Humana
Healthy Horizons®
in South Carolina

Healthy Connections

Provider Orientation and Training

Information for Medicaid Healthcare Providers and Administrators

2023

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

Humana®

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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 South Carolina Department of Health and Human Services' (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 to 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.

Primary care provider (PCP) assignment and reassignment

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

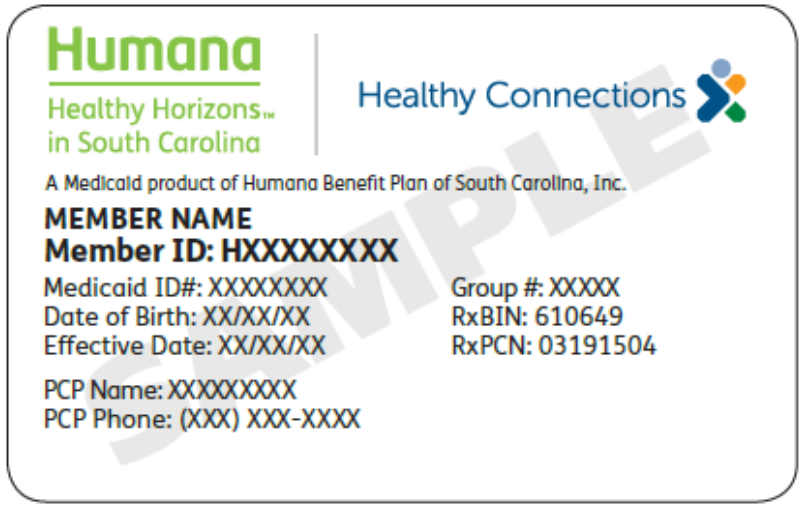
Automatic assignment process:

- Assign to member's previous PCP if participating with Humana Healthy Horizons' PCP panel.
- 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**.

Member eligibility – identification (ID) cards

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

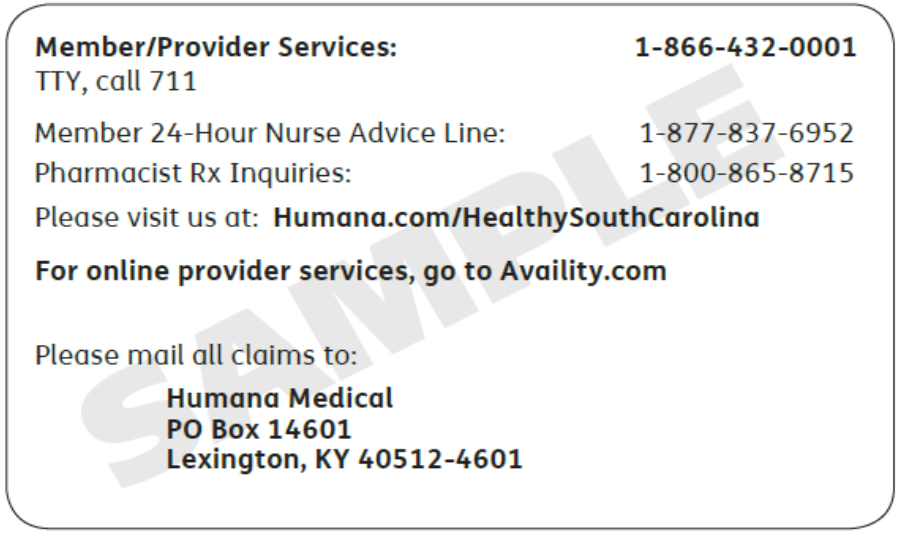


Please note: This PDF meets state/compliance guidelines and is subject to change at any time. Notification will be communicated if compliance guidance changes.

