Provider Orientation and Training

Information for Florida Medicaid Healthcare Providers and Administrators

2024

Humana
Healthy Horizons®
in Florida

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

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Notable changes

Slides 32 – 33:
Information regarding the Centers for Medicare & Medicaid Services (CMS) mandate that effective Jan. 1, 2024, authorizations and inquiries must include the National Provider Identifier (NPI).

Slides 43 – 45:
These slides include guidance and links regarding the Jan. 25, 2024, change requiring providers to submit claims based on their enrollment and information on the Provider Master List (PML).

Training topics

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Training topics are based on the following:

- Humana's contract with the Florida Agency for Health Care Administration (AHCA)
- Humana's policies and procedures

Training topics—continued

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About Humana Healthy Horizons in Florida

Statewide Medical Managed Care Program (SMMC) Purpose and Eligibility

SMMC is designed to care for all eligible individuals by providing access to:

Long-Term Care (LTC)

- Adults with disabilities and members who meet nursing home level of care

Eligibility requirements:

- 18 or older
- Resides in Florida
- Meets physical (nursing home level of care) and financial requirements as determined by the AHCA

Managed Medical Assistance (MMA)

- Florida's Medicaid program that provides members with services other than long-term care services

Eligibility requirements:

- Any age
- Resides in Florida
- Meets the eligibility requirements as established by the AHCA

Comprehensive

- Includes MMA and LTC

About Humana Healthy Horizons in Florida

- In 2018 Humana was awarded a contract for all 11 regions in Florida to serve as a comprehensive plan for the SMMC.
- Comprehensive plans are awarded to managed care plans that are qualified to provide MMA and LTC services to eligible recipients.
  - To qualify, health plans are required to meet high standards in network, member quality and clinical performance metrics.
- Humana Healthy Horizons® is available to all eligible Medicaid recipients in the state of Florida.

Humana Healthy Horizons in Florida

The SMMC program has three components:

- **LTC**
  Medicaid recipients who qualify and enroll in the Florida Long-term Care Managed Care (LTCMC) program receive LTC services through an LTC-managed care plan.

- **MMA**
  Medicaid recipients who qualify and enroll in the Florida MMA program receive all healthcare services other than long-term care though a managed care plan.

- **Comprehensive plan**
  Medicaid recipients who qualify for both LTC and MMA can enroll in Humana's comprehensive plan.

The foundation for Humana Healthy Horizons in Florida

Our focus is on member well-being achieved through coordinated care via community and provider partnerships. Humana Healthy Horizons offers a strong support infrastructure to engage both members and providers with the goal of improving member outcomes and overall health.

Member engagement

- Continuity of care
- Member outreach
- Healthy behavior incentives
- Case management
- Disease management
- Care coordination (LTC)
- Interdisciplinary care team (LTC)
- HumanaBeginnings®

Community engagement

- Advisory panels
- Healthy Start collaboration
- Community outreach

Provider engagement

- Initial and ongoing training
- Town halls for each region
- Quarterly primary care provider (PCP) staff visits
- Quality bonuses and value-based programs
- Preferred PCP network
- Obstetrician incentive program
- Quality performance review and support

Support infrastructure

- Member and provider contact centers
- Quality management and improvement
- Compliance
- Collaboration and alignment with AHCA
- Availity Essentials™ provider portal
- Claims inquiry and resolution support

Strategy and implementation approach

How Humana Healthy Horizons in Florida will provide a seamless transition and continuity of care for Florida members:

- Organizational structure
- Clinical staffing support
- Florida training program
- Transition/continuity of care
- Leveraging behavioral health expertise

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. You can find covered service descriptions and details in the provider handbook.

MMA Covered Services	
Advanced Practice Registered Nurse (APRN)	Hospice services
Ambulatory surgical center services	Hospital services
Assistive care services	Immunizations
Behavioral health services	Laboratory and imaging services
Birth center and licensed midwife services	Medical foster care services
Child health checkup	Medical supplies, equipment, prostheses and orthoses
Clinical services	Nursing facility services
Chiropractic services	Optometric and vision services
Early intervention services	Physician Assistant services
Emergency services	Podiatric services
Family planning services and supplies	Prescribed drug services
Hearing services	Renal dialysis services
Healthy Start services	Therapy services
Home health services and nursing care	Transportation services

Covered services—continued

LTC Covered Services	
Adult companion care	Medical equipment and supplies
Adult day health care	Medication administration
Assistive care services	Medication management
Assisted living	Nutritional assessment/Risk reduction services
Attendant nursing care	Nursing facility services
Behavioral management	Personal care
Caregiver training	Personal Emergency Response Systems (PERS)
Care coordination/Case management	Physical therapy
Home accessibility adaption services	Occupational therapy
Home delivered meals	Respiratory therapy
Homemaker services	Respite care
Hospice	Speech therapy
Intermittent and skilled nursing	Transportation

Telemedicine

Telemedicine is the practice of healthcare delivery by a provider, who is not in the same location as the patient, for the purposes of evaluation, diagnosis or recommendation of treatment. Telephone conversations, chart review, email messages or faxes are not considered telemedicine and are not reimbursed.

- Florida Medicaid reimburses the practitioner who provides the evaluation, diagnosis or treatment recommendation and is at a site other than where the recipient is located. Practitioners must include modifier GT on the CMS-1500 claim form.
- Florida Medicaid does not reimburse for equipment required to provide telemedicine services.
- The practitioner must implement telemedicine fraud and abuse protocols.
- Providers are encouraged to contact their Provider Relations representative if they offer or plan to offer these services to patients with Humana Healthy Horizons coverage.

Humana Healthy Horizons in Florida Pharmacy Benefit Summary

34-day supply

Medications are limited to a 34-day supply. Select maintenance medications may receive

a 100-day supply.

No copayments

Medicaid members have a $0 copay at network pharmacies.

Over-the-counter (OTC) benefit

$25 per-household-per-month

OTC benefit allowance through CenterWell™

State-mandated preferred drug list (PDL)

All plans use AHCA's formulary.

Online access found at Humana.com/Medicaid/Florida/MMA.

Pharmacy benefit

Request an authorization

- Fast and easy electronic submission via **CoverMyMeds.com/epa/Humana**
- Fax **877-486-2621**
- Call Humana Pharmacy Clinical Review (HCPR) at **800-555-CLIN (800-555-2546)**

Psychotropic informed consent

Informed consent must accompany prescriptions for psychotropic drugs when prescribed for children younger than 13.

Find the consent form here

Hemophilia

AHCA contracts with Coram and Caremark CVS to provide statewide care management and pharmacy benefits management for eligible Medicaid beneficiaries with hemophilia or Von Willebrand disease.

Opioids

For the treatment of opioid dependency, some medication-assisted treatment (MAT) products are available on the formulary without prior authorization (PA).

To find preferred products, please visit **Humana.com/HealthyFlorida**.

Medication Intake Team preauthorization list

For drugs administered in the provider's office, authorization may be obtained by calling **866-461-7273.**

If you prefer, complete the appropriate form at **Humana.com/medpa** and fax it to **888-447-3430.**

Prescriber quick reference guide

Humana Clinical Pharmacy Review (HCPR)

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

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

Humana Medication Intake Team (MIT)

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

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

General Humana contact information

Claims address	Located on the patient's Humana member ID card
Pharmacy appeals	**Commercial and Medicaid:** Humana Appeals, P.O. Box 14546, Lexington, KY 40512-4546; Fax: **800-949-2961** **Medicare:** Humana Appeals, P.O. Box 14165, Lexington, KY 40512-4165; Fax: **800-949-2961** To file a Part D redetermination online: **Humana.com/provider/pharmacy-resources/exceptions-appeals**

Pharmacy

CenterWell Pharmacy® (mail-delivery pharmacy for maintenance medications and durable medical equipment)	**800-379-0092** (Fax: **800-379-7617**), Monday through Friday, 8 a.m. to 1 p.m., Eastern time; Saturday, 8 a.m. to 6:30 p.m., Eastern time; CenterWellPharmacy.com
CenterWell Specialty Pharmacy® (mail-delivery pharmacy for specialty medications)	**800-486-2668** (Fax: **877-405-7940**), Monday through Friday, 8 a.m. to 8 p.m., Eastern time; Saturday, 8 a.m. to 6 p.m., Eastern time; CenterWellPharmacy/specialty-medications.html
CenterWell Pharmacy-Miramar location (mail delivery for Florida Medicaid)	**800-526-1490** (Fax**: 800-526-1491**), Monday through Friday, 8 a.m. to 5 p.m., Eastern time.

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

Humana Healthy Horizons expanded benefits

Expanded benefits

- Expanded benefits are those offered by Humana Healthy Horizons in Florida that are not otherwise covered or that exceed limits outlined in the Medicaid state plan, Florida Medicaid coverage policies and the Florida Medicaid fee schedules.

- Expanded benefits descriptions and details can be found in the member handbook.

- All expanded benefits have waived copayments. Therefore, providers must not charge members copayments. However, there are some expanded benefits that, if a member requests them, are paid out of pocket first and subsequently reimbursed when Humana receives proper documentation.

