Provider Orientation and Training

Information for Medicaid Healthcare Providers and Administrators 2024

Humana
Healthy Horizons®
in Kentucky

Humana Healthy Horizons in Kentucky is a Medicaid product of Humana Health Plan, Inc.

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Training topics

This material is based on Humana's contract with the Kentucky Department of Medicaid Services (KDMS) and Humana's policies and procedures.

Topic	General guidance	Slides
Enrollee Eligibility	• Enrollee eligibility • Populations served • Identification (ID) cards • Verifying eligibility • Primary care provider (PCP) assignments • Involuntary dismissal from PCP practice • Medicaid redetermination process	6 – 15
Covered Services	• Covered services • Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services • EPSDT special services • Behavioral health • Substance use disorder identification and referrals • Urine drug testing • Kentucky Medicaid pharmacy benefit • Prior authorization for medications administered in medical office • Virtual urgent care services: MDLive (Telehealth)	16 – 27
Humana Healthy Horizons in Kentucky's Added Benefits	• Added benefits • Go365 for Humana Healthy Horizons® Wellness Rewards	28 – 34
Provider Services	• Provider and enrollee rights and responsibilities • Credentialing and recredentialing • Provider status changes • Provider relations	35 – 40

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This material is based on Humana's contract with the Kentucky Department of Medicaid Services (KDMS) and Humana's policies and procedures.

Topic	General guidance	Slides
Clinical	• Referrals • Prior authorizations • Prior authorizations for behavioral health and medical procedures • Online authorizations • Information to provide with prior authorization requests • Prior authorization partners: EviCore healthcare • Prior authorization partners: Tivity Health • Prior authorization partners: Avēsis • Prior authorization partners: Evolent • Determination time frames for prior authorizations • Retrospective review • Preventive health service and clinical practice guidelines • Access to care requirements • PCP after-hours availability • Enrollees with special healthcare needs • Transitioning during pregnancy	42 – 62

Training topics

This material is based on Humana's contract with the Kentucky Department of Medicaid Services (KDMS) and Humana's policies and procedures.

Topic	General guidance	Slides
Clinical	• Care management overview • Care management functions • Population health management (PHM) • Provider role and integrated healthcare with PHM • PHM—Integrated program that addresses social determinants of health and population health management initiatives • PHM—Population Insights Compass • Chronic condition management • Enrollee incentive programs • Maternal health and transition programs • Interpretation and translation services • Cultural sensitivity • Advance medical directives • Enrollee medical record reviews • Enrollee medical record requirements • Reporting of communicable diseases	63 – 82

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This material is based on Humana's contract with the Kentucky Department of Medicaid Services (KDMS) and Humana's policies and procedures.

Topic	General guidance	Slides
Claims Processing	• Provider-preventable conditions • Electronic claim submission • Avēsis dental and vision claims submission • How to avoid claims submissions errors • Provider types required to bill with referring/ordering provider on claim • Timely filing • Payment options • Claims payment: Electronic funds transfer (EFT) and electronic remittance advice (ERA) • Additional assistance with ERA/EFT setup • Balance billing	82 – 92
Electronic Health Records	• Electronic health records (EHR) • EHR assistance • EHR incentive program	93 – 96
Provider Grievance and Appeals	• Provider grievance and appeals • What happens when Humana receives an appeal? • Grievances submitted to Kentucky DMS • What happens when Humana receives a grievance? • Expedited appeal • Claim dispute process	97 – 103
Utilization Management	• Health services and Utilization Management • Utilization Management • Discharge supports	104 – 107

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This material is based on Humana's contract with the Kentucky Department of Medicaid Services (KDMS) and Humana's policies and procedures.

Topic	General guidance	Slides
Quality	• Quality Assurance and Performance Improvement (QAPI) program • Quality improvement requirements • Quality improvement resource • QAPI requirements	108 – 112
Marketing Guidelines	• Marketing guidelines	113 – 114
PCP Quality Recognition Programs	• PCP quality recognition programs • Humana Healthy Horizons PCP quality recognition programs	115 – 117
Provider Training Requirements	• Additional training requirements	118 – 119
Fraud, Waste and Abuse	• Fraud, waste and abuse (FWA) reporting requirement and reporting options • FWA reporting information (continued) • False Claims Act	120 – 123
Humana Healthy Horizons Websites and Numbers	• Provider website • Provider orientation and training revisions • Availity Essentials™ • Helpful contact information	124 – 129

Enrollee Eligibility

Enrollee eligibility

- Medicaid eligibility is determined by the Kentucky Department for Community Based Services (DCBS) in the county where the consumer resides.
- Consumers who meet the definition of unemployed in accordance with federal regulation 45 CFR 233.100 are eligible on the date they are deemed unemployed.

Eligibility begins on the first day of each calendar month, including the initial application month, with two exceptions:

- Newborns born to an eligible mother are eligible at birth.
  - The delivery hospital is required to enter the birth record in the Kentucky Certificate of Live Birth, Hearing, Immunization and Lab Data (i.e., KY CHILD) birth record system. The delivery hospital is required to use this information to auto-enroll eligible newborns within 24 hours of birth. All claims for newborns must be submitted using the newborn's Humana Healthy Horizons® in Kentucky and Kentucky Medicaid ID numbers.
  - When the mother is enrolled in Humana Healthy Horizons, newborn coverage begins on the date of birth. The newborn appears on the primary care provider's (PCP's) enrollee eligibility list after Humana Healthy Horizons adds the newborn to its system.

Populations served

Kentucky Medicaid and the Children's Health Insurance Program (CHIP) provide healthcare coverage to low-income children, pregnant women, adults, seniors and people with disabilities in the commonwealth of Kentucky.

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

- Temporary Assistance to Needy Families
- Children- and family-related
- Aged, blind and disabled
- Pass-through
- Poverty-level pregnant women and children, including presumptive eligibility
- Aged, blind and disabled receiving state supplementation
- Aged, blind and disabled receiving Supplemental Security Income (SSI)
- Younger than 21 and in an inpatient psychiatric facility
- Children younger than 18 who receive adoption assistance and have special needs
- Dual-eligible enrollees
- Disabled children
- Adults ages 19 to 64 with income less than 138% of the federal poverty level

Identification (ID) cards

All Humana Healthy Horizons enrollees receive an identification card.

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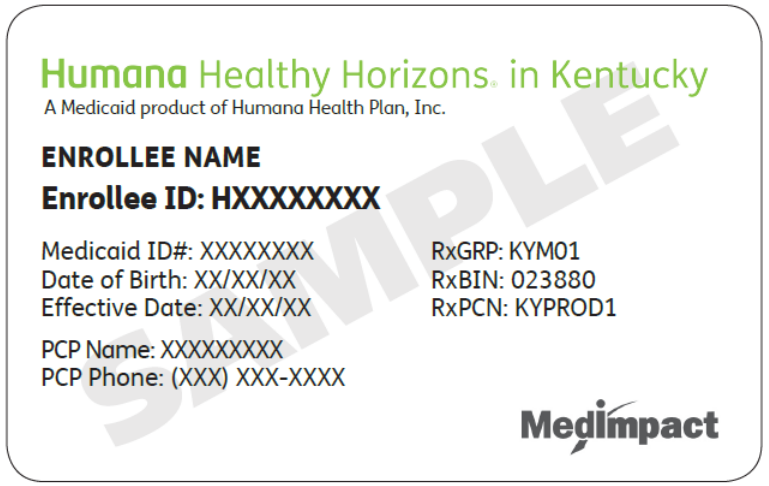