Front of Humana Healthy Horizons in South Carolina 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 in South Carolina 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.com: 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)	Pharmacy/prescription drugs
Ambulance transportation • Transportation for out-of-state medical services	Physician services
Ancillary medical services	Rehabilitative therapies for children –non-hospital based
Audiological services	Sterilization services
Behavioral health services	Independent laboratory and X-ray services
Chiropractic services • Limited six visits per year for manual manipulation of the spine to correct a subluxation	Inpatient hospital services
Communicable disease services	Institutional long-term care (LTC) facilities/nursing homes
Durable medical equipment (DME)	Maternity services
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/well-child visits	Outpatient services
Emergency/post-stabilization services	Substance abuse
Family planning services	Telehealth services
Home health	Transplant and transplant-related services
Hysterectomies	Vision services – limited to members 21 and younger

*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 the following members:

- 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.

Early and Periodic Screening, Diagnosis and Treatment (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 coverage 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 are 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 online at Humana.com/HealthySC.

Telehealth

Virtual Visits

For medical and behavioral health services, virtual visits are available through select providers. Similar to using FaceTime or Skype, the member uses a webcam and a 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 90-day supply at both retail and mail order locations.

Preferred drug list (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

$10 per member per month OTC benefit allowance through CenterWell™

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

Drug prior authorization and notification

Get forms at Humana.com/pa or call **800-555-2546** (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** (800-555-2546).

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

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

State Pharmacy Lock-in Program (SPLIP)

- 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 located at Humana.com/HealthySC.

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, seven 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 primary care provider
- Access to grievances and appeals processes
- Support for claims issue resolution
- Help with benefit inquiries
- Access to pharmacy benefits
- Help with prior authorization requests
- Interpretation services support

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 SC State Medicaid Plan:

- Medical (non-ambulance) transportation
- Broker-based transportation (routine nonemergency medical transportation)
- Dental services
- TCM services
- Home- and community-based waiver services
- MAPPS family planning services
- DECs

Payment for these services remains Medicaid fee-for-service. MCOs are expected to be 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, 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 offered by providers who are not part of Humana Healthy Horizons
Hospital stays for treatments that can be delivered outside the hospital	Services that are not medically necessary
Hysterectomy for sterilization purposes	Unauthorized services

Humana Healthy Horizons in South Carolina 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 (VAB); for a full listing, please consult the provider manual.

Value-added Benefit	Details and Limitations
Car seat (convertible car seat)	Pregnant female members must consent to participate and actively engage in the HumanaBeginnings™ program, complete a comprehensive assessment and complete one additional follow-up call within 56 days of enrollment with the program or identification of a pregnancy indicator; one convertible car seat, along with educational material for installation for each infant, per pregnancy.
Durable medical equipment (DME) — breast pumps	Female members can receive one non-hospital grade breast pump every two years, or one rental of a hospital grade breast pump if the baby requires an inpatient stay in a neonatal intensive care unit (NICU).
Free cellphone	Free cellphone through the Federal Lifeline Program. One phone per household. Members who are younger than 18 require a parent or guardian to sign up. This benefit covers per lifetime: one phone, one charger, one set of instructions, 350 minutes per month, 4.5 GB of data per month, unlimited text messages per month, training for the member and their caregiver at the first case manager orientation visit. This benefit also includes unlimited calls to Humana Member Services for health plan assistance and 911 for emergencies, even if the member is out of minutes. Member must make at least one phone call or send one text message every month to keep the benefit. The member also may qualify for enhanced benefits through the Affordable Connectivity Program (ACP) that provides unlimited minutes, 5 GB hotspot and 25 GB of data. Members can opt into this benefit by contacting SafeLink at 877-631-2550 or online at www.safelink.com. Benefits are subject to change by the Federal Communications Commission (FCC) under the Lifeline program
GED testing	GED test preparation assistance for members 16 and older including 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. Also includes test pass guarantee to provide members multiple attempts at passing the test. Members 16 to 18 need a South Carolina Verification of School Withdrawal Form completed by the principal or attendance supervisor of the last school attended. The GED may be taken at age 19 or older without the South Carolina Verification of School Withdrawal Form.

Added benefits (cont'd.)