Expanded benefits

- Acupuncture services
- Assisted living facility - bed hold expansion
- Assisted living facility - move-in basket
- Behavioral health (BH) services
  - BH assessment services
  - BH day services/day treatment
  - BH medical services (medication management)
  - BH medical services (drug screening)
  - BH medical services (verbal interaction)
  - BH screening services
  - Computerized cognitive behavioral therapy
  - Group therapy
  - Home visits by a clinical social worker
  - Individual/Family therapy
  - Individual therapy sessions to caregivers
  - Intensive outpatient treatment
  - Medication-assisted treatment
  - Psychosocial rehabilitation
  - Substance use treatment or detox services (outpatient)
  - Targeted case management
  - Therapeutic behavioral on-site services
- Chiropractic services
- Doula services
- Durable medical equipment - biometric equipment
- Durable medical equipment - CPAP machine and oxygen
- Durable medical equipment - glucose pods
- Durable medical equipment - supplies for continuous glucose monitoring
- Financial literacy
- Go365® wellness for pediatrics
- Hearing service expansion
- Healthy living benefit
- Hospital services - outpatient
- Housing assistance
- Increased transition assistance - nursing facility to community
- Legal guardianship
- Meals - day trip - meal reimbursement/allowance
- Meals - disaster preparedness/relief
- Meals - home delivered
- Meals - post-discharge
- Newborn circumcisions
- Nutritional counseling
- Pharmacy - (OTC) additional allowance
- Prenatal/Perinatal visits
  - Antepartum management
  - Breast pump
  - Hospital grade breast pump
  - Postpartum care
- Prevention kit - flu/pandemic
- Primary care visits
- Smartphone service expansion
- Swimming lessons (drowning prevention)
- Therapy - massage, occupational, physical, respiratory, and speech-language pathology services
- Transportation - caregiver
- Transportation - non-medical
- Tutoring
- Vaccine - flu, hepatitis A, pneumonia, shingles, Tdap
- Visual aid services
- Waived copayments

Contracting and credentialing

Contractual and demographic changes

- Contracted providers are required to notify Humana of legal and demographic changes to ensure the provider directory and claim processing remain accurate.
- Contracted providers are also required to notify Humana of changes to their Tax Identification Number (TIN).
- The following changes should be sent to Humana using a standard roster or Humana form:
  - New providers added to group
  - Providers leaving group
  - Service demographic updates
    - e.g., new locations, address, phone, email, fax, standard hours of operation, languages spoken, billing address updates, after-hours availability, telehealth participation
  - Access to public transportation
  - Credentialing updates
    - e.g., licensure changes, Council for Affordable Quality Healthcare (CAQH®) updates, professional liability insurance changes
  - Accepting new patients
  - Patient Centered Medical Home (PCMH) certification

Contractual and demographic changed—continued

Humana:

- **Humana MMA: Humana_FL_Centralized_Provider_Relations@humana.com**
- **Humana LTC**: **LTCNetworkRequests@humana.com**

For additional ways to contact us, please visit: **Humana.com/provider/contact**.

Contracting process—required information

- An updated roster that includes all providers and group or facility name
- Service address with phone, fax and email information
- A list of counties where services are rendered
- Billing address, if different than service address
- Tax Identification Number (TIN)
- Provider or facility specialty and registered taxonomies
- Medicaid provider number for all National Provider Identifier (NPI), group/billing, and rendering providers.
  - Indicate enrolled or limited status with corresponding registered provider specialty code and provider type code (see page 38 for additional details on Medicaid enrollment)
- (NPI)
- (CAQH®) number
- Indicate which lines of business are of interest (e.g., Medicaid, Medicare, etc.)
- Type of contract (e.g., individual, group, facility)
- Disclosure of Ownership
- Practitioner Office Site Evaluation Tool (POSET)
- Americans with Disabilities Act (ADA), provider survey
- PCP patient load attestation
- For LTC: Florida state license and proof of insurance

Credentialing

- Humana participates with (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.
- Healthcare providers must be credentialed prior to network participation to treat Humana-covered patients.
- Provider office site evaluations must be completed for all PCP and OB-GYN provider locations prior to participation with Humana and during recredentialing.
- Prior to participation with Humana and during recredentialing, PCPs are required to attest that their total active patient load is not more than the Medicaid standard.
- Recredentialing occurs at least every 3 years. Some circumstances require shorter recredentialing cycles.
  - Humana will leverage applications via CAQH during the recredentialing cycle, as applicable by provider type.
  - If we are unable to access your CAQH application, CAQH does not support your provider type or the supporting documentation available via CAQH is expired or incomplete, providers will receive a request to provide the necessary documentation prior to the 36-month anniversary date of the last credentialing cycle.
- Healthcare providers must have an active Florida provider Medicaid ID to be considered for participation.
- In addition to being in good standing with Medicare, federal, state and local agencies, healthcare providers must be free from active sanctions imposed by the AHCA.

Further details regarding Humana’s credentialing/recredentialing requirements can be found in **Humana's Provider Manual**.

CAQH Proview streamlined credentialing process

Physicians and healthcare professionals need to use the CAQH ProView® tool to provide credentialing information to Humana. Please note: This excludes facilities as they are not supported by CAQH at this time.

CAQH ProView is the trusted source and industry standard for self-reported provider data and eliminates redundant applications, including state applications, required by a healthcare professional's contracted health plans, including Humana. Using CAQH reduces the amount of time healthcare professionals spend on credentialing and recredentialing by allowing them to submit information to the tool once and then update it via the attestation process.

How this affects you:

- Initial applicants must use CAQH for credentialing requests submitted Jan. 1, 2017, and after.
- Healthcare professionals due for recredentialing Sept. 1, 2017, and after must submit their information through CAQH.
- If you are not registered with CAQH, please complete a registration form on **Proview's registration page**. Once registration is submitted, you should receive an email from CAQH containing a CAQH Provider ID. Please use the provider ID to complete the online CAQH application and grant Humana authorization to review/receive your information.
- If you are already registered with CAQH, please ensure your information is current and complete and that you grant Humana authorization to review/receive the credentialing information.
- During recredentialing, healthcare professionals who have outdated or missing information will be contacted via fax and/or email and asked to provide current information and/or documentation.
- Questions can be emailed **to CredentialingInquiries@Humana.com**.

Access to care requirements

Access to care requirements

The PCP provides or arranges medically necessary covered services for members to include 24/7 authorization requests and/or review and approval for referrals from Florida Medicaid-enrolled providers who accept Medicaid reimbursement. PCPs must provide an AHCA approved means of after-hours contact which could include, but is not limited to, an answering service, call forwarding or other approved provider call coverage.

The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after-hours coverage must be accessible using the medical office's daytime telephone number. The PCP should arrange for coverage of primary care services during absences due to vacation, illness or other situations that make the PCP unavailable.

A Medicaid-eligible PCP must provide coverage. Members should be triaged and provided appointments for care within the time frames listed on the following slide.

Access to care requirements—continued

Appointments for urgent medical or behavioral healthcare services shall be provided:

- Within 48 hours of a request for medical or behavioral healthcare services that do not require PA
- Within 96 hours of a request for medical or behavioral healthcare services that do require PA

Appointments for non-urgent care services shall be provided:

- Within 7 days post-discharge from an inpatient behavioral health admission for follow-up behavioral health treatment
- Within 14 days for initial outpatient behavioral health treatment
- Within 14 days of a request for ancillary services for the diagnosis or treatment of injury, illness or other health condition
- Within 30 days of a request for a primary care appointment
- Within 60 days of a request for a specialist appointment after the appropriate referral is received by the specialist

Early Intervention Services shall be provided:

- Within 30 days of an Individualized Family Support Plan (IFSP) completed for children enrolled in the Early Steps Program to receive early intervention services

For more information, please review the Access to Care Requirements for Humana Healthy Horizons in Florida Members flyer.

Transfer-for-cause process

Provider-initiated request to transfer member off their panel for cause

To ensure an access-to-care issue does not occur, the transfer-for-cause (TFC) process details the steps healthcare providers should follow when submitting a member transfer request to Humana due to disruptive, unruly, abusive or uncooperative member/caregiver behavior that seriously impairs a provider's ability to furnish services**.**

The TFC process does not apply to members who:

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

For more detailed information on the TFC process and what steps should be followed prior to initiating a request, please review the **Humana Healthy Horizons in Florida Provider Manual** or the **Provider Request to Transfer Process** FAQ flyer.

Preauthorization and notification

Preauthorization notification

Humana requires preauthorization for some services to facilitate care coordination and maximize benefits for your patients with Humana Healthy Horizons plans. Preauthorization also confirms services are provided according to AHCA coverage policies.

Please note:

- Preauthorization is required for some services and medications.
- Physicians and other healthcare providers should review the current Humana Healthy Horizons in Florida Preauthorization and Notification List online at **Humana.com/PAL**.
- Preauthorization must be obtained prior to the date of service.
- Authorizations can be requested via **Availity Essentials** or by calling **800-523-0023,** Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Please note there are important changes for authorization and inquiries due to a new CMS requirement.

What is changing?

CMS will require NPI on authorizations submitted to Humana Healthy Horizons starting Dec. 1, 2023. The NPI is an industry standard requirement for Health Insurance Portability and Accountability (HIPAA)-mandated. transactions. Humana currently requires TIN.

This requirement applies to authorization submissions and inquiries for all providers and lines of business, except atypical providers. Humana Healthy Horizons already requires NPI for claim transactions.

Why is this changing?

CMS mandate requires NPI be added for authorizations.

What actions do you need to take?

Start including the NPI on authorization submissions. It will be required on the authorization for:

- Requesting/referring provider
- Rendering/treating provider
- Rendering/treating facility

Any submission without an NPI will be returned.

Preauthorization for medical procedures and LTC services

Humana Healthy Horizons in Florida – MMA

- Call **800-523-0023** (available 24 hours a day) for automated requests.
- Representatives are available Monday – Friday, 8 a.m. – 8 p.m., Eastern time, (excluding major federal holidays).
- Press “0” or say “representative” for live help.
- Provide TIN.

Humana Healthy Horizons in Florida – LTC

- The provider or the member’s Humana care manager requests authorizations.
- Authorizations are requested by the provider or the member’s care manager.
- In either instance, the provider will receive a faxed copy of the authorization.