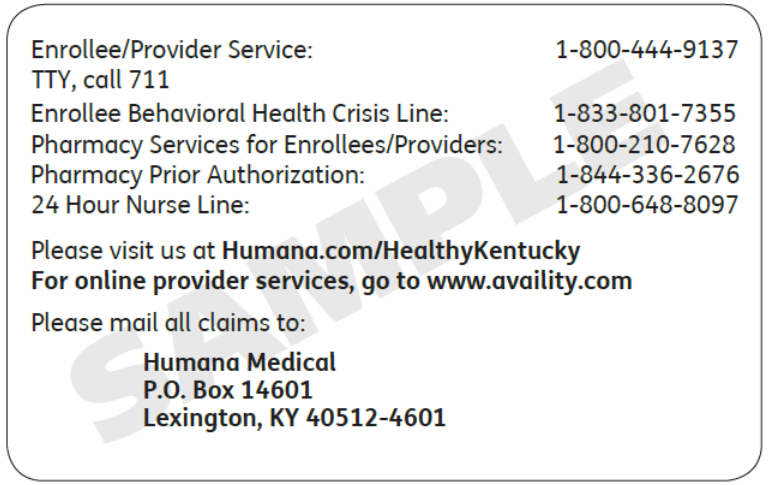

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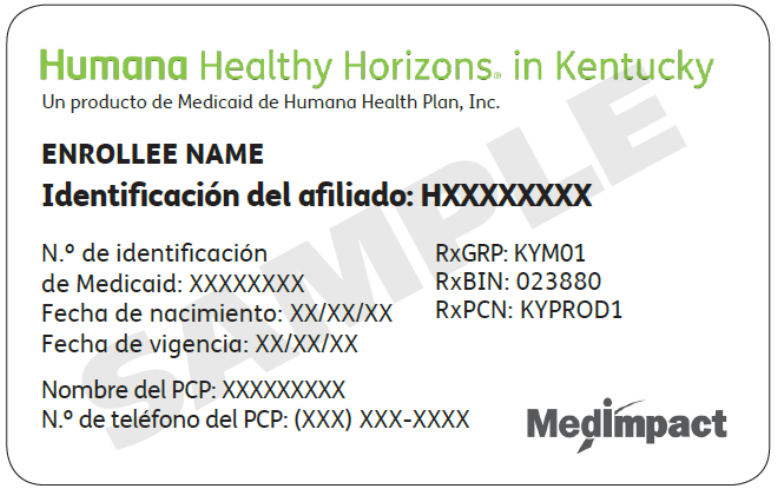
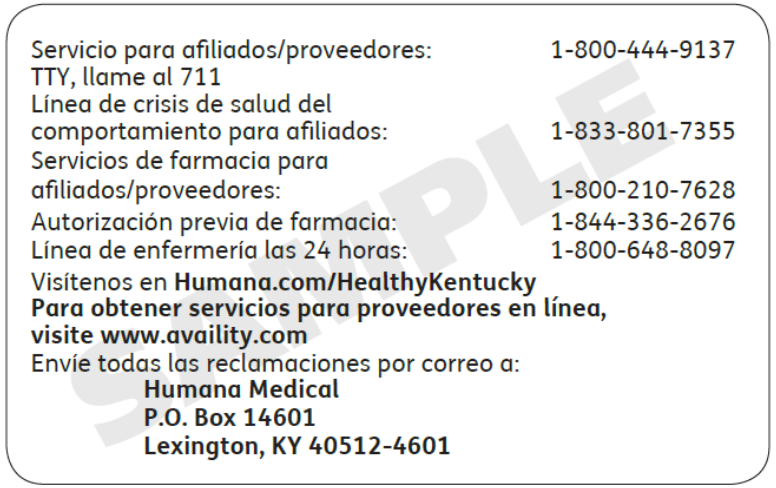
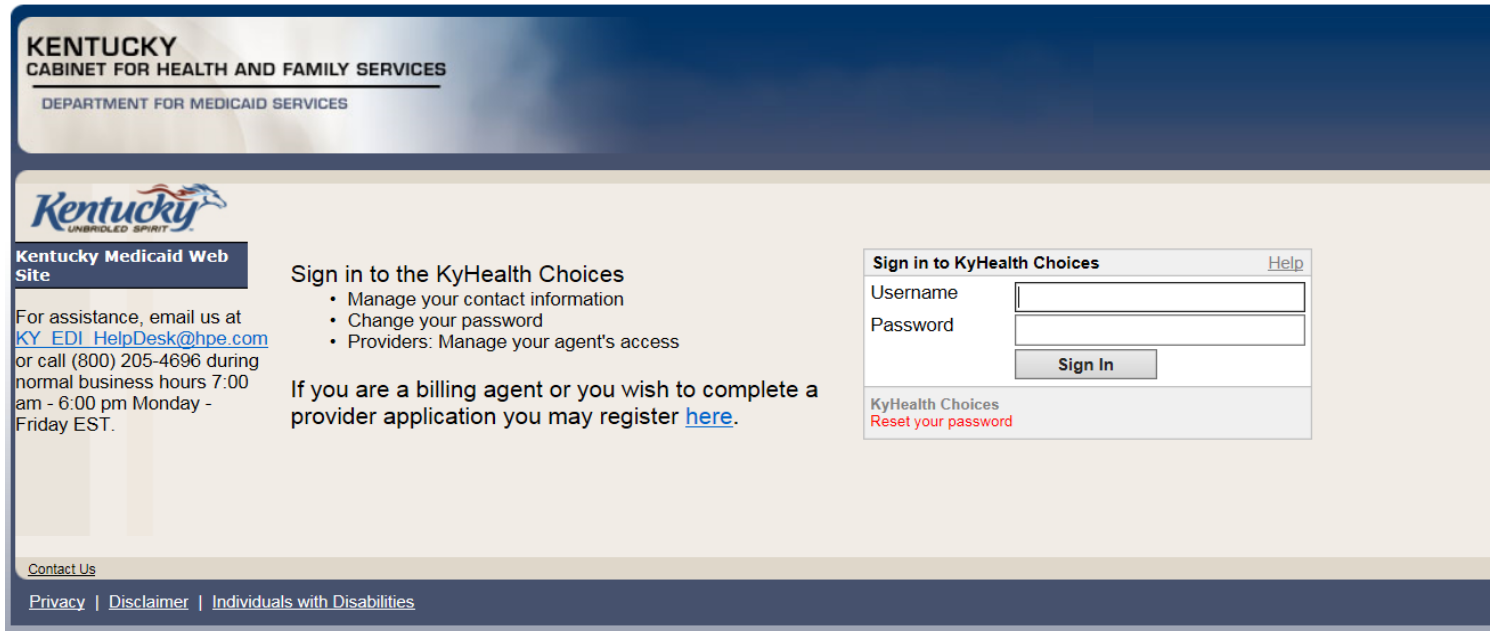




Verifying eligibility

- Before providing any services (except emergency services), healthcare providers should verify enrollee eligibility via the KY HealthNet portal.
  - To access HealthNet, please visit kymmis.com/kymmis/index.aspx.



Primary care provider (PCP) assignment

Enrollees may select a PCP at the time of enrollment with Kentucky DMS. For enrollees who do not select a PCP at the time of enrollment, Humana Healthy Horizons automatically assigns a PCP based on the following criteria:

- Enrollee is assigned to their previous PCP if that PCP participates with Humana Healthy Horizons' PCP panel.
- The selection of a PCP is based on family relationships.
- Geographic assignment is used when an enrollee has no record of past PCP relationships within the participating Humana Healthy Horizons PCP panel.

Enrollees have the option to change participating PCPs as often as needed. Enrollees can initiate a change by calling Enrollee Services. PCP changes are effective on the first day of the month following the change request.

Humana monitors enrollees' claim histories and utilization and may periodically update PCP assignments of enrollees when a patient relationship with a PCP other than the one assigned is evident.

Involuntary dismissal from PCP practice

There may be instances in which an enrollee is not a good match for a PCP, or an enrollee might be living through circumstances that make it difficult to abide by established provider-patient protocols.

PCPs have the right to request an enrollee's disenrollment from their practice and reassignment of the enrollee to a new PCP under the following circumstances:

- PCP/patient relationship is incompatible
- Enrollee has not utilized PCP's practice services within 1 year of enrollment
  - The PCP must have documented unsuccessful contact attempts by mail and phone on at least 6 separate occasions during the year
- PCP is unable to meet the medical needs of the enrollee

More details are available in the Involuntary Dismissal section of the Kentucky Provider Manual.

Involuntary dismissal from PCP practice (continued)

After 6 unsuccessful communication attempts, the PCP can initiate dismissal procedures by:

- Notifying the enrollee of dismissal by certified letter, which includes:
  - A statement notifying the enrollee they must contact Humana Healthy Horizons in Kentucky Enrollee Services to choose another PCP
  - The reason for the dismissal

- Mailing or faxing a copy of the letter to Humana:

  Humana Provider Relations
  Grievance and Appeals Department
  P.O. Box 14546
  Lexington, KY 40512-4546
  Fax: 800-949-2961

- After receipt of the letter, Humana Healthy Horizons' Provider Relations team reviews the notice to ensure the provider met all criteria to request dismissal. Humana then notifies the PCP with the determination and any further action to take. The dismissing PCP must continue to serve the affected patient until a new PCP is assigned.

Medicaid redetermination process

Humana Healthy Horizons enrollees must complete the Medicaid eligibility redetermination process to ensure they do not lose their Medicaid coverage and benefits.

- When it is time to initiate the redetermination process, the DCBS sends enrollees a form by mail.
- Humana Healthy Horizons also reminds enrollees to complete the redetermination process or risk losing their coverage and benefits.
- **If a Humana Healthy Horizons-covered patient asks about completing the redetermination process, please advise that it is required to maintain Medicaid coverage.**

Medicaid redetermination process (continued)

Enrollees can complete the process in 1 of 4 ways:

Online

Enrollees who applied for Medicaid online should visit the self-service portal to complete the redetermination process.

Mail

Enrollees can mail a completed **Renewal Form for Medical Coverage** (sent to Medicaid recipients in Kentucky) to:

DCBS Family Support
P.O. Box 2104
Frankfort, KY 40602

Phone

Enrollees can call 855-306-8959.

In Person

Enrollees can visit their local DCBS county office. Office locations are available online.

Covered Services

Covered services

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

Alternative birthing center services	Dental, including oral surgery, orthodontics and prosthodontics	Hearing services, including hearing aids	Inpatient mental health services
Ambulatory surgical center services	Durable medical equipment (DME), including prosthetic and orthotic devices and disposable medical supplies	Home health services	Meals and lodging for appropriate escort of enrollees
Behavioral health services—mental health and substance use disorders (SUDs)	Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening and special services	Hospice services (noninstitutional only)	Medical detoxification—management of symptoms during the acute withdrawal phrase
Chiropractic services	End-stage renal dialysis services	Independent laboratory services	Medical services including those provided by physicians, advanced-practice registered nurses, physician assistants, federally qualified health centers (FQHCs), primary care centers and rural health clinics (RHCs)
Community mental health center services	Family planning services in accordance with federal and state law and judicial opinion	Inpatient hospital services	

Covered services (continued)

Organ transplant services not considered investigational by the Food and Drug Administration (FDA)	Preventive health services, including those currently provided in public health departments, FQHCs/primary care centers and RHCs	Transportation to covered services, including emergency and ambulance stretcher services, and nonemergency medical transportation (NEMT)
Other laboratory and X-ray services	Psychiatric residential treatment facilities (Level I and Level II)	Urgent and emergency care services
Outpatient hospital services	Outpatient mental health services	Specialized case management services - for enrollees with complex chronic illnesses (includes adult- and child targeted case management)
Vision, including vision examinations, services of opticians, optometrists and ophthalmologists, and glasses and contacts	Pharmacy and limited over-the-counter (OTC) drugs including mental/behavioral health drugs	Specialized children's services clinics
Podiatry services	Targeted case management	Therapeutic evaluation and treatment, including physical therapy, speech therapy, occupational therapy

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

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. More information is available on the Kentucky Cabinet for Health and Family Services website.

PCPs are encouraged to enroll in the Department for Public Health and Department for Medicaid Services Vaccines for Children Program, which offers certain vaccines free of charge to Medicaid enrollees younger than 21. For more information, please visit the Kentucky DMS Vaccines for Children website.