Value-added Benefit	Details and limitations
Housing assistance	Members 18 and older may receive up to $750 per member per lifetime (unused allowance does not roll over to the next year) 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 member's permanent residence (late payment notice required) • Moving expenses via licensed moving company when transitioning from a public housing authority Must be approved by care manager. Please note: Funds are not paid directly to the member. If the bill is in the spouse's name, a marriage certificate may be submitted as proof.
GED testing	GED test preparation assistance for members 16 and older including 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. Also includes test pass guarantee to provide members multiple attempts at passing the test. Members 16 to 18 need a South Carolina Verification of School Withdrawal Form completed by the principal or attendance supervisor of the last school attended. The GED may be taken at age 19 or older without the South Carolina Verification of School Withdrawal Form.
Housing assistance	Members 18 and older may receive up to $750 per member per lifetime (unused allowance does not roll over to the next year) 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 member's permanent residence (late payment notice required) • Moving expenses via licensed moving company when transitioning from a public housing authority Must be approved by care manager. Please note: Funds are not paid directly to the member. If the bill is in the spouse's name, a marriage certificate may be submitted as proof.

Added benefits (cont'd.)

Value-added Benefit	Details and limitations
Meals – fresh fruits and vegetables	Limited to four boxes per year. Member must identify as food-insecure or diabetic and receive treatment for heart failure or hypertension. Must be care manager approved.
Meals – baby and me	Up to two pre-cooked home-delivered meals per day for 10 weeks for pregnant women who are high-risk. Must be care manager approved.
Meals – post-discharge	Up to 14 pre-cooked home-delivered meals up to 14 days following discharge from an inpatient or residential facility. Limited to four discharges per year.
Newborn circumcision	Covered from 29 days old through 12 months.
Over the counter (OTC) allowance	$10 per member per month for OTC items each year from OTC catalog. Examples of over-the-counter medicines include cough syrup, sinus and allergy medicines and pain medicine (including acetaminophen, naproxen and ibuprofen, etc.).
Personal growth and development	Members 18 and younger may receive a reimbursement up to $250 annually per member for youth programs.
Sports physical	One free sports physical annually for members ages 6 to 18.
Tutoring	Members in grades K-12 can access online tutoring services for two hours per week.
Vision services – adult	• Comprehensive vision exams every 12 months for members 21 and older • One set of eyeglasses (lenses and frames) or contacts every two ears • Luxury frames are not allowed.
Waive copays	No copays for members 19 and older for medical only.

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 in South Carolina recommends that all providers submit their claims on behalf of a member by end of August 2023. 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	$25 in rewards for female members 50 and older who obtain a mammogram once per year.
Cervical cancer screening	$25 in rewards for female members 21 and older who obtain a Pap test once per year.
Colorectal cancer screening	$25 in rewards for members 45 and older who obtain a colorectal cancer screening as recommended by their PCP once per year.
COVID-19 vaccine	$25 in rewards for members who upload a picture/file of their completed COVID-19 vaccine card, one per year (eligible ages, per CDC). • Members who were vaccinated prior to enrollment with Humana plan may upload vaccination card within 90 days of enrollment to receive the reward. • New members that were not vaccinated prior to enrollment with Humana have 90 days from completion of vaccination and upload the vaccination card to receive the reward.
Diabetic retinal eye exam	$25 in rewards for diabetic members 18 and older who complete a retinal eye exam once per year.
Diabetic screening	$25 in rewards for diabetic members 18 and older who complete an annual screening with their primary care provider for HbA1c and blood pressure once per year.
Follow-up after high-intensity care for substance use disorder	$25 in rewards 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 in rewards for members who received a follow-up visit with a mental health provider care within 30 days after a hospital discharge for a diagnosis of select mental illness or intentional self-harm.
Flu vaccine	$25 in rewards for members who receive an annual flu vaccine from their provider, pharmacy or self-reporting if they received the vaccine from another source.