Claims processing

Medicaid enrollment for claims payment

An entity that renders Medicaid-compensable services to Medicaid recipients, or that provides services of any Medicaid provider type, must be active and enrolled as a Medicaid provider with the AHCA. To meet AHCA requirements, Humana can pay only those claims and/or encounters submitted by physicians and healthcare providers with valid Medicaid enrollment. Physicians and other healthcare professionals can verify their enrollment via the Provider Master List (PML) on the AHCA website at **AHCA website**.

The following are some of the criteria indicating a physician or healthcare professional is properly enrolled:

- Listing that shows “enrollment” or “limited” in the enrollment type column
- Active (A) listing in the current Medicaid Enrollment Status column
- Accurate NPI listing related to attending, billing, ordering, prescribing, referring and rendering providers (not applicable to atypical providers) affiliated with the correct Medicaid ID
- Listing with all active service and/or billing locations, provider type and specialty codes associated with its respective NPI, Taxonomy and Medicaid ID

Electronic claim submission

Claims clearinghouses:

Availity Essentials	Availity.com
Change Healthcare	ChangeHealthcare.com
TriZetto	TrizettoProvider.com
McKesson	McKesson.com
SSI Group	TheSSIGroup.com

NOTE: Availity Essentials is Humana's preferred clearinghouse, and there are no service fees when submitting Humana electronic claims. Some clearinghouses and vendors charge a service fee. Contact the clearinghouse for more information.

Humana MMA providers

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

Paper claims submission

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

Medical claims
Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Encounters
Humana Claims Office
P.O. Box 14605
Lexington, KY 40512-4605

Behavioral health claims
Regions 1 and 2
Access Behavioral Health
1221 W. Lakeview Ave.
Pensacola, FL 32501

Behavioral health claims
Regions 3 — 11
Carelon Behavioral Health
P.O. Box 1870
Hicksville, NY 11802-1870

Humana LTC claims
Humana Long-Term Care Plan
P.O. Box 14732
Lexington, KY 40512-4732

Payer IDs

When filing electronic claims, you will need to utilize one of the following payer IDs:

Humana MMA

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

Humana LTC

- **61115** for all claims
- **61105** for delegated providers

Please submit questions about MMA or LTC via Availity.com.

Importance of encounter submissions in Medicaid

AHCA requires 100% encounter submissions. Goal: 95% pass rate through state system.

- Key items for compliance:

1. Initial submission—Managed care plan shall submit encounter data no later than 7 days from the date the managed care plan adjudicated the claim.
2. Accuracy—Encounter line submissions must pass Florida Medicaid Management Information System (FLMMIS) edits.
3. Provider—Billing and rendering provider information on the encounter submissions must be recognized by the FLMMIS system.
4. Encounter provider information must match provider information filed with AHCA.

Importance of encounter submissions in Medicaid—continued

Consequences for noncompliance

- Fines
- Enrollment freezes
- Claim rejections

Encounters that identify members who received services:

- Decrease the need for medical record review during Healthcare Effectiveness Data and Information Set (HEDIS®) surveys
- Are critical for the future of Medicaid Risk Adjustment
- Help identify members receiving preventive screenings and decreases members listed in GAP reports

Encounter submission errors and how to avoid them

Common reasons for rejection or denial:

- Providers submitting an incorrect NPI/ZIP code/taxonomy code/address/NPI type
- Encounters missing NPI/ZIP code/ taxonomy code/address/NPI type
- Providers submitting with a billing and/or rendering NPI that is not enrolled/registered for Medicaid with AHCA

How to avoid these errors:

- Confirm the provider information submitted matches exactly the provider information registered with AHCA and in accordance with the services provided (e.g., NPI, taxonomy code, ZIP code + 4, address, etc.)
- Ensure the billing and rendering NPIs on the claim are correct and are enrolled/registered for Medicaid with AHCA.
- Verify enrollment within the Provider Master List (PML) located in the **Florida Medicaid Web Portal**.
- Follow AHCA's PML Tip Sheet for claim submissions: **PML Tip Sheet—Updated Aug. 29, 2023**.

Claims submissions errors and how to avoid them

Common rejection or denial reasons:

- Patient not found.
- Insured subscriber not found.
- Invalid Healthcare Common Procedure Coding System (HCPCS) code submitted.
- No authorization or referral found.
- Billed amount missing.
- National Drug Code (NDC) not covered or invalid.
- Billing/rendering NPIs not enrolled for Medicaid with AHCA.

How to avoid these errors:

- Confirm patient information received and submitted is accurate and correct.
- Ensure all required claim form fields are complete and accurate.
- Obtain proper authorizations and/or referrals for services rendered.
- Submit billed charges.
- Ensure you have a valid Medicaid ID for the billing/rendering NPIs submitted on the claims. NPIs must exactly match those listed in the applicable active PML record.

Billing guidance

Humana Healthy Horizons aligns to AHCA's guidance. Please ensure you submit claims based on your enrollment and information on the PML.

Effective Jan. 25, 2024, submitted claims that do not match the provider information appearing on the PML will be rejected.

The following slides provide highlights of the claim submission process.

Billing guidance—continued

To keep claims from being rejected, denied or impacted by future recoupments, be sure to bill according to the appropriate PML record fields:

- NPI Type (1-Indvidual or 2-Organization)
- Taxonomy
  - Please review **Taxonomy Master List (TML)** to ensure the appropriate taxonomy codes for the provider's specialty are submitted on the application.
  - Service Location Address ZIP code +4
  - Service Location Address 1
- To see how your information appears on the PML, go to the **Registration section of the Florida Medicaid web portal**.
  - Once you open the PML spreadsheet, you can search by your NPI.
- If you need to update your PML record(s), you can do so through the secured provider web portal or by calling **800-289-7799** and selecting option 4.

Billing guidance—continued

NPI mapping logic

The current NPI mapping logic will have the following updates:

- The system will only consider provider Medicaid IDs with a Date of Service that falls within the provider's contract effective and end dates.
  - The default logic will automatically select the provider's Medicaid ID within the most recent contract effective date ranges.
  - Claims that do not pass the logic are subject to recovery or rejections prior to payments being made.

For more information about the NPI initiative, visit the **NPI Initiative FAQ page**.

Timely filling

- **MMA:** Fee-for-service claims should be filed no later than 6 months after date of service.
- **LTC:** Claims should be filed no later than 6 months after the date of service.
- **MMA and LTC crossover:** Questions regarding specifics around timely filing should be directed to customer service.
- **Encounter claims** should be submitted within 7 days of the adjudication date for initial encounters and 30 days for the resubmission of corrected encounters.
- Timely filing of claims and HEDIS:
  - Providers are required to file their claims/encounters for all services rendered to members in a timely manner. Timely filing is an essential component reflected in Humana's HEDIS reporting and can ultimately affect how a plan and its providers are measured in member preventive care and screening compliance.

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

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

Receive HIPAA-compliant ERA transactions.

Get paid up to 7 days faster than mail.

Have remittances sent to your clearinghouse or view them online.

Reduce the risk of lost or stolen checks.

Reduce paper mail and time spent on manual processes.

Claim inquiry process

Step 1: Call the number on the back of the member's ID card.

- Record the reference number issued to you by the provider services call center.
- If your issue is not resolved by the call center representative, you can ask for a supervisor.

Step 2: If there is a factual disagreement with the response, send a secure email with the reference number to **HumanaProviderServices@humana.com**.

For additional information, please refer to **Claims Payment Inquiry Resources - Humana**.

Information regarding the Provider Complaint System is available in the Humana Healthy Horizons in Florida Provider Manual located at **Humana.com/HealthyFL**.

eBusiness resources

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

eBusiness resources—continued

To set up ERA/EFT:

1. Sign in to Availity Essentials at Availity.com (registration required).

2. From the Payer Spaces menu, select Humana.

3. From the Applications tab, select the ERA/EFT Enrollment app. (If you don’t see the app, contact your Availity Essentials administrator to discuss your need for this tool.)

Balance billing

Per Humana Healthy Horizons in Florida's Provider Manual:

The provider is prohibited from balance billing members for **covered** services referenced in the Medicaid Addendum of the provider contract.

Continuity of care (COC)

Transition/continuity of care (COC): Member services/care coordination/utilization management

Through the following process, we **ensure that transitioning members still receive care** even if Humana does not have a contract with their current provider:

Transitioning process		Florida-based case managers
 **Continue care plan as is for up to 60 days**	 **Reassess and update personalized plan of care**	 **Pair with new case manager**
• Ensure no care disruptions • Emphasize maintaining member's well-being and safety while addressing unmet needs • Contract with nonparticipating providers	• Identify members to transition • Determine unmet needs and put necessary services in place • Coordinate and build relationships with providers	• Based on location to ensure familiarity with local resources • Assign PCP center to facilitate coordinated care with PCP • Consider cultural and language needs

Transition/continuity of care (COC): Member services/care coordination/utilization management—continued

The following services may continue past 60 days from the member's transition to Humana:

- Prenatal/postpartum care up to 6 weeks after birth
- Transplant services up to 1 year post-transplant
- Current round of oncology treatment
- Full course of hepatitis C treatment drugs

Authorization is not required for COC of transitioning members.

Coordination with carved-out service contractors

- Humana's referral processes, whether Humana services, Medicaid fee-for-service (FFS) delivery system or prepaid dental plan, support the best possible quality outcomes for members throughout the healthcare system.
- Humana's proactive approach enables identification of needed services covered by Medicaid FFS or prepaid dental plan and coordinates a referral.
- The process identifies members who may qualify for Medicaid FFS or prepaid dental plan services through a variety of resources, including the following:
  - Outbound and inbound calls with members
  - Case management program, supports and assessments
  - Disease management
- Providers can call Humana Healthy Horizons in Florida—MMA member/provider services at **800-477-6931** to coordinate a Medicaid FFS or dental referral.

