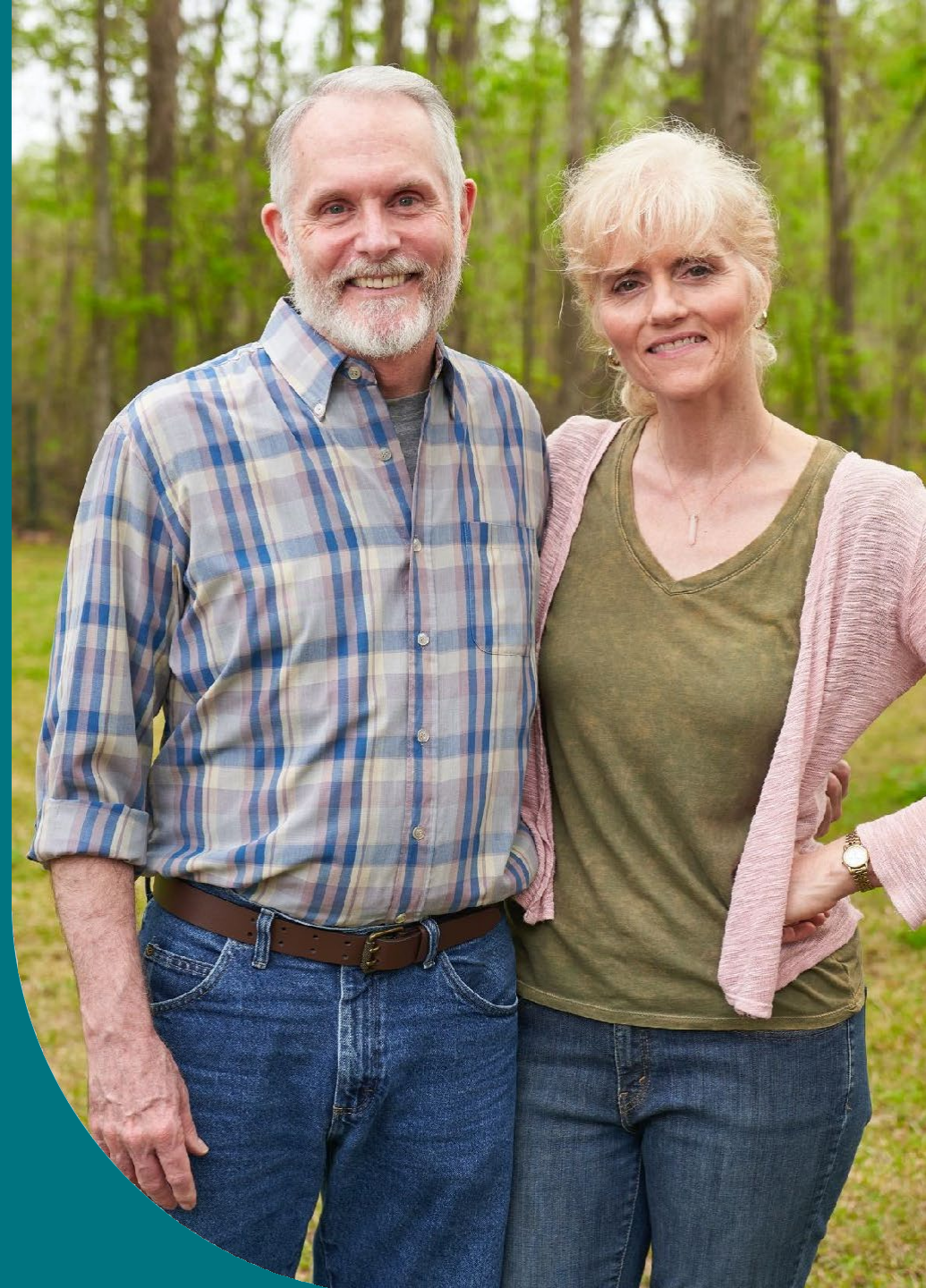
Provider disputes (cont'd.)

- Disputes can be filed for the following situations:
  - One member/claim
  - One member and multiple claims
  - Consolidated list of multiple members and claims when the claims involve identical or similar issues

How to file:

Verbally	In writing	Provider portal
Call: **866-432-0001** In person: • Meet with Humana staff. • Visit a Humana Healthy Horizons office.	Mail: Humana Healthy Horizons in South Carolina Provider Disputes P.O. Box 14601 Lexington, KY 40512-4601 Email: **SCMCDProviderDispute@humana.com**	Complete a claims status application at **Availity Essentials**.

