2024 Provider Policy and Procedures Manual

HUMANA HEALTHY HORIZONS IN INDIANA

Humana Healthy Horizons in Indiana is a Medicaid Product of Arcadian Health Plan, Inc.

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Chapter 1: Introduction

Welcome

Thank you for becoming a participating provider with Indiana PathWays for Aging brought to you by Humana Healthy Horizons® in Indiana and administered by the Indiana Family and Social Services Administration (FSSA). This plan is for members with Indiana PathWays for Aging Medicaid benefits that are administered through the Indiana Family and Social Services Administration (FSSA). We strive to make doing business with Humana Healthy Horizons as easy as possible for our providers, facilitating high-quality care and a positive experience for both you and our members. We have a robust support structure for our provider network to deliver a best-in-class experience that is operationally efficient and enables high-quality care. To build a strong relationship between Humana Healthy Horizons and its contracted providers, your assigned Provider Education/Outreach Representative will serve as your primary point of contact to facilitate communication between the provider and Humana Healthy Horizons.

About Humana

For more than 60 years, Humana has been helping members improve and maintain their health through clinical excellence and coordinated care. Our successful history in care delivery and health plan administration is helping us create a new kind of integrated care with the power to improve health and well-being and lower costs.

We are committed to building strong relationships with PathWays providers that foster member well-being. Our range of clinical capabilities, combined with our member programs and resources, produce a simplified experience that makes healthcare easier to navigate and more effective.

Compliance and ethics

Humana Healthy Horizons and our PathWays providers are all responsible for complying with applicable Indiana and federal regulations, along with applicable Humana Healthy Horizons policies and procedures. Humana Healthy Horizons is committed to conducting business in a legal and ethical manner. Humana Healthy Horizons has an established compliance plan that does the following:

- Formalizes Humana Healthy Horizons' commitment to honest communication within the company and within the community, inclusive of our providers, members and employees.
- Develops and maintains a culture that promotes integrity and ethical behavior.
- Facilitates compliance with all applicable local, state, and federal laws and regulations.
- Implements a system for (a) early detection and noncompliance reporting with laws and regulations; (b) fraud, waste and abuse concerns; and (c) noncompliance with Humana Healthy Horizons policy or professional, ethical or legal standards.
- Allows us to resolve problems promptly and minimize negative impact on our members or business, including financial losses, civil damages, penalties and sanctions.

The following outlines general compliance and ethics expectations for our PathWays providers:

- Act according to professional ethics and business standards.
- Notify us of suspected violations, misconduct, or fraud, waste and abuse concerns.
- Cooperate fully with any investigation of alleged, suspected or detected violations of applicable Indiana or federal laws and regulations.
- Notify us if you have questions or need guidance for proper protocol.

For questions about ethical and compliance expectations, please contact your Provider Education/Outreach Representative or call the Member/Provider Services Contact Center at **866-274-5888 (TTY: 711)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

About Humana Healthy Horizons in Indiana

Thank you for partnering with us to serve members in our Humana Healthy Horizons in Indiana plan. Humana has a proud history in the healthcare industry. We began in 1961 as a nursing home company called Extendicare and became known as Humana in 1974. Since the 1980s, Humana has been centered on healthcare. We have served Indiana families, including seniors and veterans, for more than 30 years and are honored to serve Indiana PathWays for Aging members statewide.

We strive to make everything as straightforward as possible, facilitating high-quality care and creating a positive experience for everyone. We have a robust support structure for our provider network to deliver a best-in-class experience that is operationally efficient and ensures high-quality care. Humana Healthy Horizons is led by a president and chief executive officer and leadership team, as well as locally dedicated provider services staff and member support teams, including care coordinators and service coordinators. To build a strong relationship between Humana Healthy Horizons and its providers, your assigned Provider Education/Outreach Representative will serve as your primary point of contact and be happy to answer any of your questions.

Humana Healthy Horizons distributes its member rights and responsibility statements to the following groups upon enrollment and annually thereafter:

- New members
- Existing members
- New providers

If you or your staff have questions or need help, go to Humana.com/Indiana or call us at **866-274-5888 (TTY: 711)**.

Thank you for partnering with Humana Healthy Horizons to improve the health and well-being of Indiana communities.

About the Indiana PathWays for Aging program

The Indiana PathWays for Aging program provides covered benefits to Hoosiers age 60 and over who meet income requirements; qualify for Medicaid based on age, blindness or disability; and do not fall into any of the excluded population categories. FSSA makes all member eligibility determinations. Full eligibility criteria are defined on FSSA's website. Upon enrollment, eligible Hoosiers are assigned to one of the Indiana PathWays for Aging managed care entities (MCEs), such as Humana Healthy Horizons. MCEs are required to cover a robust set of medical, behavioral health, and long-term services and supports (LTSS). Humana Healthy Horizons also offers its members additional enhanced services, which they can use to achieve their self-directed quality of life goals. More information on covered Indiana PathWays for Aging benefits and enhanced services can be found in Chapter 7. Each MCE will contract with a network of providers to serve their Indiana PathWays for Aging members. In order to participate in Humana Healthy Horizons' network or serve any of the Indiana PathWays for Aging members, you must first enroll in the Indiana Health Coverage Programs (IHCP).

For information on Indiana PathWays for Aging, including member eligibility criteria and required covered services, please visit FSSA: https://www.in.gov/medicaid/. If you are not yet enrolled in IHCP and wish to do so, more information is available here: https://www.in.gov/medicaid/providers/provider-enrollment/become-a-provider. Additional state resources can be found in the table below.

State resources

Resource	Contact information
About IHCP	Website: https://www.in.gov/medicaid/providers/about-ihcp-programs/
Business transactions	Website: https://www.in.gov/medicaid/providers/business-transactions/
Clinical services	Website: https://www.in.gov/medicaid/providers/clinical-services/
IHCP Professional and Outpatient Fee Schedules	Website: https://www.in.gov/medicaid/providers/business-transactions/billing-and-remittance/ihcp-fee-schedules/
IHCP provider healthcare portal	Website: https://portal.indianamedicaid.com/hcp/Default.aspx?alias=portal.indianamedicaid.com/hcp/provider
IHCP provider locator	Website: https://www.in.gov/medicaid/providers/provider-references/ihcp-provider-locator/
Acentra Health/Kepro Atrezzo provider portal	Website: https://portal.kepro.com/
Long-term care	Website: https://www.in.gov/health/ltc/contact/
Optum Rx portal	Website: https://www2.optumrx.com/

Resource	Contact information
Ordering, prescribing or referring (OPR) provider search	Website: https://provider.indianamedicaid.com/ihcp/ProviderServices/OPRProviderSearch.aspx
Provider education	Website: https://www.in.gov/medicaid/providers/provider-education/
Provider enrollment	Website: https://www.in.gov/medicaid/providers/provider-enrollment/
Provider references	Website: https://www.in.gov/medicaid/providers/provider-references/
Sandata portal	Website: https://evv.sandata.com/VM/Login

How to join Humana's Indiana PathWays for Aging network

Humana Healthy Horizons is committed to offering accessible and high-quality care to its Indiana PathWays for Aging members. We would be honored to partner with you. If you are not yet participating in Humana Healthy Horizons' network but are interested in joining, please reach out to:

Area	Contact information
Home and Community-Based Services (HCBS)/ LTSS contracting team	Email: LTSSContracting@humana.com Website: https://humana-6853.quickbase.com/db/bsxaqn5yc
Physical health contracting team	Email: INproviderupdates@humana.com Website: https://humana-6853.quickbase.com/db/btnam42he
Behavioral health contracting team	Email: INBHMedicaid@humana.com Website: https://humana-6853.quickbase.com/db/btnam42he
Dental	Website: https://govservices.dentaquest.com/
Vision	Email: TSatterfield@eyemed.com or JDick@eyemed.com
Pharmacy	Email: PharmacyContractRequest@Humana.com
Home and vehicle modification	Website: https://www.evolve-emod.com/healthcare-providers
Nonemergency medical transportation (NEMT)	Website: https://www.lcptransportation.com/

About this manual

This Humana Healthy Horizons in Indiana Provider Policy and Procedures Manual applies to providers who offer services to our members in the Indiana PathWays for Aging program.

This provider manual highlights key points related to Humana Healthy Horizons policies and procedures for PathWays members and is intended to inform you and your staff of our requirements, what we need from you and what you can expect from us.

In this manual, you can easily find key information including:

- Covered services
- Member eligibility
- Prior authorization
- Claim and encounter submission
- Provider responsibilities
- Quality and compliance
- Care management
- Grievances and appeals

Manual updates and changes

You will be notified of updates to this manual via bulletins and notices posted on our website at **https://www.humana.com/provider/**. Hard copies of this manual are available upon request, without cost, when you initially join the network, when there are any changes in policies and procedures, and upon request. If you need further explanation on topics discussed in this manual or to request a hard copy of this manual, please contact your local Provider Education/Outreach Representative, located on the provider website: **https://www.humana.com/provider/medical-resources/indiana-medicaid/contactus**. We look forward to a long and productive relationship with you and your staff.

Chapter 2: Contact information for Humana, FSSA and the Office of Medicaid Policy and Planning (OMPP)

Contact information

Humana resources for PathWays providers

Department	Contact information
Humana Provider Services Contact Center	Phone: **866-274-5888** Hours of operation: Monday through Friday, 8 a.m. – 8 p.m., Eastern time
Humana Provider Education/Outreach Representatives	Email: INMedicaidProviderRelations@humana.com Fax: **317-808-6099**
Humana Member Services	Phone: **866-274-5888** Hours of operation: Monday through Friday, 8 a.m. – 8 p.m., Eastern time
Humana 24-Hour Nurse Advice Line	Phone: **800-449-9039**
Humana Case Management	Email: INPathWaysCareManagement@humana.com
Humana Utilization Management	Emails: INMCDUM@humana.com (physical health) or INMCDBHUM@humana.com (behavioral health)

FSSA resources

Resource	Contact information
988 Suicide and Suicide Lifeline (both for the member or someone they know who needs help)	Phone/Text: **988** Chat: 988lifeline.org Websites: https://988indiana.org/ and https://www.samhsa.gov/
Adult Protective Services (APS)	Phone: **800-992-6978**
Behavioral and primary healthcare coordination	Phone: **317-232-7800** Email: bphcservice@fssa.in.gov
Behavioral Crisis Line	Phone: **800-273-8255**
Centers for Independent Living (full list of centers available on p.77 of the FSSA resource guide linked in the Contact Information column)	Document: http://www.in.gov/fssa/files/FSSA_Resource_Guide.pdf
Community and home options to institutional care for the elderly (CHOICE) and disabled program	Phone: **800-713-9023** Website: https://www.in.gov/fssa/da/community-and-home-options-to-institutional-care-for-the-elderly-and-disabled/
Deaf and hard of hearing services	Email: dhhshelp@fssa.in.gov Address: 402 W. Washington St., MS 23 IGCS – W453 Indianapolis, IN 46204
Division of Family Resources (program eligibility)	Phone: **800-403-0864** Fax: **888-436-9199**
Division of Mental Health and Addiction	Phone: **317-232-7800** Email: amhhservices@fssa.in.gov Website: http://www.fssa.in.gov/dmha

Resource	Contact information
Family Caregiver program	Phone: **800-713-9023** Website: https://www.in.gov/fssa/da/older-americans-act-family-caregiver-support/
Fraud reporting	Phone: **800-403-0864** Email: reportfraud@fssa.in.gov
Group home/assisted living issues	LTC Ombudsman: Phone: **800-622-4484** or **317-232-7134** Fax: **317-972-3285** Email: LongTermCareOmbudsman@ombudsman.IN.gov Indiana Department of Health: Website: https://www.in.gov/health/ltc/facility-licensing-and-certification/residential/ Phone: **317-233-7442** Fax: **317-233-7322** Email: LTCProviderServices@health.IN.gov
HoosierRx	Phone: **866-267-4679** Website: http://www.in.gov/medicaid/members/member-programs/hoosierrx/
IHCP (application)	Phone: **800-403-0864** https://www.in.gov/fssa/dfr/ebt-hoosier-works-card/find-my-local-dfr-office/ or https://www.in.gov/medicaid/members/
INconnect Alliance	Phone: **800-713-9023** Website: https://www.in.gov/fssa/inconnectalliance/
Long-term care ombudsman	Phone: **800-246-8909** (complaint line) or **800-622-4484** Email: longtermcareombudsman@ombudsman.in.gov Website: https://www.in.gov/ombudsman/long-term-care-ombudsman/
Older Independent Blind program	Phone: **877-241-8144** Website: https://www.in.gov/fssa/ddrs/rehabilitation-employment/blind-and-visually-impaired/older-independent-blind-program/
OMPP contact information	Website: https://www.in.gov/fssa/ompp/about-ompp/
Residential Care Assistance program	Phone: **800-713-9023** Email: rcap.provider@fssa.in.gov Website: https://www.in.gov/fssa/da/provider-resources/residential-care-assistance-program/
Supplemental Nutrition Assistance Program (SNAP)	Phone: **800-403-0864** Websites: http://www.fssabenefits.in.gov/ or http://www.dfrbenefits.in.gov

Expected response times for provider inquiries

Your dedicated Provider Education/Outreach Representative will respond to all provider inquiries, including telephone calls, letters, emails and faxes, within two business days.

Chapter 3: Member eligibility and enrollment

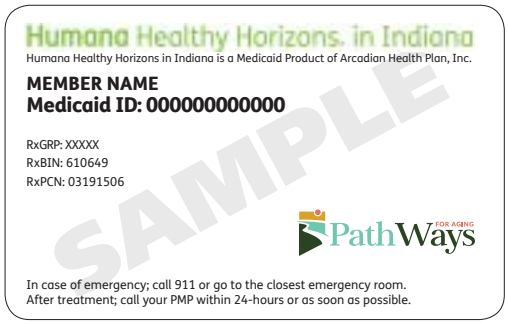
Member eligibility

Indiana PathWays for Aging is a statewide managed care program for Indiana's eligible Hoosiers who are 60 years of age and older; are eligible for Medicaid based on age, blindness, or disability; and have limited income and resources.

New member kits

Within five calendar days of a new member's full enrollment with Humana Healthy Horizons Indiana PathWays for Aging, the member will receive a Welcome Kit. Contained within the Welcome Kit are various documents and forms. A welcome letter includes education confirming the member's enrollment and information on coordination of care with current providers and how the member can receive care coordination assistance. The Member Handbook includes more in-depth material ranging from Humana Healthy Horizons contact information to the availability of pharmacy services, also including member rights and preventive health services. The quick start guide includes information around enhanced services, confirming a provider, creating a Go365® account and pharmacy benefits. Optional forms regarding privacy and continuity of care are made available to each PathWays member. The member ID card also will be included within these materials.

Member ID card



Member Services

Humana Healthy Horizons will assist members who have questions or concerns about benefits and services. Member Services representatives are available by telephone at **866-274-5888**, Monday through Friday, 8 a.m. to 8 p.m., Eastern time, except on Humana-observed holidays. If the holiday falls on a Saturday, Humana Healthy Horizons will be closed the Friday before. If the holiday falls on a Sunday, we will be closed the Monday after.

Member request for new provider

Members have the right to choose a provider that meets their needs. To find a doctor, specialist, hospital, healthcare facility or other type of in-network service provider, the member can call Member Services or access our online provider directory, Find a Doctor.

Primary medical provider (PMP) assignment

A PMP will be assigned automatically to all PathWays-only members who do not self-select a PMP. Humana Healthy Horizons will utilize the PMP assignment history file for assignment. If a PMP is not provided, Humana Healthy Horizons' internal enrollment system can identify a member's previous PMPs within the participating Humana Healthy Horizons PMP panel and assist through auto assignment. Geographic assignment will be used when a member has no record of past PMP relationships within the participating Humana Healthy Horizons PMP panel or the PMP assignment history file.

Member-initiated PMP changes

Members select a PMP from our health plan's provider directory. Members have the option to change to another participating PMP with cause as often as needed. Members initiate the change by calling Member Services. PMP changes are effective on the first day of the month following the requested change.

Referrals for release due to ethical reasons

Humana Healthy Horizons has no moral or religious objections for providing any covered services; however, you are not required to perform any treatment or procedure that is contrary to your conscience, religious beliefs or ethical principles, in accordance with 42 CFR 438.102. Humana Healthy Horizons will inform members of the decision not to cover the requested service and how to access the requested service from another provider.

Verifying member eligibility

All new Humana Healthy Horizons PathWays members receive a member ID card. After the issuance of the initial card, a new card is issued only when the card information changes, if a member loses a card or if a member requests an additional card.

1. The member ID card is used to identify a Humana Healthy Horizons PathWays member; it does not guarantee eligibility or benefits coverage. Members may disenroll from Humana Healthy Horizons and retain their ID card. Likewise, members may lose PathWays eligibility at any time. Therefore, it is important that you verify member eligibility prior to every service. Except in emergencies, you must verify member eligibility and request healthcare insurance information before rendering services. You can verify member eligibility and obtain information for other healthcare insurance coverage on file by accessing Availity Essentials™ at **www.availity.com**.
2. Verification for Indiana PathWays for Aging is completed by the enrollment broker and the state to ensure all eligibility requirements are met and correct.

Member disenrollment

Indiana PathWays for Aging members can change their MCE only at the following intervals:

- Within 90 days of starting coverage
- At any time their Medicare and PathWays plans become unaligned
- Once per calendar year, for any reason
- During the Medicare open enrollment window (mid-October-mid December) to be effective the following calendar year

Additionally, any member may change their MCE for just cause. Determination as to whether a member has met one of these reasons is solely the determination of the enrollment broker and the state. Valid reasons include but are not limited to the following:

- Receiving poor quality of care or circumstances determined by the office or its designee to constitute poor quality of healthcare coverage
  - Poor quality of care includes failure to comply with established standards of medical care administration and significant language or cultural barriers.
- Failure to provide covered services
- Failure of the MCE to comply with established standards of medical care administration
- Lack of access to providers experienced in dealing with the member's healthcare needs
- Significant language or cultural barriers
- Corrective action levied against the MCE by the office
- Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence
- Determination that another MCE's formulary is more consistent with a new member's existing healthcare needs
- Lack of access to medically necessary services covered under the MCE's contract with the state
- A service not covered by the MCE for moral or religious objections
- Related services required to be performed at the same time and not all related services available within the MCE's network and member's provider determines receiving services separately will subject member to unnecessary risk
- The member's PMP disenrolls from the member's current MCE and reenrolls with another MCE. If a member's PMP disenrolls from the member's current MCE and reenrolls in a new MCE, the member can change plans to follow the member's PMP to the new MCE.

Members must file a grievance with their MCE before a determination will be made upon their just cause request. If the member remains dissatisfied with the outcome, the member can contact the enrollment broker to request disenrollment. Members may submit requests to change MCEs to the enrollment broker verbally or in writing. The MCE shall provide the enrollment broker's contact information and explain that the member must contact the enrollment broker with questions about the process.

The enrollment broker reviews the request and makes a disenrollment recommendation. In making the disenrollment recommendation, the enrollment broker will review a copy of the member's grievance and appeal record from the MCE, to confirm that the grievance and appeal process was exhausted. All enrollment broker reviews that result in a recommendation to approve MCE disenrollment are sent to the state, which makes the final determination on the request.

Chapter 4: Member rights and responsibilities

Member rights

Members have the right to:

- Receive care in a culturally competent manner.
- Be assured that their information will be kept confidential, as defined by federal and state statutes or regulations.
  - Be assured that member's right to appeal adverse action affecting services will be displayed in public areas of provider's facility in accordance with regulatory rules.
  - Not be billed for covered services, with the exception of applicable copayments or other cost-sharing requirements, or for a bill that was denied due to incorrect billing. Provider may bill a member for a service not covered by the applicable Indiana PathWays for Aging product or plan, provided the member was previously informed of the noncovered service and agreed in advance in writing to pay for such service.
- Be treated with dignity and respect when getting health services.
- Be given information on their medical benefits and plan.
- Be given privacy for themselves and their medical records.
- Be given easy-to-understand explanations of their medical problems and treatment choices.
- Be involved in decisions about treatment choices.
  - Select or be assigned to a new PMP when such a change is mutually agreed to by Humana Healthy Horizons and the member, when a PMP is terminated from coverage or when a PMP change is part of the resolution to an appeal.
- Be able to make recommendations regarding the members' rights and responsibilities policy.
- Be able to review their service plan of care if they are receiving HCBS.
- Be able to request a fair hearing when not given the choice of Home and Community-Based Waiver Services as an alternative to institutional level of care, who are denied the service(s) of their choice or the provider(s) of their choice, or whose services are denied, suspended, reduced or terminated. The right to request a fair hearing includes providing a notice of action.
- Get care 24 hours a day, seven days a week.
- Get timely answers to their complaints or appeals.
- Appeal decisions made about healthcare they receive.
- Use buildings and services that meet the standards of the Americans with Disabilities Act (ADA). This means that members with disabilities or physical problems can get into medical buildings and use important services.
- Get a second opinion.
- Receive a copy of their medical records and request that they be changed or corrected.
- Say no to treatment or therapy. If they say no, the healthcare provider or health plan must talk to them about what could happen, and a note must be placed in their medical record about the treatment refusal.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, in accordance with federal regulations.
- Be free from any restrictions on freedom of choice among network providers.
- Receive information on available treatment options and alternatives, presented in a way that is right for their condition and that they can understand.
- Request a practitioner that has their same race, ethnicity and language if such a practitioner is available in the network.

PathWays member responsibilities

Members have the following responsibilities:

- Tell their provider (PMP) about medical conditions to the best of their ability
- Call their personal provider (PMP) for all medical care.
- Keep all appointments and call to cancel or reschedule as soon as possible.
- Tell their provider if they do not understand what is being communicated about their condition, care or what they need to do
- Call their provider if they are not sure they are having a true emergency
- Follow the rules of their provider's office

Chapter 5: Provider rights and responsibilities

Provider rights

Please call the Provider Services Contact Center at **866-274-5888** if you have questions about disenrollment reasons or procedures.

While acting in your lawful scope of practice, you have the right to advise members about their health status or medical care or treatment as provided in section 1932(b)(3) of the Social Security Act or 42 CFR 438.102. This includes:

- Discussing with members treatment or nontreatment options or social supports, including any alternative treatment that may be self-administered, that may not reflect Humana Healthy Horizons' position or may not be covered by Humana Healthy Horizons
- Providing any information the member needs to decide among all relevant treatment and service options
- Discussing the risks, benefits and consequences of treatment or nontreatment

Provider responsibilities

You are responsible for adhering to provisions from your agreement with Humana Healthy Horizons, including the following:

- Provide members all covered services that are within the normal scope of and in accordance with provider's licenses and/or certifications and members' access to those covered services through making appointments or otherwise contacting the provider.
- Respect members' right to participate in decisions regarding their healthcare, including the right to refuse treatment and to express preferences about future treatment decisions.
- Render emergency services without a requirement for prior authorization. A member who has an emergency medical condition, as defined by applicable law, shall not be liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition.
- As laboratory service providers, meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988.
- Adhere to marketing restrictions defined in federal and state regulations as applicable and any other requirements described in the contract.
- Participate and cooperate in internal and external quality management or quality improvement activities, such as monitoring, utilization review, peer review and/or appeal procedures established by Humana Healthy Horizons and/or FSSA.
- Follow the standards for medical necessity as required under the contract and the regulatory rules.
- Participate in administration-directed and -facilitated provider forums, particularly for administration's agenda on LTSS.
- Comply with necessary and authorized member communications, movement and/or reassignment, as required or compelled by FSSA or authorized enforcement body.
- Use the **https://www.in.gov/medicaid/providers/files/pa-form.pdf** for submission of prior authorization requests.
- Submit promptly all information needed for Humana Healthy Horizons to make payment for authorized items, services or procedures under the member's PathWays health benefit plan.
- Submit timely, complete and accurate encounter claims in accordance with contract requirements and applicable regulations.
- Submit all claims that do not involve a third-party payer for services rendered to Humana Healthy Horizons members within 90 days of the date of service. This timely filing requirement will be waived in cases of member retroactive coverage.
- Ensure claims are submitted properly and within the required time frames. Humana Healthy Horizons only accepts uniform claim forms that have been approved by FSSA and completed according to administration guidelines.
- Accept payment from Humana Healthy Horizons as payment for services performed and not from FSSA or the member.
- Maintain all records relating to services provided to members for a 10-year period and make all member medical records or other service records available for the purpose of quality review conducted by FSSA, or its designated agents, both during and after the term of the agreement. The medical records shall be on paper or in an electronic format.