Coordination with carved-out service contractors—continued

Humana will coordinate a referral for the following services that are not provided by the managed care plan, but are available to eligible Medicaid recipients through the Medicaid FFS delivery system:

- County health department (CHD)-certified match program services
- Developmental disabilities individual budgeting (iBudget) home- and community-based services (HCBS) waiver services
- Familial dysautonomia HCBS waiver services
- Hemophilia factor-related drugs distributed through the comprehensive hemophilia disease management program services
- Intermediate care facilities for individuals with an intellectual disability or related conditions (ICF/IID) services
- School-based services provided through the Medicaid-certified school match program
- Model HCBS waiver services
- Newborn hearing services
- Prescribed pediatric extended care services (PPEC)
- Program for all-inclusive care for children services
- Behavior analysis services
- Substance use disorder county match program services
- Programs of All-inclusive Care for the Elderly (PACE) services
- Forensic Assertive Community Treatment (FACT) services

Coordination with carved-out service contractors—dental

Under the new SMMC contract, eligible adults and children can select a prepaid dental plan offered by the following contractors:

- Managed Care of North America – www.mcnafl.net
- DentaQuest of Florida – www.dentaquest.com/state-plans/regions/florida/member-page/member-documents
- Liberty Dental Plan of Florida – www.libertydentalplan.com/Florida/Florida-Providers/Florida-Medicaid.aspx

Humana will assist members with the prepaid dental plan enrollment process and coordinate services and referrals.

Dental plan or health plan: Who covers what?

Type of dental service(s)	Dental plan covers:	Health plan covers:
Emergency dental services in a facility	___	All emergency dental services and reimbursement to the facility
Non-emergency scheduled dental services in a facility	Dental services by a dental provider	Reimbursement to the facility, anesthesiologist and ancillary services
Dental services with sedation in an office setting	Dental services by a dental provider with a required sedation permit D-codes when rendered by the dental provider	Anesthesiologist (M.D. or ARNP) when required for sedation
Dental services (general or specialty) without sedation in an office setting, county health department or federally qualified health center (FQHC)	Dental services by a dental provider	Dental services provided by a nondental provider
Pharmacy	___	Drugs prescribed by a healthcare provider or a dental provider within scope of practice
Transportation	___	Transportation to all dental services provided by the dental or health plan, including expanded dental benefits

Member special needs consideration

Member special needs consideration

- Healthcare providers must make efforts to understand the special needs required by members. The member may have challenges that include physical compromises as well as cognitive, behavioral, social and financial issues. Multiple comorbidities, complex conditions, frailty, disability, end-of-life issues, end-stage renal disease (ESRD), isolation, depression and polypharmacy are some of the challenges facing these members each day.
- Recognizing the significant needs of members, Humana incorporates person-centered care planning, coordination and treatment in our care coordination program.

Member special needs consideration—continued

- Care management is delivered within a multidisciplinary team (MDT) structure and holistically addresses the needs of each member.
- The member and/or his/her authorized caregiver are maintained at the core of the model of care, ensuring person-centered care and supported self-care.
- The Humana case manager leads the member's MDT and links closely to the member's PCP to support him/her in ensuring the member gets the care needed across the full spectrum of medical, behavioral health and other services. PCP participation in the MDT is a critical component in the success of the member's care.
- Humana's predictive model, based on claims history and analytics, is used to determine each member's risk level and level of intervention required in order to channel the member to the required level of coordination.
- A comprehensive assessment is completed for each member to evaluate his or her medical, behavioral and psychosocial status to determine the plan of care.

Member screening for alcohol or substance use

Member screening for alcohol abuse or substance use disorder

Participating PCPs must screen members for signs of alcohol or substance use as part of prevention evaluations during:

- Initial contact with a new member
- Routine physical examinations
- Initial prenatal contact
- Times when the member shows evidence of serious overutilization of medical, surgical, trauma or emergency services
- Times when documentation of emergency room (ER) visits suggests the need

Education regarding Screening, Brief Intervention, and Referral to Treatment (SBIRT) of pregnant patients is available at **SBIRT Provider Education**.

Benefits of alcohol or substance use screening:

- Detect current health problems related to at-risk alcohol and substance use at an early stage—before they result in more serious disease or other health problems.
- Detect alcohol and substance use patterns that can increase future injury or illness risks.
- Intervene and educate about at-risk alcohol and other substance use.

Detecting risk factors early

- Screening can be a significant step toward effective intervention.
- The clinician is often the first point of contact.
- Early identification and intervention lead to better outcomes.
- Patients are often seen by a clinician because of a related physical problem.

Member screening for alcohol or substance use—continued

In addition, participating providers are encouraged to use AHCA's newly adopted SBIRT codes for screening (H0049) and brief intervention (H0050).

Members who meet one of the indicators on the previous slide may be referred to an appropriate participating behavioral health provider or to Humana Healthy Horizons to enroll in the substance use program by calling **800-229-9880**.

Clinical management programs

Clinical management programs

- Clinical management programs are designed to:
  - Reinforce medical provider's plan of care
  - Promote healthy living
  - Provide guidance to members with complex conditions

- To learn more, visit **Humana.com/HealthWellness**.

Health services and utilization management

Utilization management (UM)

- Provide on-site and telephonic concurrent review and discharge planning
- Promote effective level of care based on member's individual needs
- Provide disease-specific education
- Refer to appropriate Humana programs

Utilization management

Front-end review team responsibilities:

- Evaluates the medical necessity and appropriateness of all inpatient acute medical requests using evidence-based criteria

Concurrent/post-acute team responsibilities:

- Facilitates the coordination of appropriate care and services in the acute/post-acute setting and facilitates timely discharge planning, continuity and appropriate setting of care and services, where applicable
- Conducts medical necessity reviews on members with continued inpatient stays
- Collaborates daily with member's healthcare team to maximize member's benefits and resources and identifies member's anticipated discharge planning needs
- Conducts medical necessity reviews for post-acute level of care requests in collaboration with medical director
- Identifies and refers members to internal Humana case management (CM)/disease management (DM) programs
- Refers member to community resources or Humana social worker, when social issues place member at risk for readmission

Health services and case management

Case management

Collaboration takes place when an MMA, LTC or MMA/LTC member is an inpatient and discharge needs are identified. When the member has both MMA and LTC benefits, LTC case management is primary.

- Receives referrals from on-site/telephonic UM nurses following discharge, PCPs, specialists, self-referral, internal/external programs, community partners, etc.
- Educates members on disease process, self care and value-added benefits, such as unlimited medical transportation, vision and dental coverage
- Completes post-discharge or post-ER visit telephonic outreach within three days of discharge, when applicable
- Identifies gaps in care, addresses post-discharge needs and assists in making follow-up appointment with PCP and specialists
- Stratifies members into various acuities using some of the following criteria:
  - Readmission Predictive Model Score
  - Admission history
  - Metric reports (e.g., high-cost members, etc.)

Complex case management

Complex case management responsibilities:

- Manages and coordinates care for members requiring ongoing case management based on assigned acuity (with varying contact expectations and required time in program for each)
- Identifies triggers for ER visit/admission and partners with members and their healthcare providers to prevent/reduce ER visits and unplanned inpatient admissions
- Completes a comprehensive assessment of the member's current health status
- Creates an individualized care plan with the member and works toward identified goals
- Addresses HEDIS measures for members' gap reports or alerts on file
- Refers to internal and external programs and community resources as needed (e.g., behavioral health, social work, transplant)
- Participates in interdisciplinary case conferences for complex members to identify the best course of action for improved outcomes
- Does not replace or interfere with the care members receive from their providers
- Reinforces the provider's plan of care and facilitates use of services that promote wellness and prevent unnecessary hospital admissions

Health services and case management

MMA programs

- Diabetes
- Asthma
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Hypertension
- HIV/AIDS
- Cancer
- Sickle cell
- Pain management

LTC DM programs

- Dementia and Alzheimer's
- End-of-life issues/advance directives
- And all other MMA program conditions listed above

Goal

- Help empower Humana Healthy Horizons members and their families through education and the development of self-management skills that foster treatment plan compliance and better health outcomes.

Overview

- Participation is voluntary
- Referrals received from claims data, on-site/telephonic nurses, after discharge PCPs, self-referral, internal/external programs, community partners, etc.
- Telephonic outreach
- Assessment includes health history, cognitive/psychological/depression screening, medication review, diet compliance
- Collaborative team approach
- Members stratified into various acuities using some of the following criteria:
  - Admission history
  - Stability of symptoms
  - Understanding/compliance of disease/plan of care

Case management

Case management program responsibilities:

- Complete a comprehensive assessment of the member's current health status
- Create an individualized care plan with the member and work toward identified goals
- Address HEDIS measures for members on gap reports or with alerts on file
- Refer to internal and external programs and community resources as needed (e.g., behavioral health, social work, transplant)

Please note:

- Case manager does not replace or interfere with care that members receive from their providers.
- Case management nurses will reinforce the healthcare provider's plan of care and facilitate utilization of services that promote wellness and prevent unnecessary hospital admissions.