Quality



Quality Assurance and Performance Improvement (QAPI) program

The QAPI program monitors, evaluates and facilitates improvement in the quality of healthcare services provided to the entire member population. Humana Healthy Horizons demonstrates its population health management (PHM) strategy via the QAPI program.

QAPI is an integrated program. Focus areas include:

- Quality monitoring
- Performance measurement
- Community partnerships
- Collaboration with national organizations
- Cultural competency training and language support
- Access to web-based educational information
- Safety programs
- Data and information sharing, value-based relationships with providers
- Population health initiatives, including SDOH and health equity
- Provider engagement programs

Quality improvement requirements

Humana Healthy Horizons monitors and evaluates provider quality and appropriateness of care and service delivery to members using the following methods:

- **Performance improvement projects** – These are ongoing measurements and interventions that demonstrate significant improvement in the quality of care and service delivery sustained over time, in both clinical and nonclinical care areas, and have a favorable effect on health outcomes and member satisfaction.
- **Medical record reviews** – Medical records may be requested for many reasons, including quality investigations, external quality review organization (EQRO) requests, HEDIS reviews and quality assurance. Your contract requires that you furnish member medical records to us for this purpose. These reviews are a permitted disclosure of a member's protected health information (PHI) in accordance with HIPAA. The reviewers protect member information from unauthorized disclosure and ensure all HIPAA guidelines are enforced.

Quality improvement requirements (cont'd.)

- **Performance measures** – Data collected on patient outcomes as defined by HEDIS or otherwise defined by the agency
- **Surveys** – Consumer Assessment of Healthcare Providers and Systems (CAHPS®), provider satisfaction, behavioral health surveys and special surveys to support quality/performance improvement initiatives
- **Peer review** – Review of provider's practice methods and patterns to determine appropriateness of care

External quality review

Humana Healthy Horizons providers are required to participate in periodic medical record reviews. The state of South Carolina may retain an external quality review (EQR) to conduct medical record reviews for Humana Healthy Horizons members. You may periodically receive requests from Humana Healthy Horizons for a review.

- Your contract with Humana Healthy Horizons requires that you furnish member medical records to us for this purpose.
- EQR reviews are a permitted disclosure of a member's PHI in accordance with HIPAA.
- Medical chart organization and documentation information is available in the Humana Healthy Horizons in South Carolina Provider Manual.

Quality improvement resource

Providers have access to a multitude of resources online, including:

- HEDIS resources
- CAHPS information
- Behavioral health guidelines
- Clinical practice guidelines
- Population Insights Compass
- Availity Essentials

Providers are encouraged to use Humana Healthy Horizons' population health programs to help members achieve their best health. Please refer members experiencing medical and/or behavioral health needs, substance use disorder or SDOH.

More quality resources are available at **Humana quality resources**.

QAPI requirements

Healthcare providers may obtain a written QAPI program description by calling Provider Services at **866-432-0001**. We welcome healthcare providers' input regarding our QAPI program.

More quality resources are available at **Humana quality resources**.

Advance medical directives

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

- Appear in the permanent medical record of the member
- Include a copy of the advance medical directive in the member's medical record inclusive of other mental health directives

Information on advance medical directives is included in the **Humana Healthy Horizons in South Carolina Provider Manual**.

Member medical record requirements

- Humana Healthy Horizons requires that all network providers and subcontractors maintain individual medical records for each Medicaid MCO member.
- Providers are responsible for ensuring all member medical records are accessible for review and audit, accurate, legible and safeguarded against loss, destruction or unauthorized use, and are maintained in an organized fashion for all individuals evaluated or treated.
- Such records should be readily available to the SCDHHS and/or its designee and contain all information necessary for the medical management of each enrolled Medicaid MCO member.
- Procedures also must exist to facilitate the prompt transfer of patient care records to other in- or out-of-plan providers.

Member medical record requirements (cont'd)

- Humana Healthy Horizons ensures that its network of providers maintains member medical records on paper or in an electronic format that are timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review.
- Complete medical records include:
  - Medical charts
  - Prescription files
  - Hospital records
  - Provider specialist reports
  - Consultant and other healthcare professionals' findings
  - Appointment records
  - Other documentation sufficient to disclose the quantity, quality, appropriateness and timeliness of services provided under the contract
- The medical record shall be signed by the provider of service.
- The member's medical record is the property of the healthcare provider who generates the record.
  - However, members have the right to request and receive a copy of their medical records and also that they be amended or corrected.
  - Medical records generally are preserved and maintained by the provider for a minimum of 5 years, unless federal requirements mandate a longer retention period (e.g., immunization and tuberculosis records are required to be kept for a person's lifetime).

Member medical record requirements (cont'd.)