- Maintain a primary medical record for each member that contains sufficient medical information from all providers involved in the member's care to ensure continuity of care.
- Give reasonable access to premises, physical facilities, equipment and records for financial and medical audit purposes both during and after the term of the agreement to authorized representatives of FSSA or other state and federal agencies.
- Provide a copy of a member's medical record at no charge upon reasonable request by the member and facilitate the transfer of the member's medical record to another provider at the member's request.
- Submit any information, including reports and clinical information, to Humana Healthy Horizons in a timely manner that is necessary for Humana Healthy Horizons to perform its obligations under the contract and the regulatory rules.
- Participate in formal periodic provider reviews conducted by Humana Healthy Horizons.
- Comply with CAPs required by Humana Healthy Horizons.
- Cooperate with Humana Healthy Horizons on any suspected allegation of abuse and cooperate fully with Humana Healthy Horizons or its designees' investigation of abuse, neglect, self-neglect and exploitation allegations and be receptive to any related Humana Healthy Horizons subject matter training and in-service or corrective action.
- Comply with program integrity requirements of the contract and the regulatory rules, as applicable, as a condition of receiving any amount of payment.
- Continue to provide services to members in the event of termination or expiration of your Humana Healthy Horizons agreement for any reason, other than for reasons of quality of care or fraud, under the terms and conditions of the agreement until the member is discharged from an inpatient facility or the active course of treatment is completed, whichever time period is greater. This continuity of care provision shall survive any termination or expiration of the agreement.
- Terminate the Humana Healthy Horizons agreement with a written notice provided at least 90 calendar days in advance of the termination or as otherwise specified in your Humana Healthy Horizons agreement.
- Advise members about their health status, medical care or treatment, regardless of whether benefits for such care are provided as covered services if the provider is acting within the lawful scope of practice.
- Comply with applicable requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and 42 CFR. 438 Subpart K, including requirements that treatment limitations applicable to mental health or substance use disorder (SUD) benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by Humana Healthy Horizons and there are no separate treatment limitations that are applicable only with respect to mental health or SUD benefits. Comply with Humana Healthy Horizons' operation of a unified appeals and grievance process with its companion Dual Eligible Special Needs Plan (D-SNP) (405 IAC 1.1 et al. and 42 CFR 422.629 through 42 CFR 422.634), as applicable to the member's PathWays health benefit plan.

Additional responsibilities of behavioral health service providers

- All members receiving inpatient behavioral health services must be scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge.
- Behavioral health network providers must notify the MCE within five calendar days of the member's visit, and submit information about the treatment plan, the member's diagnosis, medications and other pertinent information.
- Every network provider, including behavioral health providers, should ask and encourage members to sign a consent form that permits release of SUD treatment information to Humana Healthy Horizons and to the PMP or behavioral health provider, if applicable.
- Providers must participate in not less than quarterly continuity of care meetings hosted by Humana Healthy Horizons and/or state-operated or state-contracted (psychiatric) facilities.
- Providers must participate in discharge planning meetings with Humana Healthy Horizons' assigned care coordinators.

Additional responsibilities of PMPs

PMPs are responsible for:

- Supervising, coordinating and providing initial and primary care to members
- Initiating referrals for specialty care as needed
- Maintaining the continuity of member care 24 hours a day

In addition, Humana Healthy Horizons PMPs play an integral part in coordinating healthcare for our members by providing:

- Assistance with coordinating a member's overall care, as appropriate for the member
- Continuity of the member's total healthcare
- Early detection and preventive healthcare services
- Elimination of inappropriate and duplicate services

PMP care coordination responsibilities include, at a minimum, the following:

- Treating Indiana PathWays for Aging members with the same dignity and respect afforded to all members including standards of care and hours of operation.
- Maintaining continuity of the member's healthcare.
- Identifying the member's health needs and taking appropriate action.
- Providing phone coverage for handling member calls 24 hours a day, seven days a week. Refer to the appointment standards section for more details.
- Making referrals for specialty care and other medically necessary services, both in and out of network, when such services are not available within the Humana Healthy Horizons network.
- Following all prior authorization policies and procedures as outlined in this manual.
- Complying with the quality standards of Humana Healthy Horizons and FSSA as outlined in this manual.
- Discussing advance medical directives with members as appropriate.
- Maintaining clinical records, including information about pharmaceuticals, referrals, inpatient history and documentation of all PMP and specialty care services, etc., in a complete and accurate medical record that meets or exceeds FSSA specifications.
- Obtaining member records from facilities visited by Humana Healthy Horizons-covered members for emergency or urgent care if notified of the visit.
- Ensuring demographic and practice information is up to date for directory and member use.
- Referring members to behavioral health providers and arranging appointments, when clinically appropriate.
- Assisting with coordination of the member's overall care, as appropriate for the member.
- Recommending referrals to specialists, as required.
- Participating in the development of care management care plans and notifying Humana Healthy Horizons of members who may benefit from care management.
- Understanding and agreeing that provider performance data can be used by Humana Healthy Horizons.
- Maintaining formalized relationships with other PMPs to refer their members for after-hours care, during certain days and for certain services or other reasons to extend their practices.
- Forwarding medical records or copies of records when a member changes a PMP to the new PMP or practice within 10 days of the receipt of request. The PMP's office shall have the member sign a release of medical records before a medical record transfer occurs.

Appointment wait time and access standards

Services are to be available 24/7 based on medical necessity and hours of operations should be identical to those that are offered to members with other health plans, such as commercial and Medicare. Taking into account the urgency of the need for services, you are expected to meet the following timely access to care standards:

Provider type	Appointment category	Appointment standards
PMP	Routine—without physical or behavioral symptoms	Not to exceed 30 calendar days
	Routine—with physical or behavioral symptoms such as persistent rash, recurring high grade temperature, nonspecific pain, fever	Within one week or five business days, whichever is earlier
	Urgent—without physical or behavioral symptoms	Within 24 hours
	Emergency	24 hours a day/7 days a week

Provider type	Appointment category	Appointment standards
PMP	Routine gynecological exam/new member	30 calendar days
	Annual physical exam	90 calendar days
Specialist	Routine	Not to exceed 60 calendar days
	Urgent	Within 24 hours
	Emergency	24 hours a day/7 days a week
Behavioral health	Non-life-threatening emergency	Not to exceed 6 hours
	Urgent	Not to exceed 24 hours
	Emergency	24 hours a day/7 days a week
	Initial visit for routine care	Not to exceed 10 business days
	Follow-up routine care—without physical or behavioral symptoms	Not to exceed 30 calendar days based on the condition
	Follow-up routine care—with physical or behavioral symptoms	Within 1 week or 5 business days, whichever is earlier
	Outpatient follow-up appointment	Within 7 days following discharge for the inpatient behavioral health hospitalization
Aftercare	Posthospital discharge appointment	Within 7 calendar days after discharge
Durable medical equipment	Nonspecialized equipment or supplies	No more than 30 business days from the time-of-service order
	Specialized equipment or supplies	No more than 120 business days from the time-of-service order
Environmental accessibility adaptions	Home modifications	No more than 90 business days from time-of-service approval
Consultative clinical and therapeutic services for informal caregivers		No more than 60 business days from time-of-service approval

Missed appointments

When members miss scheduled appointments, your office is responsible for contacting the member within 24 hours to attempt to reschedule the appointment. You are responsible for documenting communication attempts in the member's file.

Requirements for after-hours availability

PMPs must provide after-hours coverage available 24 hours a day, seven days a week. PMPs or a designated provider must answer member phone calls after normal business hours in English and Spanish. After-hours coverage may include an answering service or a shared-call service with other medical providers.

Provider accessibility monitoring

Humana Healthy Horizons will annually, or sooner when directed by FSSA, conduct surveys to assess the accessibility and availability of provider services outside of normal business hours.

The survey will assess the members' ability to contact the PMP 24 hours a day, seven days per week, for emergent and urgent needs, to include holidays.

ADA compliance

All Humana Healthy Horizons contracted healthcare providers must comply with the ADA, as well as all applicable state and/or federal laws, rules and regulations. More details are available in your Humana Healthy Horizons provider agreement. Humana Healthy Horizons develops individualized care plans (ICPs) that consider members' special and unique needs. Members who need interpretation services can call the number on the back of their member ID cards, call the Humana Healthy Horizons Concierge Service for Accessibility at **877-320-2233** or visit **http://humana.com/accessibility-resources** to schedule interpretation services at least 48 hours prior to an appointment. While last minute interpreters may be available, this cannot be guaranteed and thus scheduling interpretation services is preferred. Oral interpretation services are provided free to members when communicating with Humana Healthy Horizons. Please see the Interpreter Services section of this manual for more information regarding American Sign Language interpreters, linguistically trained interpreters for visually impaired customers, TTY services, and written materials in alternative formats.

Consideration and accommodation of member special needs

Healthcare providers must also meet all accessibility requirements specified by their Humana Healthy Horizons contracts. Humana Healthy Horizons' minimum provider agreement requirements include the following. More details are available in the Humana Healthy Horizons provider agreement.

- Provide physical access, reasonable accommodations and accessible equipment for members with physical or mental disabilities, in accordance with 42 CFR § 438.206(c)(3).
- Identify provider locations that provide physical access, accessible equipment and/or reasonable accommodations for members with physical or cognitive disabilities.

Humana Healthy Horizons' provider directory contains information on:

- Physical accessibility
- Accessible equipment
- Reasonable accommodations for members with physical or cognitive disabilities

Additional educational resources are available on our website to help you learn more about ADA requirements and best practices for maintaining accessible and inclusive practices, such as tips and suggestions for providing inclusive and member centric care to those with intellectual disabilities, speech impairments or difficulties and more.

Nondiscrimination

Humana Healthy Horizons is an equal opportunity organization. Provider participation decisions are nondiscriminatory and based on merit and business needs, not race, color, national origin, disability, age or gender or any other factor protected by law.

Provider nondiscrimination information

Humana Healthy Horizons employs a member advocate/nondiscrimination coordinator to support and ensure members receive their services in a nondiscriminatory manner. Providers will not discriminate against any member based on race, color, age, national origin, sex, sexual orientation, gender identity, genetic information, income status, Indiana PathWays for Aging membership or disability and will not use any policy or practice that has the effect of discriminating in such manner.

Affirmative action, diversity and the Cultural Competency Plan

We are committed to embracing diversity in the provision of member services and providing fair and equal opportunities for all qualified minority businesses. Humana Healthy Horizons wishes to accommodate religious and cultural preferences of all members and will seek provider input that might be useful in meeting member preferences. To request a paper copy of Humana Healthy Horizons' Cultural Competency Plan, please contact Humana Healthy Horizons Member Services at **866-274-5888**, Monday through Friday, 8 a.m. – 8 p.m., Eastern time), or call your Provider Education/Outreach Representative. A copy of Humana Healthy Horizons' Cultural Competency Plan will be provided at no charge.

You are responsible for arranging for oral interpretation services for members seeking healthcare-related and LTSS services in your office or service location. Providers that provide 24-hour access to healthcare-related services in their location or via telephone, such as PMPs and hospital emergency departments, must provide members with 24-hour oral interpreter services, either through interpreters or telephone services, for example, TTY services for hard-of-hearing

members, oral interpreters and American Sign Language interpreters. If you have members who require interpretive services, you may contact the Humana Healthy Horizons Concierge Service for Accessibility at **877-320-2233**, Monday through Sunday, 8 a.m. – 8 p.m., Eastern time).

Humana Healthy Horizons conducts site surveys of all office locations that include PMPs and gynecologists during initial credentialing and again every three years during recredentialing. Defined high-volume specialist office locations also will receive a site survey during recredentialing. The site survey will assess office compliance with Humana Healthy Horizons' organizational standards, including ADA compliance, accessibility and accommodations for members with physical or cognitive disabilities.

Other significant Humana Healthy Horizons policies affecting providers

- Provider accessibility: See **Appointment wait time and access standards** in Chapter 5 of this manual for more information.
- Provider compliance: See **Provider accessibility monitoring** in Chapter 5 of this manual for more information.
- Provider enrollment and disenrollment: See **Continuity of care requirements** in Chapter 9 and **Provider rights and responsibilities** in Chapter 5 of this manual for more information.
- CLIA certification: See **Chapter 14: Credentialing and recredentialing** in this manual for more information.
- Skilled nursing facilities: Humana Healthy Horizons will accept into the network any skilled nursing facility that agrees to Humana Healthy Horizons' standard provider agreement and meets all applicable state and federal participation requirements for the first three years of the program.
- LTSS providers: Humana Healthy Horizons will accept into the network any LTSS provider that agrees to the contractor's standard provider agreement and meets all applicable state and federal participation requirements for the first three years of the program.
- Provider terminations and notifications: Humana Healthy Horizons notifies providers of participation agreement (i.e., contract) termination or nonrenewal according to the terms outlined in the participation agreement or, if not specified, then no less than 90 calendar days prior to the effective termination date or as otherwise required by state or federal regulations or accreditation requirements. Providers must provide Humana Healthy Horizons with notice according to the terms outlined in the participation agreement regarding any termination or nonrenewal to allow Humana Healthy Horizons to comply with the member notification time frames required by applicable state and/or federal law, accreditation standards and FSSA contract requirements. The notification to Humana Healthy Horizons must be in writing and comply with the contractual requirements for notice to initiate the participation agreement termination. See your provider agreement for more details.
- Provider communications: See **Chapter 5: Provider rights and responsibilities** of this manual for more information.

Advance directives

PMPs have a responsibility to discuss advance medical directives at the first medical appointment with adult members who are of sound mind. The discussion should subsequently be charted in the permanent medical record of the member. A copy of the advance directive should be included in the member's medical record inclusive of other advance directives for mental health. The PMP should discuss potential medical emergencies with the member and document that discussion in the member's medical record.

For more information on advance directives and to find forms available to you, please visit **https://www.in.gov/health/cshcr/indiana-health-care-quality-resource-center/advance-directives-resource-center/**.

Critical incident reporting

Providers are expected to protect the health and welfare of all members and to address identified issues related to quality of care and quality of service. Indiana is a mandatory reporting state. Everyone, including providers, are required by law to report cases of suspected abuse, neglect or exploitation of an endangered adult. HCBS providers are required to submit an incident report for any reportable incident within forty-eight (48) hours of the time of the incident or becoming aware of the incident. However, if an initial report involves a member death, or an allegation or suspicion of abuse, neglect or exploitation, the report must be submitted within twenty-four (24) hours of "first knowledge" of the incident. Any incident involving abuse, neglect or exploitation and/or a member death must be immediately reported to APS via the Adult Protective Services website, **https://www.in.gov/fssa/da/adult-protective-services/** or by

calling the APS Hotline at **800-992-6978**. All other Critical Incidents must be reported through the IFUR tool at **https://ddrsprovider.fssa.in.gov/IFUR/**. If IFUR is not functioning, reports can be sent to FSSA OMPP Quality Improvement at **OMPPQualityImprovement@fssa.in.gov** on the blank critical incident form.

Providers are expected to protect the health and welfare of all members and to address identified issues related to quality of care and quality of service. Indiana is a mandatory reporting state. Everyone, including providers, are required by law to report cases of suspected abuse, neglect or exploitation of an endangered adult. Once reporting is complete, providers and their staff are expected to cooperate with critical incident investigations.

Critical incident types are outlined in the section that follows. For the purposes of this manual, critical incidents are categorized as (a) HCBS critical incidents, and (b) abuse, neglect and exploitation (ANE) critical incidents.

Critical incidents

Critical incidents in the HCBS setting are defined in accordance with Indiana Administrative Code 455 IAC 2-8-2, Protecting Individuals (Unusual Occurrence; Reporting), also known as incidents falling into the category of unusual occurrences, including the following, as applicable:

- Any major injury to individual, including, but not limited to:
  - Fracture or broken bones
  - Greater than a first degree burn
  - Choking incident that requires intervention
  - Lacerations or contusions
- Injuries of an unknown origin
- Suicidal ideation or suicide attempt that had the potential to cause physical harm, injury, or death
- Arrest/Police involvement on behalf of member
- Admission of an individual to a nursing facility, excluding respite stays
- Member elopement or missing person
- Inadequate formal or informal support for a member, including inadequate supervision which endangers the member
- Medication errors resulting in outcomes that require medical treatment beyond an emergency room or physician evaluation or monitoring vital signs
- Any instance of restrictive intervention (including chemical or physical restraints, or seclusion) that results in harm to the member
- Living area or residence that risks health and safety due to:
  - Significant interruption of a major utility
  - Environmental, structural or other significant issue
- Environmental or structural problems associated with a dwelling where individuals reside that compromise the health and safety of the individuals
- Disturbance or threat to public safety created in the community by the individual
- Police arrest of member or any person responsible for the care of the member
- Falls with injury, in accordance with the U.S. Center for Disease Control's (CDC) Behavioral Risk Factor Surveillance System (BRFSS)
- A residential fire that displaces, causes personal injury, relocation or property loss
- Suspected or observed criminal activity by:
  - Provider's staff when it affects or has the potential to affect member care
  - A family member of a member receiving services when it affects or has the potential to affect the member care or services
  - The member receiving services

Abuse, neglect and exploitation critical incidents

The following types of critical incidents are not considered HCBS critical incidents, but they do meet the definition of and are categorized as abuse, neglect and exploitation critical incidents. They include:

- Alleged, suspected, reported, observed, or actual abuse/battery, assault, neglect, or exploitation of a member.
- Death of a member

Noncompliance of HCBS providers

Humana Healthy Horizons works with HCBS providers to correct noncompliance with critical incident reporting and management. If noncompliance persists, Humana Healthy Horizons will issue one written warning before implementing a corrective action plan (CAP). When a CAP is implemented, Humana Healthy Horizons will monitor that CAP by:

- Requesting and obtaining information from the provider
- Conducting on-site inspections
- Meeting with an individual or the individual's legal representative as applicable
- Reviewing provider records and the records of an individual
- Conducting follow-up inspections as frequently as deemed necessary to determine compliance required in the CAP

In cases when providers are not compliant with critical incident management requirements, Humana Healthy Horizons may terminate such providers only after an investigation has been completed and all other options are exhausted; specifically, Humana Healthy Horizons should make every attempt to bring the provider into compliance via technical assistance, education or other similar resources.

Only if such technical assistance and education are ineffective should Humana Healthy Horizons issue a CAP. If the CAP does not bring the provider into compliance, termination for noncompliance is acceptable. In addition to submitting non-HCBS critical incident reports to the appropriate state authority, Humana Healthy Horizons requires that all providers in the Humana Healthy Horizons network submit HCBS critical incident reports via the IFUR tool available at **https://ddrsprovider.fssa.in.gov/IFUR/** in accordance with the provider initial incident reporting process referenced above. This requirement applies to all network providers with knowledge of a critical incident that occurred in an HCBS setting.

Noncompliance that is repeated or that endangers the health or welfare of an individual or general health and safety will result in provider termination. A 30 day termination notice will be provided to the provider and members unless there is a health and safety concern.

Member ANE

Who is an endangered adult?

An Indiana PathWays for Aging member may be considered an endangered adult if the member is incapable by reason of mental illness, intellectual disability, dementia, habitual drunkenness, excessive drug use or other physical or mental incapacity, of managing or directing the management of the individual's property or of providing self-care or harmed or threatened with harm as a result of neglect, battery or exploitation of the individual's personal services and property.

What are the definitions of ANE in Indiana?

According to the Indiana Administrative Code, the following ANE definitions apply:

Abuse/battery

- A person who knowingly or intentionally:
  - Touches another person in a rude, insolent or angry manner
  - Places any bodily fluid or waste on another person in a rude, insolent or angry manner

Signs and symptoms of physical abuse

- Sprains, dislocations, fractures or broken smaller bones (e.g., wrist, ankle, finger)
- Burns from cigarettes, appliances or hot water
- Abrasions on arms, legs or torso that resemble rope or strap marks
- Cuts, lacerations or puncture wounds
- Fractures of long bones and ribs
- Internal injuries evidenced by pain, difficulty with normal functioning of organs and bleeding from body orifices
- Bruises, welts or discolorations of the following types:
  - Bilateral (i.e., matching) bruises on both arms that may indicate the member was shaken, grabbed or restrained.
  - Bilateral bruising of the inner thighs that may indicate sexual abuse
  - Wrap-around bruises encircling the member's arms, legs or torso that may indicate the individual was physically restrained
  - Clustered bruising on the trunk or another area of the body
  - Bruising in the shape of an object that may have been used to inflict injury

- Multicolored bruises that may indicate the person sustained multiple traumas over time (i.e., presence of old and new bruises at the same time)
- Injuries healing through secondary intention that indicate the member did not receive appropriate treatment, including, but not limited, to:
  - Lack of bandages on injuries or stitches when indicated
  - Evidence of unset bones
  - Signs of traumatic hair loss, possibly with hemorrhaging below scalp
  - Signs of traumatic tooth loss
  - Injuries that are incompatible with the member's explanation
  - Inconsistent or conflicting information from family members about how injuries were sustained
  - A history of similar injuries and/or numerous or suspicious hospitalizations
  - A history of member being brought to different medical facilities for treatment to prevent medical practitioners from observing patterns
  - Delays between the onset of injury and seeking of medical care
  - Signs of confinement (e.g., member is locked in a room)

Signs and symptoms of sexual abuse

- Vaginal or anal pain, irritation or bleeding
- Bruises on external genitalia, inner thighs, abdomen or pelvis
- Difficulty walking or sitting not explained by other physical conditions
- Stained or bloody underclothing
- Sexually transmitted diseases
- Urinary tract infections
- Signs of psychological trauma, including excessive sleep, depression or fearfulness

Neglect

- The endangered adult or the person who takes care of the endangered adult is unable to, or fails to, provide adequate food, clothing, shelter or medical care.

Indicators of an issue with neglect

- Weight loss that cannot be explained by other causes
- Lack of toileting that causes incontinence
- Members sitting in their own urine and feces.
- Increased falls and agitation
- Indignity and skin breakdown
- Uncommon pressure ulcers
- Evidence of inadequate or inappropriate use of medication
- Neglect of personal hygiene; emotional withdrawal
- Lack of assistance with eating, drinking, walking, bathing and participating in activities
- Little or no response to requests for personal assistance

Exploitation

- Exploitation of the individual's personal services or property: A person who recklessly, knowingly or intentionally exerts unauthorized use of the personal services or property of the following, for the person's own profit or advantage or for the profit or advantage of another person:
  - An endangered adult
  - An adult dependent
- Includes sexual misuse as well as the use of the endangered adult's labor without pay or exerting unauthorized control over the finances or property of the endangered adult

Indicators of exploitation

- Caregiver expressing excessive interest in the amount of money being spent on the member
- Missing belongings or property
- Suspicious signatures on checks or other documents
- Signatures not matching the member's

- Signatures and other writing by a member who cannot write
- Absence of documentation about financial arrangements
- Implausible explanations about the member's finances from the member or the caregiver
- An unaware member or a member who does not understand financial arrangements that have been made on the member's behalf
- Unpaid bills
- Family and caregivers:
  - Do not provide an opportunity for the member to speak on the member's behalf
  - See others who could impact a member's situation without the presence of the member
  - Have an attitude of indifference or anger toward the member
  - Blame the member for the member's condition
    - For example, an accusation that incontinence is a deliberate act
  - Show aggressive behavior toward the member
    - Threaten
    - Insult
    - Harass

How to file a report

Indiana is a mandatory reporting state, meaning everyone is required by law to report cases of suspected neglect, battery or exploitation of an endangered adult to an APS unit or law enforcement. All reports are secured and kept confidential.