Case management—continued

Additional features for LTC members in a disease management program:

- Education based on the member assessment of health risks and chronic conditions
- Symptom management, including addressing needs such as working with the member on health goals
- Emotional issues of the caregiver
- Behavioral management issues of the member
- Communicating effectively with providers
- Medication management, including the review of medications that a member is taking to ensure that the member does not suffer adverse effects or interactions from contraindicated medications

Health services and other programs for MMA members

Other health services programs

HumanaBeginnings

- Manages prenatal and postpartum members from onset of pregnancy up to 12 weeks postpartum or until gap(s) closed
- Facilitates care coordination with Women, Infants, Children Program, Healthy Start and other internal/external programs
- Ensures provision of Healthy Behavior Reward for program participation and visit compliance
- Works with member and provider to ensure compliance with prenatal and postpartum appointments

Social worker

- Assists members with social needs including transportation and community resources
- Receives referrals from CM, DM and utilization management nurse

Pediatric case management and pediatric utilization management

- Provides telephonic case and disease management for pediatric members
- Provides enhanced care coordination to special needs pediatric members with private duty nursing, residing in a nursing facility or medical foster care
- Manages all pediatric inpatient utilization

Healthy Behaviors Program: Go365 for Humana Healthy Horizons®

About Go365

- Launched in April 2021
- A wellness program that offers members the opportunity to earn rewards for taking healthy actions
- Once members download the Go365® app on their mobile devices and create an account, they can:
  - See programs they are eligible to participate in
  - Complete the Health Risk Assessment (HRA)
  - Earn and redeem rewards

Target Population

- All ages
- Dual members
- Members can call Humana Healthy Horizons for program details and how to join a program
- PCPs may be asked to provide program goals and accomplishments

Rewards

Members can:

- Redeem rewards in the Go365 Mall
- Choose from a selection of gift cards from popular retailers
- Receive e-gift cards via email

Healthy Behaviors Programs designed for our members

HRA

- Complete HRA within 90 days of enrollment: $20
- Complete HRA after 90 days of enrollment: $10

All ages

To complete HRA: Patients can call us at **855-351-7877 (TTY: 711)**

Annual well visit program

- Annual well visit PCP: $20

18 years and older

Outbound team encourages members to visit PCP during welcome call

HumanaBeginnings

- Enroll in and complete HumanaBeginnings program: $20
- Visit OB-GYN during first trimester or within 42 days of enrollment with the plan: $15
- Visit OB-GYN for a postpartum visit within 7-84 days after delivery: $15

13 years and older

To enroll: You or your patient can call us at **800-322-2758,** ext. **1500290**

Well-child visit program

- Wellness visit with PCP: $20
- The plan will contact and remind members overdue for a well-child visit to schedule an appointment.

Younger than 18 years old

Outbound team encourages parent/guardian to schedule appointment

COVID-19 vaccine program

- Members 6 months and older who get a complete COVID-19 vaccine: $20

6 months and older

Outbound team encourages members to get COVID-19 vaccine

Weight management

- Enroll in the program **and** complete initial well-being visit with PCP: $10
- Complete 6 telephonic coaching sessions within 12 months. At the end of the sixth coaching session: $30

12 years and older

To enroll: You or your patient can: Call: 855-330-8053

Tobacco cessation

- Complete 2 telephonic coaching sessions with a health coach within the first 45 days of enrollment in the program: $25
- Complete 6 additional telephonic coaching sessions (total of 8) with a health coach within 12 months of the first coaching session: $25

12 years and older

To enroll: You or your patient can: Call: 855-330-8053

Substance use disorder

- Enroll and complete 3 coaching calls within 3 months: $15
- Complete 3 additional coaching calls (total of 6) within 6 months: $15
- Participate actively in an outpatient program for 28-30 days: $20

18 years and older

To enroll: You or your patient can call us at 800-229-9880

Mammogram

- Annual mammogram screening: $20

*40 years and older**

Cervical Cancer Screening

- Annual cervical cancer screening: $20

21 years and older

Outbound t encourages members to have their screenings

Colorectal cancer screening

- Annual colorectal cancer screening: $20

45 years and older

Outbound team encourages members to visit PCP during welcome call

* Mammogram also available to members younger than 40 who are at high risk.

Electronic health records (EHRs)

Electronic health records (EHRs)

- An EHR is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users. While an EHR does contain the medical and treatment histories of patients, an EHR system is built to go beyond standard clinical data collected in a provider's office and can include a broader view of a patient's care.
- Florida Medicaid-eligible hospitals and professionals as defined by the Health Information Technology for Economic and Clinical Health (HITECH) Act are required to use certified EHRs.

EHRs—continued

EHR advantages:

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

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

EHRs—continued

EHR advantages:

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

EHRs—continued

For assistance:

Regional extension centers

If providers need assistance selecting an EHR system, they can contact 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 (ONC), also can serve as a two-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. Visit **HealthIT FAQ** for more information.

Florida Health Information Exchange (Florida HIE)

If providers need assistance in technically connecting to other providers, they can reach out to the Florida HIE or visit **Florida-hie.net**. The Florida HIE enables the secure exchange of health information between healthcare providers.

Annual Medical Record Documentation Review (MRDR audits)

Annual Medical Record Documentation Review

Primary Language and Advance Directives elements have demonstrated opportunity.

The purpose of the Medical Record Documentation Review (MRDR) Strategy Plan is to ensure Humana Healthy Horizons in Florida compliance with maintenance of a member record for each member in accordance with the agency contract FP059, 42 CFR 431 and 42 CFR 456. Member records will include documents related to the quality, quantity, appropriateness and timeliness of services performed under this contract. The table below lists the evaluated record elements. Detailed descriptions of each element can be found at the following links:

PCP Medical Record Review Element Descriptions

OB Medical Record Review Element Descriptions

Member identification	Medical history	Referrals (e.g., consultation, therapy)	*Advance directives
Provider identification	Physical exam	X-ray, lab, imaging results	Prescribed medication
Date of service/Entry dates	History and physical	Smoking/Tobacco use	**Primary language
Legibility	Working diagnosis	Alcohol use	Healthy Start records (OB providers)
Problem list	Plan/treatment	Substance use	
Allergies	Records (e.g., consultation, discharge summaries and emergency room [ER] reports)	Immunization record	

* **Advance Directives -** For members ages 21 and older, records should contain evidence ~~that~~ the member has been asked if he or she has an advance directive (written directions about healthcare decisions), with a yes or no response documented. If the response is yes, a copy of the advance directive must be included in the medical record. Records for Humana Healthy Horizons in Florida members should indicate that neither the managed care plan nor any of its providers shall, as a condition of treatment, require the member to execute or waive an advance directive.

** **Primary Language -** Use of the member's primary language should be documented, along with any communication assistance provided.

Patient-centered medical home (PCMH)

Patient-centered medical home (PCMH)

- PCMH is a model of care that strengthens the provider-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship.
- Humana implemented the PCMH program to empower patients as they interact with their PCPs and healthcare delivery teams (e.g., family, therapist, specialist, diagnostic center, hospital and laboratory). The PCMH program focuses on a team-based approach to healthcare delivery. Open communication between the healthcare team and patient allows the patient to be more involved in healthcare decisions with a potential for better health outcomes and cost-effective treatment of ongoing health conditions.

PCMH—continued

According to the Agency for Healthcare Research and Quality (AHRQ), a PCMH program includes the following functions that transform traditional primary care into advanced primary care:

- **Comprehensive care:** A team that includes physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators and care coordinators to guide patients through the healthcare delivery system.
- **Patient-centered care:** The patient is primary in the relationship and drives decisions that influence his or her health. Providers educate and establish a comprehensive plan of care.
- **Coordinated care:** The PCP communicates with the healthcare delivery team and manages coordination of care.

PCMH—continued

- **Accessible services:** The patient's access-to-care preferences are important. The provider considers shorter wait times, same-day appointments for urgent needs, after-hours and around-the-clock access, as well as openness to different types of communication besides the telephone.
- **Quality and safety:** The PCP uses evidence-based medicine and clinical decision-support tools to guide the patient and healthcare delivery.

PCPs who are interested in the PCMH program, certification requirements and benefits can contact:

Latoya Powell, PCMH CCE
Phone: **305-626-5746**
Email: **PCMH@Humana.com**

Medicaid Risk Adjustment (MRA)

MRA disclaimer

The information contained in this presentation and responses to the questions asked are not intended to serve as official coding or legal advice. All coding decisions should be considered on a case-by-case basis and should be supported by medical necessity and the appropriate documentation in the medical record.

History and risk model definitions

Chronic Illness and Disability Payment System (CDPS)

- The model was developed in 1996 using Medicaid claims data on disabled beneficiaries.
- The model was modified in 2000 using additional data for both disabled and Temporary Assistance for Needy Families (TANF) beneficiaries.
- The model maps ICD-10* diagnosis codes to 72 CDPS categories in Florida within 19 major categories corresponding to major body systems (e.g., cardiovascular) or type of disease (e.g., diabetes).
- CDPS condition categories are groups of ICD-10 codes, typically identified at the three-digit level but occasionally codes are grouped at the fourth- or fifth-digit level and up to seven digits for ICD-10.

Medicaid prescription (MRx)

- A pharmacy-based risk adjustment model was developed in 2001 using CDPS prescription data.
- The model maps National Drug Code (NDC) codes to 45 Medicaid prescription categories.

CDPS + Rx

- The model was developed in 2008 and uses both diagnostic and pharmacy data.
- The model combines CDPS and Medicaid prescription and maps NDC codes to 15 Medicaid prescription categories.

*International Classification of Diseases, Tenth Revision

Hierarchies and comorbidities

- CDPS categories are hierarchical within each major category.
- Weights/cofactors are additive across major categories.
- Within major categories, only the most severe diagnosis counts.
- CDPS categories allow an accounting of comorbidities across medical and pharmacy.

When it comes to coding comorbidities, for which Medicaid allows up to 12 diagnosis codes on electronic forms, please consider the following:

- The diagnosis shown in the record to be chiefly responsible for the services delivered should be coded first.
- All documented conditions that coexist and require or affect patient care, treatment or management should be coded.