Rewards are not transferrable to other managed care plans or other programs. Rewards are non-transferable 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
Haircuts for Kids	One standard haircut for members in grades K-12 valued at $20, who upload a photo of their school registration form or school ID or class schedule (redemption period July 2023 through September 2023).
Health risk assessment (HRA)	$25 in rewards for members 18 and older who complete their HRA within 90 days of enrollment with Humana, one reward per lifetime.
HumanaBeginnings™ program	$25 in rewards, per pregnancy, for ~~all~~ pregnant females who enroll and complete the HumanaBeginnings care management program.
Human papillomavirus (HPV) vaccine	$25 in rewards once per lifetime for members who receive two doses of the HPV vaccine between their 9th and 13th birthday.
Postpartum visit	$25 in rewards for all postpartum females who complete one postpartum visit within seven to 84 days after delivery, once per pregnancy.
Prenatal visit	$25 in rewards for all pregnant females who complete one prenatal visit within the first trimester or one prenatal visit within 42 days of enrollment with Humana, once per pregnancy.
Tobacco cessation program	For all members 12 and older, up to eight health coaching/cessation support calls within 12 months from enrollment date. For members 18 and older, nicotine replacement therapy is available on request. This program will have two opportunities where members can earn rewards: • $25 in rewards for members who complete two calls within the first 45 days of enrollment in the coaching program, once per year. • $25 in rewards for members who complete six additional Wellness Coaching calls (eight in total) within 12 months of the first coaching session, once per year.

Rewards are not transferrable to other managed care plans or other programs. Rewards are non-transferable 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	Enrollment in the Weight Management program, completion of a well-being check-up and form with their primary care provider, completion of six total wellness coaching calls within 12 months of enrollment date. This program has two opportunities for members 12 and older to earn rewards: • $25 in rewards: Enrollment in the Weight Management program • Completion of well-being checkup with PCP • Submission of PCP form • $25 in rewards: Completion of the program • Six wellness coaching calls within 12 months of the first coaching session
Well-child visits	Up to $120 in rewards; members birth to 15 months who complete a well-child visit are eligible for $20 in rewards per visit with a six-visit limit.
Well-child visits	Up to $30 in rewards; members 16-30 months who complete a well-child visit are eligible for $15 per visit with a two-visit limit.
Wellness visits	$25 in rewards for members 3 and older who complete one annual wellness visit.

Rewards are not transferrable to other managed care plans or other programs. Rewards are non-transferable 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 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/ChoiceCare	**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:

- Physician/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)
- National Provider Identifier (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 or Humana Behavioral Health Network (HBHN) provider contracting representative will contact you.

Credentialing

- Providers must be credentialed prior to participation 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 continually maintain your CAQH application to ensure it is complete and current.
- Recredentialing occurs at least every three years. Some circumstances require shorter recredentialing cycles.
  - Humana Healthy Horizons in South Carolina 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 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 a Qualified Medicaid Provider with SCDHHS prior to being considered for network participation.
- In addition to being in good standing with Medicare, 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 at Humana.com/HealthySC.

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.

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 provider manual located on the Humana Healthy Horizons in South Carolina website at Humana.com/HealthySC.

Clinical

Health services and utilization management (UM)

Utilization management 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

Utilization management

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 regularly screen their patients 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 SCMCDCareManagment@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. 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 your patient.
- Brief Intervention – Use clinical expertise to engage patients in a conversation about how risky behaviors are affecting them and develop the patient's interest in treatment.
- Referral to Treatment – Refer patient 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 www.integration.samhsa.gov/clinical-practice/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 special 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.

Prior authorizations for medical procedures

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

- Visit Availity Essentials at Availity.com
- Call 866-432-0001 and follow the menu prompts for authorization requests, depending on your need, or 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 at Availity.com

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 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 or 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 determined to be retroactively eligible for Medicaid. (Retroactive Medicaid coverage is defined as a period of time up to three months prior to the application month.)
- Exception: An authorization obtained prior to a member transitioning from another managed care organization 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 **883-441-0950**. The following documentation must be included:

- Patient name and Humana Healthy Horizons ID number
- Authorization number of the previously authorized service for the related request
- 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.