Please note that APS is not an emergency responder. If you believe someone is in danger, call 911 immediately. Individuals may file a report online or by calling the state hotline or an APS field office:

- https://aps-govcloud.my.site.com/APSOnlineReport/s/
- State hotline: **800-992-6978**

The APS program receives and investigates reports regarding adults within the state of Indiana who may be endangered and, as appropriate, coordinates a proper response to protect endangered adults who are victims of abuse, neglect or exploitation.

APS field investigators operate out of the offices of county prosecutors throughout the state. If the APS unit has reason to believe that an individual is an endangered adult, the unit shall investigate the complaint or cause the complaint to be investigated by law enforcement or another agency and decide whether the individual reported is an endangered adult.

Hospitals, other acute facilities, and comprehensive care and residential care facilities

Staff and personnel of acute care facilities and comprehensive care and residential care facilities licensed by the Indiana Department of Health (IDOH), including ambulatory surgery centers and hospitals, should submit incident reports online via the IDOH Gateway https://gateway.isdh.in.gov/Gateway/SignIn.aspx. Incident follow-up and/or additional information regarding an incident also may be submitted via the Incident Reporting System.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance

The task of handling member records and related administration functions is accomplished in strict compliance HIPAA. Member files are kept confidential at all times. Providers should take some or all of the following precautions:

- Only request and work with protected health information (PHI) related to treatment, payment or healthcare operations.
- Email should not be used to transfer files with member info unless encrypted.
- Fax machines should be positioned for privacy.
- Fax numbers should be confirmed before sending information to Humana Healthy Horizons.
- Leave minimum data on voicemail.

Provider-based marketing activities

You may advertise or utilize marketing materials, logos, trade names, service marks or other materials created or owned by Humana Healthy Horizons after obtaining Humana Healthy Horizons' written consent. You cannot acquire any right or title to Humana Healthy Horizons-approved materials.

Provider training

As part of our partnership with you, we offer education and training for key requirements of the Indiana PathWays for Aging program, as well as new and existing provider training and information resources on useful industry and Humana Healthy Horizons-specific topics. You will have a Provider Education/Outreach Representative assigned to assist you with ongoing training. Each year, you must complete annual required compliance training and attest that you have done so. You can access the training and attestation instructions online at **https://www.humana.com/provider/news/provider-compliance**.

In addition to the required annual compliance-based training, we offer ongoing education through multiple channels, with options and opportunities for all provider types depending on need and availability. Provider Education/Outreach Representatives work with their assigned providers to develop customized training programs, which are available online through an e-learning library of more than 300 courses. Topics include business ethics, continuity of care, behavioral health screenings in a primary care setting, self-determination, telehealth, advance directives, working with care coordination teams, social determinants of health (SDOH), health equity, quality improvement and value-based payment (VBP). Training and other information and resources are available online at **https://www.humana.com/provider/**.

Required annual compliance training

Humana Healthy Horizons' annual compliance-based provider training program is ongoing. Throughout the year, we send multiple reminders to providers via email, fax and phone using multiple communication mechanisms to ensure providers' compliance with our required annual training. Our annual web-based training is delivered through Humana Healthy Horizons' provider portal and our **Humana.com** website and includes the following:

- Indiana PathWays for Aging program updates or updates to relevant Humana Healthy Horizons policies and procedures
- Health, safety and welfare training on ANE, how to handle and report, as well as critical incident reporting
- Annual training on topics such as ethics, cultural competency, program integrity (including fraud, waste and abuse), compliance with ADA, advance directives and electronic visit verification (EVV).

Chapter 6: Cultural competency and linguistic services

Cultural competency

Humana Healthy Horizons recognizes cultural differences and the influence that race, ethnicity, language and socioeconomic status have on the healthcare experience and health outcomes. We are committed to developing strategies that eliminate health disparities and address opportunities for better care. Communication is paramount in delivering effective care. Mutual understanding may be difficult during cross-cultural interaction between members and providers. Some disparities may be attributed to miscommunication between providers and members, language barriers, cultural norms, and beliefs and attitudes that determine healthcare-seeking behaviors. Providers can address racial and ethnic gaps in healthcare with an awareness of cultural needs and improving communication with a growing number of diverse members.

Cultural competency refers to a set of interpersonal skills that promote the delivery of services in a culturally competent manner to all Medicaid managed care members—including those with limited English proficiency and diverse cultural and ethnic backgrounds—allowing for individuals to increase their understanding, appreciation, acceptance and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Medicaid managed care members (as required by 42 CFR §438.206).
Subculture is a term that describes ethnic, regional, economic or social groups that exhibit characteristic behavior patterns that distinguish them from others within an embracing culture or society. Understanding the many different subcultures that exist within our own culture also is an important aspect of cross-culture healthcare.

Participating providers are expected to provide services in a culturally competent manner that includes removing all language barriers to service and accommodating the special needs of the ethnic, cultural and social circumstances of the member. Participating providers also must meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the ADA and the Rehabilitation Act of 1973.

Cultural competence in a hospital or care system produces numerous benefits for the organization, members and community. Organizations that are culturally competent have improved health outcomes, increased respect and mutual understanding from members, and increased participation from the local community. Additionally, organizations that are culturally competent may have lower costs and fewer care disparities.
Providers striving to deliver high-quality care to all members understand that cultural factors influence members' health beliefs, behaviors and responses to medical issues. This section provides guidance for how to consider cultural differences as you build effective relationships with your members during shared decision making.

Learn how to interact with diverse members

- Keep an open mind. Remember that each member has a unique set of beliefs and values, and members may not share yours.
- Ask members about their beliefs regarding their health condition (e.g., "What do you think caused the problem? What do you fear most about the sickness? Why do you think it started when it did?"). This information will allow you to make the most of your interactions during shared decision making. Recognize and understand that the meaning or value of health prevention, intervention and treatment may vary greatly among cultures, specifically for behavioral health.
- Attend cultural competence training at your organization, through Humana's cultural competency training offerings, or through a continuing education program.
- Be aware of your own culture and how that may affect how you communicate with your members.

Reach out to cultural brokers to help you learn more about the differences and similarities between cultures. They can tell you how to better address the members you serve regarding cultural appropriateness, beliefs about health and barriers in communication. Cultural brokers might include healthcare and social service workers and cultural group leaders. Ask them to suggest resources you can use to learn more about your members' cultures.

Know what you don't know. You won't be able to learn about every aspect of every member's culture. Don't be afraid to let your members know that you are unfamiliar with their culture. Invite them to explain what is important to them and how getting and staying well works in their community.

Keep in mind that culture is not homogenous. There is great diversity among individuals—even in the smallest cultural group. Remember, culture changes over time, especially when one cultural group is exposed to and influenced by another culture.

Provide culturally appropriate decision aids

Ask your members about their learning preferences so you can present information better during shared decision making. Find out if your members prefer for you to offer materials in print, video or audio format. Ask your members if they would like you to explain by talking, using a model, making a drawing or demonstrating how to do something. You may find your members want you to present information in a variety of ways.

Make sure that multimedia decision aids (videos, DVDs, CDs, audiotapes), other health resources for treatment and other intervention materials reflect the cultures of the members you serve.

When possible, offer decision aids, treatment summaries and educational materials that have culturally relevant descriptions of risks and benefits of treatment options. The best decision aids meet cultural and health literacy or plain language standards.

Implicit bias

Implicit bias, a phrase that is not unique to healthcare, refers to the unconscious prejudice individuals might feel about another thing, group or person.

In healthcare, implicit bias can shape the way medical providers interact with members. Because everyone is susceptible to implicit bias, even clinicians, unconscious preconceptions will naturally seep into member-provider communication.

As with any interaction, implicit bias can have adverse effects on the member experience. By damaging member-provider interactions, implicit bias can adversely impact health outcomes.

In many situations, members notice a provider's implicit bias, and members often report a poor experience as a result. And naturally, a member who notices a provider's implicit bias may feel less inclined to engage deeply with care.

Eliminating implicit bias is a challenging task, because as the experts at Ohio State University's Kirwan Institute said, one's own implicit bias is not something most people are aware of. Implicit bias is not purposeful—purposeful discrimination is referred to as explicit.

But a strong education campaign can be a good first step in helping clinicians notice their own biases. The process of identifying and acknowledging implicit bias in healthcare is only in its infancy. But as more organizations commit to ending racial health disparities and working toward health equity, this will be an important step toward that end.

Actions healthcare providers can take to combat implicit bias include the following:

- Having a basic understanding of the cultures from which your members come.
- Avoiding stereotyping your members; individuate them.
- Understanding and respecting the magnitude of unconscious bias.
- Recognizing situations that magnify stereotyping and bias.
- Knowing the national standards for culturally and linguistically appropriate services (CLAS) in health and healthcare (the **https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53**).
- Performing "teach back" (e.g., the National Patient Safety Foundation's Ask Me 3® educational program).
- Assiduously practicing evidence-based medicine.
- Using techniques to debias member care, which include training (including cultural competency training offered through Humana Healthy Horizons), intergroup contact, perspective-taking, emotional expression and counter-stereotypical exemplars.

Linguistic services

Humana Healthy Horizons' programs and initiatives

Humana Healthy Horizons offers several initiatives to deliver services to all PathWays members regardless of ethnicity, socioeconomic status, culture and primary language. These include:

- Language assistance services
- Race and ethnicity data collection and analysis
- Internal staff training on cultural humility, health equity, health literacy and implicit bias

- All print resources available in English are also available in Spanish. Written materials available in languages other than English can be requested by the PathWays provider or the member by calling the Humana Healthy Horizons Provider Services Contact Center at **866-274-5888 (TTY: 711)**.

Our care coordinators and service coordinators are assigned to members based on their language needs, cultural compatibility and gender preference, to better align with the individual's choice.
All Humana Healthy Horizons clinical associates complete cultural humility and implicit bias training.
Recognizing that complete and accurate provider data is foundational to ensuring an adequate and responsive network, Humana Healthy Horizons has an annual provider education campaign encouraging our network to self-report language, race and ethnicity data and educates providers on how Humana Healthy Horizons uses this data to ensure culturally competent and equitable care. We seek to collaborate with other selected MCEs on this campaign to promote systemwide accessibility for this important data.

Interpreter services
If you are assisting a PathWays member who needs interpretive services, please be aware that Humana Healthy Horizons provides the following communication services at no cost when the member is interacting with us. You can connect Humana Healthy Horizons members via the following:

- Over-the-phone interpretation available in 150 languages at all Humana Healthy Horizons touchpoints.
- American Sign Language interpreters (in person or via video)—Call **877-320-2233** to schedule at least 48 hours in advance.
- Linguistically trained interpreters for visually impaired customers—Call **877-320-2233** to schedule at least 48 hours in advance.
- TTY services—This is voice to text provided by the federal relay service (and no special instructions) and is available at all touchpoints.
- Written materials available in languages other than English, and in alternative formats including Braille, audio, large print and accessible PDF, can be requested by the PathWays provider or the member by calling the Humana Healthy Horizons Provider Services Contact Center at **866-274-5888 (TTY: 711)**.

Person-centered thinking

Humana Healthy Horizons trains all care coordinators, service coordinators, and care and service coordination leaders on person-centered thinking through the Learning Community for Person-Centered Practices (LCPCP) and Charting the LifeCourse. Person-centered planning/thinking training emphasizes relationship building and promotes member/family engagement, and cultural and linguistic competence in addition to stressing the importance of developing service plans based on a member's strengths, preferences, needs and self-identified goals.

Chapter 7: Covered services

Covered medical services

General services

Indiana PathWays for Aging provides benefit packages, and there are two packages of service. The first package of service is State Plan Medicaid, which includes the nursing facility, home health and hospice care. The second package of service, State Plan Medicaid plus HCBS, offers an HCBS waiver to those members who meet the nursing facility level of care (NFLOC) but wish to, or are able to, receive care in their homes or communities.

Humana Healthy Horizons is required to provide "medically necessary" care, at the very least, with current limitations for the services listed below. Medically necessary services are those utilized in the state Medicaid program, including quantitative and nonquantitative treatment limits, as indicated in state statutes and regulations, the State Plan, and other state policy and procedures. While appropriate and necessary care must be provided, Indiana PathWays for Aging is not bound by the current variety of service settings.

More detailed information on Indiana Medicaid policy for services and benefits may be found in the corresponding provider reference modules for each service and provider type. These provider reference modules are available electronically on the https://www.in.gov/medicaid/providers/provider-references/bulletins-banner-pages-and-reference-modules/.

Services	State Plan Medicaid package
Anesthesia services	Covered
Audiology services (including hearing aids)	Audiological assessments covered for up to 1 assessment every 3 years Binaural aids and CROS-type aids covered in circumstances when a significant, objective benefit to the member can be shown Hearing aid repairs covered for up to once every 12 months or more often with prior authorization Hearing aid replacements covered for up to once every 5 years or more often with prior authorization
Care conferences	Covered
Chiropractic services	Covered for up to 5 visits and 50 therapeutic physical medicine treatments per member, per year New member office visits covered for up to once per provider per lifetime of the member Full spine X-rays limited to 1 series per year
Diabetes Self-Management Training (DSMT)	Covered for members who have a diabetes diagnosis or a diagnosis that represents a significant change in the member's condition or symptoms or need reeducation Covered for up to 16 15-minute units per member per year
Durable medical equipment	Covered
Emergency services	Covered
Family planning services and supplies	Covered
Food and nutritional supplements	Covered

Services	State Plan Medicaid package
Home health services	Covered when home health agencies deliver necessary skilled nursing services by a registered nurse or licensed practical nurse; home health aide services; physical, occupational and respiratory therapy services; speech language services; and renal dialysis for homebound individuals
Hospice care	Covered for members expected to die from illness within 6 months Hospice services available for 2 consecutive periods of 90 calendar days followed by an unlimited number of periods of 60 calendar days
Hospital services (including inpatient, outpatient and acute care services)	Acute care hospital admissions covered for members whose medical condition meets the necessary criteria for severity of illness and intensity of services Physical rehabilitation services covered for members who are medically stable, responsive to stimuli and can participate in the service
Laboratory services	Specimen collections covered up to once per day
Long-term acute care (LTAC) hospitalization	Covered for up to 50 days per calendar year Admissions to an LTAC hospital covered for members transferring directly from an acute care facility or who are being readmitted to the LTAC hospital from a nursing facility or rehabilitation facility
Medical and surgical services	The postoperative care days for a surgical procedure covered for up to 90 days following a major surgical procedure and 10 days following a minor surgical procedure Medical supplies not covered in quantities greater than a 1-month supply for each calendar month, except when: • Packaged by the manufacturer only in larger quantities • Member is a Medicare member and Medicare allows reimbursement for a larger quantity
Medical supplies	Covered
Mental and behavioral health services—inpatient	Inpatient psychiatric services covered for members
Mental and behavioral health services—outpatient	Mental health services provided in an outpatient or office setting (except for neuropsychological and psychological testing) covered for up to 20 units, per provider, per rolling 12 months Partial hospitalization services covered for members who have a diagnosed or suspected behavioral health condition and a short-term deficit in daily functioning or indications of a high probability of serious deterioration of the member's general medical or behavioral health Psychiatric diagnostic interview examinations covered for up to 1 unit per provider, per rolling 12-month period, except as follows: A maximum of 20 units per rolling 12-month period of time per provider available when a member is separately evaluated by both a physician and a mid-level practitioner.
Mental and behavioral health services—state psychiatric hospital	Covered

Services	State Plan Medicaid package
Nursing facility services (long term and short term)	Covered for members who have been screened for level-of-care determination
Nursing services (including nurse practitioner and registered, licensed practical and home health agency nursing services)	Covered for up to 120 units within 30 days
Occupational therapy	Covered for up to 1 hour per day Covered for up to 30 units in 30 calendar days when ordered prior to discharge from an inpatient hospital Services to treat an acute medical condition provided in an outpatient setting covered for up to 12 units in 30 calendar days Therapy for rehabilitative services covered for up to 2 years from the initiation of the therapy unless there is a significant change in the member's medical condition requiring longer therapy
Organ transplants	Covered
Out-of-state medical services	Out-of-state services covered in the following circumstances: • To increase access to medically necessary services in areas where the distance to an in-state facility would subject member, or member's family, to significant financial hardship or create an unnecessary significant burden on member • To allow members to retain a PMP • To allow members to obtain specialty services from a facility, such as centers of excellence, when the care may not be available from an in-state provider or would require significant hardship due to geographic location • To address an emergency health crisis Authorization required for out-of-state services (except emergency services) and may be granted for any period of time, from 1 day to 1 year, if the service is medically necessary and any one of the following criteria also is met: • The service is not available in Indiana. However, care provided by out-of-state Veterans Health Administration facilities is an exception to this requirement. • The member has received services from the provider previously. • The out-of-state provider is a regional treatment center or distributor. • The out-of-state provider is significantly less expensive than Indiana providers.
Pharmacy services (including legend and nonlegend drugs)	Covered

Services	State Plan Medicaid package
Physical therapy	Covered for up to 1 hour per day Covered for up to 30 units in 30 calendar days when ordered prior to discharge from an inpatient hospital Services to treat an acute medical condition provided in an outpatient setting covered for up to 12 units in 30 calendar days Therapy for rehabilitative services covered for up to 2 years from the initiation of the therapy unless there is a significant change in the member's medical condition requiring longer therapy
Podiatric services	Routine foot care visits covered for up to 6 visits per year Routine foot care visits covered for members: • With a systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous • Who have been seen by a provider for treatment or evaluation of the systemic disease during the 6 month period prior to the rendering of routine foot care services Podiatric office visits are covered once per calendar year and additional claims will trigger an audit to suspend for medical review Podiatric office visits for new members covered for up to 1 per member within the last 3 years
Provider services	Office visits covered up to 30 per calendar, per provider New member office visits covered up to 1 per provider within the last 3 years Consultations covered in instances when a specific condition has not previously been diagnosed or managed by the consulting provider Consultations covered up to 1 per inpatient hospital or nursing facility admission Evaluation and management office visits covered for a maximum of 30 per calendar year, per provider New member evaluation and management office visits covered up to one per provider within the last 3 years
Radiology services	Covered
Rehabilitation unit services	Covered for members who have demonstrated the inability to function independently, with demonstrated impairment with the following: • Cognitive function • Communication • Continence • Mobility • Pain management • Perceptual motor function • Self-care activities Any combination of therapy services covered for up to 30 hours, sessions or visits in 30 calendar days
Residential SUD services	Covered for up to 14 days but may be extended with prior authorization and medical necessity

Services	State Plan Medicaid package
Respiratory therapy	Covered for up to 1 hour per day Covered for up to 30 units in 30 calendar days when ordered prior to discharge from an inpatient hospital Covered for up to 2 years from the date of initiation of the therapy Services to treat an acute medical condition covered for up to 14 hours on 14 calendar days
Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) services	Covered
Speech pathology services	Covered for up to 1 hour per day Covered for up to 30 units in 30 calendar days when ordered prior to discharge from an inpatient hospital Services to treat an acute medical condition provided in an outpatient setting covered for up to 12 units in 30 calendar days
Telemedicine services	Telemedicine services covered when rendered by the following types of providers: • FQHCs • RHCs • Community mental health centers • Critical access hospitals • A provider eligible to provide telemedicine services
Transportation services	Medical transportation: Covered for up to 20 one-way trips per rolling 12-month period; however, the following trips are exempt from the limitation: • Emergency ambulance services • Transportation to or from a hospital for the purpose of an inpatient admission or discharge • Transportation for members on renal dialysis or those residing in nursing homes • Accompanying parent or member attendant, or both • Return trip from the emergency room (ER) in an ambulance Trips covered for up to 50 miles one way Nonmedical transportation (for Medicaid only members): Covered for up to 12 round trips (or 24 one-way trips) up to 30 miles for nonmedical transportation per year to locations such as: • Social support groups • Wellness classes • Women, Infants, and Children and SNAP appointments • Food banks • Locations providing social benefits and community integration for members (neighborhood centers, parks, recreation areas, churches) Nonwaiver members must reside in a home and/or community-based setting

Dental services

Dental services	State Plan Medicaid package
Crowns	
Recement crowns	Covered
Stainless steel crown permanent	Covered
Steel crown primary	Covered
Dentures and partials	
Dentures	Covered
Partials	Covered
Diagnostic and preventative services	
Comprehensive evaluations	Covered for up to 1 per lifetime, per member, with an annual limit of 2 per member
Initial evaluations	Covered
Periodic evaluations	Periodic or limited oral evaluations covered for up to 1 every 6 months
Prophylaxis	Covered for up to 1 unit every 12 months for noninstitutionalized members and for up to 1 unit every 6 months for institutionalized members
Oral hygiene instructions	Covered
Emergency treatment and trauma care	
Incision and drainage abscess	Covered
Palliative treatment of facial pain	Covered
Extractions	
Preoperative care	Covered
Postoperative care	Covered
Tissue trim	Covered
Periodontal care	
Periodontal surgery	Covered only for cases of drug induced periodontal hyperplasia
Periodontic procedures	Periodontal root planning and scaling covered for up to 4 units per lifetime
Treatment of dental caries	
Amalgam	Covered for up to 1 treatment per tooth, per lifetime
Composites	Covered for up to 1 treatment per tooth, per lifetime
Resin anteriors and posteriors	Covered for up to 1 treatment per tooth, per lifetime
X-rays	
Bitewing radiographs	Covered for up to 1 set every 12 months
Full mouth series or panorex	Covered for up to 1 set every 3 years
Intraoral radiographs	Covered for 1 first film and 7 additional films per member every 12 months
Additional dental services	
Alveoplasty	Covered

Dental services	State Plan Medicaid package
Additional dental services	
Compound fracture of the mandible and maxilla	Covered
Drugs and medicaments	Covered
Excision of lesions and benign tumors (including oral biopsies)	Covered
Fracture simple stabilize	Covered
General anesthesia and intravenous sedation	General anesthesia covered only in a hospital (inpatient or outpatient) or ambulatory surgical center Intravenous sedation covered only for oral surgical services
Medically necessary hospital admissions	Covered
Odontogenic and nonodontogenic cyst removal	Covered
Orthodontic services	Covered only in cases of craniofacial deformity or cleft palate
Repair of wounds	Covered
Suturing	Covered
Therapeutic pulpotomy	Covered

Vision services

Vision services	State Plan Medicaid package
Initial vision care exams	
Biocular measure	Covered for up to 1 examination every 2 years unless more frequent care is medically necessary
External eye exam	Covered for up to 1 examination every 2 years unless more frequent care is medically necessary
Routine ophthalmoscopy Tonometry and gross visual field testing (including color vision, depth perception and stereopsis)	Covered for up to 1 examination every 2 years unless more frequent care is medically necessary Covered for up to 1 examination every 2 years unless more frequent care is medically necessary
Visual acuity determination	Covered for up to 1 examination every 2 years unless more frequent care is medically necessary
Corrective vision care	
Contact lenses	Covered if medically necessary
Eyeglasses (frames and lenses)	Covered for a maximum of 1 pair every 5 years Allowable cost for frames is limited to a maximum of $20 per pair
Neutralization of lens, lenses or contact lenses	Covered if medically necessary
Repairs or replacement of eyeglasses	Covered only in instances in which the repair or replacement is necessary due to extenuating circumstances beyond the member's control
Safety lenses	Covered only for corneal lacerations or other severe intractable ocular or ocular adnexal disease
Tinted lenses	Tint numbers 1 and 2 covered if medically necessary.