Risk-adjusted populations

Included

- TANF
- Adult (14 and older)
- Children (1 – 13 years old)
- Supplemental Security Income (SSI) persons with disabilities
- Severely mentally ill members

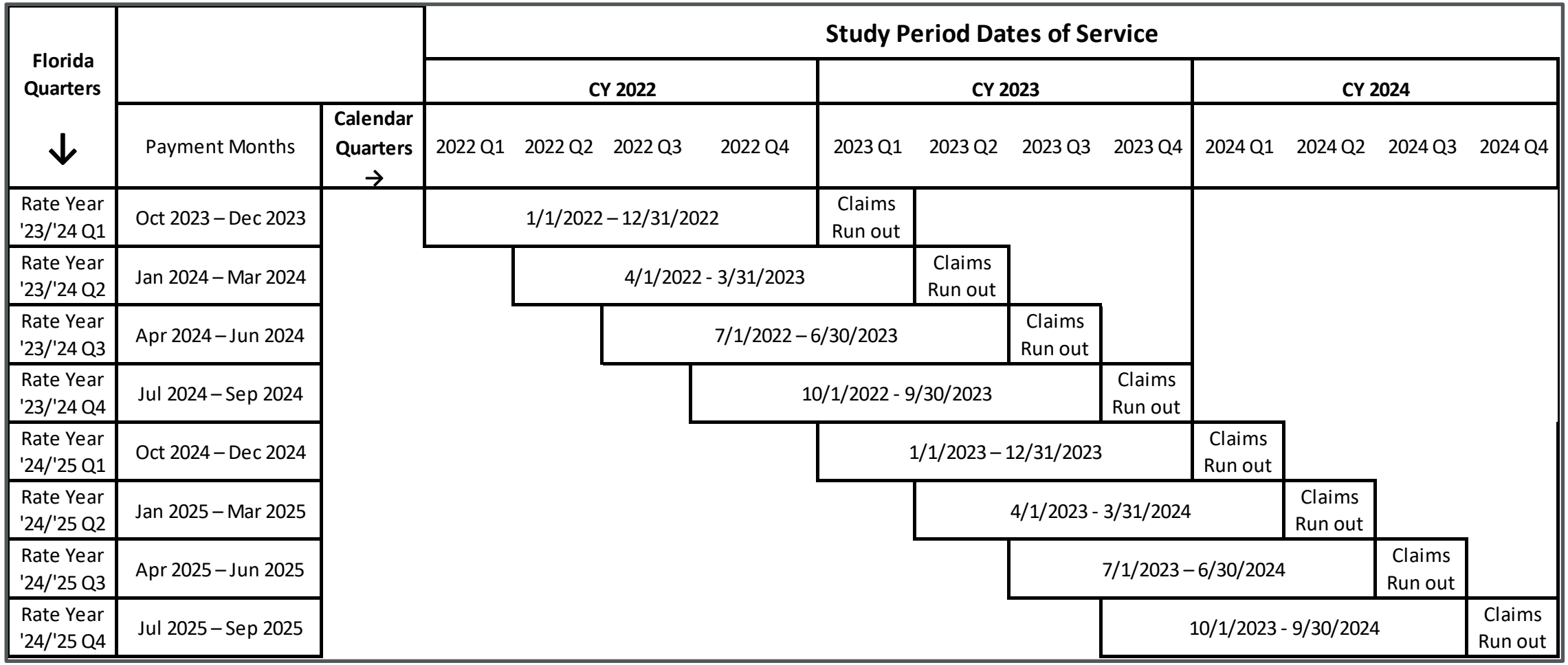
Excluded

- TANF children (younger than 1 year old)
- SSI children (younger than 1 year old)
- Dual eligible (duals are risk-adjusted by Medicare hierarchical condition categories [HCCs])
- Stand-alone long-term care
- Members with less than six months of eligibility during the observation period

Comparing risk-adjustment models

Medicare Advantage	Florida Medicaid
CMS HCC Model	**CDPS + Rx Model**
Prospective (future payments adjusted twice per year and one lump sum reconciliation payment)	Prospective (future payments adjusted quarterly)
Risk score based on age, gender, diagnosis and geography	Risk score based on age, gender, diagnosis, geography and Medicaid population (TANF, SSI)
Individual member risk scores	Individual member risk scores grouped at plan level, population types and age band (e.g., rate cells)
Three annual data submission deadlines (March, September and January)	Four annual data submission deadlines (March, June, September and December)
ICD-10 codes grouped into 79 HCCs	ICD-10 and NDC codes grouped into 58 CDPS categories and 15 MRx categories
Unlimited risk adjustment payments (theoretically)	Zero-sum settlement/budget neutral
Managed care organization (MCO) may code diagnoses	MCO cannot code diagnoses—only providers can code diagnoses

Florida MMA risk-adjustment timeline (Rate years 2023-2025)



Sources: Agency for Health Care Administration (AHCA) and MCG

Best Documentation Practices for Diagnosis Coding

LEGIBLE

- Makes entire medical record legible to any objective reader of the record

CLEAR

- Communicates the documenter's intent to all readers

CONCISE

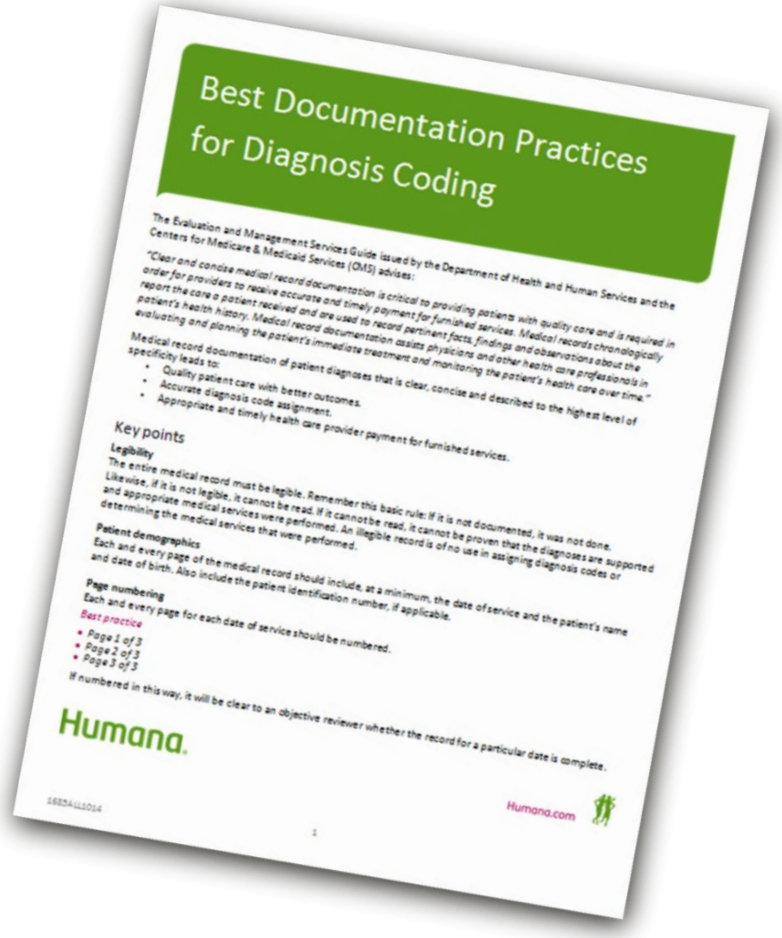
- Describes each diagnosis succinctly and to the highest level of specificity
- Limits or avoids altogether the use of abbreviations

CONSISTENT

- Avoids conflicts or contradictions

COMPLETE

- Includes documentation of all conditions evaluated and treated, as well as all chronic or other conditions that affect patient care, treatment or management
- Includes date of service, patient name and date of birth on each page
- Includes healthcare provider name, credentials and timely signature


Best Documentation Practices for Diagnosis Coding

The Evaluation and Management Services Guide issued by the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) advises:

"Clear and concise medical record documentation is critical to providing patients with quality care and is required in order for providers to receive accurate and timely payment for furnished services. Medical records chronologically report the care a patient received and are used to record pertinent facts, findings and observations about the patient's health history. Medical record documentation assists physicians and other health care professionals in evaluating and planning the patient's immediate treatment and monitoring the patient's health care over time."

Medical record documentation of patient diagnoses that is clear, concise and described to the highest level of specificity leads to:

- Quality patient care with better outcomes.
- Accurate diagnosis code assignment.
- Appropriate and timely health care provider payment for furnished services.

Key points

Legibility

The entire medical record must be legible. Remember this basic rule: If it is not documented, it was not done. Likewise, if it is not legible, it cannot be read. If it cannot be read, it cannot be proven that the diagnoses are supported and appropriate medical services were performed. An illegible record is of no use in assigning diagnosis codes or determining the medical services that were performed.

Patient demographics

Each and every page of the medical record should include, at a minimum, the date of service and the patient's name and date of birth. Also include the patient identification number, if applicable.

Page numbering

Each and every page for each date of service should be numbered.

Best practice

- *Page 1 of 3*
- *Page 2 of 3*
- *Page 3 of 3*

If numbered in this way, it will be clear to an objective reviewer whether the record for a particular date is complete.

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Clinical coding example

Excerpt from full medical record

History of present illness: 49-year-old homeless diabetic male complains of right ankle wound. He lost his balance while coming downstairs at a facility. Unable to check blood sugars given his living situation, but told it was uncontrolled at last clinic visit a few months ago. He admits to noncompliance with his diabetic diet as he eats what's given to him. Sometimes he feels pins and needles sensation in his feet.

Physical exam:

- **General:** No acute distress, ambulating without assistance.
- **Head, eye, ears, nose and throat (HEENT):** No abnormalities noted.
- **Heart:** Regular rate and rhythm with no murmurs, rubs or gallops.
- **Lungs:** Clear bilaterally.
- **Abdomen:** Soft non-tender with good bowel sounds, no masses or bruits.
- **Extremities:** No clubbing or cyanosis, normal range of motion, right ankle 1+ edema; pedal pulses 1+.
- **Neuro:** Alert and oriented, ankle and knee DTR 1+/4, positive monofilament exam on plantar and dorsal surface of right foot, negative Romberg, steady gait.
- **Skin:** Warm and dry, tender erythematous 1 cm superficial ulceration noted right medial malleolus, but no discharge.