- The plan ensures the PCP maintains a primary medical record for each member, which contains sufficient medical information from all providers involved in the member's care, to ensure continuity of care.
- The medical record organization and documentation must contain, at a minimum, the following:
  - Patient name, Medicaid identification number, age, sex, places of residence and employment, and responsible party (parent or guardian)
  - Assurance that health records and/or other appropriate documentation for each member substantiate the need for services, include all findings and information supporting medical necessity and justification for services, and details of all treatment provided
  - Services provided, date of service, service site and name of service provider
  - Medical history, diagnoses, prescribed treatment and/or therapy and drug(s) administered or dispensed; health record shall commence on the date of first patient examination
  - Referrals and results of specialist referrals
  - Documentation of emergency and/or after-hours encounters and follow-up
  - Signed and dated consent forms
  - Record of immunization status in pediatric records (i.e., patients younger than 19)

Member medical record requirements (cont'd.)

- Documentation of advance directives, if completed
- Documentation for each visit that includes:
  - Date
  - Purpose of visit
  - Diagnosis or medical impression
  - Objective finding
  - Assessment of patient findings
  - Plan of treatment, diagnostic tests, therapies and other prescribed regimens
  - Medications prescribed
  - Health education provided
  - Signature and title or initials of the provider rendering the service
- If more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials.

Reporting of communicable diseases

PCPs are expected to report instances of tuberculosis and other communicable diseases to the South Carolina Department of Health and Environmental Control for clinical management, treatment and direct observed therapy.

- Contact the local public health department serving the county in which the member resides. The local public health department:
  - Provides a range of primary and secondary prevention services
  - Coordinates communicable disease control services

Please note: Reporting is required for both positive and negative COVID-19 test results.

PCP quality recognition programs

PCP recognition programs

Humana Healthy Horizons is committed to lowering costs and improving care in the communities we serve. We utilize value-based programs that allow primary care providers to earn financial incentives based on quality and clinical outcomes. The programs are designed based on the provider's panel size and engagement. The programs are reviewed and reimbursed annually. Annual payments are made one quarter in arrears to allow for reporting/data collection.

Humana Healthy Horizons

PCP quality recognition programs

South Carolina

Medicaid quality recognition

Annual incentive paid to provider practices for achieving quality and clinical measures

Program highlights

- Adult and pediatric membership categories are measured separately.
- HEDIS quality measures are identified within each category.
- Practices are eligible for incentive based on achieving the target threshold for a subset of measures.

Practice requirements

- Contracted for the Medicaid line of business
- Meet a threshold of 30 Humana Healthy Horizons-covered patients in one or both categories at the beginning and end of the measurement year

Model practice

Quarterly incentive paid to provider practices for achieving quality and clinical measures*.

Program highlights

- Adult and pediatric membership categories are measured separately.
- HEDIS quality and clinical utilization measures are identified within each category.
- Practice can earn a per-member-per-month (PMPM) incentive per target achieved (may include a shared-savings opportunity).

Practice requirements

- Sign a value-based contract to participate
- Have more than 250 Humana Healthy Horizons-covered patients
- Meet a threshold of 30 Humana Healthy Horizons-covered patients for category eligibility at the beginning and end of the measurement year

Medical home

Quarterly incentive paid to provider practices for achieving quality and clinical measures*.

Program highlights

- Adult and pediatric membership categories are measured separately.
- A practices identified as a patient-centered medical home (PCMH) will be eligible to receive a monthly incentive fee.
- Practices can earn a PMPM incentive per target achieved (may include a shared-savings opportunity).

Practice requirements

- Sign a value-based contract to participate and have a location(s) recognized as a PCMH

* Measurement year 2023 program will be administered annually.

Provider training requirements

Additional training requirements

- Providers must complete additional annual required compliance training on the following topics:
  - General compliance and fraud, waste and abuse
  - Cultural competency
  - Health, safety and welfare (abuse, neglect and exploitation)
  - Others as required
- This training can be located on the following secure provider websites: **Humana.com/ProviderCompliance** and **Availity**.
- **Be sure to complete the Medicaid Partner Training Attestation form to ensure completion is documented.**
- To schedule general training for your organization, please email our provider relations team at **SCMedicaid@humana.com**

Fraud, waste and abuse

Fraud, waste and abuse (FWA) reporting requirement and reporting options

Those who suspect or detect an FWA violation are required to report it either to Humana Healthy Horizons or within their respective organization, which then must report it to Humana Healthy Horizons via the following methods:

- **Telephone:**
  - Special Investigations Unit Hotline: **800-614-4126** (24 hours a day, 7 days a week)
  - Ethics Help Line: **877-5-THE-KEY (584-3539)**
- **Email: SIUReferrals@humana.com** or **Ethics@humana.com**
- **Web: EthicsHelpline**

All information will be kept confidential.

Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Also, Humana has a zero-tolerance policy for retaliation or retribution against any person who reports suspected misconduct.

FWA reporting requirement and reporting options (cont'd.)

You can send an alert to SCDHHS for investigation:

- Email: **fraudres@scdhhs.gov**
- Hotline phone number: **888-364-3224**

Or write the Office of the Inspector General:

Office of the Inspector General
111 Executive Center Drive, Suite 204
Columbia, SC 29210-8416

False Claims Act

- The False Claims Act permits a person with knowledge of fraud against the U.S. government to file a lawsuit (plaintiff) on behalf of the government against the person or business that committed the fraud (defendant).
- Individuals who file such suits are known as "whistleblowers." If the action is successful, the plaintiff is rewarded with a percentage of the recovery. Retaliation against individuals for investigating, filing or participating in a whistleblower action is prohibited.

Compliance Policy for Contracted Healthcare Providers and Third Parties (31 U.S.C. §§ 3729-3733)

Links to the previously mentioned provisions of this act are listed within Humana's Compliance Policy for Contracted Healthcare Providers and Business Partners, which is available at **Humana.com/Fraud**.

Liability (31 U.S.C. 3729(a)(1) and (a)(3)): Liability for the foregoing acts includes:

- A civil penalty of $5,000–$10,000
- 3 times the amount of damages, which the government sustains because of the act of that person

A person or company who violates the False Claims Act can also be held liable to the U.S. government.

Web resources

Provider website–Public

Humana.com/HealthySC

- Health and wellness programs
- Clinical practice guidelines
- Provider publications (including the provider manual)
- Pharmacy services
- Claim resources
- Quality resources
- What's new

For questions about and assistance with the Humana sites, please call Provider Services at **866-432-0001**.

Provider orientation and training revisions

This provider orientation and training document is reviewed and updated at least once a year. Orientation updates include the following:

- New or revised policy and procedures and administrative clinical practices
- Modifications to existing services
- New or amended Medicaid policies and procedures, including state and federal mandates

Updated versions of the Provider Orientation and Training document are posted on the South Carolina Medicaid provider website at **Humana.com/HealthySC**.

Working with Humana Healthy Horizons online? Use the multipayer Availity Essentials

Availity Essentials is Humana Healthy Horizons' preferred method for online transactions.

- ✓ Use one consistent site to work with Humana and other payers
- ✓ Check eligibility and benefits
- ✓ Submit referrals and authorizations
- ✓ Submit claims and check claim status
- ✓ Use Humana-specific tools
- ✓ Submit disputes

About Availity Essentials

- Cofounded by Humana
- Humana Healthy Horizons clearinghouse for electronic transactions with providers

How to register

- Go to **Availity** and select the **Register** button.

Join us for training sessions

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

Questions

- Availity Essentials helps with registration and tools: Call **800-AVAILITY (282-4548)**.
- Questions? Call Humana Healthy Horizons Provider Services at **866-432-0001**.

Helpful numbers

Behavioral health crisis line

For members experiencing a behavioral health crisis, South Carolina has a statewide behavioral response network that operates 24 hours a day, 7 days a week, through its Community Crisis Response and Intervention Access Line at **833-364-2274**.

Emergency mental health conditions include:

- Those that create a danger to the member or others
- Those that render the member unable to carry out actions of daily life due to functional harm
- Those resulting in serious bodily harm that may cause death

Once a member is directed to the most appropriate resource, we work with those providers to authorize services and ensure continuity of care for the member.

Humana contact information

- Humana Healthy Horizons' interactive response line: **866-432-0001**
  - Provider and member services
  - Prior authorization – assistance for medical procedures and medication billed as a medical claim
  - UM – Medical and behavioral health inquiries
  - Medicaid care management chronic condition management
- Medication intake team (prior authorization for medications administered in a medical office): **866-461-7273**
- Prior authorization for pharmacy drugs: **800-555-2546**
- CenterWell Pharmacy (mail order for maintenance medications): **800-379-0092**
- CenterWell Specialty Pharmacy: **800-486-2668**

Humana contact information (cont'd.)

Pharmacy Help Desk: **800-865-8715**

Member 24-hour nurse advice line: **877-837-6952**

Behavioral health crisis line: **833-801-7355**

Availity customer service/tech support: **800-282-4548**

Ethics and compliance concerns: **877-5-THE-KEY (584-3539)**

Reporting Medicaid fraud: **800-614-4126**

Information about arranging interpretation services for member appointments: **877-320-1235**

Humana

Healthy Horizons®

in South Carolina