Vision services	State Plan Medicaid package
Office visits	
Consultations	Covered if medically necessary
Office visits	Covered if medically necessary
Out-of-office visits	Covered if medically necessary
Additional vision services	
Bifocal and trifocal determinations	Covered if medically necessary
Binocular ophthalmoscope	Covered if medically necessary
Central and peripheral field studies	Covered if medically necessary
Clinical photography	Covered if medically necessary
Color field study	Covered if medically necessary
Definitive fundus evaluation	Covered if medically necessary
Electrophysiology	Covered if medically necessary
Extended ophthalmoscopy	Covered if medically necessary
Gonioscopy	Covered if medically necessary
Multiple pattern fields, including roberts, harrington or flods	Covered if medically necessary
Other supplemental testing	Covered if medically necessary
Refractions	Covered if medically necessary
Serial tonometry	Covered if medically necessary
Supplemental evaluations	Covered if medically necessary
Tangent screen study	Covered if medically necessary
Visual skills study and testing	Covered if medically necessary

Home and Community-Based Services—HCBS waiver package

Services	HCBS waiver package
Adult day services	Covered for 10 hours per day
Adult family care	Covered for members who have nursing facility level of care needs and whose needs can be met in a home-like environment
Assisted living	Covered
Attendant care	Covered for members who have nursing facility level of care needs; service may be provided by agency or nonagency or be participant directed
Care management	Covered
Community transition	Covered for members who are directly responsible for their own living expenses in the community Covered for up to $1,500 per lifetime for setup expenses

Services	HCBS waiver package
Home and community assistance	Covered for members who are living in their home and are unable to meet their needs or when their informal caregiver or helper is unable to perform these needs
Home-delivered meals – Post Discharge	Covered for members who are unable to prepare their own meals and for whom there are no other persons available to do so or where the provision of a home delivered meal is the most cost-effective method of delivering a nutritionally adequate meal Covered for up to 2 meals per day
Home modification assessments	Covered for members receiving services. Covered for up to $500 annually
Home modifications	Covered for members who would require institutionalization without physical home adaptations Installation costs covered for a lifetime cap of $20,000; the limit on any single project is $15,000 In addition to the $20,000 lifetime cap, $1,000 allowable annually for the repair, replacement or adjustment to an existing home modification that was funded by an HCBS waiver Maintenance costs covered for up to $1,000 annually for the repair and service of environmental modifications that were funded by an HCBS waiver
Informal caregiver coaching	Covered
Integrated Health Care Coordination	Covered for members receiving services Covered for up to 16 hours per month
Nutritional supplements	Covered for up to $1,200 annually
Personal emergency response system (PERS)	Covered
Pest control	Covered for up to $4,000 annually
Respite services	Covered
Specialized medical equipment and supplies	Maintenance for specialized medical equipment and supplies covered for to $1,000 annually for repair and service.
Structured family caregiving	Covered for members receiving services Unskilled respite covered for a maximum of 15 days per calendar year
Transportation services— nonmedical transportation	Covered
Vehicle modifications	Covered for up to $15,000 for 1 vehicle every 10 years The repair, replacement or adjustment to an existing modification funded by an HCBS waiver covered for up to $1,000 annually (in addition to the $15,000 limit)

Nonemergency medical transportation

Transportation (ride) benefits are included for PathWays members. Members should call Member Services at **866-274-5888 (TTD/TTY: 711)** to schedule rides.

Coverage

Members may receive rides to and from (a) any provider visit or healthcare appointment, (b) eligibility redetermination appointments with the state, (c) recurring appointments and (d) approved urgent appointments. Members may direct their questions to Member Services at **866-274-5888 (TTY: 711)**.

How to schedule

Rides must be scheduled at least two business days before the member's appointment. Members experiencing an emergency should be directed to 911 or their nearest emergency room (ER).

Following the member's appointment, the member may ask the respective office to call the ride company for a return trip home. Stops for pharmacy pickups may be arranged with the driver via a call from the office to the transportation company when scheduling the return trip.

Vendor contact

NEMT is provided by **https://www.lcptransportation.com/ (800-508-7230)**.

Noncovered services

The services detailed below are not covered by the Indiana Medicaid program (405-IAC-5-29-1). Information regarding noncovered services can be found on the Indiana Medicaid website.

Indiana PathWays for Aging will not pay for services that are not medically necessary or for the following services or supplies received:

- All anorectics, except amphetamines, both prescription and nonprescription.
- Amphetamines when prescribed for weight control or treatment of obesity.
- Any new product, service or technology until such time as the Indiana Office of Medicaid Policy and Planning authorizes the coverage of the product, service or technology. This does not apply to prescription drugs.
- Augmentation mammoplasties for cosmetic purposes.
- Blepharoplasties when not related to a significant obstructive vision problem.
- Cybex evaluation or testing or treatment.
- Dermabrasion surgery for acne pitting or marsupialization.
- Ear lobe reconstruction.
- Ear piercing.
- Experimental drugs, treatments or procedures and all related services.
- Experimental radiological or surgical or other modalities and procedures, including the following:
  - Acupuncture
  - Biofeedback therapy
  - Carbon dioxide 5% inhalator therapy for inner ear disease
  - Hyperthermia
  - Hypnotherapy
- Fallopian tuboplasty for infertility or vasovasostomy. This procedure is covered only in conjunction with disease.
- Hair transplants.
- High colonic irrigation.
- Miscellaneous procedures or modalities, including, but not limited to, the following:
  - Artificial insemination
  - Autopsy
  - Cognitive rehabilitation, except for treatment of TBI
  - Cryosurgery for chloasma
  - Conray® dye injection supervision
  - Day care or partial day care (Please note that adult day services for HCBS waiver package members are an exception to this exclusion.)
  - Formalized and predesigned rehabilitation programs, including the following:

    - Pulmonary
    - Cardiovascular
    - Work-hardening or strengthening
  - Telephone consultation, or any other means of communication, from one provider to another
  - Telephone transmitter used for transtelephonic monitor
- Otoplasty for protruding ears unless one of the following applies to the case:
  - Multifaceted craniofacial abnormalities due to congenital malformation or maldevelopment, for example, Pierre Robin syndrome
  - Pending or actual employment where protruding ears would interfere with the wearing of required protective devices
- Penile implants.
- Perineoplasty for sexual dysfunction.
- Personal comfort or convenience items, including television, radio or telephone rental.
- Provider samples.
- Radial keratotomy.
- Reconstructive or plastic surgery unless related to disease or trauma deformity.
- Removal of keloids caused from pierced ears unless one of the following is present:
  - Keloids are larger than 3 centimeters.
  - Obstruction of the ear canal is 50% or more.
- Rhinoplasty or bridge repair of the nose in the absence of a significant obstructive breathing problem.
- Rhytidectomy.
- Scar or tattoo removals by excision or abrasion.
- Services for the remediation of learning disabilities.
- Services provided outside the scope of a provider's license, registration, certification or other authority to practice under state or federal law.
- Services that are not prior authorized under the level-of-care methodology.
- Sliding mandibular osteotomies unless related to prognathism or micrognathism.
- Treatments or therapies of an educational nature.
- Under federal law, drug efficacy study implementation drugs not covered by Medicaid.

Excluded services

The benefits outlined below are excluded from the Indiana PathWays for Aging program. If a member is receiving or will receive the following services, the member will be disenrolled from the Indiana PathWays for Aging program in order to be eligible for the services and transitioned to traditional Medicaid or other waiver programs where the member qualifies and these services are covered. Humana Healthy Horizons will be responsible for the member's care until the member is disenrolled. The following services are excluded from the Indiana PathWays for Aging program:

- **Psychiatric treatment in a state hospital:** Indiana PathWays for Aging members receiving psychiatric treatment in a state hospital will be disenrolled from the program.
- **Intermediate care facilities for individuals with intellectual disabilities (ICFs/IID):** Indiana PathWays for Aging members who are admitted to an ICF/IID will be disenrolled from the program and enrolled in traditional Medicaid. Before the stay will be reimbursed by the IHCP, the level of care must be approved by the state. Humana Healthy Horizons will coordinate for members that are transitioning into an ICF/IID by working with the facility and is responsible for payment for up to 60 calendar days for members placed in an ICD/IID while the level-of-care determination is pending.
- **Traumatic brain injury (TBI) waiver:** Indiana PathWays for Aging members who become eligible for the TBI waiver will be disenrolled from the program and enrolled in traditional Medicaid. The TBI waiver provides HCBS services to individuals who, but for the provision of such services, would require institutional care.
- **Community integration and habilitation waiver:** Indiana PathWays for Aging members who become eligible for the community integration and habilitation waiver will be disenrolled from the program and enrolled in traditional Medicaid. The community integration and habilitation waiver is a Medicaid HCBS waiver for children and adults with intellectual and developmental disabilities.

- **Family supports waiver:** Indiana PathWays for Aging members who become eligible for the family supports waiver will be disenrolled from the program and enrolled in traditional Medicaid. The family supports waiver is a Medicaid HCBS waiver for children and adults with intellectual and developmental disabilities.

Enhanced services

Indiana PathWays for Aging offers members extra benefits, tools and services (at no cost to the member) that are not otherwise covered or that exceed limits outlined in the Indiana State Plan and the Indiana Medicaid fee schedules. These added benefits are in excess of the amount, duration and scope of those services listed above.

In instances where an enhanced service also is a Medicaid-covered service, Humana Healthy Horizons administers the benefit in accordance with all applicable service standards pursuant to our contract, the Indiana Medicaid State Plan and all Medicaid coverage and limitations handbooks.

Humana Healthy Horizons members have specific enhanced services:

Enhanced service	Details and limitations
Dental	Up to $500 allowance toward topical fluoride, oral sedation (along with nitrous), post op complications, and mouthguards.
Fall Prevention Kit	Members at risk for falls may receive Fall Prevention Kit once per lifetime Kit contains: • Nonslip socks • Reacher/grabber • Bath mat • Stair treads Member must not reside in residential facility or nursing facility Care coordinator approval required
Hearing services	Unlimited visits for fitting and evaluation of hearing aids; up to $1,500 for hearing aids every 3 years; annual supply of 60 hearing aid batteries
Home-based respiratory intervention	Members living with respiratory diseases can receive up to $200 per calendar year for the following goods and services: • Allergy-free bedding • Carpet cleaning • Air purifier Member can select multiple items within one year provided total spend remains within the $200 allowance.

Enhanced service	Details and limitations
Home-based virtual assistance technology	Members participating in our care management or disease management programs with the following conditions may be eligible to receive 1 artificial intelligence (AI)-enabled virtual assistance device; 1 device per lifetime, per member: • Social isolation • Depression • Memory loss Care coordinator approval required
Post-discharge meals	14 refrigerated home-delivered meals following discharge from an inpatient or residential facility, limited to 4 discharges per year. Nonwaiver members must reside in a home and/or community-based setting.
Housing assistance	Up to $500 per member, per year, to assist with the following housing expenses (unused allowance does not roll over to the next year): • Apartment rent or mortgage payment (late payment notice required) • Utility payment for electric, water, gas or internet (late payment notice required) • Trailer park and lot rent if permanent residence (late payment notice required) • Moving expenses via licensed moving company when transitioning from a public housing authority Plan approval required: • Member must not live in a residential facility or nursing facility. • Funds will not be paid directly to the member. • If the bill is in the spouse's name, a marriage certificate may be submitted as proof. Nonwaiver members must reside in a home and/or community-based setting.
Name bands	Members with dementia, Alzheimer's disease and/or diabetes and in our care management or disease management programs may receive 20 name bands per year Care coordinator approval required
Nonmedical transportation	Up to 12 round trips (or 24 one-way trips), up to 30 miles each trip, for nonmedical transportation per year to locations such as social support groups, wellness classes and food banks. This benefit also offers transportation to locations providing social benefits and community integration for members such as community and neighborhood centers, parks, recreation areas and churches. Nonwaiver members must reside in a home and/or community-based setting.
Nutritional coaching program	The nutritional coaching program delivers nutritional coaching intervention for members 60 years and older. After receiving provider clearance, the member can complete 6 nutritional coaching sessions with a health coach equaling approximately 1 call per month for a period of 6 months.

Enhanced service	Details and limitations
PERS	Members in our care management or disease management programs may receive 1 PERS device per lifetime to provide round-the-clock emergency service. Member must not reside in a residential or nursing facility. Care coordinator approval required.
Pest control	Up to $320 per year for pest control for nonwaiver members: • If member resides with caregiver, member must show proof. • Members must reside in a home and/or community based setting. Care coordinator approval required
Photo albums	Members in our care management or disease management programs may receive 1 photo album per year. Member must not reside in a residential or nursing facility. Care coordinator approval required. Members must reside in a home and/or community based setting.
Pill box	Member may receive one 7-day pill box per lifetime. Members must reside in a home and/or community based setting.
Podiatry visits	Up to an additional 6 podiatry visits for the following: • Members in need of medical or surgical treatment of injuries and diseases of the foot • Members with conditions affecting the legs, such as diabetes
Transition assistance into community living	All non-waiver members moving from a nursing facility to their own home may receive up to $5,000 per lifetime. • Assistance for paying with security and utility deposits, household furnishings/supplies, and moving expenses • Member must be moving out of a nursing facility into the member's own home where they are responsible for their own living expenses Care coordinator approval required
Vision services	• Up to $150 annual allowance for 1 set of glasses (frames and lenses) and/or contacts every 24 months. Member pays any cost over $150.

Go365®for Humana Healthy Horizons®

Go365 for Humana Healthy Horizons® is a wellness program that offers members the opportunity to earn rewards for taking healthy actions. Most of the rewards are earned by Humana Healthy Horizons' receipt of the provider's claim for services rendered.

Indiana PathWays for Aging recommends that all providers submit their claims on behalf of a member by March 15, 2025. This allows members time to redeem their rewards. Members have 90 days from one plan year to another to redeem their rewards, assuming they remain continuously enrolled.

Go365 is available to all members who meet the requirements of the program. Rewards are not used to direct the member to select a certain provider. Rewards are nontransferable to other managed care plans or other programs. Rewards are nontransferable and have no cash value. E-gift cards may not be used for tobacco, alcohol, firearms, lottery tickets and other items that do not support a healthy lifestyle.

Members can qualify to earn rewards by completing one or more of the following healthy activities:

Unless otherwise stated, all rewards are offered to Medicaid-only members.	
Healthy activity	**Reward**
Breast cancer screening	Annual $25 reward for female members who obtain a mammogram
Colorectal cancer screening	Annual $25 reward for members who obtain a colorectal cancer screening as recommended by their PMP
Diabetic retinal eye exam	Annual $10 reward for diabetic members who complete a retinal eye exam.
Diabetic screening	Annual $10 reward for diabetic members who obtain a screening with their PMP for HbA1c and blood pressure.
Fall prevention program	$10 in rewards for members who complete education aimed at raising awareness to reduce falls once per year; members must register on the Go365 mobile app to view the health education video and be eligible for the reward.
Flu vaccine	Annual $10 reward for members who receive an annual flu vaccine from their provider or pharmacy or for a self report if they received a vaccine from another source.
Follow-up after high-intensity care for SUD	$25 in rewards for members who received follow-up care within 30 days of an inpatient hospital discharge, residential treatment or detoxification visit for a diagnosis of SUD.
Follow-up after hospitalization for mental illness	$25 in rewards for members who received follow-up care within 30 days after a hospital discharge for a diagnosis of select mental illness or intentional self-harm.
Health Needs Screening (HNS)	$25 in rewards for members who complete their HNS within 90 days of enrollment with Humana Healthy Horizons; 1 reward per lifetime.
Nutritional coaching reward	Members who enroll in the nutritional coaching program will have 2 opportunities to earn up to $30 in rewards: • Completing a well-being checkup • Completing the program Members must opt into Go365 to be eligible for the reward.
Wellness visit	Annual $25 reward for completing an annual wellness visit.
Transitions of care member incentive program	$25 in rewards for receiving follow-up care within 30 days of an inpatient discharge.

Member cost-sharing requirements

Indiana PathWays for Aging will not require copayments from any member for Medicaid-covered medical services.

Patient or Wavier Liability

Indiana PathWays for Aging members may be required to pay a monthly patient or waiver liability. Patient liability is the amount of an enrollee's income, as determined by the State, to be collected each month to help pay for the member's nursing facility stay. Patient liability applies to members who are determined to meet nursing facility level of care (NFLOC) and receive institutional LTSS.

Waiver liability is similar to a deductible and applies to members who live in the community, such as their own home, an adult family home, a community-based residential facility, or a residential care apartment complex. Waiver liability applies to members who are determined to meet nursing facility level of care (NFLOC) and receive home- and community-based services (HCBS).

Humana Healthy Horizons is responsible for the ongoing monitoring of the waiver or patient liability amounts as provided by the state, will apply allowable costs against the liability to ensure member responsibility is met, and will cover allowable costs after the liability is met. Humana Healthy Horizons will advise the member via monthly waiver liability letters indicating the amount owed for claims submitted in the prior month. The member is not required to pay the provider until the expense has been included in the waiver liability summary notice. Providers are not to indicate or exclude the liability when submitting claims. The provider should be able to see the patient or waiver liability obligation and balance in the portal or when checking eligibility.

Member billing

State requirements and federal regulations prohibit providers from billing Humana Healthy Horizons members for medically necessary covered services except under very limited circumstances. Members cannot be billed and will be held harmless for services that are administratively denied. The only exception is if a Humana Healthy Horizons member agrees in advance, in writing, to pay for a non-Medicaid-covered service. This agreement must be completed prior to providing the service and the member must sign and date the agreement acknowledging member financial responsibility.

Providers can bill a member for covered services when a prior authorization is denied and all the following conditions have been met in the following order:

A Authorization has been requested and denied prior to rendering the service.

B. The provider has requested a review of the denial decision or the time period for requesting such review has passed.

C. If the decision is maintained, the provider must inform the member that the service requires authorization and has been denied. For out-of-network providers, the member also must be informed that covered services may be authorized for an in-network provider without cost.

D. The provider must inform the member of the member's responsibility for payment if the member still chooses to receive the services without an authorization.

E. If the provider chooses to use a waiver to document the member's responsibility for payment, the waiver must:
   a. Be signed by the member only after the member has been notified
   b. Be obtained for each patient visit or encounter for noncovered services
   c. Specify the dates of service and identify the services to which the waiver applies
   d. Not contain any conditional language to the effect that a denied authorization indicates the member is responsible for payment

F. Member must be informed of the right to contact Humana to file an appeal if member disagrees with the prior authorization denial. **See the Appeals section in Chapter 11 of this manual for more information**.

G. The provider must have the right to appeal any denial of payment by Humana for denial of authorization.

If the member attempts to receive a non-covered service, providers must inform the member the cost of the service and how much they may be billed prior to providing the service.

See **Prior Authorizations** in Chapter 11 of this manual for more information.

Providers who knowingly and willfully bill a member for a Medicaid-covered service are guilty of a felony and on conviction are fined, imprisoned or both, as defined in the Social Security Act. Providers should call the Provider Services Contact Center at **866-274-5888 (TTY: 711)** for guidance before billing members for services.

Chapter 8: Behavioral health

Provider requirements in coordinating behavioral healthcare

Network providers are required to coordinate care when PathWays members are experiencing behavioral health conditions that require ongoing care.

PMPs are required to:

- Provide basic behavioral health services to members to include:
  - Screening for mental health and substance use issues during routine and emergent visits.
  - Prevention and early intervention.
  - Medication management.
  - Treatment for mild to moderate behavioral health conditions.
- Refer or assist members with finding a specialized behavioral health provider for severe or chronic behavioral health conditions
- Follow up with behavioral health providers to coordinate integrated and nonduplicitous care to the member
- Obtain a necessary signed release of information for the sharing of PHI, including compliance with 42CFR Part 2 requirements around behavioral health and SUD

Behavioral health providers are required to:

- Notify the PMP when a member initiates behavioral health services with the provider.
- Obtain a signed release of information for the sharing of PHI in compliance with 42CFR Part 2 requirements around behavioral health and SUD prior to sharing information with the PMP.
- Provide initial and summary reports to the PMP (after receiving above release of information).
- Refer members with known or suspected and/or untreated physical health problems or disorders to their PMP for examination and treatment, with the member's or the member's legal guardian's consent. Behavioral health providers may only provide physical healthcare services if they are licensed to do so.
- Ensure members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. This treatment shall be provided within seven calendar days from the date of the member's discharge.

Humana Healthy Horizons assists with provider referrals, scheduling appointments and coordinating an integrated approach to the member's health and well-being by coordinating care between behavioral health providers, PMPs and specialists.

In the best interest of our members and to promote positive healthcare outcomes, Humana Healthy Horizons supports and encourages continuity of care and coordination of care between medical and behavioral health providers. Providers may contact Humana Healthy Horizons to refer members in need of care management assistance by calling **866-274-5888 (TTY: 711)**.

Behavioral health crisis line for emergency services

For members experiencing a behavioral health crisis in Indiana, Humana Healthy Horizons has contracted with Professional Management Enterprises to provide a behavioral health crisis line that is available to Humana Healthy Horizons' members 24 hours a day, seven days a week, 365 days a year. This voluntary service is designed to provide crisis intervention and connect members to the appropriate level of treatment within the community to prevent unnecessary hospitalizations and institutional levels of care. Once a member is directed to the most appropriate intervention, Humana Healthy Horizons will work with providers to authorize services and ensure continuity of care for the member.

Behavioral health conditions include, but are not limited to:

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

The behavioral health crisis line can be accessed at **855-254-1758**.

Addiction

The American Society of Addiction Medicine (ASAM) defines addiction as a treatable, chronic medical disease impacted by brain circuitry, genetics, environmental factors and life experience. Dysfunction in the brain circuits leads to characteristic biological, psychological, social and spiritual manifestations. This condition is reflected through pathological reward pursuit and/or relief by substance use and other behaviors. Addiction is characterized by:

- Inability to consistently abstain
- Impairment in behavioral control
- Craving, or increased craving, for drugs or rewarding experiences
- Diminished recognition of significant problems with one's behaviors and interpersonal relationships
- A dysfunctional emotional response

The diagnosis of addiction requires a comprehensive biological, psychological, social and spiritual assessment by a trained and certified professional.

Addiction is more than a behavioral disorder. Features of addiction include aspects of a person's behaviors, cognitions, emotions and interactions with others, including a person's ability to relate to family or community members or the person's own psychological state and to things that transcend daily experience. Successful prevention and treatment outcomes for addiction are similar to those for chronic medical diseases. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Should you encounter a member that may suffer from addiction, you may refer the member to Humana.com to utilize the provider directory. Our provider directory will allow members to search by specialty or condition to find the appropriate provider for their needs. Members also can connect with a care coordinator via **866-274-5888 (TTY: 711)** to obtain assistance with their behavioral health needs. Humana Healthy Horizons is contracted with provider types that provide a variety of services that offer addiction services including opioid treatment programs (OTPs), medication-assisted treatment (MAT) and various SUD treatments. Humana includes a robust network of providers who are authorized to provide MAT, including buprenorphine. Providers who provide MAT who are interested in joining the network should reach out to the Behavioral Health Contract Team at **INBHMedicaid@humana.com** or access the request to join portal.