Clinical coding example—continued

Assessment:

- Diabetes mellitus, type 2, uncontrolled with hyperglycemia
- Diabetic ulcer right ankle involving skin only
- Diabetic peripheral neuropathy

Plan:

Keep wound clean and dry

- Follow-up visit in 10 to 14 days
- Prescription given for Keflex 500 mg by mouth twice daily for 10 days
- Over-the-counter (OTC) Tylenol for pain as directed
- X-ray right ankle
- Sent to lab for CBC, CMP, TSH, HbA1c, random urine albumin, urine albumin creatinine ratio
- Diabetic teaching with nutrition consult for diabetic diet

Example coded as:

Incomplete coding

E11.9	Type 2 diabetes mellitus without complications
S91. ØØ1A	Unspecified open wound, right ankle, initial encounter
G62.9	Polyneuropathy, unspecified

Complete coding

E11.622	Type 2 diabetes with other skin ulcer
L97.311	Non-pressure chronic ulcer of right ankle limited to breakdown of skin
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
E11.65	Type 2 diabetes mellitus with hyperglycemia
J59.10	Inadequate housing

Service-level agreements (SLA)

Service-level agreements (SLA)

SMMC-contracted MCOs must adhere to certain service-level agreements for the following categories:

- Birth outcomes
- Transportation
- Network adequacy
- Claims payment
- Service authorization
- Member call center metrics
- Provider call center metrics

Find out more about these SLAs at **Humana.com/FLMedicaidSLAs**.

AHCA provider-based marketing guidelines

AHCA provider-based marketing guidelines

- If the managed care plan chooses to utilize its provider network to distribute marketing materials, the managed care plan shall ensure through its provider agreements that providers shall remain neutral.

- The managed care plan may permit providers to make available and/or distribute managed care plan marketing materials as long as the provider does so for all managed care plans with which the provider participates.

- The managed care plan may permit providers to display posters or other materials in common areas, such as the provider's waiting room.

- The managed care plan may permit LTC facilities to provide materials in admission packets announcing all managed care plan contractual relationships.

The above information was extracted directly from AHCA contractual requirements.

AHCA provider-based marketing guidelines—continued

Providers may:

- Announce new or continuing affiliations with the managed care plan through general advertising (e.g., radio, television, websites).
- Make new affiliation announcements within the first 30 days of the new provider agreement.
- Make one announcement to patients of a new affiliation that names only the managed care plan when such announcement is conveyed through direct mail, email or phone.*

Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all managed care plans with which the provider has agreements.*

The above information was extracted directly from AHCA contractual requirements.

* Materials must be reviewed/approved by the plan and submitted to AHCA for approval, as necessary, before distributing.

AHCA provider-based marketing guidelines—continued

Materials that indicate the provider has an affiliation with certain managed care plans and that only list managed care plan names, logos, product taglines, telephone contact numbers and/or websites do not require agency approval.

The above information was extracted directly from AHCA contractual requirements.

AHCA provider-based marketing guidelines—continued

Providers may not:

- Offer marketing/appointment forms.
- Make phone calls or direct, urge or attempt to persuade potential members to enroll in the managed care plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of the managed care plan.
- Offer anything of value to persuade potential members to select them as their provider or to enroll in a particular managed care plan.
- Accept compensation directly or indirectly from the managed care plan for marketing activities.

The above information was extracted directly from AHCA contractual requirements.

MMA Physician Incentive Program (MPIP)

Managed Medical Assistance Physician Incentive Program (MPIP)

The aim of the MPIP is to promote quality of care for our Medicaid members and recognize those providers who demonstrate high levels of performance for selected criteria.

The MPIP provides the opportunity for designated physician types to earn enhanced payments equivalent to the appropriate Medicare fee-for-service rate, as established by AHCA, based on the achievement of key access and quality measures.

Providers eligible and qualified to participate in the MPIP are the physician types listed below who meet the state designed MPIP programs specific medical and/or quality criteria:

- **Pediatric primary care providers (PCPs)** – Pediatricians, family practitioners and general practitioners who provide medical services to members younger than 21. There are 2 ways pediatric PCPs may qualify:

  1. **PCMH** recognized on or before Oct. 1, 2023, by one of the following organizations:
     - National Committee for Quality Assurance (NCQA)
     - Accreditation Association for Ambulatory Health Care (AAAHC)
     - The Joint Commission (TJC)
     - Utilization Review Accreditation Commission (URAC)
  2. A site with 50 Humana Healthy Horizons pediatric members and meeting or achieving all HEDIS benchmarks included in program

➢ Please visit AHCA's MPIP Program site to learn more about the program qualifying measures.

MPIP—continued

- **OB-GYNs** – There are 2 ways OB-GYN providers may qualify :

  1. Recognized by NCQA as a Patient Centered Specialty Practice (PCSP) on or before Oct. 1, 2023, or PCMH by one of the following organizations:

     - NCQA
     - AAAHC
     - TJC
     - URAC

  2. A site must achieve or exceed the benchmark for all 3 of the following metrics:

     - Timeliness of Prenatal Care ≥ 83.53%
     - Postpartum Care ≥ 76.18%
     - Florida Medicaid C-Section Rate ≤ 35%

- **Pediatric specialists –** Providers who provide medical services to members younger than 21.

MPIP—continued

The incentive program will not be extended to the following providers:

- Providers not participating in the Humana Healthy Horizons in Florida network
- PCPs without PCMH accreditation or fewer than 50 members who did not meet all the program HEDIS measures
- OB-GYNs without PCSP or PCMH accreditation
- OB-GYN with fewer than 30 members or with 30 members but did not meet all measures
- PCPs with adult panels
- FQHCs
- Rural health clinics (RHCs)
- CHDs
- Medical school faculty plans

Complete information regarding the incentive program and timelines can be found on the AHCA website at **AHCA MMA Physician Incentive Information**.

Humana web resources and contact numbers

Provider website—public

Medical Resources for Humana Healthcare Providers
Humana.com/Provider

- Claims and payment policies
- Credentialing
- Preauthorization/referrals
- Clinical practice guidelines
- Drug PA
- News and provider publications (including provider manual)
- Network participation information
- Reconsideration and appeals
- Health and wellness programs
- Pharmacy services
- Quality resources
- Self-service portal
- EFT/ERA resources
- What's new?

Humana Healthy Horizons in Florida—LTC
Humana.com/FLLTC

- Provider manual
- Provider directory
- Provider education

Humana Healthy Horizons in Florida—MMA
Humana.com/HealthyFL

- Provider manual
- Provider resource guide
- Provider education
- Provider newsletter
- COVID webpage
- Pharmacy, quality and training materials

Provider self-service help

For help or more information regarding web-based tools:

Humana Healthy Horizons in Florida—MMA

For help with registration or questions about Availity Essentials, please call Availity at **800-AVAILITY (800-282-4548)**.

Humana Healthy Horizons in Florida—LTC

Please call **888-998-7735.**

For training:

Humana Healthy Horizons in Florida—MMA

Please visit:

- **Humana.com/FLEducation**
- **Humana.com/FLTraining**

Humana Healthy Horizons in Florida—LTC

Please visit **Humana.com/FLLTC.**

Working with Humana online? Use multipayer Availity Essentials

Availity Essentials is Humana's preferred method for online transactions.

- ✓ Use one consistent site to work with Humana and other payers.
- ✓ Check eligibility and benefits.
- ✓ Submit referrals and authorizations (MMA).
- ✓ Manage claim status.
- ✓ Use Humana-specific tools.

About Availity Essentials

- Cofounded by Humana
- Humana's 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)**.

Helpful numbers

Humana Healthy Horizons in Florida customer service:

Please call the number on the back of the member's ID card for the most efficient call routing.

PA assistance for medical procedures:

800-523-0023 Monday through Friday, 8 a.m. to 8 p.m., Eastern time

PA for medication billed as medical claim:

866-461-7273 Monday through Friday, 8 a.m. to 6 p.m., Eastern time

PA for pharmacy drugs:

800-555-2546 Monday through Friday, 8 a.m. to 6 p.m., Eastern time

Provider relations:

- **MMA: 800-477-6931** Monday through Friday, 8 a.m. to 8 p.m., Eastern time, for fee schedule requests, demographic changes and credentialing status
- **LTC Provider Helpline: 888-998-7735**, Monday through Friday, 8 a.m. to 8 p.m., Eastern time

Helpful numbers—continued

- Commercial case management: **800-327-9496**
- Medicaid case management: **800-229-9880**
- Referrals: **FL_MMA_CM_Referrals@humana.com**
- HumanaBeginnings: **800-322-2758**, ext. **1500290** or email **FL_MMA_OB_Referrals@humana.com**
- Commercial concurrent review: **800-545-6775**
- Medicare/Medicaid concurrent review: **800-322-2758**
- Clinical management program information: **800-491-4164**
- CenterWell Pharmacy: **800-526-1490**
- Availity customer service/tech support: **800-282-4548**
- Ethics and compliance concerns: **877-5 THE KEY (877-584-3539)**
- Fraud, waste and abuse reporting: **800-614-4126**
- Questions about arranging interpretation services for member appointments: **877-320-1235**

Additional training requirements

Additional training requirements

Providers must complete additional compliance training on other topics, as required.

These and other training units is located on the following provider websites:

- **Humana.com/ProviderCompliance** (public)
- **Availity.com** (secure, registration required)

FWA reporting requirement and reporting options

Anyone who suspects or detects an FWA violation is required to report it either to Humana or within his/her respective organization, which then must report it to Humana.