The Kentucky Medicaid Department for Public Health Childhood Lead Poisoning Prevention Program offers a comprehensive approach to primary and secondary prevention of childhood and prenatal lead poisoning and other housing-related health hazards. More Information is available on the Kentucky Medicaid Department for Public Childhood Lead Poisoning Prevention Program website.

EPSDT special services

EPSDT special services include coverage for other medically necessary healthcare, evaluation, diagnostic services, preventive services, rehabilitative services, and treatment or other measures not covered under Kentucky 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 are available regardless of whether those services are covered by Kentucky Medicaid:

- Medical necessity is determined on a case-by-case basis.
- EPSDT special services subject to medical necessity often require prior authorization (PA).
- Consideration must be given to the child's long-term needs and all aspects of the child's needs, such as physical, developmental, behavioral, etc.

Behavioral health

PCPs are required by Kentucky DMS to employ screening and evaluation procedures for the identification of behavioral health or substance use conditions in their patients.

Referral to appropriate behavioral health specialists is an expected standard of care.

Training is available to integrate aspects of behavioral healthcare, including interventions and screenings, into PCP practices.

Educational sessions on prevalent mental health and SUD diagnoses are available to Humana Healthy Horizons-enrolled providers through Relias.

Providers can enroll in these courses at a time that is convenient for them.

Substance use disorder identification and referrals

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

For additional training on how to use SBIRT in your practice, please visit the Substance Abuse and Mental Health Services Administration (SAMHSA).

To refer a patient for SUD residential treatment, please visit Find Help Now Kentucky's website to view real-time admission availability.

Urine drug testing

Humana implemented the Kentucky DMS Urine Drug Testing (UDT) policy, effective July 1, 2020.

UDT claims are processed for payment as indicated by the department's policy, per the provider's Humana contract agreement and/or the Humana out-of-network payment policy. Once the enrollee exceeds the benefit limit as established by the department, Humana denies the claim.

- Providers may appeal a claim denial. If a provider does not agree with the decision on a processed claim, the provider has 60 calendar days from the date of the original claim submission denial to file an appeal.
- Humana recommends providers submit medical records as supporting documentation to prove the medical necessity for the service with the appeal request.
  - For more information on appeals, please refer to the Provider Grievance and Appeals section of the Kentucky Provider Manual.
- Claims paid for UDT services that exceed the enrollee's benefit are reviewed for recovery. Humana recommends that providers submit medical records as supporting documentation to support the medical necessity for the service when disputing an overpayment recovery.

The full Humana UDT policy and the Kentucky DMS UDT policy are available online.

Kentucky Medicaid pharmacy benefit

All Kentucky Medicaid managed care organizations (MCOs), including Humana Healthy Horizons, use pharmacy benefit manager (PBM) MedImpact for all pharmacy claims processing and PA.

All outpatient drugs, including OTC drugs, are covered under a single Kentucky formulary and preferred drug list (PDL) managed by MedImpact.

This does not include physician-administered drugs, which continue to be managed by MCOs under their medical benefit.

Please visit the CHFS website for a list of preferred drugs covered under the Kentucky PDL.

Kentucky Medicaid pharmacy benefit (continued)

All prior authorizations are managed by MedImpact.

- The Kentucky DMS-approved MedImpact Universal PA Form is posted on the MedImpact Single PBM.
- Pharmacy PA requests can be called in to 844-336-2676 or faxed to 858-357-2612.
- You also may submit your request online through Cover My Meds, Surescripts or CenterX ePA portals.

Prior authorization for medications administered in medical office

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

Online

Obtain forms at **Humana.com/medPA**.

Fax

Submit request to 888-447-3430.

Virtual urgent care services: MDLive (Telehealth)

Humana Healthy Horizons enrollees can connect with a board-certified provider for virtual urgent care (i.e., telehealth visit). All virtual visits are available on demand, 24 hours a day, 365 days a year, or by scheduled appointment with MDLive. Visits are convenient, private and secure via mobile app, video or phone. Virtual visits avoid high-cost emergency rooms (ERs) and urgent care facilities. All prescriptions can be sent directly to a local pharmacy if medically necessary.

MDLive scope of services:

- 24/7 urgent care services for nonemergency needs
- Medical evaluation and management
- Virtual urgent care common conditions treated: minor headache, minor sprain, nausea, vomiting, diarrhea, bumps, scrapes, cough, sore throat, congestion and respiratory issues

Board-certified provider types:

- Internal medicine
- Family practice

Humana Healthy Horizons in Kentucky's Added Benefits

Added benefits

Humana offers enrollees extra benefits, tools and services, at no cost to the enrollee, that are not otherwise covered or that exceed limits outlined in the Kentucky State Plan and the Kentucky Medicaid Fee Schedules.

Value-added service	Details and limitations
Baby and Me meals	Up to 2 precooked home-delivered meals per day are provided for 10 weeks for high-risk pregnant women. Care manager approval required.
Convertible car seat or portable crib	Pregnant enrollees who enroll and actively participate in our HumanaBeginnings® Care Management program and complete a comprehensive assessment and at least 1 follow-up call with a HumanaBeginnings care manager can select 1 convertible car seat or portable crib per infant, per pregnancy.
Criminal expungement services	Enrollees 18 and older can receive reimbursement up to $340 for criminal record expungement, as allowed per KYCourts.gov, per lifetime.
Disaster preparedness meals	1 box of 14 shelf-stable meals before or after a natural disaster are provided twice per year. • Enrollee must not live in a residential or nursing facility. • The governor must declare the disaster for the enrollee to be eligible for the meals.
Doula services*	Doula assistance is provided for pregnant females to provide emotional and physical support to the laboring mother and her family, including 5 prenatal visits, 3 postpartum visits and 1 visit for delivery assistance per pregnancy.
Fresh produce box	Up to 4 boxes of in-season nutritious, fresh fruits and vegetable are provided annually for enrollees under care management for diabetes or heart conditions. Care manager approval required.

* Humana will publish billing guidelines on Humana.com/HealthyKY for services indicated above with an asterisk.

Added benefits (continued)

Value-added service	Details and limitations
General Education Development (GED) testing	For enrollees 18 and older, GED test preparation assistance, including a bilingual advisor, access to guidance and study materials, and unlimited use of practice tests are provided. Test preparation assistance is provided virtually to allow maximum flexibility for enrollees. This service also includes test pass guarantee to provide enrollees multiple attempts at passing the test.
Haircuts for Kids	1 standard haircut is provided for enrollees in grades K-12 valued at $20, who upload a photo of their school registration form or school ID or class schedule. Redemption periods are March 2024 through April 2024 and July 2024 through September 2024. Enrollees may redeem this reward through the Go365 for Humana Healthy Horizons® app by uploading a photo of their school registration form, school ID or class schedule.
Housing assistance	For enrollees 18 and older, up to $500 per enrollee per year (unused allowance does not roll over to the next year) is provided 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 your permanent residence (late payment notice required) • Moving expenses via licensed moving company when transitioning from a public housing authority Plan approval required. • Enrollee must not live in a residential facility or nursing facility. • Funds will not be paid directly to the enrollee. • If the bill is in the spouse's name, a marriage certificate may be submitted as proof.

* Humana will publish billing guidelines on Humana.com/HealthyKY for services indicated above with an asterisk.

Added benefits (continued)

Value-added service	Details and limitations
Post-discharge meals	10 refrigerated home-delivered meals are provided following discharge from an inpatient or residential facility. Limited to 4 discharges per year.
Self-monitoring devices—blood pressure kit	Enrollees 21 and older under care management may receive 1 digital blood pressure kit once every 3 years. Kit includes the cuff and monitor. Care manager approval required.
Self-monitoring devices—weight scale	Enrollees 21 and older under care management may receive 1 weight scale every 3 years. Care Manager approval required.
Smartphone app for diabetes management	For enrollees 18 and older with type 2 diabetes who are not already receiving care management services, unlimited access to an innovative digital therapeutic smartphone app for diabetes management is provided.
Smartphone services	1 free smartphone is provided through the federal Lifeline program, per household. Enrollees who are younger than 18 will need a parent or guardian to sign up. This benefit covers per lifetime: 1 phone, 1 charger, 1 set of instructions, unlimited talk, text and high-speed data, training for the enrollee and their caregiver at the first case manager orientation visit. This benefit includes calls to Canada and Mexico. The enrollee must make 1 phone call or send 1 text message every month to keep benefit. The enrollee may qualify for enhanced benefits through the Affordable Connectivity Program (ACP) that provides unlimited minutes, 10 GB hotspot and unlimited data. Enrollees can opt in to this benefit by calling SafeLink at 800-SAFELINK (800-723-3546) or online at www.safelink.com/en/ACP11. Benefits are subject to change by the Federal Communications Commission under the Lifeline program.

* Humana will publish billing guidelines on Humana.com/HealthyKY for services indicated above with an asterisk.

Added benefits (continued)

Value-added service	Details and limitations
Sports physical*	1 sports physical is provided per year for enrollees ages 6 to 18.
Tobacco and vaping cessation coaching	Tobacco and vaping cessation coaching is for enrollees ages 12 and older. The program is designed as a 6-month engagement for a total of 8 coaching calls, but enrollees have 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.
Weight management coaching	Weight management coaching delivers weight management intervention for enrollees 12 and older. Upon receiving provider clearance, enrollee can complete 6 weight management coaching sessions with a health coach, 1 call per month for a period of 6 months.
Workforce development program	For enrollees 18 and older, up to 12 months of assistance to support each participant in planning for the future (e.g., education, training, financial counseling) and engaging in and maintaining meaningful work (e.g., job support and retention coaching) is provided. 3 round-trip bus vouchers for transportation when enrolled in the program where available also are provided. Enrollee reimbursement for childcare of $40 maximum per quarter, up to 4 times per year, for caretakers seeking job opportunities is provided. The enrollee must participate in the Humana Workforce Development program to be eligible for reimbursement consideration.

* Humana will publish billing guidelines on Humana.com/HealthyKY for services indicated above with an asterisk.