Humana includes a robust network of providers who are authorized to provide MAT, including buprenorphine. Providers who provide MAT and are interested in joining the network should reach out to the behavioral health contract team at **INBHMedicaid@humana.com** or visit the request to join the network site at **https://humana-6853.quickbase.com/db/btnam42he**.

Opioid treatment program

Humana covers a daily OTP that includes:

- Administration and coverage of a Food and Drug Administration (FDA)-approved opioid agonist or antagonist MAT
- Routine drug testing
- Group therapy
- Individual therapy
- Pharmacological management
- Follow-up examinations
- One evaluation and management office visit every 90 days for the management of member activities identified in the individualized treatment plan that assist in member goal attainment, including referring members to other service providers and linking members to recovery support groups

OTP-eligible members include the following:

- Members eighteen (18) years and older who have become addicted at least one year prior to admission and are placed in the Opioid Treatment Services (OTS) Level of Care according to all six dimensions of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.
- Members under 18 years of age who have had two documented unsuccessful attempts at short-term withdrawal management or drug free treatment within a 12-month period.
- All members released from penal institution (within 6 months of release)

- Pregnant members
- Previously treated members (up to 2 years after discharge)

Chapter 9: Care management

Referral to complex case management

Humana Healthy Horizons offers individualized education and support to PathWays members for many conditions and needs, including complex case management, assistance with housing and accessing community support.

Humana Healthy Horizons' contracted providers may contact Humana Healthy Horizons to refer members in need of care management assistance by calling **866-274-5888 (TTY: 711)**.

Continuity of care requirements

To avoid disruptions in care and services as members transition between MCEs, IHCP or other delivery systems and PathWays enrollment, we collaborate with our internal programs and external entities to achieve continuity of care and coordination of medically necessary healthcare services, whether members are coming to Humana Healthy Horizons or are transitioning to another MCE.

We apply scalable resources to ensure a consistently smooth transition, continuity of care at all service levels in all care settings across programs and continuation of medically necessary services in compliance with Indiana-defined timelines:

- We provide 90 days of continuity of care for authorized services and choice of providers during the first year of the program.
- When we receive members from another MCE, fee-for-service (FFS) or commercial coverage, we will honor the previous care authorization for either the first 90 days of enrollment or the remainder of the prior authorized dates or services, or until the approved service units are exhausted. This is determined by whichever date comes first.
- For HCBS level of care, we honor the care plan approved by the FSSA or previous MCE for 90 days from the enrollment date.

Skilled nursing facilities are an exception to the continuity of care periods above, as skilled nursing facilities may serve as the member's residence and not continuing coverage at their current skilled facility could pose a risk for the member's overall well-being. Humana Healthy Horizons provides for continuity of care at the skilled nursing facility for the duration of the program if the member chooses to remain in the facility. The information above is applicable to members who continue to meet skilled NFLOC.

Humana Healthy Horizons care coordinators will ensure member's records, treatment plans and other pertinent medical information follow the member regardless of where the member is transitioning to.

Humana Healthy Horizons understands the importance and complexity of transitioning members into, out of or between health plans or programs, especially for members with complex conditions and those receiving LTSS. Humana Healthy Horizons' transition coordinator oversees our Indiana member transition and continuity of care process and a dedicated team of transition coordination support staff to share and/or obtain the information necessary to ensure continuity of care. Shared information includes appropriate member transition data transfer files (claims/encounter history and prior authorization data) and member specific socioclinical information.

Our transition coordinator oversees and coordinates the initial and ongoing member transitions in and out of Indiana PathWays for Aging, Humana Healthy Horizons' enrollment and among care settings; assists members with repatriation into home and community-based settings; and oversees our Custodial Prevention Care program to support the prevention of custodial placement. Our transition coordinator has prior experience in LTSS or with similar populations.

Our transition coordinator and our transition coordination support staff work with care coordinators and service coordinators to monitor, oversee and assist with transitions to prioritize members' individualized and person-centered needs, provide timely supports and services and avoid disruptions in care.
Provider's roles and responsibilities in care coordination and care transitions include:

- Delivering evidence-based medical management addressing member needs, choices and cultural preferences
- Ensuring members are informed of specific follow-up healthcare needs and receive training in self-care, which includes medication adherence and other measures that promote member health
- Ensuring members receive necessary and appropriate specialty, ancillary, emergency and hospital care
- Providing necessary referrals and communication to specialists, hospitalists, skilled nursing facilities and other providers

- Providing information that assists in member understanding and choice regarding consultation and recommending treatments, equipment and/or member services
- Ensuring demographic and practice information is up to date for directory and member use (practitioners are strongly encouraged to provide their race and ethnicity for Humana Healthy Horizons to reference when members request practitioners with the same race, ethnicity and language as themselves)
- Providing coordination of care for members who are homebound or have significant mobility limitations to ensure access to care through home visits by nurse practitioners or providers
- Tracking and documenting member appointments, clinical findings and treatment plans to ensure continuity of care from referred specialists, other healthcare providers or agencies
- Obtaining authorizations and notifying Humana Healthy Horizons of all out-of-network services when a participating specialty provider is unavailable in the geographic area
- Initiating or assisting with member discharge or transfer from an inpatient facility to the most medically appropriate level-of-care facility or the member's permanent home
- Supporting and communicating with the interdisciplinary care team (ICT) (in person and/or writing) in developing and implementing an individualized plan of care to facilitate effective care coordination. Providers must participate in the overall goal to coordinate services across the member's continuum of care.

  The ICT is a team of caregivers from different professional disciplines who work together to deliver care plan services that optimize quality of life and support for the member and the member's family. Provider participation is an integral part of the ICT. Other team members may include:
  - The member and/or the member's authorized caregiver
  - The member's providers and/or nurses
  - Humana Healthy Horizons' care coordinators
  - Social workers and community social service providers
  - Humana Healthy Horizons' and/or the member's behavioral health professionals
  - Humana Healthy Horizons' community health educators
- Providing timely access to medical records or information requested that assists in transitions
- Transmitting the transition record (discharge instructions) to the facility, PMP or other healthcare professional designated for follow-up care, including the diagnosis and care plan, within 24 hours of discharge from an inpatient facility

To coordinate with the interdisciplinary care team (ICT), and with member consent, the ICT will have visibility into member hospitalization(s) and/or receipt of emergency treatment for behavioral health services, including inpatient psychiatric or SUD services within five business days (seven calendar days). For members receiving inpatient psychiatric services, and those who are scheduled for outpatient follow-up and/or continuing treatment prior to discharge, the following applies:

- This treatment should be provided within seven calendar days from the date of the member's discharge.
- If a member misses an outpatient follow-up or continuing treatment, the member's Humana Healthy Horizons care coordinator and/or service coordinator will contact the member within three business days of notification of the missed appointment.
- With the appropriate consent, the care coordinator and/or service coordinator notifies the ICT when a member is hospitalized or receives emergency treatment for behavioral health services, including SUD. This notification shall occur within five calendar days of the hospital admission or emergency treatment.

For PathWays members who have utilized the behavioral health crisis line, care coordinators/service coordinators will outreach the member within 24 hours to offer assistance and evaluate ongoing needs.

For Humana Healthy Horizons members transitioning to another MCE, our transition coordinators will diligently provide the necessary clinical information to include current service coordination details, individualized care plans (ICPs), disease management care and case management notes. Our care coordination activities continue even with disenrollment during an inpatient stay, and we coordinate discharge plans with the new MCE to ensure continuity of care with minimal disruption for a PathWays member.

Behavioral health coordination

Humana Healthy Horizons ensures coordination of a member's care team across all physical and behavioral health providers treating the member. This includes facilitating the reciprocal exchange of health information between physical and behavioral health providers and, when required, to the extent permitted by law and in accordance with the member's consent. To promote this collaboration, the following applies:

- Contracted behavioral health providers will be required to notify Humana Healthy Horizons within five calendar days of the member's visit and submit information about the treatment plan, the member's diagnosis, medications and other pertinent information. Disclosure of mental health records by the provider to Humana Healthy Horizons and to the member's provider is permissible under HIPAA and state law (IC 16-39-2-6(a)) without consent of the member as it pertains to the member's treatment. Please note that consent is required when exchanging records that pertain to an SUD diagnosis. Humana Healthy Horizons must, on at least a quarterly basis, send a behavioral health profile to the respective PMP. The behavioral health profile lists the physical and behavioral health treatment received by that member during the previous reporting period. Information about SUD treatment and HIV/AIDS should only be released if member consent is obtained.
- For each member receiving behavioral health treatment, Humana Healthy Horizons will contractually require behavioral and physical health providers to document and share reciprocally the following information for that member:
  - Findings from assessments
  - Medication prescribed
  - Primary and secondary diagnoses
  - Psychotherapy prescribed
  - Other relevant information

All of our members are enrolled in care coordination and have an assigned care coordinator and/or service coordinator. The coordinators will be notified of state-identified trigger events, which could come through multiple sources including claims, admission, discharge, and transfer (ADT) data, health information exchange (HIE) feed, assessments, member/caregiver reports or provider reports. Upon receipt of the notification, the care coordinator/service coordinator contacts the member no more than five business days after the occurrence of the event to gather more information and update the necessary assessments and care plans. Additionally, there are triggers that would immediately move the member to a more intensive level of care coordination. Some of these triggers include:

- Inpatient psychiatric or SUD hospitalization
- Newly identified risk for inpatient psychiatric, drug overdose or substance use disorder treatment
- New serious mental illness (SMI) diagnosis
- New SUD diagnosis

Members who have been transitioned to a more intensive level of care coordination will remain in that stratification risk level for no fewer than 90 days following the event.

In this integrated approach, care coordinators and service coordinators have access to an integrated member profile within our platforms that displays claim and service details and allows them a comprehensive view of all behavioral health and physical health authorizations for members. As part of care coordination, the care and service coordinators are able to view the member holistically while also identifying members with emerging needs that may be at risk for negative health outcomes.

Model of care and care coordination

Stratification methodology

We employ the following process to determine the initial and ongoing stratified care coordination level of service for all members:

- Identify members systematically and stratify them into an initial care coordination level of service using integrated data streams from multiple sources using predictive modeling tools and enrollment report data.
- Conduct the FSSA Health Needs Screening (HNS) tool and review all available historical information including information from aligned and unaligned D-SNP payers as well as other payer sources. Additionally, the care coordinator reevaluates the stratified care coordination level of service for appropriateness and determines if there is a need for a rush designation.

- Conduct the comprehensive health assessment tool (CHAT) or brief CHAT and review all available historical information, including information from aligned and unaligned Medicare payers as well as other payer sources. Additionally, the care coordinator reevaluates the stratified care coordination level of service for appropriateness and determines if there is a need for a rush designation.
- Monitor continually for changes in condition or needs that warrant adjustment in the member's care coordination level of service, based on associates' interaction with members and data-derived insights.
- Reevaluate annually the member's care coordination level of service and reassign as appropriate based on the member's needs.

Member engagement

Our outreach process to engage our members includes four telephonic attempts and a letter. If our initial efforts to reach the member are unsuccessful, the care coordinator dispatches a community health worker for in-person outreach.

Should the member and/or caregiver opt out of care coordination, we have established protocols and continue to monitor for change in status and/or risk. For members we are unable to reach, we also utilize multiple methods to identify the correct number via medical records, claims, pharmacy and/or providers.

Assessments

We use evidence-based comprehensive assessments, such as the FSSA Health Needs Screening (HNS) tool and CHAT, to assist in identifying gaps and further modify the stratification based on clinical judgment. We also utilize additional assessments that allow us to hone-in to specific topics and special needs (e.g., disease specific, social determinants of health (SDOH), environmental, wellness plan, disaster plan) to create a comprehensive ICP.

Members are assessed using the most appropriate assessments based on their level of care, current setting and service delivery options (e.g., home, assisted living, adult day health and self-directed).
Our assessments process supports the evaluation of certain conditions and systems, such as:

- Pain
- Sleeping patterns
- Anxiety/depression
- Medications including polypharmacy evaluation and inappropriate use of medications
- Skin
- Bowel/bladder
- Transitions
- Health maintenance; preventative care and chronic disease management
- Mobility
- Nutrition
- Advance care planning
- Informal caregiver burden
- Oral health
- Assessment of activities of daily living
- Evaluation of gait and fall prevention
- Sensory impairment

The care coordinator also uses all available clinical information, input from the PMP and other ICT members, and historic claims to gain a full picture of the member's needs.

As part of the initial, quarterly and annual onsite assessment and care planning visit with members in nursing facilities, the service coordinator conducts the previously mentioned needs assessments and all other state-approved assessments deemed necessary by the service coordinator. The service coordinator and care coordinator jointly assess the member's potential for an interest in transition to the community at least annually, engaging the long-term care ombudsman as applicable.

The service or care coordinator conducts an informal caregiver assessment using a state-developed or state-determined tool as part of the initial onsite visit with new members receiving LTSS or as part of the onsite intake visit for current members applying for LTSS. In addition, the care coordinator administers this assessment to all other members with

an informal caregiver (with member consent) as part of the initial assessment visit. The informal caregiver assessment includes, at a minimum:

- An overall assessment of the informal caregiver(s) providing services to the member to determine the willingness and ability of the informal caregiver(s) to contribute effectively to the needs of the member, including employment status, schedule and other caregiving responsibilities
- An assessment of the informal caregiver's own health and well-being, including medical, behavioral, physical, social or environmental limitations, such as food, utility, housing and healthcare insecurities, as they relate to the informal caregiver's ability to support the member
- An assessment of the informal caregiver's level of stress related to caregiving responsibilities and potential feelings of being overwhelmed
- Identification of the informal caregiver's needs for training in knowledge and skills assisting the person needing care
- Identification of all service and support needs for training in knowledge and skills to be better prepared for the caregiving role
- Identification of the member's SDOH needs, including current or potential lack of healthcare, food insecurity, utility instability, housing insecurity, transportation issues and more

The care coordinator and service coordinator complete a reassessment annually, at a minimum; after a state-defined trigger event; or after member or ICT request. This includes a review of the member's progress toward achieving health and personal goals. The care coordinator and service coordinator review the reassessment results with the member and the member's ICT, further described, to inform updates to the member's ICP.

All assessments are available in the member portal and viewable by providers with member/caregiver consent.

Reassessments

We will reassess members:

- When their circumstances or needs change significantly
- At the request of the member
- No less often than annually
- When an identified state trigger event occurs

With the member's consent, the member's family members and informal caregivers can participate in reviewing and updating their ICPs.

The care coordinator and service coordinator, if applicable, will conduct a CHAT onsite and provide the results to the state for an updated NFLOC determination.

For nursing facility residents, the state conducts an annual level-of-care reassessment and sends it to the care coordinator and service coordinator to update the care plan and complete any additional assessments needed.

When a state trigger event is identified, the care coordinator reassesses the member's needs no later than five business days after the event occurs. These events include:

- A significant healthcare event to include but not be limited to a hospital admission, a transition between healthcare settings or a hospital discharge
- A change or loss of informal caregiver
- A decline in social status (increased isolation/loneliness)
- A change in the home setting or environment if the change impacts one or more areas of health or functional status
- A change in diagnosis that is not temporary or episodic and that impacts one or more areas of health status or functioning
- A request by the member or member's designee, caregiver, provider, the member's ICT or the state

Members who are on a complex medical regimen and/or behavior modifying medication will be reassessed by an ICT clinician every six months to ensure the effectiveness and desired outcomes are accomplished.

Plan

The care coordinator and service coordinator (if engaged) review recommended interventions with the member based on the identified needs and the member's personal and health goals. Humana Healthy Horizons creates a person-centered individualized care plan (ICP) and a service plan for each of our Indiana managed LTSS members. The member's

ICP is available to view in the provider portal. The care coordinator shares updates or changes to the individualized care plan with the member's chosen interdisciplinary care team (ICT) via the provider portal, member portal or other ICT-preferred methods to request feedback and input. This feedback is shared with the member prior to ICP finalization. Our Care Coordinator will contact you to request member information or ask for your participation in ICT conversations. Your role, as a provider, is to cooperate and engage with our care management team.

Implement

The ICP indicates the steps to be taken by the care coordinator and service coordinator to ensure the member has access to needed services and support. Following ICP creation, the care coordinator and service coordinator use the ICP to guide their next steps, including communicating with providers, executing the appropriate community-based referrals and providing member education and resources. During each subsequent contact, the care coordinator and service coordinator discuss the member's progress toward the ICP's goals, whether the member is accessing all listed services and supports and whether adjustments are needed to meet the member's needs or help the member achieve goals. ICP modifications are shared with the member's ICT for awareness and feedback.

Review and modification of the ICP as the member's healthcare needs change

The ICP is formally reviewed and modified at least annually. In addition, during each monthly and/or quarterly contact between the care coordinator, service coordinator and member, the care coordinator and/or service coordinator review the member's goals and ICP to determine if the services rendered meet the member's needs. If not, the care coordinator and service coordinator work with the member and ICT to make the necessary modifications.

The care coordinator and service coordinator also conduct a reassessment and update the ICP to reflect the member's changing needs following a trigger event. The ICP is based on the Centers for Medicare & Medicaid Services (CMS)-approved D-SNP model of care:

- Initial and ongoing health risk screening and comprehensive assessment results
- Claims history
- ICT-developed member plans
- Inclusion of member-driven short-term and long-term goals, objectives and interventions
- Addressing of specific services and benefits
- Provision for measurable outcomes

The ICT is a team of caregivers from different professional disciplines who work together to deliver care plan services that optimize quality of life and support for the member and the member's family. Provider participation is an integral part of the ICT. Other team members may include:

- The member and/or the member's authorized caregiver
- The member's providers and/or nurses
- Humana Healthy Horizons' care coordinators
- Social workers and community social service providers
- Humana Healthy Horizons' and/or the member's behavioral health professionals
- Humana Healthy Horizons' community health educators
- Additional participants of the member's choice

The provider-inclusive ICT model supports the following:

- Provider treatment and medication plan.
- Provider goals via the Humana Healthy Horizons care management team of nurses, social workers, and pharmacy and behavioral health specialists.
- Member education and enhancement of direct member/provider communication.
- Self-care management and informed healthcare decision making.
- Care coordination and care transitions.
- Access and connections to additional community resources.
- Coordination of Medicare and Medicaid benefits and services including LTSS.
- Appropriate advance illness and end-of-life planning. Indiana law allows for the following two types of advance directives: designation of a healthcare power of attorney and creation of a written healthcare directive, also known as a living will. Providers should ensure members are informed of these rights.

Expected provider communication and reporting responsibilities:

- Maintain frequent in-person or phone communication with the ICT (and other providers of care and services including specialist providers, hospitals and/or ancillary providers) to ensure continuity of care and effective care coordination.
- Report immediately actual or suspected elder abuse or domestic violence to the local law enforcement agency by telephone and submit a follow-up written report within the time frames as required by law. For information, see the **critical incident reporting** section of this manual.
- Provide all requested medical record documentation and information to support Humana Healthy Horizons' fulfillment of state and federal regulatory and accreditation obligations (e.g., Healthcare Effectiveness Data and Information Set HEDIS®* and National Committee for Quality Assurance NCQA), including applicable access to electronic health records.

Evaluate

The care coordinator and service coordinator evaluate the ICP on a quarterly basis (at a minimum) to confirm that the services contained within are meeting the member's needs and that the member is making progress toward health and personal goals. Information found to the contrary prompts a full or partial reassessment and update to the ICP. In addition, a trigger event or change in the member's condition may signal the services on the ICP are not sufficient to meet the member's needs, including needs related to chronic condition management, preventive care, social needs or remaining in the least restrictive setting. The care coordinator and service coordinator complete a timely full or partial reassessment and ICP after a trigger event or change in condition.

Chronic and complex conditions

Humana Healthy Horizons' clinical practice guidelines, available to both affiliated and nonaffiliated providers on the Humana Healthy Horizons website, incorporate relevant, evidence-based medical and behavioral health guidelines (preventive and certain nonpreventive acute and chronic conditions) from recognized sources such as professional medical associations, voluntary health organizations and National Institutes of Health (NIH) centers and institutes. Identification of chronic conditions are assessed via CHAT or other state-approved assessments; questions evaluate member knowledge/understanding of chronic condition(s), the established relationship with the PMP and specialty providers, and completion of recommended monitoring visits and care.

Electronic visit verification and service gap reporting procedures for LTSS

In compliance with the 21st Century Cures Act, providers of personal care services and home health services are required to utilize electronic visit verification (EVV) to electronically monitor, track and confirm personal care and home health services provided in the home setting.

Personal Care Services include:

- Respite Care (skilled or unskilled)
- Attendant Care
- Homemaker Services

Home Health Services include:

- Home infusion
- Home Health Visits (home health aide, licensed practical nurse, and registered nurse)
- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech Therapy (ST)
- PT, OT, and/or ST evaluations

Federal law requires that providers use the EVV system to document the following information:

- Date of service
- Location of service
- Individual providing service
- Individual receiving the service
- Type of service
- Time the service begins and ends

Service gaps are identified and must be addressed in a timely manner, including gaps in critical services. Providers play an important role in supporting the timely notification to Humana Healthy Horizons of missed visits and/or schedule changes.

If providers discover the information in the EVV portal does not match the current authorization on file, the provider is advised to contact the Provider Services Contact Center for support. The International Journal of Critical Infrastructure Protection is using Sandata as the state-sponsored system for implementing federal EVV requirements. During the initial authorization process, providers are provided contact information to encourage active collaboration and participation in the ICT process. The provider agency can execute a member's backup plan by finding an alternative employee for the scheduled service at the scheduled time, alerting the service coordinator of the need to either support the scheduled service or implement other measures.

For additional information, see **EVV** in Chapter 12.

*HEDIS is a registered trademark of the NCQA.

Chapter 10: Quality management

Quality improvement program overview

Humana Healthy Horizons' Quality Management and Improvement Program (QMIP) is a comprehensive quality improvement program that encompasses clinical care, preventive care, population health management and Humana Healthy Horizons' administrative functions. It is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable medical and behavioral health services. Strategies are identified and activities implemented in response to findings. Using a continuous quality improvement methodology, the QMIP works to:

- Monitor systemwide issues
- Identify opportunities for improvement
- Determine the root cause of problems identified
- Explore alternatives and develop a plan of action
- Activate the plan, measure the results, evaluate effectiveness of actions and modify the approach as needed

The QMIP activities include monitoring clinical indicators or outcomes, quality studies, HEDIS measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program, National Core Indicators Survey—Aging and Disabilities results and medical record audits. The quality management and improvement committee (QMIC) is delegated by Humana Healthy Horizons' internal board of directors to monitor and evaluate the results of program initiatives and to implement corrective action when the results are less than desired or when areas needing improvement are identified. The QMIC is accountable to Humana Healthy Horizons' executive management team.

The goals of the QMIP:

- Developing clinical strategies and providing clinical programs that look at the whole person, while integrating behavioral and physical healthcare
- Identifying and resolving issues related to member access and availability to healthcare services
- Providing a mechanism where members, practitioners and providers can express concerns to Humana Healthy Horizons regarding care and service
- Providing effective customer service for member and provider needs and requests
- Monitoring coordination and integration of member care across provider sites
- Monitoring, evaluating and improving the quality and appropriateness of care and service delivery to members through peer review, quality improvement projects (QIPs), medical/case record audits, performance measures, surveys and related activities
- Providing a comprehensive strategy for population health management that addresses member needs across the continuum of care
- Providing mechanisms to assess the quality and appropriateness of care furnished to members with special healthcare needs
- Providing mechanisms to detect both underutilization and overutilization
- Providing mechanisms where members with complex needs and multiple chronic conditions can achieve optimal health outcomes
- Guiding members to achieve optimal health by providing tools that help them understand their healthcare options and take control of their health needs
- Monitoring and promoting the safety of clinical care and service
- Adopting reimbursement models that incentivize the delivery of high-quality care
- Promoting better communication between departments and improved service and satisfaction to members, practitioners, providers and associates
- Promoting improved clinician experience for providers and all clinicians to promote member safety, provider satisfaction and provider retention

Activities of the QMIP include developing clinical practice guidelines, reviewing medical record documentation, monitoring HEDIS measures, measuring member satisfaction and performing external quality reviews.