Continuity-of-care process information is available at Humana.com/HealthySC.

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.

Continuity of care process information is available at Humana.com/HealthySC.

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, seven 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 practitioner 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	Within 48 hours of a request
Routine care needs	Within four to six weeks of member's request
Walk-in members with non-urgent 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 on receiving referral for emergent specialty visit
Urgent care	Within 48 hours of referral or notification from PCP
Routine care needs	Within four weeks of member's request 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	Immediately on receiving referral for emergent visit
Urgent care	Within 48 hours of referral or notification from PCP
Routine office visit	Within four 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, 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 (CM):

- 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 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.
- More information is available at Humana.com/HealthySC.

Care management functions

Humana Healthy Horizons also:

- Identifies triggers for emergency room (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 and value-added benefits, 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

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

Care 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.

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.
- Care 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 CM program, HumanaBeginnings. Through this program, our members receive registered nurse-led maternity CM 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 eight weeks post-partum or eligibility loss
- Facilitates care coordination with internal and external programs

Claims Processing

Electronic claim submission

Claims clearinghouses*

Availity Essentials	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

- Go to Humana.com/ClaimResources
- Choose “Claims and encounter submission”

Humana payer IDs

- 61101 for fee-for-service claims
- 61102 for encounter claims

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

Importance of encounter submissions in Medicaid

Encounters identify members who received services:

- Decrease the need for medical record review during HEDIS audits
- Critical to future implementation of Medicaid Risk Adjustment
- Help identify members receiving preventive screenings and decreases members listed in gaps-in-care reports

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 and Kentucky DMS.
- If provider has a one-to-one NPI/Taxonomy on the state's Master Provider List, a taxonomy code is NOT required on the claim.
- Ensure billed amounts are not zero dollars (i.e., 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 five 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 seven 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.

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 Essentials 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 in South Carolina not to be medically necessary, the provider shall not bill, charge, seek payment nor have any recourse against the member for such services.

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

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.

Electronic health records (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 provide better 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

Electronic health records (cont'd.)

Advantages of EHRs:

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

Member Grievance and Appeals and Provider Disputes

Provider education

- Find member grievance and appeals (G&A) 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:
  - Member appeals can be submitted verbally, via telephone or online, etc.
  - 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 in South Carolina receives a grievance

- Humana Healthy Horizons acknowledges the receipt of each grievance to the individual filing the grievance within five business days.
- The investigation and final resolution for standard grievances are completed within 90 calendar days.
- If additional information and time to resolve the grievance is 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.

What happens when Humana Healthy Horizons in South Carolina receives an appeal

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

Expedited appeal

- Humana Healthy Horizons acknowledges expedited grievances and appeals within 24 hours the receipt of each appeal.
- Expedited appeals may be requested on behalf of the member and are resolved within 72 hours of the initiation of the expedited appeal process.
- If additional information and time to resolve the appeal is 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.

State Fair Hearing

- Providers or an authorized representative may request an appeal, file a grievance or request a state fair hearing on behalf of a member, with written consent. However, providers cannot request continuation of benefits.
- If a member or authorized representative has exhausted Humana's appeal process, he/she may request a state fair hearing 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.