Go365 for Humana Healthy Horizons wellness rewards

Go365 for Humana Healthy Horizons® is a wellness program that offers enrollees the opportunity to earn rewards for taking healthy actions. Most are awarded based on Humana's receipt of the provider's claim services rendered. **Humana recommends that all providers submit their claims on behalf of an enrollee by the end of February 2025.** This allows the enrollee time to redeem their rewards. Go365 is available to all enrollees who meet the requirements of the program. Rewards are not used to direct the enrollee to select a specific provider.

Healthy behavior rewards	Details and limitations
Breast cancer screening	Annual $25 reward for female enrollees 40 and older who obtain a mammogram
Cervical cancer screening	Annual $25 reward for female enrollees 21 and older who obtain a Pap test
Chlamydia screening	Annual $25 reward for female enrollees who obtain a chlamydia screening when sexually active and as recommended by their healthcare provider
Colorectal cancer screening	Annual $25 reward for enrollees 45 and older who obtain a colorectal cancer screening as recommended by their PCP
COVID-19 vaccine	Annual $25 reward for enrollees 5 and older who upload a picture/file of their completed COVID-19 vaccine card Enrollees who were vaccinated prior to enrollment in Humana plan can upload vaccination card within 90 days of enrollment to receive the reward. New enrollees who were not vaccinated prior to enrollment in Humana have 90 days from completion of the vaccination to upload the vaccination card to receive the reward.
Diabetic retinal exam	Annual $25 reward for diabetic enrollees 18 and older who complete a retinal eye exam
Diabetic screening	Annual $20 reward for diabetic enrollees 18 and older who obtain a screening with their PCP for HbA1c and blood pressure
Digital onboarding	One-time $25 reward for downloading the Go365 mobile app and completing the registration

Rewards are nontransferable to other managed care plans or other programs. Rewards 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.

Go365 for Humana Healthy Horizons wellness rewards (continued)

Healthy behavior rewards	Details and limitations
Flu vaccine	Annual $25 reward for enrollees who receive an annual flu vaccine from their provider, pharmacy or self-reporting if they received a vaccine from another source
Health Risk Assessment (HRA) completion	One-time $50 reward for completing the Health Risk Assessment (HRA) within 30 days of enrollment
HPV vaccine	One-time $80 reward for enrollees who receive 2 doses of the HPV vaccine between their 9th and 13th birthdays
Level of care education	Annual $10 reward for enrollees 19 and older upon watching a short educational video about when to access the emergency room
Notification of Pregnancy (NOP)	$25 reward when pregnant enrollees notify Humana of pregnancy prior to delivery once per pregnancy
Postpartum visit	$50 reward for all postpartum females who complete 1 postpartum visit within 7 to 84 days of delivery once per pregnancy
Prenatal visits	$10 per prenatal visit for pregnant enrollees, up to 10 prenatal visits, for a total of up to $100 once per pregnancy
Tobacco and vaping cessation coaching	Enrollees 12 and older who enroll in tobacco and vaping cessation coaching will have 2 opportunities to earn rewards annually: • $25 reward for completing 2 calls within 45 days of enrollment in the program • $25 reward for completing the full program
Weight management coaching	Enrollees 12 and older who enroll in weight management coaching will have 2 opportunities to earn rewards: • $15 in rewards for completing a well-being checkup • $15 in rewards for completing the program
Well-child visits, (0-15 months)	Up to $60 reward for enrollees who complete routine well-child visits; enrollees can receive $10 in rewards per visit with a 6-visit limit
Well-child visits, (16-30 months)	$20 reward for enrollees who complete routine well-child visits; enrollees can receive $10 in rewards per visit with a 2-visit limit
Wellness visit	Annual $25 reward for enrollees 3 and older for completing an annual wellness visit

Rewards are nontransferable to other managed care plans or other programs. Rewards 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.

Provider Services

Provider and enrollee rights and responsibilities

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

More information regarding these rights is included in the Enrollee Rights and Responsibilities section of the Kentucky Provider Manual available online.

Credentialing and recredentialing

- Healthcare providers must be credentialed prior to network participation to treat Humana Healthy Horizons enrollees.
- Humana participates with the Council for Affordable Quality Healthcare (CAQH®) for applicable provider types.
  - 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 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 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 with Kentucky DMS to be considered for participation.
- In addition to being in good standing with Medicare, federal, state and local agencies, healthcare providers must not appear on the Terminated and Excluded Provider List published by Kentucky DMS.

More information is included in the Credentialing and Recredentialing section of the Kentucky Provider Manual available online.

Provider status changes

Advance written notice of status changes, such as a change in address, phone, or adding or removing a provider at your practice, should be sent to ProviderDevelopmentKYWV@humana.com or KYBHMedicaid@humana.com for behavioral health providers.

Timely status updates keep our records current and are critical to process your claims. Status updates also ensure our provider directories are up to date and reduce unnecessary calls to your practice. This information also is reportable to the Centers for Medicare & Medicaid Services (CMS).

Type of change	Minimum notice required
Healthcare providers entering or leaving the practice, ownership changes or convictions	**Immediate**
Phone number change	**10 calendar days**
Address change	**60 calendar days**
Change in capacity to accept enrollees	**60 calendar days**
Healthcare provider's intent to terminate	**90 days or as specified in provider agreement**

Provider relations

Humana Healthy Horizons' Provider Relations representatives provide support with:

Assisting all network providers in navigating Humana resources

Helping providers access resources for billing and coding issues

Educating providers regarding new policy changes, system updates and availability standards

Instructing on resolution processes and assisting with escalated issues

Communicating important information with the provider network via meetings, newsletters, network notices and emails

Provider relations (continued)

Your Provider Relations representative conducts required yearly on-site visits to PCP offices to offer education resources and ensure compliance for:

Access and availability standards	**Privacy practices**	**Health Insurance Portability and Accountability Act (HIPAA) policies and procedures**	**Patient rights and responsibilities**	**Provider resources**	**Cultural competency**
Case management programs	**Encounter submissions**	**Grievance and appeals processes**	**Kentucky Health Information Exchange (KHIE) participation**	**Vaccines for Children program**	**Enrollee disenrollment processes**

Provider Relations representative assignments can be found on the Kentucky Documents and Resources website. If you are unable to determine who your representative is, please send an email to KYMCDPR@humana.com.

For Medicaid claims-related inquiries, please email KYMCDCRR@humana.com and include the name of your Provider Relations representative.

Clinical

Referrals

PCPs are the home base for enrollees and responsible for coordinating enrollee care. Humana does not require referrals for enrollees to seek care from participating providers. Enrollees may self-refer to any participating provider;† however, Humana encourages enrollees to notify their PCP of other provider visits.

PCPs should regularly screen their patients for behavioral health disorders, including SUDs, and make appropriate referrals.

If PCPs need assistance referring enrollees to appropriate behavioral healthcare, Humana Healthy Horizons' Case Management team can assist you and the enrollee. The referral can be sent to the Medicaid Case Management team at the following email address: KYMCDCaseManagement@humana.com

† Exceptions to this policy apply to enrollees eligible for participation in the Lock-in Program.

Referrals (continued)

Healthcare providers are encouraged to implement SBIRT best practices for all enrollees who may be affected by an SUD.

Screening
Utilize a standard screening tool to assess risks for your patient.

Brief Intervention
Utilize clinical expertise to engage patients in a conversation about how risky behaviors affect them and develop the patient's interest in treatment.

Referral to Treatment
Refer patient to professionals who specialize in behavioral health or SUD treatment.

- For referral and up-to-date openings in facilities for addiction treatment in Kentucky, please visit the KY Help Now website.
- For more information on how to use SBIRT in your practice, please visit SAMHSA's SBIRT website.

Prior authorizations

- Humana requires PA for certain services to facilitate care coordination as well as to confirm the services are provided according to Kentucky DMS coverage policies.
- Enrollee eligibility is verified when PA 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 enrollees.
- PA is required for specific services and medications. Please see the Pharmacy section of this presentation for details on drug PAs.
- Healthcare providers should review the Kentucky Medicaid Prior Authorization List online at Humana.com/PAL.
- PA for services, including EPSDT special services, must be obtained prior to the date of service to determine medical necessity of the request.
- Information regarding public health emergencies and Kentucky's policies regarding authorization requirements can be found at Kentucky's COVID-19 webpage.

Prior authorizations for behavioral health and medical procedures

PA for healthcare services can be obtained by contacting the Utilization Management department online or via phone or fax:

Online

Visit Availity Essentials

Phone or Fax

Call 800-444-9137 (Monday through Friday, 8 a.m. to 6 p.m., Eastern time) and follow the menu prompts for authorization requests, depending on your need, or fax the request to 833-974-0059.

Online authorizations

Submission

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

Management

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

Sign in to Availity Essentials

Information to provide with prior authorization requests

When requesting authorization, please provide the following information:

- Enrollee/patient name and Humana Healthy Horizons enrollee ID number
- Provider name, National Provider Identifier (NPI), Tax Identification Number (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-network provider, if applicable
- Clinical information to support the medical necessity of the service, including a current treatment plan and assessments, when 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 name, admit date, admitting diagnosis, and presenting symptoms, plan of treatment, all appropriate clinical review and anticipated discharge needs, if the request is for inpatient surgery
- Date of surgery, surgeon name, facility, diagnosis and procedure planned, and anticipated discharge needs, if the request is for outpatient surgery

Prior authorization partners: EviCore

Humana Healthy Horizons partners with WholeHealth Living® (a brand of Tivity Health), EviCore healthcare, Avēsis and Evolent Health (formerly New Century Health) for PA reviews.