Quality improvement committee

The Humana Healthy Horizons QMIC directs the quality activities of the plan. The QMIC meets quarterly and reports to the corporate quality improvement committee. Humana Healthy Horizons' medical director, LTSS program manager and pharmacy director are active members of the QMIC. The QMIC also comprises leadership across the organization, including provider relations and LTSS support, as well as stakeholders such as members, aging and disability-led advocacy groups, medical and behavioral health providers, LTSS providers, community partners, caregivers and subcontractors as appropriate. The QMIC contains voting members showcasing multidepartment representation of the centralized and regionalized areas of operations. Their recommendations are expected to be based on sound operational data, in support of member service and well-being.

The QMIC is responsible for the following:

- Reviewing and approving any changes to the QMIP program description, work plan and/or evaluation
- Monitoring and reviewing work plan execution, performance on quality and outcome measures and progress toward goals and performance of QIP initiatives
- Reviewing and approving any changes to quality management policies and procedures
- Tracking and managing responsibilities of quality management staff and assessing compliance with program expectations
- Managing the dissemination of information to providers regarding quality outcomes

Quality measures

HEDIS and other performance measures

HEDIS is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. HEDIS includes care coordination measures for members transitioning from a hospital or emergency department to home for which hospitals and providers have additional responsibilities. Humana Healthy Horizons may conduct medical record reviews to validate HEDIS measures. In addition to medical record reviews, information for HEDIS is gathered administratively via claims, encounters and submitted supplemental data. There are two primary routes for supplemental data:

- Nonstandard supplemental data involves directly submitted, scanned images (e.g., PDF documents) of completed attestation forms and medical records. Nonstandard data also can be accepted electronically via a proprietary Electronic Attestation Form or Practitioner Assessment Form. Submitted nonstandard supplemental data is subject to audit by a team of nurse reviewers before ending a HEDIS improvement opportunity.
- Standard supplemental data flows directly from one electronic database (e.g., population health system, electronic medical record) to another without manual interpretation. Therefore, standard supplemental data is exempt from audit consideration. Standard supplemental data can be accepted via HEDIS-specific custom reports extracted directly from the provider's EMR or population health tool and is submitted to Humana Healthy Horizons via either secure email or FTP transmission. Humana also accepts lab data files in the same way. Humana partners with various EMRs to provide member summaries and detail reports and to automatically retrieve scanned charts.

Encounter validation study

Accurate and complete encounter data is critical to the success of any managed care program. State Medicaid agencies rely on the quality of the encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates and obtain complete and accurate utilization information. The completeness and accuracy of this data is essential to the success of the state's overall management and oversight of its Medicaid managed care program and in demonstrating its responsibility and stewardship. The state has the right to audit all encounter data at its choosing. This often includes validating the information on the encounter against providers' medical records. In the event of an encounter data validation review, providers may be asked for their medical records in support of the encounters submitted.

Provider participation in the Quality Management and Improvement Program

Network providers are contractually required to comply with Humana Healthy Horizons' Quality Management and Improvement Program (QMIP), which includes providing member records for assessing quality of care and external quality review organization activities. In addition, the HIPAA Privacy Rule of 45 CFR 164.506 and rules and regulations

promulgated thereunder (45 CFR Parts 160, 162 and 164) permit a covered entity (provider) to use and disclose PHI to health plans without member authorization for treatment, payment and healthcare operations activities. Healthcare operations include but are not limited to the health plan conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing healthcare costs, care management and care coordination. Providers also must allow Humana Healthy Horizons to use provider performance data.

Evaluation of the Quality Management and Improvement Program

Humana Healthy Horizons evaluates the effectiveness of the QMIP on an annual basis. The annual report reviews completed and continuing QMIP activities, assesses the progress in meeting goals, addresses the quality of clinical care and service, trends measures to assess performance in quality of clinical care and quality of service, identifies any corrective actions implemented or corrective actions that are recommended or in progress and identifies any modifications to the QMIP. Information regarding the QMIP is available upon request.

Medical record requirements

Providers must maintain a detailed and comprehensive health record that reflects all aspects of care for each member. Providers must maintain medical records in a secure, timely, legible, current, detailed, accurate and organized manner that permits effective and confidential member care and quality review and facilitates accurate follow-up treatment.

Confidentiality of member information must always be maintained. Records should be safeguarded against loss, destruction or unauthorized use and must be accessible for review and audit. Such records must be readily available to Humana Healthy Horizons, FSSA and/or its designee within the time frame identified in the request and contain all information necessary for the medical management of each Indiana PathWays for Aging member. Providers must have procedures in place to permit the timely access and submission of health records to Humana Healthy Horizons on request. Failure to submit records in a timely manner may result in additional action and follow-up.

Providers must maintain individual health records for each Indiana PathWays for Aging member. On reasonable request by a member, providers must provide a copy of a member's medical record at no charge. Procedures also should exist to facilitate the prompt transfer of member care records to other in-plan or out-of-plan providers.

Minimum standards for member medical records

In accordance with 405 IAC 1-1.4-2, a member's medical record must include the following information, at minimum:

- The identity of the individual to whom service was rendered
- The identity of the provider rendering the service
- The identity, including date signature or initials, and position of the provider employee rendering the service, if applicable
- The date on which the service was rendered
- The diagnosis of the medical condition of the individual to whom service was rendered (relevant only to providers, optometrists and dentists)
- A detailed statement describing the type and duration of services rendered
- The location where services were rendered
- The amount claimed through Medicaid for each specific service rendered
- Written evidence of provider involvement, including signature or initials, and personal member evaluation to document the acute medical needs, excluding HCBS services
- Plan of treatment and progress notes that confirm effectiveness of treatment, including regular evaluations to assess performance and refine goals when applicable (e.g., pest control and home modification would not require a treatment plan)
- X-rays, mammograms, electrocardiograms, ultrasounds and other electronic imaging records

Medical records should be signed (manually or electronically), dated, preserved and maintained by the provider for a minimum of seven years unless federal requirements mandate a longer retention period (i.e., immunization and tuberculosis records are required to be kept for a person's lifetime).

Providers must permit Humana Healthy Horizons and representatives of FSSA to review members' medical records for the purposes of monitoring provider compliance with medical record standards, capturing information for clinical studies and monitoring quality or any other reason, in accordance with 405 IAC 1-1.4-2. Identified areas for improvement are

tracked and corrective actions are taken as indicated. Effectiveness of corrective actions is monitored until problem resolution occurs. Information from the health records review may be used in the recredentialing process.

Primary medical provider value-based programs

Humana Healthy Horizons is committed to reducing costs and improving quality of care in the communities we serve. We have developed VBP programs that allow PMPs to earn financial incentives based on quality and clinical outcomes. The programs are designed based on the provider's panel size and engagement. PMPs managing a panel with a minimum of 30 Humana Healthy Horizons members as of the end of February and December of each calendar year may be eligible to participate in an upside-only pay-for-performance program with incentive payments to providers for meeting quality measure goals that encourage timely access to care and improved outcomes. PMPs with larger panels may also be eligible to participate in shared savings or two-sided risk arrangements. If you are interested, you should reach out to your Provider Education/Outreach Representative for more information. Quality (pay-for-performance) incentives are reviewed and reimbursed annually, one quarter in arrears to allow for reporting/data collection. Shared savings or two-sided arrangements are reconciled on an agreement-specific basis.

Compliance plan

Compliance and ethics

At Humana Healthy Horizons, we serve a variety of audiences: members, providers, government regulators and community partners. We serve them best by working together with honesty, respect and integrity. We are all responsible for complying with all applicable state and federal regulations along with applicable Humana Healthy Horizons policies and procedures. Humana Healthy Horizons is committed to conducting business in a legal and ethical environment. A compliance plan has been established by Humana Healthy Horizons that:

- Formalizes Humana Healthy Horizons' commitment to honest communication within the company and within the community, inclusive of our providers, members and employees
- Develops and maintains a culture that promotes integrity and ethical behavior
- Facilitates compliance with all applicable local, state and federal laws and regulations
- Implements a system for early detection and noncompliance reporting with laws and regulations; fraud, waste and abuse concerns; or noncompliance with Humana Healthy Horizons policy, professional, ethical or legal standards
- Allows us to resolve problems promptly and minimize negative impact on our members or business including financial losses, civil damages, penalties and sanctions
- Acts according to professional ethics and business standards
- Ensures member privacy standards through strict adherence to best practices in combating HIPAA violations
- Creates a cultivated curriculum of education training and materials for members, staff, contractors and member caregivers to share critical content
- Establishes effective monitoring and audits to help ensure accurate claims and the identification of risks, particularly in high-volume service areas
- Notifies us of suspected violations, misconduct, or fraud, waste and abuse concerns.
- Cooperates fully with any investigation of alleged, suspected or detected violations of applicable state or federal laws and regulations.

We appreciate your commitment to compliance with ethics standards and the reporting of identified or alleged violations of such matters.

Member safety

Humana Healthy Horizons supports implementation of a complete range of member safety activities. These activities include medical record legibility and documentation standards, communication and coordination of care across the healthcare network, utilization of evidence-based clinical guidelines to reduce practice variations, tracking and trending adverse events/quality of care issues and grievances related to safety and quality of care.

Member safety also is addressed through adherence to clinical guidelines that target preventable conditions. Preventive services include:

- Regular checkups for adults.
- Tests for cholesterol, blood sugar, colon and rectal cancer, bone density and sexually transmitted diseases, and PAP tests and mammograms

Preventive guidelines address prevention and/or early detection interventions and the recommended frequency and conditions under which interventions are required. Prevention activities are based on reasonable scientific evidence, best practices and member needs.

Prevention activities include distribution of information, encouragement to use screening tools and ongoing monitoring and measuring of outcomes. While Humana Healthy Horizons implements activities to identify interventions, the support and activities of families, friends, caregivers, providers and the community have a significant impact on prevention.

Preventive guidelines and clinical practice guidelines

These protocols, developed in consultation with our contracting professionals, incorporate relevant, evidence-based medical and behavioral health guidelines from recognized sources such as professional medical associations, voluntary health organizations and NIH centers and institutes. Humana Healthy Horizons considers the needs of our members when adopting guidelines. Humana Healthy Horizons reviews newly adopted and updated clinical practice guidelines in its QMIC under the direction of the medical director and participation of contracted network providers. The guidelines help providers make decisions regarding appropriate healthcare for specific clinical circumstances. Condition-specific and/or disease-related practice guidelines include elements such as:

- Overview of condition/disease
- Information related to anticipating, recognizing and responding to condition/disease-related symptoms
- Information related to best practice standards for prevention and management of condition/disease
- Guidelines/process for the ICT to use regarding negotiating incorporation of condition/disease prevention and management plan with member into the care plan
- Plan for quality assurance monitoring of guideline effectiveness

We strongly encourage providers to consider and use these guidelines whenever they promote positive outcomes for clients. The provider remains responsible for determining the applicable treatment for each individual.

The use of these guidelines allows Humana Healthy Horizons to measure the impact of the guidelines on outcomes of care. Humana Healthy Horizons monitors provider implementation of guidelines using claim, pharmacy and utilization data. Areas identified for improvement are tracked and corrective actions are taken as indicated.

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

- Provider manual updates
- Provider communications
- Provider website

Providers also can receive preventive health and clinical practice guidelines through their provider engagement representative. Clinical practice guidelines also are available to providers, members and the public on our website at **Humana.com**.

Chapter 11: Utilization Management

Utilization Management program overview

Our Utilization Management program is designed to ensure members receive access to the right care, in the right place, at the right time. Our goal is to optimize the member's benefits by providing quality healthcare services that meet professionally recognized standards of care; are a covered benefit, medically necessary and appropriate for the individual member's condition; and are provided at the most appropriate level of care. Humana Healthy Horizons does not reward providers or our staff for denying coverage or services. There are no financial incentives for Humana Healthy Horizons staff to encourage decisions that result in underutilization. Humana Healthy Horizons does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition. Services supporting individuals with continuing or chronic conditions or who require LTSS are authorized in a manner that reflects the member's ongoing need for such services and supports. Authorization is not a guarantee of payment. Authorization is based on medical necessity and is contingent on eligibility, benefits and other factors. Benefits may be subject to limitations and or qualifications and are determined when the claim is received for processing.

The Utilization Management department performs all Utilization Management activities including prior authorization, concurrent review, discharge planning and other activities that monitor inpatient and outpatient admissions and procedures to ensure appropriate medical care is rendered in the most appropriate setting, using the most appropriate resources. Only providers licensed in Indiana or a licensed doctorate-level behavioral health clinician may deny a service authorization request based on medical necessity criteria or authorize a service in an amount, duration or scope that is less than requested. We assure that behavioral health services are integrated and coordinated with physical health services, regardless of whether the member resides in a facility or the community and that behavioral health services are provided as part of the treatment continuum of care. Humana Healthy Horizons completes an assessment of satisfaction with the Utilization Management process on an annual basis, identifying areas for improvement.

Prior authorization

Information required for a prior authorization request or notification may include, but is not limited to:

- Member's State Medicaid ID number, date of birth and address
- Dates of service or hospital admission
- Requesting provider name, address, National Provider Identifier (NPI) and Tax Identification Number (TIN)
- Rendering provider name, address, NPI and TIN
- OPR provider information
- Preparer's name, phone and fax number
- International Classification of Diseases (ICD) diagnosis codes
- Procedure/service codes and description
- Modifiers
- Taxonomy
- Place of service
- Relevant clinical information

Submitting all relevant clinical information at the time of the request will facilitate a quicker determination. If additional clinical information is required, a Humana Healthy Horizons representative will request the specific information needed to complete the authorization process.

Requesting prior authorization

Prior authorization

Healthcare providers should review the PathWays Preauthorization and Notification List (PAL) online at **Humana.com/PAL**.

How to request prior authorization

To initiate a prior authorization, notification or referral request, a provider may:

A. Visit Availity Essentials at **www.availity.com** (registration required). For many services that require prior authorization, you can answer a series of questions when requesting the prior authorization. If approved, you will

receive notification immediately. If pended for further review, you can attach relevant clinical information to the request to expedite the process.

B. Submit a B2B or batch Health Care Services Review and Response transaction (278) via electronic data interchange (EDI).

C. Use our interactive voice response (IVR) system.

D. Call the number for precertification on the back of the member's Humana Healthy Horizons ID card.

E. Fax the IHCP Prior Authorization Request Form to **502-324-6376** (Medicaid only) or **502-405-5020** (dual eligible) for both physical health and behavioral health authorizations.

If a request needs to be expedited due the severity of a member's condition, call **866-274-5888 (TTY: 711)**. A copy of the Indiana Prior Authorization Form is located on the provider website.

Services that require prior authorization

Humana Healthy Horizons offers providers an authorization lookup tool using Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes. You can call Member Services at **866-274-5888 (TTY: 711)** to request a hard copy of the PAL. Please note that the PAL is subject to change. Changes to the prior authorization requirements will be posted a minimum of 45 days prior to the effective date of the change at **Humana.com/PAL**.

Medical services and behavioral health/SUD services are evaluated for addition or removal from the PAL, utilizing the same factors in accordance with the MHPAEA. Requests for preauthorization should be made as soon as possible but at least 14 days in advance of the service date. If preauthorization is required and not obtained, it may result in reduction or denial of payment.

Services provided without preauthorization also may be subject to retrospective review. When retrospective review is required, providers must include clinical information to perform a medical necessity review, as well as a summary of why preauthorization was not obtained.

Self-referrals

Humana Healthy Horizons does not require a referral from the member's PMP to any IHCP provider qualified to provide the below services:

- Chiropractic services by a licensed chiropractor enrolled as an Indiana Medicaid provider, when rendered within the scope of practice of chiropractic as defined in IC 25-10-1-1 and 846 IAC 1-1
- Eye care services, except surgical services, by any IHCP-licensed provider under IC 25-22.5 (doctor of medicine, doctor of osteopathy) or IC 25-24 (optometrist)
- Routine dental services by any in-network, IHCP-licensed dental provider under IC 25-13 (dental hygienist) or IC 25-14 (dentist)
- Podiatric services by any IHCP-licensed provider under IC 25-22.5 (doctor of medicine, doctor of osteopathy) or IC 25 29 (doctor of podiatric medicine)
- Psychiatric services by any provider licensed under IC 25-22.5

Humana Healthy Horizons members may self-refer to in-network providers for behavioral health services not provided by a psychiatrist, including mental health, substance use and chemical dependency services rendered by mental health specialty providers. The providers to which the member may self-refer within network are:

- Outpatient mental health clinics
- Community mental health centers (CMHCs)
- Psychologists
- Licensed psychologists
- Health service providers in psychology (HSPPs)
- Licensed social workers (LSWs)
- Licensed clinical social workers (LCSWs)
- Psychiatric nurses
- Independent practice school psychologists
- Advanced practice nurses (APN) under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center

- Persons holding a degree in social work, marital and family therapy, or mental health counseling (under the clinic option)

The services to which the member may self-refer within network are:

- Sexually transmitted disease testing
- Women's health (if rendered by an in-network women's health specialist).
  - Women's health services cover routine and preventive healthcare services, such as mammography screening and influenza vaccinations that are provided as basic benefits for women. This is in addition to the member's designated PMP if that provider is not a women's health specialist.
- Immunizations from any IHCP-enrolled provider, which are covered regardless of where they are received.
- Diabetes self-management services received from an IHCP enrolled DSMT provider.
- Urgent care services.
- Emergency services (without the need for prior authorization in and out of network)
  - Emergency services shall be available 24 hours a day, seven days a week. Humana Healthy Horizons does not require authorization for any emergency room (ER) services or emergent conditions categorized as such by any prudent layperson. We also do not reduce payments for treatment room charges, thus eliminating the need for any autopay lists, authorizations or medical necessity reviews.

Members may not self-refer to a provider who is not enrolled in IHCP.

Humana Healthy Horizons members may see any participating network provider, including specialists and inpatient hospitals, without a PMP referral. However, prior authorization must be obtained for nonparticipating providers.

Ensuring that Humana Healthy Horizons allows for continuity of care, a PMP may request a standing referral for members with special healthcare needs that the PMP determines are in need of a course of treatment or regular care monitoring, to access a specialist to receive this treatment over a prolonged period of time.

Specialist referrals

The PMP is responsible for recommending or initiating referrals for specialty care as needed. However, Humana Healthy Horizons does not require a referral from the member's PMP for some self-referred services. See **Self-referrals** in Chapter 11 of this manual for more details.

Referrals may be made by the PMP for specialty care and other medically necessary services, both in and out of network, when such services are not available within the Humana Healthy Horizons network. The PMP is responsible for maintaining clinical records regarding referrals in a complete and accurate medical record that meets or exceeds FSSA specifications.

For behavioral healthcare, Humana Healthy Horizons assists with provider referrals by coordinating care between behavioral health providers, PMPs and specialists.

See **How to request prior authorization** in Chapter 11 of this manual for more details on initiating a referral request.

Service plan authorization

Humana Healthy Horizons partners with members to support the development of its member-directed service plans to deliver services that are person-centered, participant-driven, and holistic, and address members' SDOH, involving their caregivers, as appropriate. The member, the member's designated representative (if applicable), providers and all others involved in and/or responsible for the service plan and its implementation must sign the service plan either electronically or in writing for it to be completed. The member's service plan is the authorization for services to be delivered. Humana Healthy Horizons does not require providers to submit additional authorization requests for these services. The service plan is the authorization for the services. The member's service plan is integrated into the member's overall ICP.

If the member disagrees with the service plan, the member may sign indicating disapproval. If this occurs, the plan provides the member with a denial notice within two business days. The denial notice will include information on the member's right to file a grievance. A copy of the signed service plan is provided to the member and all the ICT members.

Special considerations for LTSS service authorizations

Humana Healthy Horizons does not interfere with the member's setting of choice once level of care is determined. If a member is determined eligible for NFLOC, Humana Healthy Horizons does not deny an authorization for the member

to receive necessary care in an in-network nursing facility. Likewise, Humana Healthy Horizons will not deny an authorization for that same member to receive the necessary care at home instead of in a facility.

Special considerations for HCBS
Humana Healthy Horizons will authorize HCBS based on the member's current needs assessment, consistent with the member's person-centered service plan.

Specialized behavioral health services
Residential SUD services that include short-term, low-intensity and high-intensity residential treatment for opioid use disorder (OUD) and other SUDs in settings of all sizes, including facilities that qualify as institutions for mental disease (IMD), are a covered benefit under the Indiana PathWays for Aging program.

Prior authorization is required for all residential SUD stays. Admission criteria for residential stays for OUD or other SUD treatment are based on the following ASAM member placement criteria: ASAM Level 3.1—Clinically Managed Low-Intensity Residential Services and ASAM Level 3.5—Clinically Managed High-Intensity Residential Services.

When residential services are determined medically necessary for a member, Humana Healthy Horizons approves the number of days based on medical necessity. If a facility determines that a member requires additional time after the initial approval of days, the provider should submit a concurrent review authorization request. That request shall include things such as a reassessment of risk, progress or barriers to achieving treatment plan goals, and updated treatment plan objectives with updates. Additional days will be reviewed for medical necessity. Notifications of determination of requests of initial and concurrent review are rendered within state-mandated turnaround times. Please see below for the determination time frames.

Institutions for mental disease (IMDs)

SMI
Humana covers short-term stays in an IMD for SMI under FSSA regulations. IMD treatment is a medically appropriate and cost-effective substitute for behavioral services covered under the State Plan in other settings. Humana may use IMD services in lieu of other behavioral health services when medically appropriate. Humana allows Indiana PathWays for Aging members between the ages of 60 and 64 an average length of stay not to exceed 30 days for all IMD stays for SMI. If medically necessary, a maximum of 60 days may be approved for short-term IMD stays for SMI.

SUD
Humana covers short-term stays in an IMD for SUD under FSSA regulations. IMD treatment is a medically appropriate and cost-effective substitute for behavioral services covered under the State Plan in other settings. Humana may use IMD services in lieu of other behavioral health services when medically appropriate. Humana allows Indiana PathWays for Aging members between the ages of 60 and 64 up to 15 days for a short-term Inpatient stay in a calendar month as medically necessary for individuals with a diagnosis of SUD. If the member's IMD SUD stay exceeds 15 days in a calendar month and the member is awaiting placement in a state-operated facility (SOF) for treatment, the member is disenrolled from the plan and enrolled in a fee-for-service plan. For SUD stays in an IMD exceeding 15 days in a calendar month in which the member is not awaiting placement in an SOF, the member will remain enrolled in the Indiana PathWays for Aging program and the state will recover the entire monthly capitation payment for the member.

Humana covers short-term crisis residential stays for SUD in a qualified IMD for Indiana PathWays for Aging members age 60 to 64 per medical necessity requirements and not to exceed an average length of stay of 30 days.

Humana is paid monthly capitation payments by the state to cover short-term inpatient stays for SMI in a qualified IMD for members age 60 to 64 per medical necessity requirements and not to exceed an average length of stay of 30 days. A maximum stay of 60 days can be approved, if medically necessary, for short-term IMD stays for SMI members.

Humana will coordinate with IMDs and providers to coordinate care for members receiving care. This will include anticipating and planning for a member's discharge and coordination of follow-up services.

For Indiana PathWays for Aging members up to age 64, IMD stays are subject to medical necessity reviews only.