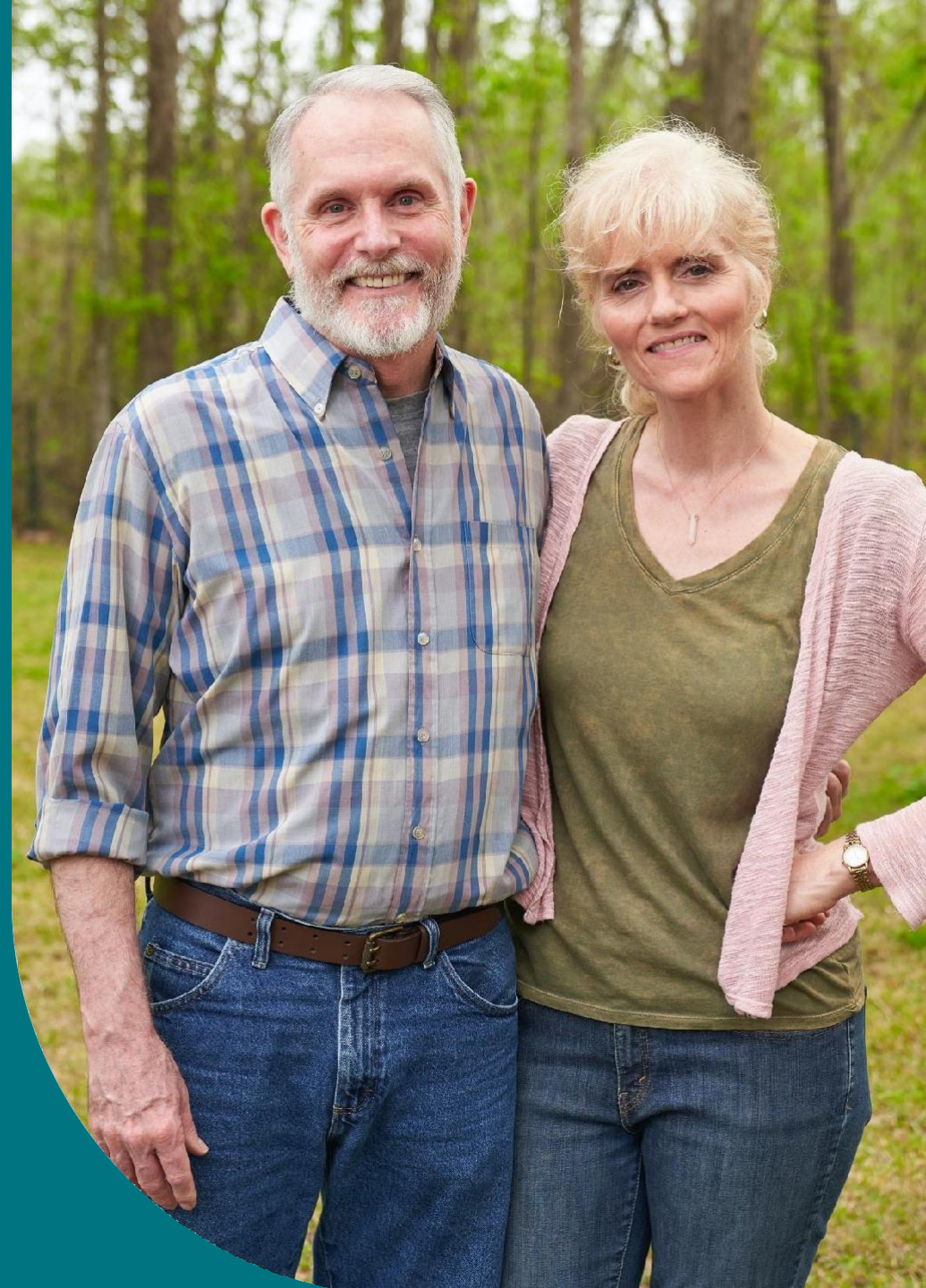
Disputes (cont'd.)

- 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 Claims Status application on **Availity.com**

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, but are not limited to:

- 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
- Bold Goal initiatives, including SDOH programs
- 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** – Ongoing measurements and interventions which demonstrate significant improvement in the quality of care and service delivery sustained over time, in both clinical and nonclinical care areas, that 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) request, HEDIS review 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 personal health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (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.