EviCore healthcare

Provides authorization services for Kentucky Medicaid enrollees for the following services:

- 3D rendering
- Computed tomography angiography (CTA)
- Computerized tomography (CT) scan
- Magnetic resonance angiography (MRA)
- Magnetic resonance imaging (MRI)
- Nuclear medicine
- Positron emission tomography (PET)
- Single-photon emission computerized tomography (SPECT) scan
- Physical, occupational and speech therapy (PT/OT/ST)

Submit authorization requests to EviCore:

- **Online**, opens new window (registration required)
- **Call** 866-672-8115, Monday – Friday, 7 a.m. – 7 p.m., Eastern time
- **Fax** advanced imaging services requests to 800-540-2406 or <855-774-1319 for PT/OT/ST services

Prior authorization partners: Tivity Health

Tivity Health

For all chiropractic services on the Kentucky DMS fee schedule, you must obtain PA through WholeHealth Living, Inc., a Tivity health company.

To submit a PA request to WholeHealth Living for chiropractic services:

Online

Use the WholeHealth Living online portal.

Fax

You can fax a completed chiropractic template to 888-492-1025, and the authorization will be entered on your behalf.

Phone

Call 855-800-9804, Monday – Friday, 8:30 a.m. – 5:30 p.m., Eastern time.

Resources

Copies of the instructions and templates are located within the Reference Library section by selecting Forms & Instructions.

Prior authorization partners: Avēsis

Avēsis

For authorizations related to dental and vision services, Humana partners with Avēsis.

Submit a PA request through the Avēsis provider portal or by mail:

Dental and eye care preauthorization (minimum notice required)	
Mail PA requests to: Avēsis Third Party Administrators, LLC Attention: Dental Prior Authorization P.O. Box 38300 Phoenix, AZ 85069-8300	**Mail PA requests to:** Avēsis Third Party Administrators, LLC Attention: Eye Care Prior Authorization P.O. Box 38300 Phoenix, AZ 85069-8300
Post review: Avēsis Third Party Administrators, LLC Attention: Dental Post Review P.O. Box 38300 Phoenix, AZ 85069-8300	**Post review:** Avēsis Third Party Administrators, LLC Attention: Eye Care Post Review P.O. Box 38300 Phoenix, AZ 85069-8300

Prior authorization partners: Evolent Health

Evolent Health

For adults 18 and older, Humana partners with Evolent Health for chemotherapy agents, supportive drugs and symptom management drug PA requests. Choose from the following options to submit a PA request to Evolent Health:

Online

Initiate an online PA request by signing in to Evolent's website. Enter your username and password. If you have not yet received a username and password, please call Evolent at 855-427-1372 and select option 1.

Phone

Call Evolent's intake coordinator department at 855-427-1372 and select option 1. Assistance is available Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

Please note: For a list of applicable drugs, please visit Humana.com/PAL. This list is subject to change with notification. However, this list may be modified throughout the year, without notification, via U.S. postal mail for additions of new to-market medications or step-therapy requirements for medications.

Determination time frames for prior authorizations

Standard determination

- Notice of decision is sent as expeditiously as the enrollee's health condition requires, but no later than 2 business days following receipt of the request for service.

Expedited determination

- When a provider indicates, or Humana determines, that following the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function, Humana will complete an expedited authorization decision within 24 hours and provide notice as expeditiously as the enrollee's health condition requires.

- Please specify in Availity Essentials or on the Humana Medicaid: Authorization Request Form 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 PA is required but not obtained in the following circumstances:

- The service is related to another service that received prior approval, and the service was already 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.
- The service is for Humana Healthy Horizons-covered patients who are determined to be retroactively eligible for Medicaid. (Retroactive Medicaid coverage is defined as a period up to 3 months prior to the application month.)
- Exception: PA obtained prior to an enrollee transitioning from another MCO to Humana Healthy Horizons will be upheld for the remainder of that PA approval time period.

Retrospective review (continued)

To request a retrospective review, providers have 90 calendar days from:

- The date of service
- The inpatient discharge date
- The initial date of a service, for a service that spans several months
- The date of the primary insurance carrier's explanation of payment or authorization denial, which demonstrates the service was not a covered service

Requests for a retrospective review that do not meet one of the above requirements or exceed the 90-calendar-day time frame will be administratively denied.

Exception to the above criteria: For enrollee retrospective eligibility, healthcare providers have up to 30 days from the Kentucky Medicaid Management Information System (KYMMIS) "Added Date" to submit a retroactive authorization request. For provider enrollment on a retrospective basis with Kentucky DMS, retroactive Medicaid eligibility will be honored for 30 days from published date.

Please include the following when submitting a retrospective review request:

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

Preventive health service and clinical practice guidelines

These clinical treatment protocols are systematically developed statements that help providers and enrollees make decisions regarding appropriate healthcare for specific clinical circumstances or for specific age ranges.

We strongly encourage providers to consider these guidelines whenever they promote positive health outcomes for clients.

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

Preventive health guidelines and clinical practice guidelines are distributed to all providers via:

- Provider manual updates
- Provider newsletters
- Provider website

Access to care requirements

Participating PCPs are required to ensure adequate accessibility to healthcare 24 hours a day, 7 days a week and may not discriminate against enrollees.

PCPs must maintain formalized relationships with other PCPs to refer enrollees for after-hours care, during certain days, for certain services and for other reasons to extend the hours of services of their practice.

Enrollees should be triaged and provided appointments for care within the time frames listed on the following slide.

Access to care requirements (continued)

PCPs

Patients with:	Should be seen:
Emergency needs	Immediately on presentation; 24 hours a day, 7 days a week
Urgent care	Not to exceed 48 hours from date of an enrollee's request
Routine care needs	Not to exceed 30 days from date of an enrollee's request

Non-PCP specialists

Patients with:	Should be seen:
Emergency needs	Immediately on presentation
Urgent care	Not to exceed 48 hours from the date of an enrollee's request
Routine care needs	Not to exceed 30 days from date of an enrollee's request

Behavioral health providers

Patients with:	Should be seen:
Care for non-life-threatening emergency	Must be provided within 6 hours, crisis stabilization
Urgent care	Must be provided within 48 hours
Initial visit or routine office visit	Must be provided within 10 business days
Post discharge from an acute psychiatric hospital	Within 7 days‡

‡ Providers must contact enrollees who have missed an appointment within 24 hours to reschedule.
General vision, dental, lab and X-ray wait times must not exceed 30 days for regular appointments and 48 hours for urgent care. Other visit types not specified above must not exceed 60 days.

PCP after-hours availability

Humana Healthy Horizons ensures the following acceptable after-hours phone arrangements are implemented by PCPs and unacceptable arrangements are amended:

Acceptable after-hours arrangement

- Office phone is answered after hours by an answering service that can contact the PCP or another designated provider, and the PCP or designee is available to return the call within a maximum of 30 minutes.
- Office phone is answered after hours by a recording directing the enrollee to call another number to reach the PCP or another designated provider to return the call within a maximum of 30 minutes.
- Office phone is transferred after office hours to another location where someone answers the phone and contacts the PCP or another designated provider within a maximum of 30 minutes.

Unacceptable after-hours arrangement

- Office phone is only answered during office hours.
- Office phone is answered after hours by a recording that tells enrollees to leave a message.
- Office phone is answered after hours by a recording that directs enrollees to go to the emergency room for any services needed.
- Return time for after-hours calls is longer than of 30 minutes.

Enrollees with special healthcare needs

When a new/transitioning enrollee 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 enrollee may be reasonably transferred without disruption, whichever is first.

Humana Healthy Horizons may require PA for continuation of the services beyond 30 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/HealthyKY.

Transitioning during pregnancy

First trimester

Humana Healthy Horizons covers the costs of continued medically necessary prenatal care, delivery and postpartum care services without PA and regardless of the provider's contract status until Humana can safely transfer the enrollee to a network provider without impeding service delivery.

Second and third trimester

Humana Healthy Horizons covers the costs of continued access to the prenatal care provider (whether the provider is contracted or not) for 60 calendar days postpartum, provided the enrollee remains covered through Humana Healthy Horizons, or the enrollee is referred to a safety-net provider if the enrollee's eligibility terminates before the end of the postpartum period.

Transitioning during pregnancy (continued)

Medically necessary services covered by the previous MCO in addition to prenatal services:

- Humana Healthy Horizons **temporarily** covers the costs of continuation of such medically necessary services.
- **After 30 days**, Humana Healthy Horizons may require PA 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 enrollee may be reasonably transferred without disruption**, whichever occurs first.
- Continuity of care process information is available at Humana.com/HealthyKY.

Care management overview

Care management

Humana Healthy Horizons manages and coordinates care for enrollees with special healthcare needs who require ongoing care management/chronic condition management.

Outreach frequency is determined by individual enrollee needs, preferences and risk level.

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

- Identifies enrollees through referrals from on-site/telephonic UM nurses, PCPs, specialists, enrollee self-referral, health needs assessments, predictive model algorithms, post-discharge assessments, etc.
- Obtains enrollees' permission/agreement to participate (Enrollees 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 members of enrollees' interdisciplinary care team and engages the PCP
- Creates an individualized comprehensive care plan with the enrollee and works toward identified goals
- Makes available the individualized care plan to providers by contacting Humana Healthy Horizons or via Availity Essentials

More information is available at **Humana.com/HealthyKY**.

Care management functions

Identify triggers for ER visit/admission and partners with enrollees and their healthcare providers to prevent/reduce ER visits and unplanned inpatient admissions.

Address Healthcare Effectiveness Data and Information Set (HEDIS®) measures for enrollees' gap reports or alerts on file.

Refer to internal and external programs and community resources as needed (e.g., maternal health program, smoking cessation, food pantry resources, etc.).

Coordinate and participate in interdisciplinary team meetings to identify the best course of action for improved outcomes based upon enrollee needs.

Educate enrollees on disease process, self-care and value-added services.

Support and reinforce medical provider instructions and facilitate appointment scheduling and attendance.