Time frames and notifications for responding to prior authorization requests

Standard

Humana Healthy Horizons will provide notice of decision as expeditiously as the member's health condition requires but no later than five business days following receipt of the request for service. The member or the member's provider may request an extension up to 14 calendar days. Humana Healthy Horizons may request an extension up to 14 calendar days if we can justify there is a need for more information and explain to the state how the extension is in the best interest of the member. Written notice of the extension will be provided to the member and will include the reason for the extension and the member's right to file a grievance.

If Humana Healthy Horizons fails to respond to a prior authorization request not pertaining to medications within five business days of receiving the necessary documentation, the authorization is considered granted.

Expedited/urgent

When a provider indicates, or Humana Healthy Horizons determines, that following the standard time frame could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function, Humana Healthy Horizons completes an expedited authorization as expeditiously as the member's health condition requires and provides the decision and notice no later than 48 hours after receipt. The member or the member's provider may request an extension up to 14 calendar days. Humana Healthy Horizons may request an extension up to 14 calendar days if we can justify there is a need for more information and explain to the state how the extension is in the best interest of the member. Written notice of the extension is provided to the member and includes the reason for the extension and the member's right to file a grievance.

Concurrent reviews

Concurrent requests are requests in which the member is in the process of receiving the requested medical care or services, even if Humana Healthy Horizons did not previously approve the earlier care. Notice of decision is provided as expeditiously as the member's health condition requires but no later than 48 hours.

Retrospective determinations

Humana Healthy Horizons will provide a notice of decision within 30 calendar days of receipt of the retrospective request. Humana Healthy Horizons will not retroactively deny authorization for the continuation of care unless the provider submitted the authorization untimely.

For authorizations originally approved by Humana Healthy Horizons, if we deny the continuation of services with the skilled nursing facility or long-term attendant care, we must provide at least five days of coverage for the services from the date of the notice of denial, to ensure the safe discharge of the member. This requirement does not apply for authorizations submitted untimely by the provider.

For requests related to HCBS, Humana Healthy Horizons will make an expedited authorization decision and issue notice to the member within 24 hours of the decision to deny authorization for services contained in the member's service plan. Under no conditions will Humana Healthy Horizons extend the 24-hour time frame.

When there are any decisions to terminate, suspend or reduce previously authorized covered services because of probable member fraud verified by the Indiana Office of Inspector General or the attorney general, Humana Healthy Horizons will provide notice five business days before the date the indicated service would be terminated, suspended or reduced.

Humana Healthy Horizons notifies the requesting provider and provides written notice of all determinations that deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested.

Court-ordered services

Humana Healthy Horizons provides medically necessary and covered behavioral health services pursuant to court order(s). These services are furnished in the same manner as services furnished to other members.

Notification requirements for hospital admissions and hospice care

Observation requirements

Humana Healthy Horizons pays the contracted or fee schedule rate for observation stays, regardless of whether a related emergency visit was determined emergent. Providers can maintain members for more than 23 hours in observation

when the member has not met criteria for admission, but the treating physician believes that allowing the member to leave the facility would likely put the member at serious risk. The observation period cannot last more than three days or 72 hours. Humana Healthy Horizons does not require prior authorization for observation stays. However, notification is requested so we can assist with discharge planning and follow the member for any needs.

Inpatient requirements
Humana Healthy Horizons requires the provider to submit notification to the plan of all inpatient admissions within one business day of the date of admission. With appropriate consent, Humana Healthy Horizons will notify the member's provider when a member is hospitalized or receives emergency treatment within five calendar days of the hospital inpatient admission or emergency treatment.

Hospice requirements
Humana Healthy Horizons requires notification within 10 days from the date of hospice election or the start date of a hospice benefit period for members who reside in a nursing facility and have elected to use the hospice benefit. Notifications can be submitted through Availity Essentials (**www.availity.com**).

Notification can be made using the **Indiana Medicaid Hospice Election Form** State Form 48737 (R2/1-12). This form can be submitted online via **Availity Essentials**, by emailing the form to **IN_MCD_Intake@humana.com**, faxing the form to the Indiana Medicaid Clinical Intake Team at **502-324-6376**, or by calling Humana Healthy Horizons' authorization intake team directly at **866-274-5888**, 8 a.m. to 8 p.m., Eastern time, Monday to Friday.

Prior authorization in transition of care

Humana Healthy Horizons will avoid disruption or sudden changes in the member's home health services without good cause and will consider the case history of each member and prioritize consistency in services. If a denial or reduction of hours occurs, Humana Healthy Horizons will work with the requesting provider and member to create a safe transition plan instead of stopping services abruptly. When a transition plan is needed, the Utilization Management clinician will initiate a referral to the assigned care coordinator. In addition, the clinician may initiate an interdisciplinary care team meeting, if needed.

Prior authorization requests review process

If additional clinical or other information is needed to determine medical necessity, Humana Healthy Horizons will request the relevant information. When requesting necessary information, at least two attempts are completed, including via telephonic outreach and/or fax. The request will clearly indicate what additional information is required to complete the prior authorization request. Humana Healthy Horizons may request additional clinical information to complete the medical necessity review, when needed, but will not request documentation that would change the authorized services or hours.

When additional information is needed, Humana Healthy Horizons can suspend the prior authorization request for up to 30 days to give the requesting provider additional time to submit the needed information. Suspending a request does not mean the request is denied but allows the requesting provider time to submit the needed information. If the prior authorization request is approved after the receipt of the additional information, the dates authorized are those on the originally suspended authorization request. If the additional requested information is not received within 30 calendar days after notification of suspension, the request will be denied.

Services that do not require prior authorization

Humana Healthy Horizons covers emergency services without prior authorization for both in- and out-of-network facilities.

Emergency and post-stabilization services

Humana Healthy Horizons covers emergency service and post-stabilization services without prior authorization for both in and out-of-network facilities.

Discharge planning

Humana Healthy Horizons believes that discharge planning is a key part of treatment and should begin at admission. Our Utilization Management staff reviews appropriateness of discharge planning as part of the clinical review to ensure the appropriateness of the member's transition plan from inpatient/higher levels of care.

Humana Healthy Horizons is available to assist in the coordination of care when a member is being discharged from a facility or transferring from one level of care to another to ensure the member's successful transition. The inpatient Utilization Management nurse works with the member, the member's authorized representative, the member's PMP, the facility care team and other providers, as appropriate.

In the event Humana Healthy Horizons is notified of a facility closure or license termination, we collaborate with the Office of the Long-Term Care (LTC) Ombudsman and local ombudsman to ensure all member transfer and discharge rights are upheld.

Humana Healthy Horizons' care or service coordination staff meets in person with facility staff and each member residing in the facility to initiate person-centered discharge planning within seven calendar days of receiving the notice of closure. Humana Healthy Horizons' care or service coordination staff collaborates with the facility and the Office of the LTC Ombudsman and local ombudsman to ensure the facility allows at least 30 days for the member's transfer out of the facility. Fewer than 30 days is permissible only if the member or authorized representative agrees with the transfer and all aspects of continuity of care are in place. Information and the communication of transfer options are based on the member's person-centered care plan and current medical and psychosocial condition. The information is communicated in person and in writing to the member.

Humana Healthy Horizons requires that members receiving inpatient psychiatric services are scheduled for outpatient follow up/or continuing treatment prior to their discharge. This treatment must be provided within seven calendar days of the date of the member's discharge.

Medical necessity review

All decisions are based on eligibility, coverage and medical necessity criteria. Humana Healthy Horizons uses the following hierarchy for medical necessity reviews:

A. Federal law
B. Indiana Code (IC)
C. State Plan
D. Indiana Administrative Code (IAC)
E. IHCP policy
    a. Applied behavioral analysis (ABA) therapy
    b. Drug testing
    c. EndoPredict breast cancer
    d. Hysterectomies
    e. ReliZorb®
    f. Speech-generating devices
    g. Spinal stenosis
    h. Transplants
    i. Bariatric procedures
    j. Oxygen usage
F. Noncustomized MCG™, ASAM for SUD treatments, Medicare national coverage determinations (NCDs) and local coverage determinations (LCDs).
    a. For MCG, diagnosis/procedure-specific guidelines will be used before general guidelines.
    b. For Medicare guidelines, NCDs are used before LCDs for Indiana.
G. Humana Healthy Horizons clinical coverage policies
    a. Professional society guidelines—guided by published, peer-reviewed literature
    b. Professional references/subject matter expert (SME)—guided by published, peer-reviewed literature
H. Best standards of care—Guided by published, peer-reviewed literature

As Humana Healthy Horizons applies coverage policies and medical necessity criteria, we consider individual member needs and an assessment of the local delivery system.

These guidelines are intended to allow Humana Healthy Horizons to provide all members with care that is consistent with national quality standards and evidence-based guidelines. These guidelines are not intended as a replacement for a provider's medical expertise; they are to provide guidance to our providers related to medically appropriate care and treatment. If a member's clinical information does not meet the criteria for approval, the case is forwarded to a medical director for further review and determination.

Clinical criteria used in making a Utilization Management determination is available upon request by contacting us at NABD_MCD_Letter_Review@humana.com.

Appeals process after medical necessity denials

If the member isn't satisfied with a decision or action Humana Healthy Horizons takes, an appeal can be filed by the member or the member's authorized representative. This section outlines the member's appeal rights. Please reference Chapter 13 of this manual for further details.

Peer-to-peer (P2P) consultations

Providers may request a P2P consultation when Humana Healthy Horizons denies a prior authorization request. P2P consultations are conducted among healthcare professionals who have clinical expertise in treating the member's condition, with the equivalent or higher credentials as the requesting/ordering provider. The P2P consultation must clearly identify what documentation the provider needs to provide to obtain approval of the specific item, procedure or service or a more appropriate course of action based on accepted clinical guidelines. If you would like to request a P2P discussion on a determination with a Humana Healthy Horizons provider reviewer, please send an email to INMCDP2PRequest@humana.com, fax your request to **502-324-6376** or leave a voicemail at **866-274-5888**. The P2P request must be made within 15 business days of the determination.

Appeals

Appeals may be requested if Humana Healthy Horizons denies a prior authorization request. The appeal request is separate from the P2P request. A provider, acting on behalf of the PathWays member, and with the member's written consent, may file an appeal. Appeals must be filed within 60 calendar days of the date of the adverse benefit determination notice.

Appeals can be filed by:

- Calling Member Services at **866-274-5888 (TTY: 711)**.
- Filling out the standard appeal form.
- Writing a letter that includes the following information:
  - Member name
  - Member identification number from the front of the member's Humana Healthy Horizons PathWays ID card
  - Member address and phone number
  - All information that will help explain the appeal

Mail the form or letter to:
Humana Healthy Horizons in Indiana
Grievance and Appeal Department
P.O. Box 14169
Lexington, KY 40512-4169
Fax the form or letter to **800-949-2961**.

Humana Healthy Horizons acknowledges receipt of the appeal within three business days of the day we received the appeal. If we extend the time frame for the appeal, we make reasonable efforts to provide a prompt oral notice of the delay. We also send written notice of the reason for the decision to extend the time frame. We also inform the member of the right to file a grievance if there is disagreement with that decision.

The member or someone that the member chooses can:

- Review all information used to make the decision
- Provide more information throughout the appeal review process
- Examine the member's case file before and during the appeals process

This includes medical records, clinical records, other documents and records, and all new or additional evidence considered, relied on or generated in connection with the appeal. This information is provided, on request, free of charge and sufficiently in advance of the resolution time frame.

If the member or the member's appointed representative feels waiting for the 30-day time frame to resolve an appeal could seriously harm the member's health, a request can be made for an expedited appeal.

You can request an expedited appeal if a delay could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain or regain maximum function.

If an expedited process is not required, we make reasonable efforts to provide prompt oral notice and the appeal will go through the normal process. We also inform the member of the right to file a grievance if there is disagreement with that decision.

Humana Healthy Horizons makes a decision on expedited appeals within 48 hours after the plan receives notice of the appeal, unless this time frame is extended. Humana Healthy Horizons also must make a reasonable attempt to give the member prompt oral notice by phone. Written notice of appeal disposition must be provided to the member, and where appropriate, the provider. Notice is made within five business days of resolution.

Negative actions are not taken against:
- A member who files an appeal
- A provider that supports a member's appeal or files an appeal or expedited appeal on behalf of a member with written consent

External review by an independent review organization (IRO)
A PathWays member, the member's authorized representative, or a provider acting on the PathWays member's behalf, with written consent, may file a written request for review of Humana Healthy Horizons' decision by an IRO. A member who exhausts Humana Healthy Horizons' appeal process may request an external review within 120 calendar days of the date on Humana Healthy Horizons' notice of resolution. An external review does not restrict or replace the member's right to appeal Humana Healthy Horizons' decision to a state fair hearing. A member may seek external review by an IRO, and this process can run concurrently with a state fair hearing.

Requesting external review by an IRO
Request for external review, along with all supporting documentation, must be submitted to:
Humana Healthy Horizons in Indiana
Attn: Grievance and Appeal Department
P.O. Box 14169
Lexington, KY 40512

When requesting an independent review, members or their representative may submit new or other relevant documentation as part of the request. The IRO will render a decision to uphold or reverse Humana Healthy Horizons' decision within 72 hours for an expedited appeal or 15 business days for a standard appeal. The determination made by the IRO is binding to Humana Healthy Horizons.

For more information about external review by an IRO, please contact **866-274-5888 (TTY: 711)**.

State fair hearing
The member, the member's authorized representative or the member's provider, with written consent, may request a state fair hearing within 120 calendar days of exhausting Humana Healthy Horizons' grievance and appeal process. The state fair hearing process may run concurrent to an external review by an IRO. If dissatisfied with the outcome of the state fair hearing, the member may request an agency review within 10 days of the administrative law judge's decision.

To request a state hair hearing, the member or the member's representative should send the request to:
Office of Administrative Law Proceedings – FSSA Hearings
100 N. Senate Avenue, Room N802,
Indianapolis, IN 46204.
Phone: **317-234-6689** or **866-259-3573**
Fax: **317-232-4412** | Email: fssa.appeals@oalp.in.gov

Second opinions

Humana Healthy Horizons complies with all PathWays member requests for a second opinion from a qualified professional. Humana Healthy Horizons does not require a second opinion for surgery or other medical services. However, providers or members may request a second opinion at no cost. If a qualified provider is not available to give a second opinion in a timely manner, Humana Healthy Horizons arranges for the member to obtain the second opinion outside of the network at no cost to the member.

The following criteria should be used when selecting a provider for a second opinion. The provider:

- Must participate in the Humana Healthy Horizons network. If not, prior authorization must be obtained.
- Must not be affiliated with the member's PMP or the specialist practice group from which the fist opinion was obtained.
- Must be in an appropriate specialty area.

Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

Out-of-network providers

Humana Healthy Horizons authorizes out-of-network care, based on medical necessity, when a network provider is not available to provide members with medically necessary covered services in a timely manner. Humana Healthy Horizons coordinates payment with the out-of-network provider to confirm that costs to the member are not greater than they would be if the service were provided in network. Humana Healthy Horizons also takes into consideration continuity of care and long term specialized care needs, including oncology and transplant services.

Utilization Management delegation

Humana Healthy Horizons does not delegate physical health or behavioral health prior authorization functions to subcontractors, with the exception of dental, vision and pharmacy.

Right Choices Program

The Right Choices Program (RCP) is designed for individuals enrolled in the Indiana PathWays for Aging program selected for review based on their behavior patterns and utilization practices compared with other members of the same population. Reviews may also be initiated by referral, based on reports of potential overuse or abuse from various sources such as providers or other agencies. It is intended to limit overuse of benefits while providing an appropriate level of care for the member. Humana Healthy Horizons will educate RCP members on how to properly use their health insurance.

Humana Healthy Horizons monitors claim activity for signs of misuse or abuse in accordance with the state and federal laws. If a review of a member's claim activity reveals overutilization of covered services such as excessive ER visits, doctor shopping/visits, large number of controlled substance prescriptions filled at different pharmacies and/or misuse of prescriptions, the member is considered a candidate for RCP.

After the review process, if it is determined that the member is overusing or abusing services, the member is placed in the RCP, which includes increased care coordination, provider assignment, member education and interventions. The member is locked into a single primary medical provider (PMP) and a single pharmacy. If the member requires services from a different provider, such as a specialist, the PMP must submit a referral.

Members identified to be enrolled in the RCP receive written notification from Humana Healthy Horizons, along with the option to select a designated lock-in pharmacy and PMP. If a PMP and pharmacy are not selected within an appropriate time frame, a selection will be made for the member.
The member will receive written communication that provides the following information:

- Name, address and phone number of the designated provider and pharmacy
- How to handle an emergency
- How to request an override
- Member responsibilities

- Effective and end date of program enrollment
- Length of limitation
- Rights to appeal the decision

The PMP must use referrals if the RCP member requires evaluation or treatment by a specialist or another provider or needs to use the pharmacy other than the primary lock-in pharmacy. The purpose of the referral is to ensure the PMP has authorized the visit to the referral provider.

If you or the member have questions, please feel free to contact Humana Healthy Horizons in one of the following ways:

- Call **855-330-8054**, option 7, from 8 a.m. to 5:30 p.m., Eastern time. After hours, please leave a voicemail with the member's name, Medicaid ID number, contact phone number and a detailed description of your request.
- Fax **502-996-8184**.
- Email **CPORM@humana.com**.

Chapter 12: Claims and billing

Claim submission

Humana Healthy Horizons follows the claim reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. It is critical that all provider addresses and phone numbers on file with Humana Healthy Horizons are up to date to ensure timely claim processing and payment delivery.

Please note: Failure to include International Classification of Diseases, 10th Revision (ICD-10) codes on submitted claims will result in claim denial.

Claims that do not involve a third-party payer for services rendered must be submitted within 90 calendar days of the date of service or from discharge for in-network providers and six months from the date of service or from discharge for out-of- network providers. Corrected claims that were originally denied are considered to be initial claims, and they also must be submitted within 90 calendar days of the date of service or from discharge for in-network providers or six months from the date of service or from discharge for out-of-network providers. Corrected claims that were originally paid or partially paid must be submitted within 60 days of the date of service or from discharge for both in-network and out-of-network providers. Humana Healthy Horizons accepts electronic claims. Submitting your routine claims electronically has the following benefits:

- Faster claims processing
- Reduced administrative costs
- Reduced probability of errors or missing information
- Faster feedback on claim status
- Minimal staff training and cost

Paper claims must be mailed to:
Humana Claims
P.O. Box 14169
Lexington, KY 40512-4169

All claims must include the following information:

- Member name.
- Member address.
- Insured's ID number: Be sure to provide the complete Medicaid ID for the member.
- Member's date of birth: Always include the member's date of birth so we can identify the correct member.
- Place of service: Use standard CMS location codes.
- International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis code(s).
- HIPAA-compliant CPT or HCPCS code(s) and modifiers when modifiers are applicable.
- Units, where applicable (anesthesia claims require number of minutes).
- Date of service: Please include dates for each individual service rendered; date ranges are not accepted, even though some claim forms contain from/to formats. Please enter each date individually.
- Prior authorization number, when applicable: A number is needed to match the claim to the corresponding prior authorization information. This is only needed if the service provided required a prior authorization.
- NPI: Please refer to the Location of Provider NPI, TIN and Member ID number section.
- Federal TIN or provider Social Security number: Every provider practice (e.g., legal business entity) has a different TIN.
- Billing and rendering taxonomy codes that match the Master Provider List (MPL).
- Billing and rendering addresses that match the MPL.
- Signature of provider or supplier: The provider's complete name should be included. If we already have the provider's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.

We do not pay claims with incomplete, incorrect or unclear information.

Electronic funds transfer (EFT)/electronic remittance advice (ERA)

EFT/ERA enrollment through Humana Healthy Horizons
Get paid faster and reduce administrative paperwork with EFT and ERA.

Healthcare providers can use the Humana Healthy Horizons ERA/EFT enrollment tool on the Availity Essentials (www.availity.com) provider portal. To access this tool:

- Sign in to Availity Essentials (www.availity.com) (registration required).
- From the Payer Spaces menu, select Humana.
- 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.)

When you enroll in EFT, Humana Healthy Horizons claim payments are deposited directly in the bank account(s) of your choice.

Submitting electronic transactions

Provider portal

Humana Healthy Horizons partners with Availity Essentials (www.availity.com) to allow providers to reference member and claim data for multiple payers by signing in only once. Availity Essentials (www.availity.com) provides information on the following:

- Eligibility and benefits
- Claim submission
- Claim status
- Remittance advice

To learn more, call **800-282-4548** or visit Availity Essentials (www.availity.com) and choose "Claims and Payments."

To submit a claim via Availity Essentials, visit (www.availity.com) and choose "Claims and Payments" and then "Claims & Encounters."

For information regarding electronic claim payment, contact your local provider engagement representative or visit https://www.humana.com/provider/medical-resources/indiana-medicaid/claims-payments or (www.availity.com).

EDI clearinghouses

EDI is the computer-to-computer exchange of business data in standardized formats. Our EDI system complies with HIPAA standards for electronic claim submission, including transaction and code set format specifications.

To submit claims electronically, providers must work with an electronic claim clearinghouse. Humana Healthy Horizons currently accepts electronic claims from Indiana providers through the clearinghouses listed below. Please contact the clearinghouse of your choice to begin electronic claim submission.

When filing an electronic claim, you will need to utilize payer ID 61101.

The following is a list of some of the commonly used claim clearinghouses:

- **Availity (www.availity.com)**
- **Trizetto (www.trizettoprovider.com)**
- **McKesson (http://mckesson.com)**
- **Change Healthcare (http://changehealthcare.com)**
- **The SSI Group (http://thessigroup.com)**

5010 transactions

In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic healthcare and pharmacy transactions. This action was taken in preparation to implement ICD-10-CM codes in 2015. The new standard is the HIPAA 5010 format.

The following transactions are covered under the 5010 requirements:

- 837 Claims encounters
- 276/277 Claim status inquiry
- 835 Electronic remittance advice
- 270/271 Eligibility
- 278 Prior authorization requests
- 834 Enrollment

Procedure and diagnosis codes

HIPAA specifies that the healthcare industry use the following four code sets when submitting healthcare claims electronically:

- ICD-10-CM, available from the U.S. Government Publishing Office by calling **202-512-1800** or faxing **202 512 2250**, and from other vendors
- CPT, available at **AMA-assn.org/practice-management/cpt**.
- HCPCS, available at **https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system**.
- National Drug Codes, available at **FDA.gov**.

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

Unlisted CPT/HCPCS codes

If a procedure is performed that cannot be classified by a CPT or HCPCS code, please include the following information with an unlisted CPT/HCPCS procedure code on the claim form:

- A full, detailed description of the service provided
- A report, such as an operative report or a plan of treatment
- Other information that would assist in determining the service rendered

As an example, the code 84999 is an unlisted lab code that requires additional explanation.

NPI, TIN and taxonomy

Your NPI and TIN are required on all claims, in addition to your provider taxonomy and specialty type codes (e.g., FQHC, RHC and/ or primary care center), using the required claim type format (CMS-1500, UB-04 or Dental ADA) for the services rendered.

Atypical providers are not required to have NPIs. Atypical providers are not considered healthcare providers and include waiver providers, transportation providers (other than ambulances and air ambulances) and medical review team copy centers. Atypical providers are required to use their IHCP provider IDs instead of NPIs.

Location of provider NPI, TIN and member ID number

Humana Healthy Horizons accepts electronic claims in the 837 ANSI ASC X12N (005010A1) file format for both professional and hospital claims.