Telephone:

- Special Investigations Unit (SIU) direct line: **800-558-4444**
  (Monday through Friday, 8 a.m. to 4 p.m., Eastern time)
- SIU Hotline: **800-614-4126** (24/7 access)
- Ethics Help Line: **877-5-THE-KEY** (877-584-3539)

Email: SIUReferrals@Humana.com or Ethics@Humana.com

Web: EthicsHelpLine.com

Fax: 920-339-3613

All information will be kept confidential.

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

Fraud, waste and abuse (FWA)

FWA reporting requirement and reporting options—continued

Suspected fraud, waste and abuse pertaining to Florida MMA/LTC must be reported to:

- **Medicaid Program Integrity (MPI)** administrator by calling **850-412-4600**
- **Florida Agency Consumer Complaint Hotline** by calling **888-419-3456**
- **Florida Attorney General** by calling **866-966-7226**
- AHCA FWA Complaint Form on the web at Medicaid Fraud and Abuse Form - Office of the Medicaid Program Integrity (myflorida.com)

In addition to reporting as indicated above, if the suspected fraud appears to be substantial, AHCA will be notified immediately.

All final resolutions of a case include a written statement notifying the provider or member that the resolution in no way binds the state of Florida nor precludes the state of Florida from taking further action for the circumstances that caused the matter.

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). The state of Florida has a statute matching the Federal False Claims Act that allows for the recovery of Medicaid funds by the state of Florida.

- Individuals who file such suits are known as "whistleblowers." If the action is successful, the plaintiff is rewarded with a percentage of the recovery. Retaliation against individuals for investigating, filing or participating in a whistleblower action is prohibited.

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

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

A person or company who violates the False Claims Act is also liable to the government.

Disallowed Actions (31 U.S.C. §§ 3729-3733)

Links to the above provisions of this act are listed within Humana's Compliance Policy for Contracted Health Care Providers and Business Partners, which is available on **Humana.com/fraud**

Health, safety and welfare

Abuse

What is abuse?

- Non-accidental infliction of physical and/or emotional harm
- Sexual abuse upon a disabled adult, an elderly person or child by a relative, caregiver, household member or any other person
- Active encouragement of any person by a relative, caregiver or household member to commit an act that inflicts or could reasonably be expected to result in physical or psychological/emotional injury to a disabled adult, an elderly person or child

Physical abuse and sexual abuse

Physical abuse of customer

- Non-accidental use of force that results in bodily injury, pain or impairment, including, but not limited to, being slapped, burned, cut, bruised or improperly physically restrained

Physical abuse

- Infliction of physical pain or injury to a disabled adult, an elderly person or child

Sexual abuse

- Includes unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an adult with disabilities
- Means touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with a disabled adult, an elderly person or child when the person is unable to understand, unwilling to consent, threatened or physically forced to engage in sexual activity

Psychological (verbal/emotional) abuse

Verbal abuse

- Includes, but is not limited to, name calling, intimidation, yelling and swearing; may also include ridicule, coercion and threats

Emotional abuse

- Verbal assaults, threats of maltreatment, harassment or intimidation intended to compel a disabled adult, an elderly person or child to engage in conduct from which he or she wishes and has a right to abstain or to refrain

Neglect

- **Neglect of customer—**The failure of another individual to provide a disabled adult, an elderly person or child with, or the willful withholding the necessities of life including, but not limited to, food, clothing, shelter or medical care
- **Neglect**—Repeated conduct or a single incident of carelessness that results or could reasonably be expected to result in serious physical or psychological/emotional injury or substantial risk of death
- **Self-neglect—**Individual does not attend to his/her own basic needs, such as personal hygiene, appropriate clothing, feeding or tending appropriately to medical conditions
- **Passive neglect—**A caregiver's failure to provide a disabled adult, an elderly person or child with the necessities of life including, but not limited to, food, clothing, shelter or medical care. This definition does not create a new affirmative duty to provide support to eligible adults; nor shall it be construed to mean that an eligible adult is a victim of neglect because of healthcare services provided or not provided by licensed healthcare professionals.

Exploitation

Exploitation is the act of a person who stands in a position of trust and confidence with a disabled adult or an elderly person and knowingly, by deception, intimidation or force:

- Obtains control over the person's funds, assets or property
- Deprives the person of the use, benefit or possession of funds, assets or property. This intentional action can be temporary or permanent.
- Uses the person's funds, assets or property for the benefit of someone other than the disabled adult, elderly person or child

Exploitation of customer

- The illegal use of assets or resources of a disabled adult, elderly person or child. It includes, but is not limited to, misappropriation of assets or resources of the alleged victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion or in a manner contrary to law.

Financial exploitation

- The misuse or withholding of resources by another person to the disadvantage of the person or the profit or advantage of a person other than the disabled adult, elderly person or child

Increased risk factors and traits—members

Likelihood of abuse, neglect or exploitation occurring increases for members in the presence of one or more risk factors. These include:

- Dependency on others for personal care
- Dependency on others for financial management
- Isolation from information about own rights and health
- Diminished mental capacity
- Serious health problems
- Taking medications that affect cognitive status
- Depression, anxiety or fearfulness
- Recent losses, including the loss of a spouse, home or friend

Increased risk factors and traits—caregiver

Contributing factors exhibited by caregivers at risk to abuse, neglect or exploit include:

- Alcoholism
- Mental illness
- Stress
- Chronic fatigue
- Frequent medical consultation
- History of marital violence and/or child abuse
- Previous relationship difficulties
- Conflicting demands of other family members
- Problems with housing, finances and/or employment
- Lack of support
- Lack of respite

Identifying victims of human trafficking

Typically, victims of human trafficking display the following signs*:

- Lack of identification documents and possible claim to be “just visiting” a certain area
- No fixed address or possibly unable to give specifics about where he or she is living
- Appears under the control of another, possibly the person accompanying him or her. The other person may attempt to speak on behalf of the victim.
- Exhibits fear, depression, submissiveness or acute anxiety
- Typically not in control of his/her own money or identification documents
- Unable or reluctant to explain the nature of an injury

If you suspect trafficking, call the National Human Trafficking Hotline at 888-373-7888.

* List from Florida Office of the Attorney General

Steps to take for prevention

- When a provider suspects there is a risk of abuse, neglect or exploitation, he/she should work with the Humana care manager assigned to the member via the Integrated Care team.
- When a care manager determines a member is at risk for abuse or neglect, but does not display signs or symptoms, the care manager will include specific interventions to reduce the member's risk in the plan of care.

What is a mandated reporter?

A mandated reporter is an individual who is required by law to report situations immediately if he/she suspects a disabled adult, elderly person or child may have been abused, neglected or exploited or is at risk of being abused, neglected or exploited.

Rights of mandated reporters

- Most states allow for:
  - Immunity from civil and criminal liability unless the report was made in bad faith or with malicious intent.
  - Identity protection. Your consent must be given to reveal your identity.
    - The court may order the identity of the reporter revealed. The court can then release confidential information without penalty.

Important reporting processes

- Provider must report any suspected abuse, neglect or exploitation to the appropriate state agency. State-specific information is available in the appendix of Health, Safety and Welfare (HSW) provider training at HSW Training.
- Provider also must report suspected abuse, neglect or exploitation to the Humana care manager participating on the member's integrated care team.
- Humana care manager also will report the suspected abuse, neglect or exploitation to the appropriate state agency.
- Humana care manager will follow internal Humana associate reporting procedures as well.

General reporting requirements including, but not limited to:

- Can you identify the person being abused? If known, provide address and/or location.
- What is the approximate age of the person?
- Does an emergency exist?
- Can you describe the circumstances of the alleged abuse, neglect or exploitation?
- What are the names and relationships of other members of the household, if applicable?
- Is the person incapacitated?
- Do you know the name and address of the caregiver? (If applicable)
- Do you know the name and relationship of the alleged perpetrators?
- Are there other people who may have knowledge?
- Do you know the name of the person's healthcare provider?
- What is your name, address, phone number? (You can report anonymously.)

Critical incident reporting

Critical incident reporting

- Humana's Risk Management program includes a critical and adverse incident reporting and management system for critical events that negatively impact the health, safety and welfare of our members.
- Report critical and adverse incidents that occur during the provision of home- and community-based services that occur in the following:
  - Adult day care
  - Adult family home care
  - Healthcare provider's office
  - During home health services

Critical incident reporting—continued

Participating providers should report the following events during the delivery of home- and/or community-based services:

- Member death (unexpected, homicide, suicide or abuse/neglect/exploitation)
- Member brain damage, spinal damage or permanent disfigurement
- Fracture or dislocation of bones or joints
- Conditions that require definitive or specialized medical attention not consistent with the routine management of the patient's case or patient's preexisting physical condition
- Conditions that require surgical intervention to correct or control
- Conditions that result in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care
- Conditions that extend the patient's length of stay
- Conditions that result in a limitation of neurological, physical or sensory function, which continues after discharge from the facility
- Suspected abuse/neglect/exploitation
- Injury or major illness as a result of care provided
- Sexual battery
- Medication error
- Suicide attempt
- Altercations requiring medical intervention
- Elopement (missing for 24 hours or more)

Critical incident reporting—continued

- Call 911 if the member is in immediate danger.
- Report suspected abuse, neglect and exploitation of a member immediately in accordance with F.S. 39-201 and F.S. 415 (i.e., police, Department of Children & Family, Adult Protective Services).
- Report the critical and/or adverse incident to Humana Health Plan Risk Management Department by emailing **RiskManagementAdministration@humana.com** within 24 hours of having knowledge of the incident.

Humana has the right to take corrective action as needed to ensure its staff, participating providers and direct service providers comply with the critical incident reporting requirements.

Humana

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in Florida