Population health management (PHM)

PHM goal

Use continuous quality improvement methodology to:

- Measure data
- Track trends
- Monitor outcomes
- Adjust the approach to achieve the Triple Aim

Overview

- Identifies enrollee needs and preferences
- Employs strategies to improve health and well-being, and implements interventions for priority populations
- Identifies enrollees with emerging risks, significant behavioral health and SDOH issues, and segments of our population experiencing health disparities
- Achieves the Triple Aim—better health, better care and better value—by increasing providers' PHM capabilities by providing access to accurate and actionable data
- Via Availity Essentials, provides a single location and consistent workflow to process transactions and securely access a wide range of financial, administrative and clinical transactions

For more information, please refer to the Provider Manual.

Provider role and integrated healthcare with PHM

Humana Healthy Horizons employs a population health model that encompasses care management, data integration, population assessments, enrollee stratification and targeted interventions, based on priority populations. Our population health model also features quality measurement and enhanced PCP support models.

Population Insights Compass is a proprietary population health platform used to enhance Humana Healthy Horizons' PCP support within our population health model. To deliver additional insight into patient panels, we encourage PCPs to use Population Insights Compass' robust data-analysis capabilities to identify recommended health screenings for enrollees to improve health outcomes. More information is available at Humana.com/compass.

PCPs may request Compass reports from their Provider Engagement representatives to help identify patients or groups requiring additional support.

PHM—An integrated program that addresses SDOH and PHM initiatives

Population health is a foundational element of Humana Healthy Horizons' enterprise mission and a core component of our managed care programs.

We assess our enrollees to:

- Identify needs and preferences
- Employ strategies to improve enrollees' health and well-being and implement interventions for priority populations
- Identify enrollees with significant behavioral health (BH) issues and deficient SDOH
- Support segments of our population experiencing health disparities

A PCP's utilization of electronic health records (EHRs) is a primary driver toward successful integration, as using EHRs facilitates real-time information exchange to promote continuity of care.

PHM—An integrated program that addresses SDOH and PHM initiatives (continued)

To support our population health initiatives, providers are encouraged to refer enrollees with identified needs to our care management and PHM community resource programs by sending referrals to:

- **Care management**
  - Call 888-285-1121, fax a request to 833-939-1312 or email KYMCDCaseManagement@humana.com.
- **Population health**
  - Call 866-331-1577 or email KYMCDPopulationhlth@humana.com.

Providers should encourage enrollees to use Go365 for Humana Healthy Horizons, Humana Healthy Horizons' population health tool.

PHM—An integrated program that addresses SDOH and PHM initiatives (continued)

Resources to help enrollees manage their own health:

KidsHealth®

KidsHealth is a library of video modules and written content on pediatric BH and physical health conditions. KidsHealth content is designed to be accessible and readable by children, adolescents and adults, enabling younger enrollees to play a role in the self-management of their condition.

Healthwise®

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 enrollees.

Vida

Humana Healthy Horizons and Vida introduce an innovative digital therapeutic app proven successful at promoting better health through a prediabetes program and through blood sugar control among persons with diabetes. It reduces associated costs through real-time feedback on critical aspects of enrollee lifestyle and behavior. The diabetes app is designed to address clinically proven dimensions of diabetes management: exercise and sleep habits, diet, psycho-social factors such as stress, clinical symptoms, medication adherence, and lab results such as blood glucose levels. Vida gives feedback to enrollees to promote self-management of critical behaviors, such as diet and exercise, and communicates lab results to enrollees and their clinical team.

PHM—Population Insights Compass

Access

- Contact your Provider Engagement representative to request access to Population Insights Compass.
- To qualify for access, a PCP must:
  - Have 30 or more Humana Healthy Horizons enrollees
  - Be on the Path to Value continuum
  - Have a signed business associate agreement on record with Humana Healthy Horizons
- Once access is granted, PCPs receive an email from Microsoft Invitation to register an account.
- After registering your account, sign in to Population Insights Compass.

Training

- Visit Humana.com/compass to register for interactive webinar training modules.
- Compass 101, a 1-hour course that reviews navigating the tool and functionality, is a prerequisite before registering for other courses.

Chronic condition management

Programs

- Asthma
- Cancer
- Diabetes
- Heart disease
- Obesity
- Tobacco use
- Infant mortality
- Low birth weight
- BH and SUD
- Others as determined

Goal

Empower enrollees through education and development of self-management skills that foster treatment plan compliance and better health outcomes.

Overview

- Participation is voluntary and enrollees may opt out at any time.
- Referrals are received 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.
- An individualized education plan is created based on enrollee needs.
- The care manager coordinates care to meet identified needs and works with enrollee to set agreed-upon contact frequency and cadence.
- The care manager educates enrollees about disease processes, self-care and value-added services. The care manager refers the enrollee 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/HealthyKY.

Enrollee incentive programs

HumanaBeginnings®

- Prenatal visits
- Postpartum visits
- Well-baby visits

Healthy behaviors

- HbA1c check
- Digital rectal exam
- Pap test
- Mammogram
- Wellness visits

- Enrollee incentive programs are healthy behavior programs designed to help enrollees live a healthier lifestyle and maintain health.
- Enrollees can call Humana Healthy Horizons to find out how to enroll in incentive programs.

Maternal health and transition programs

HumanaBeginnings

- Manages prenatal and postpartum enrollees from onset of pregnancy up to eight weeks postpartum or eligibility loss
- Facilitates care coordination with Women, Infants and Children (WIC), Healthy Start and other internal/external programs

Transition support

- Supports enrollees as they transition out of inpatient care to the community
- Supports follow-up appointments
- Ensures delivery of at-home, post-discharge items
- Reviews discharge instructions and changes to medication

Interpretation and translation services

Improved communication with enrollees can:

- Improve health outcomes
- Increase safety and adherence
- Lead to more efficient office processes, resulting in time and money saved
- Increase provider and patient satisfaction
- Reduce malpractice risk

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
- Services provided at no cost to the enrollee, per federal law

Healthcare providers with questions about Humana Healthy Horizons' language assistance requirements and resources should call Humana Healthy Horizons at the phone number listed on the enrollee's Humana Healthy Horizons ID card.

Cultural sensitivity

Humana Healthy Horizons offers a variety of resources to deliver healthcare services to all enrollees in ways that are respectful to the enrollee's race, ethnicity, socioeconomic status, gender, culture and primary language, including:

- Language assistance services
- Detailed demographic information about contracted providers
- Internal staff training for providers
- Spanish language resources

A copy of Humana Healthy Horizons' Cultural Competency Plan is provided at no charge and can be found online at Humana's language assistance and diversity webpage. To request a paper copy, please call Humana Healthy Horizons Provider Services at 800-444-9137.

Advance medical directives

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

- The discussion should be charted in the enrollee's permanent medical record.
- Include a copy of the advance medical directive in the enrollee's medical record inclusive of other mental health directives.

Information on advance medical directives is included in the Kentucky Provider Manual.

Enrollee medical record reviews

Humana Healthy Horizons monitors a PCP's actions to ensure they comply with Kentucky DMS and plan policies including:

- Maintaining continuity of the enrollee's healthcare
- Maintaining a current medical record for the enrollee, including documentation of all PCP and specialty care services
- Documenting all care rendered in a complete and accurate medical record that meets or exceeds the department's specifications

The completion of record reviews can result in the implementation of improvement plans and actions when standards are not met by the PCP. The enrollee medical records review process also assesses the effectiveness of practice site follow-up plans to increase compliance with established medical records standards and goals. The Kentucky Provider Manual includes details regarding medical record standards and reviews.

Enrollee medical record reviews are implemented with methods for assessing performance and compliance with medical record standards that evaluate:

- PCPs' compliance with clinical and preventative care guidelines
- Tracking and trending of individual and network provider performance over time
- Mechanisms and processes that allow for the identification, investigation and resolution of quality-of-care concerns
- Mechanisms for detecting instances of over-, under- and misutilization

Enrollee medical record requirements

- The plan ensures its network of providers maintains enrollee medical records on paper or in an electronic format and maintains timely, legible, current, detailed and organized information 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 providers' findings
  - Appointment records
  - Other documentation sufficient to disclose the quantity, quality, appropriateness and timeliness of services provided
- The medical record shall be signed by the healthcare provider of service.
- The enrollee's medical record is the property of the healthcare provider who generates the record.
  - However, each enrollee or their representative is entitled to 1 free copy of their medical record.
    - Additional copies are made available to enrollees at cost.
  - 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).
- The plan ensures the PCP maintains a primary medical record for each enrollee containing sufficient medical information from all providers involved in the enrollee's care, to ensure continuity of care.

Enrollee medical record requirements (continued)

- The medical chart organization and documentation must contain, at a minimum, the following:
  - Enrollee/patient identification information, on each page
  - Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and, if the Humana Healthy Horizons-covered patient does not have a phone number, numbers of emergency contacts, consent forms, language spoken, and guardianship information
  - Date of data entry and date of encounter
  - Provider name
  - Allergies and adverse reactions noted in a prominent location
  - Past medical history, including serious accidents, operations and illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (e.g., documentation of chicken pox).
  - Identification of current problems
  - The consultation, laboratory and radiology reports containing the ordering provider's initials or other documentation indicating review
  - Documentation of immunizations pursuant to 902 Kentucky Administrative Regulation (KAR) 2:060
  - Identification and history of nicotine, alcohol use or substance use

Enrollee medical record requirements (continued)

- Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health, pursuant to 902 KAR 2:020
- Follow-up visits provided secondary to reports of emergency room care
- Hospital discharge summaries
- Advance medical directives (for adults)
- All written denials of service and the reason for the denial
- Record legibility to at least a peer of the writer (Records judged illegible by one reviewer are evaluated by another reviewer.)