EQRO

Humana Healthy Horizons providers are required to participate in periodic medical record reviews. The state of South Carolina may retain an EQRO 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.
- EQRO reviews are a permitted disclosure of a member's personal health information in accordance with the HIPAA.
- Medical chart organization and documentation information is available in 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

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

More quality resources are available at Humana.com/provider/medical-resources/clinical/quality-resources.

QAPI requirements

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

More quality resources are available at Humana.com/provider/medical-resources/clinical/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:

- Be charted 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 located at Humana.com/HealthySC.

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 accurate, legible and safeguarded against loss, destruction or unauthorized use, and are maintained in an organized fashion for all individuals evaluated or treated, accessible for review and audit.
- 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

1. 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.
2. Complete medical records include, but are not limited to:
   - 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
3. The medical record shall be signed by the provider of service.
4. 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 request that they be amended or corrected.
   - Medical records generally are preserved and maintained by the provider for a minimum of five 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.)

5. The plan ensures that 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.
6. The medical record organization and documentation must contain, at a minimum, the following:
   a. Patient name, Medicaid identification number, age, sex and places of residence and employment and responsible party (parent or guardian)
   b. Assurance that health records 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
   c. Services provided, date of service, service site, and name of service provider
   d. Medical history, diagnoses, prescribed treatment and/or therapy, and drug(s) administered or dispensed. The health record shall commence on the date of the first patient examination.
   e. Referrals and results of specialist referrals
   f. Documentation of emergency and/or after-hours encounters and follow-up
   g. Signed and dated consent forms
   h. Record of immunization status in pediatric records (i.e., patients younger than 19)

Member medical record requirements (cont'd.)

i. Documentation of advance directives, if completed

j. 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 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 preventions services
  - Coordinates communicable disease control services

Please note: Reporting is required of both positive and negative test results for Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), the virus that causes COVID-19.

PCP Quality Recognition Program

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[1]

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[1]

Program Highlights

- **Adult** and **Pediatric** membership categories are measured separately.
- 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

[1]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
- These trainings can be located on the following secure provider websites: Humana.com/ProviderCompliance and Availity.com.
- **Be sure to complete the Medicaid Partner Training Attestation form to ensure completion is documented.**

Fraud, waste and abuse

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

Anyone who suspects or detects an FWA violation is required to report it either to Humana Healthy Horizons in South Carolina or within his/her respective organization, which then must report it to Humana Healthy Horizons in South Carolina via the following methods:

- **Telephone:**
  - Special Investigations Unit (SIU) Direct Line: **800-558-4444**
    (Monday – Friday, 8 a.m. – 4 p.m., Eastern time)
  - Special Investigations Unit Hotline: **800-614-4126** (24 hours a day, 7 days a week)
  - Ethics Help Line: 877-5-THE-KEY (877-584-3539)
- **Email:** SIUReferrals@humana.com or ethics@humana.com
- **Web:** EthicsHelpline.com

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 information (cont'd.)

You can send an alert to South Carolina's Department of Health and Human Services 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 also 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.

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
- Three times the amount of damages which the government sustains because of that act
- A person or company who violates the False Claims Act is also liable to the government

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.

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.com 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, but are not limited to, 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 in South Carolina 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

- Cofounded by Humana
- Humana Healthy Horizons in South Carolina's clearinghouse for electronic transactions with providers

How to register

- Go to Availity.com and click the Register button.

Join us for training session

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

Questions

- Availity help with registration and tools: Call 800-AVAILITY (800-282-4548)
- Questions? Call the Humana Healthy Horizons in South Carolina 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, seven days a week, through their 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 numbers

Humana Healthy Horizons in South Carolina's interactive response line (IVR):

866-432-0001

- Provider and Member Services
- Prior-authorization (PA) assistance for medical procedures and medication billed as medical claim
- Utilization Management – Medical and behavioral health inquiries
- Medicaid care management chronic condition management

Medication intake team (prior authorization for medications administered in 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**

Helpful numbers (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 (3539)**

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

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

Humana

Healthy Horizons®

in South Carolina