- An enrollee's medical record should include the following minimal detail for individual clinical encounters:
  - History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health and SUD status
  - Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (e.g., EPSDT) addressed from previous visits
  - Plan of treatment, including:
    - Medication history and medications prescribed, including the strength, amount, directions for use and refills
    - Therapies and other prescribed regimens
    - Follow-up plans that include consultation, referrals and directions, and an estimated time to return for a follow-up visit

Enrollee medical record requirements (continued)

When documenting medical and mental health hospital visits, an enrollee's medical record must include, at minimum, the following:

- Enrollee name/ID number
- Provider name
- Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission
- The plan of care (as required under 42 C.F.R. 456.172 [mental hospitals] or 42 C.F.R. 456.70 [hospitals])
- Initial and subsequent continued stay review dates (described under 42 C.F.R. 456.233 and 42 C.F.R. 465.234 [for mental hospitals] and 42 C.F.R. 456.128 and 42 C.F.R. 456.133 [for hospitals])
- Reasons and plan for continued stay, if applicable
- For non-mental hospitals only, other appropriate supporting material to include:
  - Date of operating room reservation
  - Justification of emergency admission, if applicable

Reporting of communicable diseases

Providers are expected to report instances of communicable disease in accordance with 902 KAR 2:020.

Contact the health department serving the county in which the enrollee resides.

Each county's health department has reporting requirements, such as reporting classifications and reporting methods, posted on their website.

Please visit the Cabinet for Health and Family Services' Infectious Disease website for a list of diseases and conditions that require reporting and instructions.

Claims Processing

Provider-preventable conditions

- Providers are required to report provider-preventable and healthcare-acquired conditions associated with claims for payment or enrollee treatments for which payment would otherwise be made.
- Claims for these conditions will not be paid.
- If not submitting a claim, providers are subject to reporting the condition in writing to DMS within 12 months of occurrence.

Electronic claim submission

Claims clearinghouses**

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

** 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 encounters by providers under a capitation agreement with Humana Healthy Horizons

Avēsis dental and vision claim submission

Avēsis Dental

Submit claims electronically through your practice management software using a clearinghouse: <

- Change Healthcare – Payer ID: 86098
- TriZetto – Payer ID: 86098
- Through the Avēsis online portal

Paper claims can be mailed to:
Avēsis Dental Claims
P.O. Box 38300
Phoenix, AZ 85069-8300

For more information regarding Avēsis claims inquiries and payments, please go to the Avesis provider portal or call Avēsis Dental Provider Relations at 888-211-0599.

Avēsis Vision

Submit claims electronically through your practice management software using a clearinghouse:

- Change Healthcare – Payer ID: 87098
- TriZetto – Payer ID: 86098
- Through the Avēsis online portal

Paper claims can be mailed to:
Avēsis Third Party Administrators, Inc.
Attention: Eye Care Claims
P.O. Box 38300
Phoenix, AZ 85069-8300

For more information regarding Avēsis claims inquiries and payments, please go to the Avesis provider portal or call Avēsis Vision Provider Relations at 844-511-5760.

How to avoid claims submissions errors

Common reasons for claims submission rejection or denial:

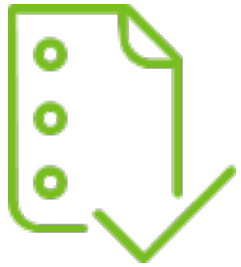
- Providers submitting an incorrect NPI/taxonomy code
- Claims missing NPI/taxonomy code
- Providers submitting claims without a required billing/rendering/referring/ordering/attending NPI
- Providers submitting NPIs not enrolled/registered for Medicaid with Kentucky DMS
- Providers submitting claims 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 claim payer ID
- Providers submitting claims with a referring/ordering/rendering/attending NPI registered as a group

How to avoid these errors:

- Confirm the provider information submitted exactly matches the provider information as it is registered with Kentucky DMS and in accordance with the services provided (e.g., NPI, Medicaid number, taxonomy code, provider specialty code, provider type code).
- Ensure billing/rendering/referring/ordering/attending NPIs on the claim are correct and are enrolled/registered with Kentucky DMS.
- If provider has an NPI registered to more than 1 active Medicaid number, a taxonomy code **must** be on the claim.
- Ensure billed amounts do not equal zero dollars (i.e., providers must submit billed charges).

Provider types required to bill with referring/ordering provider on claim

Billing provider type	Billing provider type descriptions
18	Private duty nursing
36	Ambulatory surgery center
37	Independent lab
50	Hearing aid dealer
52	Optician
54	Pharmacy: all crossover services billed
70	Audiologist
76	Multi-therapy agency
79	Speech language pathologist
86	X-ray/miscellaneous supplier
87	Physical therapy
88	Occupational therapist
90	DME



Providers submitting claims with a billing, rendering, referring, attending and/or ordering NPI **must be registered** with Kentucky DMS for Medicaid.

Timely filing

- Claims must be submitted within 365 calendar days of the date of service or discharge.
- Providers have 365 calendar days from the date of service or discharge to submit a corrected claim.
- The time frame for providers to submit an appeal is 60 calendar days from receipt of notice that payment for a submitted claim was reduced or denied.
- Claims, timely filing and HEDIS:
  - Providers are required to file their claims in a timely manner for all services rendered to enrollees. Timely filing is an essential component reflected in Humana Healthy Horizons' HEDIS reporting and can ultimately affect how a plan and its providers are measured in enrollee preventive care and screening compliance.
- Claims determined by Humana Healthy Horizons to have been incorrectly paid or denied and are within 24 months of Humana's claims adjudication date will be reprocessed. Providers will not be required to resubmit the claim.
- Visit Humana.com/MakingItEasier for more information on claims and payment processes.

Payment options

Humana Healthy Horizons utilizes 3 payment options for providers:

- Paper check and remittance
  - Default provider payment option
  - Humana Healthy Horizons selects providers utilizing paper checks and remittance to participate in virtual credit card payments (VCC)

- VCC
  - Humana Healthy Horizons partners with PNC Healthcare and ECHO Health Inc. to pay claims to eligible healthcare providers via VCC.
  - We notify healthcare professionals and organizations prior to their enrollment in virtual card payments.
  - Healthcare providers may opt out of the program by calling ECHO at 888-483-9212, Monday – Friday, 8 a.m. – 6 p.m., Eastern time; alternatively, providers can enroll in electronic funds transfer/electronic remittance advice (EFT/ERA).

- ERA/EFT

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.

Get paid up to 7 days faster than via mail.

Reduce the risk of lost or stolen checks.

Receive HIPAA-compliant ERA transactions.

Have remittances sent to your clearinghouse or view them online.

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 1 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 800-444-9137.

Balance billing

As described within the Kentucky Provider Manual:

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

Humana Healthy Horizons in Kentucky Provider Manual and other provider communications can be found at Humana.com/HealthyKY.

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

Electronic Health Records

Electronic Health Records (EHR)

An EHR is a digital version of a patient's paper chart.

They 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, EHR systems are 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.

EHR assistance

Regional extension centers

- If providers need assistance selecting an EHR system, they can reach out to their local regional extension center (REC). RECs offer unbiased EHR implementation support throughout the implementation process. These organizations, funded by the Office of the National Coordinator for Health Information Technology, also serve as a 2-way pipeline to local and federal resources.
- RECs can help with EHR implementation and project management, vendor selection, workflow redesign, privacy and security, training, ongoing technical assistance, and more. Please visit the HealthIT.gov website for more information.

Kentucky Health Information Exchange (KHIE)

- KHIE enables the secure exchange of enrollee health information between healthcare providers.
- Providers who contract with Humana Healthy Horizons sign a participation agreement with KHIE within 1 month of joining the Humana Healthy Horizons network. If providers need assistance connecting to other providers online, they can visit khie.ky.gov/Pages/index.aspx.

EHR incentive program

Humana Healthy Horizons encourages all healthcare professionals who meet the EHR incentive program requirements to participate. Talk to your Provider Engagement representative about:

- Collaboration with Kentucky RECs to promote EHR adoption and connectivity to KHIE
- EHR capabilities
- KHIE direct messaging
- Practice transformation incentives

For more information on how to attest and participate, please visit the KHIE website.

Provider Grievance and Appeals

Provider grievance and appeals

Providers have 60 days from the date on Humana Healthy Horizons' Notice of Adverse Determination or date of original claim submission denial to file a grievance or appeal. Grievances and appeals can be submitted to Humana using any of the following methods:

- Verbal submissions: Please call Humana Healthy Horizons Provider Services at 800-444-9137 or contact your Provider Relations representative.
- Written submissions, please mail to:

  Humana Provider Correspondence

  Grievance and Appeals Department

  P.O. Box 14546

  Lexington, KY 40512-4546
- Fax: 800-949-2961
- Online: Providers can submit encrypted grievances, view appeal documentation or check grievance and appeals status online via Availity Essentials.

Please note: Appeals are handled in accordance with Kentucky regulations.

What happens when Humana Healthy Horizons receives an appeal?

Humana Healthy Horizons acknowledges receipt of each appeal within 5 business days.

For all standard appeals, Humana Healthy Horizons provides written notice of the resolution within 30 calendar days.

If the appeal is not resolved within 30 calendar days because additional information is needed, Humana Healthy Horizons can request a 14-day extension to resolve the matter.

Grievances submitted to Kentucky DMS

Grievances submitted directly to Kentucky DMS using the state's forms are handled in our Critical Inquiry department.

All critical inquiries are responded to as requested by Kentucky DMS within that specific inquiry.

What happens when Humana Healthy Horizons receives a grievance?

Humana Healthy Horizons acknowledges the receipt of each grievance within 5 business days.

The investigation and final resolution for standard grievances are completed within 30 calendar days.

If the grievance is not resolved within 30 calendar days because additional information is needed, Humana Healthy Horizons can request a 14-day extension to resolve the matter.

Expedited appeal

- Expedited appeals may be requested on behalf of the enrollee and are resolved within 72 hours of initiation of the expedited appeal process.
- If the appeal is not resolved within 72 hours because additional information is needed, Humana Healthy Horizons can request a 14-day extension to resolve the matter.

Claim dispute process

- Humana Healthy Horizons established a formal claim dispute process to ensure timely resolution of provider disputes.
- Providers who have a contract or letter of agreement with Humana Healthy Horizons to provide Medicaid services in Kentucky can utilize this claim dispute process, pursuant to Kentucky Revised Statute (KRS) 304.17A-708.
- This process grants an opportunity for providers to dispute errors in payment in which Humana Healthy Horizons has not paid the claim according to the contracted rate.
- The Claim Dispute Form and claim dispute documentation must be received by Humana Healthy Horizons within 24 months of the original claim adjudication date.

Utilization Management

Health services and Utilization Management

Utilization Management

Helps maintain the quality and appropriateness of healthcare services provided to Humana enrollees

- Provides on-site and telephonic concurrent review and discharge planning
- Promotes effective level of care based on enrollee's individual needs
- Refers to appropriate Humana programs

Utilization Management

Front-end review clinician responsibilities:

- Reviews inpatient admissions for medical necessity during PA or upon notification of admission

Concurrent clinician responsibilities:

- Completes comprehensive discharge planning assessments on enrollees with inpatient admission
- Conducts medical-necessity reviews on enrollees with continued inpatient stays
- Collaborates with enrollee's healthcare team to maximize enrollee's benefits and resources, and identifies enrollee's anticipated discharge planning needs
- Conducts medical-necessity reviews for post-acute, level-of-care requests in collaboration with medical director
- Identifies and refers enrollees to internal Humana Healthy Horizons case management/disease management programs as appropriate
- Refers enrollee to community resources or Humana Healthy Horizons social worker when social issues place enrollee at risk for readmission

Discharge supports

Case Management

When inpatient discharge notes indicate the need, Humana's Case Management team collaborates with multiple areas to coordinate care.

- Refers from on-site/telephonic UM clinicians following discharge, PCPs, specialists, self-referral, internal/external programs, community partners, etc.
- Educates enrollees on disease processes, self-care and value-added benefits, such as vision and dental coverage and unlimited medical transportation
- Completes post-discharge or post-ER visit telephonic outreach within 3 days of discharge (when applicable)
- Identifies gaps in care, addresses post-discharge needs and assists in making follow-up appointment(s) with PCPs and specialists

Quality

Quality Assurance and Performance Improvement (QAPI) program

The QAPI program develops and monitors a cohesive plan of action to address enrollee needs across the continuum of care and influences outcomes related to the improvement of care and health of the entire enrollee population.

Humana Healthy Horizons supports the commonwealth of Kentucky in its goal to transform the Medicaid program to empower individuals to improve their health, engage in their healthcare, drastically improve quality of care and healthcare outcomes, and reduce or eliminate health disparities. To support these goals, Humana Healthy Horizons implements innovative and strategic solutions to quality management and improvement and collaborates with the state and other contracted MCOs, to develop data-driven, outcomes-based continuous quality improvement (QI) processes.

Activities include:

- Monitoring special health care needs and use of preventive services
- Coordinating behavioral and physical healthcare needs, monitoring and providing feedback on provider performance, involving enrollees in QI initiatives
- Monitoring underutilization and overutilization of services
- Conducting performance improvement projects

Quality improvement requirements

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

Performance improvement projects (PIPs)

PIPs provide ongoing measurements and interventions to demonstrate significant improvement in the quality of care and service delivery sustained over time, that have a favorable effect on health outcomes and enrollee satisfaction.

Medical record reviews

Medical record reviews evaluate providers' adherence to enrollee record documentation standards. Medical records also may be requested when investigating complaints of poor quality of service or clinical outcomes.

Performance measures

Performance measures include data collected on patient outcomes as defined by HEDIS or otherwise defined by the National Committee for Quality Assurance (NCQA).

Peer review

Peer review consists of review of a provider's practice methods and patterns to determine appropriateness of care.

Surveys

Consumer Assessment of Healthcare Providers and Systems (CAHPS), provider satisfaction, behavioral health surveys and special surveys support quality/performance improvement initiatives.

Quality improvement resource

Providers have access to many resources on the provider website documents and resources page, including:

HEDIS resources	CAHPS information	Behavioral health guidelines	Clinical practice guidelines	Health and wellness resources

Providers are encouraged to use our population health programs to help enrollees achieve their best health. Please refer enrollees experiencing medical, BH and/or SUD needs.

More quality resources are available on the provider website.

QAPI requirements

Healthcare providers may obtain a written QAPI program description by calling Provider Services at 800-444-9137. We welcome healthcare providers' input regarding our QAPI program.

Providers can request feedback by writing to:

Humana Healthy Horizons in Kentucky
Quality Improvement Department
101 E. Main St.
Louisville, KY 40202

Marketing Guidelines

Marketing guidelines

No marketing materials are distributed through the Humana Healthy Horizons provider network.

If Humana supplies branded health education materials to its provider network, distribution is limited to Humana Healthy Horizons enrollees, and materials are not to be made available to those visiting the provider's facility.

Such branded health education materials do not provide enrollment or disenrollment information.

PCP Quality Recognition Programs

PCP quality recognition programs

Humana Healthy Horizons is committed to decreasing costs and improving care in the communities we serve.

Value-based programs allow PCPs the opportunity to earn financial incentives based on quality and clinical outcomes.

- These programs are designed based on the healthcare provider's panel size and engagement.
- Programs are reviewed and revised annually.
- Payment timelines will vary by program, allowing for reporting/data collection.

Humana Healthy Horizons
PCP quality recognition programs

The Humana Healthy Horizons PCP quality recognition programs encourage provider practices to achieve superior outcomes in quality, clinical and strategic measures.

Quality Plus

Program highlights

- Noncontracted, quality-focused program
- Annually paid incentives
- Practices can earn incentives by achieving or exceeding program measure targets for adult and/or pediatric categories.*,†

Program requirements

- Maintain an active fee-for-service contract with Humana Healthy Horizons
- Meet and maintain a panel of 50 Humana Healthy Horizons patients for the applicable category

Model Practice

Program highlights

- Contracted quality-focused program
- Annually paid incentives
- Practices can earn incentives by achieving or exceeding program measure targets for adult and/or pediatric categories.*,†
- Opportunity for shared savings

Program requirements

- Value-based contract with a Model Practice program attachment
- Meet a minimum panel of 250 Humana Healthy Horizons patients‡

* Participant must meet minimum panel sizes for a category at beginning of year and end of year to be eligible for measurement in that category.
†Adult and pediatric membership categories are measured and incentivized separately.
‡ Minimum panel requirement is combination of adult and pediatric; a minimum membership of 150 is required for payment eligibility, with at least 75 in a category for payment in that category.

Provider Training Requirements

Additional training requirements

- Providers must complete 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 training modules are located on Humana's Provider Compliance website and on Availity Essentials.
- Be sure to complete the Medicaid Partner Training Attestation form in Availity Essentials to ensure your training 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 or within their respective organization, which then must report it to Humana Healthy Horizons via one of the following methods:

Telephone:

Special Investigations Unit hotline: 800-614-4126
Business hours: Monday – Friday, 7 a.m. – 3 p.m. Eastern time
Voicemail access: 24 hours a day, 7 days a week

Ethics Help Line: 877-5-THE-KEY (877-584-3539)

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.

Mail:

Fraud, Waste and Abuse
Humana
1100 Employers Blvd.
Green Bay, WI 54344

Email:

SIUReferrals@humana.com or ethics@humana.com

Web:

Ethicshelpline.com or https://www.humana.com/legal/fraud-waste-and-abuse

FWA reporting information (continued)

There are several ways you can alert the Kentucky Cabinet for Health and Family Services (CHFS) of need for investigation:

- By phone: 800-372-2970 Monday through Friday, 8 a.m. to 4:30 p.m., Eastern time
  - Voicemail available 24 hours a day, 7 days a week

- In writing:

  Office of Inspector General

  Division of Audits and Investigations

  275 E. Main St., 5E-D

  Frankfort, KY 40621

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.

Disallowed Actions (31 U.S.C. §§ 3729-3733)
Links to the previously mentioned provisions of this act are listed within Humana's Compliance Policy for Contracted Health Care 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 that act

A person or company who violates the False Claims Act is also liable to the government for the costs of civil action brought to recover these penalties or damages.

Humana Healthy Horizons Websites and Numbers

Resources available on the provider website

Humana.com/HealthyKY

- Provider communications and network notices
- Provider documents and resources
- Provider training
- Health and wellness programs
- Clinical practice guidelines
- COVID updates and resources
- Prior authorizations
- Pharmacy services
- Claim resources
- Quality resources
- Provider Relations representative assignment list

For assistance with the Humana.com websites, please call Provider Services at 800-444-9137.

Provider orientation and training revisions

This provider orientation and training document is reviewed and updated at least once per year. Orientation updates can include:

- New or revised policies 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 Humana Healthy Horizons provider website at Humana.com/HealthyKY.

Updates also are communicated via the provider newsletter at Humana.com/NewHorizon.

Availity Essentials

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

- ✓ Use one consistent site to work with Humana and other payers.
- ✓ Submit and manage referrals and authorizations.
- ✓ Submit claims and review claims status.
- ✓ Manage claim status.
- ✓ Use Humana-specific tools.
- ✓ Submit grievances.

About Availity Essentials

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

How to register

- Go to Availity.com

Join us for a 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 for Humana Healthy Horizons: Call Provider Services at 800-444-9137

Helpful contact information

Humana Healthy Horizons provider interactive voice response (IVR) line	800-444-9137
Prior authorization (PA) assistance for medical procedures and medication billed as a medical claim	800-444-9137
Medication intake team (PA for medications administered in a medical office)	866-461-7273
PA for pharmacy drugs	Call MedImpact at 844-336-2676
Medical and Behavioral Health Clinical Intake team	800-444-9137
Claim inquiries	Send a detailed email to: KYMCDCRR@humana.com

Helpful contact information (continued)

24-hour nurse hotline	800-648-8097
Behavioral health crisis line	833-801-7355
Medicaid care management	888-285-1121
Medicaid care and chronic condition management	888-285-1121
Availity Essentials customer service/tech support	800-282-4548
Ethics and compliance concerns	877-5-THE KEY (877-584-3539)
Reporting Medicaid fraud	800-614-4126
Information about arranging interpretation services for enrollee appointments	877-320-1235

Humana

Healthy Horizons®

in Kentucky