On 5010 (837P) professional claims:

The provider NPI should be in the following location:

- 2010AA loop—billing provider name
- Identification code qualifier—NM108 = XX
- Identification code—NM109 = billing provider NPI
- 2310B Loop—rendering provider name
- Identification code qualifier—NM108 = XX
- Identification code—NM109 = rendering provider NPI
- For form CMS-1500, rendering provider taxonomy code in box 24J.ZZ, qualifier in box 24I for rendering provider taxonomy

The billing provider TIN must be submitted as the secondary provider identifier using an REF segment, which is either the employer identification number for organizations (EIN) or the Social Security number (SSN) for individuals:

- Reference identification qualifier—REF01 = EI (for EIN) or SY (for SSN)
- Reference identification—REF02 = billing provider TIN or SSN
- The billing provider taxonomy code in box 33b on 5010 (837I) institutional claims

The billing provider NPI should be in the following location:

- 2010AA loop—billing provider name
- Identification code qualifier—NM108 = XX
- Identification code—NM109 = billing provider NPI

The billing provider TIN must be submitted as the secondary provider identifier using an REF segment, which is either the EIN for organizations or the SSN for individuals:

- Reference identification qualifier—REF01 = EI (for EIN) or SY (for SSN)
- Reference identification—REF02 = billing provider TIN or SSN
- The billing taxonomy code in box 81 on all electronic claims

The Humana Healthy Horizons member ID number should go on:

- 2010BA loop = subscriber name
- NM109 = member ID number

Electronic visit verification

In compliance with the 21st Century Cures Act, providers are required to utilize electronic visit verification (EVV) to electronically monitor, track and confirm services provided in the home setting. Providers must ensure that services are provided as specified in the health plan and member's care plan and in accordance with the established schedule, including the amount, frequency, duration and scope of each service, and that services are provided timely. Providers must work with Humana Healthy Horizons to identify and immediately address opportunities for improved care, including late and missed visits.

The state of Indiana currently has a relationship with Sandata and requires network providers to use the Sandata EVV system for personal care and home health services or as otherwise specified by the state. Refer to Service Codes That Require EVV.

The data collected from the EVV data collection system is used to validate all claims against EVV data (100% review) during the claim adjudication process.

Providers needing assistance using the EVV data collection system can email **inxixevv@gainwelltechnologies.com** or call **800-457-4584**, option 5. Frequently asked questions related to EVV are available on the **https://www.in.gov/medicaid/providers/files/Electronic_Visit_Verification_FAQs.pdf**.

For additional information, see **EVV** in Chapter 9.

Out-of-network claims

Humana Healthy Horizons requires authorization for out-of-network care for non-self-referral or nonemergent services except as otherwise noted, based on medical necessity, when a network provider is not available to provide members with medically necessary covered services in a timely manner.

An out-of-network provider must be enrolled in the IHCP to receive payment. More information regarding IHCP provider enrollment can be found at **https://www.in.gov/medicaid/providers/973.htm**.

Authorization requests must be submitted via Availity Essentials (**www.availity.com**) for members to receive out-of-network services.

With some exceptions, these services will be reimbursed at a negotiated rate, or in the absence of a negotiated rate, an amount not less than 100% of the Medicaid fee-for-service rate. Out-of-network emergency services will be reimbursed at 100% of the Medicaid rate, unless other payment arrangements are made.

Claim processing guidelines

Claim compliance standards

A clean claim is one in which all information required for processing the claim is present on the claim form. Humana Healthy Horizons ensures electronic clean claims are paid/denied within the following time frames:

- Within 21 calendar days of receipt for non-HCBS claims
- Within seven business days of receipt for HCBS claims

Humana Healthy Horizons acknowledges all electronically submitted claims for services within 48 hours after the beginning of the next business day after receipt of the claim.

The ERA provides a detailed explanation of all denials, payments and adjustments. For nonelectronic claims, Humana Healthy Horizons ensures the following time frames:

- Within 20 days after receipt of the claim, provide acknowledgment of receipt of the claim to the provider or designee or offer the provider or designee electronic access to the status of a submitted claim.
- Pay or deny both the HCBS-related and non-HCBS-related claim within 30 days after receipt of a clean claim.

If Humana Healthy Horizons fails to pay or deny a clean claim within these timeframes and subsequently pays for any services billed on the claim, interest will also be paid to the provider at the rate set forth in the state claims payment statute of IC 12-15-21-3(7)(A).

Interest applies to:
- All clean claims paid late
- In-network and out-of-network providers
- Payments made inaccurately (paid once the claim is adjudicated properly)
- Payments for which Humana Healthy Horizons is responsible, unless alternate written payment arrangements have been made with the provider

Unclean claims must be rejected or denied within 30 days of claim receipt.

Crossover claims

If a member has both Original Medicare and Medicaid coverage, providers should file claims in the appropriate manner with the regional Medicare intermediary/carrier, making sure the member's Medicaid number is included on the Medicare claim form. Once the Medicare intermediary/carrier has processed/paid its percentage of the approved charges, Original Medicare will electronically submit a "crossover" claim to the Medicaid fiscal intermediary that includes the coinsurance and/or deductible.

For Medicare Part C, also known as Medicare Advantage, providers should file claims to Medicaid once the Medicare Advantage plan's Explanation of Remittance or Explanation of Benefits (EOB) is received.

Medicaid program rules generally require members to exhaust other insurance coverage, including group health, workers' compensation and no-fault medical payment coverage before claims are submitted to the Medicaid program. Humana Healthy Horizons will coordinate benefits and process as secondary whenever these other forms of coverage are available. When a provider is aware of other coverage, claims should be submitted to the primary payer for a payment determination before claims are submitted to Humana Healthy Horizons. Claims involving coordination of benefits (COB) will not be processed until an explanation of payment (EOP)/explanation of benefits (EOB) or electronic data interchange (EDI) payment information file is received, indicating the amount the primary carrier processed. Claims indicating that the primary carrier paid in full (i.e., $0 balance) must still be submitted to Humana Healthy Horizons for processing due to regulatory requirements.

When coordinating between distinct Medicare and Medicaid plans, providers should wait for the full disposition of the Medicaid claim and not pursue unpaid Medicare cost share from the member.

Claim status

You can track the progress of submitted claims through our provider portal, Availity Essentials (**www.availity.com**). Claim status is updated daily and provides information on claims submitted in the previous 24 months. Search by state Medicaid ID number, member name, and date of birth or claim number.

You can find the following claim information on the provider portal:
- Reason for payment or denial
- Check number(s) and date
- Procedure/diagnostic code
- Claim payment date

Claim payments by Humana Healthy Horizons to providers are accompanied by an itemized accounting of the individual claims in the payment, including the member's name, the date of service, the procedure code, service units, the reimbursement amount and identification of the Humana Healthy Horizons entity.

Code editing and payment policies

Humana Healthy Horizons processes accurate and complete provider claims in accordance with Humana Healthy Horizons' normal claim processing procedures, including claim processing edits and claim payment policies, and applicable state and/or federal laws, rules and regulations. See the **https://www.humana.com/provider/medical-**

resources/claims-payments/processing-edits and https://www.humana.com/provider/medical-resources/claims-payments/claims-payment-policies pages of the providers' section on https://www.humana.com/ to access notifications on these types of claim processing procedures. The notifications published on these pages are not intended to be an exhaustive list of all processes that may result in an adjustment or denial of reimbursement, a request for the submission of relevant medical records prior to or after payment, or the recoupment or refund request of a previous reimbursement.

Such claim processing procedures include review of the interaction of various factors. The result of Humana Healthy Horizons' claim processing procedures is dependent on the factors reported on each claim. Accordingly, it is not feasible to provide an exhaustive description of the claim processing procedures, but examples of the most used factors include:

- The complexity of a service
- Whether a service is one of multiple same-day services such that the cost of the service to the provider is less than if the service had been provided on a different day. For example:
  - Two or more surgeries performed the same day
  - Two or more endoscopic procedures performed the same day
  - Two or more therapy services performed the same day
- Whether a co-surgeon, assistant surgeon, surgical assistant or other provider who is billing independently is involved
- When a charge includes more than one claim line, whether service is part of or incidental to the primary service that was provided or if these services cannot be performed together
- Whether the service is reasonably expected to be provided for the diagnosis reported
- Whether a service was performed specifically for the member
- Whether services can be billed as a complete set of services under one billing code

Humana Healthy Horizons develops claim processing procedures in our sole discretion based on our review of correct coding initiatives, national benchmarks, industry standards and industry sources, such as the following, including any successors of the same:

- Indiana FSSA regulations, manuals and other related guidance
- Federal and state laws, rules and regulations, including instructions published in the Federal Register
- National Uniform Billing Committee (NUBC) guidance, including the UB-04 Data Specifications Manual
- American Medical Association's (AMA) CPT and associated AMA publications and services
- CMS HCPCS and associated CMS publications and services
- ICD
- American Hospital Association's (AHA) Coding Clinic Guidelines
- Uniform Billing Editor
- American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services
- FDA guidance
- Medical and surgical specialty societies and associations
- Industry-standard Utilization Management criteria and/or care guidelines
- Our medical and pharmacy coverage policies
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published, peer-reviewed literature

Changes to any one of the sources may lead Humana Healthy Horizons to modify current or adopt new claim processing procedures.

These claim processing procedures may result in an adjustment or denial of reimbursement, a request for the submission of relevant medical records, prior to or after payment, or the recoupment or refund request of a previous reimbursement. You can access additional information at the https://www.humana.com/provider/medical-resources/claims-payments page on http://humana.com/.

An adjustment in reimbursement after completing claim processing procedures is not an indication that the service provided is a noncovered service. Providers can submit a dispute request for adjustments produced by these claim processing procedures by submitting a timely request to Humana Healthy Horizons. For additional information, see the Provider disputes section of this manual.

Humana Healthy Horizons provides notification of upcoming code editing changes. We publish new code editing rules and our rationales for these changes on the first Friday of each month at **Humana.com/Edits**.

Humana Healthy Horizons will provide at least 30 days' written notice prior to any change in payment structure or reimbursement amount, unless mandated otherwise by FSSA upon which Humana Healthy Horizons will notify providers. The written notice will contain clear and detailed information about the change and will not be retroactive, unless mandated by FSSA.

Suspension of provider payments
A network provider's claim payments are subject to suspension when the Indiana OMPP determines that there is a credible allegation of fraud and notifies Humana Healthy Horizons.

Provider preventable conditions/never events
Humana Healthy Horizons will not make payment on claims that have been identified to include provider-preventable conditions, also known as never events. If payment is made prior to the identification of the provider-preventable condition, payment will be recovered by Humana Healthy Horizons through its program integrity overpayment recovery process.

COB
Humana Healthy Horizons collects COB information for our members. This information helps us ensure that we pay claims appropriately and comply with federal regulations that Medicaid programs are the payer of last resort.

While we try to maintain accurate information at all times, we rely on numerous sources for information updated periodically, and some updates may not always be fully reflected on Availity Essentials. Humana Healthy Horizons will pay up to the Medicaid allowable limit under the appropriate payment schedule minus any other insurance paid amounts. If the member responsibility amount from the other carrier is less than the difference between the Medicaid allowable limit and the other insurance paid, it will pay the other carrier member responsibility amount.

- COB requires a copy of the appropriate remittance statement from the primary carrier.
  - Electronic and paper claims
  - Primary carrier's payment information
  - EOB from primary carrier
- If a claim is denied for COB information needed, the provider must submit the appropriate remittance statement from the primary payer within the remainder of the initial claim timely filing period.

Humana Healthy Horizons' timely filing limits for provider claims are within 90 days of the date of the claim's recovery or recoupment notice from the previous payer.

Third-party liability
Humana Healthy Horizons' plans allow claims for healthcare services provided due to automobile and workplace injuries according to applicable state Medicaid agency requirements.

However, a provider must make all reasonable efforts to determine whether there is other coverage for an automobile or workplace injury, such as under automobile or workers' compensation insurance, and must promptly report as described below, in claims submitted to Humana Healthy Horizons and any such other coverage that is identified. Additionally, a provider must bill a member's automobile or workplace injury insurance plan, if applicable, before billing the member's Humana Healthy Horizons plan. Finally, a provider must promptly forward to Humana Healthy Horizons any determination by an automobile or workplace insurance plan made with respect to a claim for a Humana Healthy Horizons member's injury. A provider's failure to promptly fulfill any requirement could affect Humana Healthy Horizons' disposition of a claim after initial receipt and/or after initial adjudication.

If a provider identifies automobile insurance, the provider must include the information below when submitting a paper claim to Humana Healthy Horizons or equivalent information when submitting an electronic claim to Humana Healthy Horizons.

For a CMS-1500 form or its electronic equivalent:
- Enter "yes" in box 10-B.
- Enter the accident date in field 14.

- Enter all diagnosis codes in section 21.
- Attach the following to the claim, if available:
  - Copy of the check from the primary insurance carrier
  - Copy of the EOB from the primary insurance carrier
  - Copy of the exhaustion denial letter from the primary insurance carrier
  - Personal injury protection (PIP) worksheet, if available
  - Statement from the member indicating no PIP coverage, if applicable

For a UB-04 form or its electronic equivalent:
- Enter occurrence code 01 or 02, as applicable, and the accident date in fields 33–35.
- Enter value code 14 in fields 39–41.
- Enter all diagnosis codes in fields 67–76.
- Attach the following to the claim, if available:
  - Copy of the check from the primary insurance carrier
  - Copy of the EOB from the primary insurance carrier
  - Copy of the exhaustion denial letter from the primary insurance carrier
  - Statement from the member indicating no PIP coverage, if applicable

If a provider identifies workers' compensation insurance, the provider must include the information below when submitting a paper claim to Humana Healthy Horizons or equivalent information when submitting an electronic claim to Humana Healthy Horizons.

For a CMS-1500 form or its electronic equivalent:
- Enter "yes" in box 10-B.
- Enter the accident date in field 14.
- Enter all diagnosis codes in section 21.
- Attach the following to the claim, if available:
  - Copy of the check from the primary insurance carrier
  - Copy of the EOB from the primary insurance carrier
  - Copy of the exhaustion denial letter from the primary insurance carrier
  - Statement from the member confirming that the member's employer does not provide workers' compensation coverage

For a UB-04 form or its electronic equivalent:
- Enter occurrence code 04 and accident date in fields 33–35.
- Enter condition code 02, 05 or 77, as applicable, in fields 18–28.
- Enter value code 15 or 41, as applicable, in fields 39–41.
- Enter all diagnosis codes in fields 67–76.
- Attach the following to the claim, if available:
  - Copy of the check from the primary insurance carrier
  - Copy of the EOB from the primary insurance carrier
  - Copy of the exhaustion denial letter from the primary insurance carrier
  - Statement from the member confirming that the member's employer does not provide workers' compensation coverage

Medicaid is the payer of last resort unless the probable existence of third-party liability cannot be established or third party benefits are not available to pay the member's medical expenses at the time the claim is filed. If either of those scenarios happen, Humana Healthy Horizons will first pay the provider and will seek reimbursement from the possibly liable third party.

COB overpayment

When a provider receives a payment from another carrier after receiving payment from Humana Healthy Horizons for the same items or services, we consider this an overpayment. Humana Healthy Horizons provides written notice to the provider at least 30 days before an adjustment for overpayment is made. If a dispute is not received from the provider, adjustments to the overpayment are made on a subsequent reimbursement.

Providers also can issue refund checks to Humana Healthy Horizons for overpayments and mail them to the following address:

Humana Healthcare Plans
P.O. Box 931655
Atlanta, GA 31193-1655

Providers should not refund money paid to a member by a third party.

When Humana Healthy Horizons is aware of other insurance coverage prior to paying for a claim, the claim will be denied, indicating that the claim should first be submitted to the appropriate third party. Humana Healthy Horizons will ensure that this does not prevent a member from receiving medically necessary services in a timely manner. If Humana Healthy Horizons is unable to establish that a member has other insurance, Humana Healthy Horizons will pay the claim and then pursue reimbursement from the potentially liable third party within 60 days after the end of the month in which we paid.

If a member retroactively becomes Medicare eligible, Humana Healthy Horizons will recover for medical expenses payable by Medicare for the months of retroactive Medicare eligibility.

Humana Healthy Horizons will engage in efforts for two years from the date of service to determine if a member had commercial insurance that was not known at the time of payment. Humana Healthy Horizons will not require providers to be involved or recoup payments from providers unless the provider was paid in full by both Humana Healthy Horizons and commercial insurance.

Chapter 13: Complaints, grievances and disputes

Humana Healthy Horizons' policies and procedures for complaints, grievances disputes and appeals are aligned with the Code of Federal Regulations.

Provider disputes

Provider claim payment dispute process

If you disagree with the outcome of a claim or have not received the outcome to a claim, you may begin the Humana Healthy Horizons provider claim payment dispute process.

The provider payment dispute process consists of two internal steps. You are not penalized for filing a claim dispute, and no action is required by the member:

1. Informal claim dispute: This is the first step in the provider payment dispute process. The informal claim dispute represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the informal claim dispute step.
2. Formal claim dispute: This is the second step in the process. If you disagree with the outcome of the informal claim dispute, you may request an additional review as a claim payment appeal.

Informal claim dispute

You can submit an informal claim dispute following one of two timelines below:

- Within 60 calendar days following the date you receive written notification from Humana Healthy Horizons
- Within 90 calendar days of your initial claim submission date if Humana Healthy Horizons fails to make a determination within 30 calendar days

You can submit a written informal claim dispute via the Humana Healthy Horizons mailing address, through the provider portal at Availity Essentials (**www.availity.com**) or via email to **INMedicaidClaimsResearch@humana.com**. The following information should be provided with your dispute in a clear and acceptable written format:

- Member name and State Medicaid ID number
- Date of service
- Relationship to the member
- Claim number
- Name of the provider who rendered services
- Charge amount, payment amount, the allegedly correct payment amount and the difference between the amount paid and the allegedly correct payment amount
- A brief explanation of the basis for the contestation

Informal claim disputes will be resolved within 30 calendar days of receipt of the request.

Claims will be reprocessed when the resolution determines the claim was paid or denied incorrectly, within 30 business days after resolution of the informal claims dispute.

You will receive resolution within 30 business days of receipt of an informal claim dispute. An informal claim dispute may be filed using any of these methods:

- Online: Providers' informal disputes about finalized claims may be submitted online via Availity Essentials (**www.availity.com**).
  - To begin, sign in at Availity Essentials (**www.availity.com**), use the Claim Status tool to locate the claim and select the "Dispute Claim" button.
  - Then go to the request in the Appeals worklist (located under Claims & Payments) to supply needed information and documentation and submit the request to Humana Healthy Horizons. Status and high level Humana Healthy Horizons determination for claim disputes submitted online can be viewed in the Appeals worklist. For training opportunities, visit **Humana.com/ProviderWebinars**.

- Via mail:
  Humana Healthy Horizons in Indiana
  Informal Claim Dispute
  P.O. Box 14169
  Lexington, KY 40512-4601
- Via email: **INMedicaidClaimsResearch@humana.com**

Formal claim disputes

If you are dissatisfied with the determination of the informal claim dispute, you may request a formal claim review referred to as a claim appeal. All appeals are reviewed by an independent panel knowledgeable about the policy, legal and clinical issues involved in the matter subject to the appeal and are individuals who have not been involved in previous consideration of the matter. All information and material you submitted that bears directly upon an issue involved in the matter are considered. You can locate additional information concerning appeal reviews at 405 IAC 1-1.6.

You may submit a written appeal within 60 calendar days after the 30 calendar days allowed for the informal claim dispute review. Humana Healthy Horizons will review and provide a determination within 45 calendar days of receiving your written formal claim dispute. Below is the process for filing a formal claim dispute:

- Your request for an informal claim dispute is required before requesting a formal claim appeal.
- You or your authorized representative have the option to submit a formal claim dispute following the informal claim dispute process. You must submit all documentation from the informal claim dispute request when submitting a formal claim dispute.
- If the appeal is on behalf of a member, written authorization from the member or the member's legal representative must be submitted, along with all required documents, prior to beginning the process. The appeal will be processed under the member's name.
- Additional or new clinical documents sent to Humana Healthy Horizons are reviewed by the medical director to determine if the additional clinical documents support the claim appeal in meeting medical necessity.
- A resolution letter is mailed within 45 calendar days of receipt of the appeal.

Providers can file an appeal in writing to:
Humana Healthy Horizons in Indiana
Attn: Formal Claim Appeals
201 N. Illinois S., Suite 1200
Indianapolis, IN 46204
Or via email to: **IndianaFormalDispute@humana.com**

Binding arbitration

In the event you completed the formal appeal process and remain dissatisfied with Humana Healthy Horizons' determination, you have the option to request binding arbitration. The binding arbitration process will be conducted in accordance with the rules and regulations of the American Health Law Association, pursuant to the Uniform Arbitration Act as adopted in the state of Indiana at IC 34-57-2, unless one of the following applies:

- You and Humana Healthy Horizons mutually agree to some other binding resolution procedure.
- Humana or you are subject to statutorily imposed arbitration procedures for the resolution of these claims. In that case, the statutorily imposed arbitration procedures shall be followed. All costs of arbitration, not including attorneys fees, are shared equally by the parties. Providers should review their contract with Humana Healthy Horizons for all specific language related to arbitration.

Mail binding arbitration notices to:
Humana Healthy Horizons in Indiana
Attn: Arbitration Notice
201 N. Illinois St., Suite 1200
Indianapolis, IN 46204

Member grievances and appeals

The section below is taken from the Humana Healthy Horizons member grievance and appeal procedure as set forth in the Humana Healthy Horizons Member Handbook. This information is provided so that you may assist Humana Healthy Horizons members in this process, should they request it. Please contact your provider contracting representative with questions you have about this process.

The Humana Healthy Horizons representatives who handle member grievances and appeals maintain appropriate records of complaints, including the reason, date and results.

Filing a grievance or appeal

If members have questions or issues, they can call **866-274-5888 (TTY: 711)**, Monday through Friday, from 8 a.m. to 8 p.m., Eastern time. If they are dissatisfied with the answers from Member Services, members can file a grievance or appeal.

Members can call Member Services to file a grievance or appeal. To file a grievance or appeal in writing, the member may send us a letter, complete a form obtained from our website or call Member Services to request a form. If a member requests a form from Humana Healthy Horizons, it will be mailed within three working days. When filling out the form, the member can request help from Humana Healthy Horizons associates.

Members also can request assistance from Member Services, ombudsmen and independent advocacy services when filing grievances and appeals.

All grievances and appeals will be considered. The member can have someone act on the member's behalf during the process, whether it is a provider or someone else. A provider, acting on behalf of the member and with the member's written consent using an Appointment of Representative (AOR) form, may file an appeal.

The member has the right to continue services during the appeal process. If the member wants services to continue, the following is required:

- The member must submit an appeal within 10 calendar days of the date on the notice of action or within 10 calendar days of the intended effective date of action, whichever is later.
- The appeal must involve the termination, suspension or reduction of a previously authorized service.
- The service must have been ordered by an authorized provider.
- The original period covered by the original authorization must not have expired.
- The member must request an extension of benefits.

If the final resolution of the appeal is adverse to the member, that is, it upholds Humana Healthy Horizons' adverse benefit determination, then Humana Healthy Horizons may recover the cost of the services furnished to the member while the appeal was pending.

The grievance or appeal submission should include the following:

- Name, address, telephone number and state Medicaid ID number
- Facts and details about the actions taken to correct the issue
- What action would resolve the grievance or appeal
- Member's signature
- Date

Grievance review timelines

The member has the right to file a verbal or written grievance. The grievance process may take up to 30 days; however, Humana Healthy Horizons resolves a member's grievance as quickly as the member's health condition requires. A letter explaining the outcome of the grievance is sent within five business days of the date Humana Healthy Horizons resolves the grievance request.

Indiana Medicaid grievance

Topic	Response
In what manner may the grievance be submitted?	Oral or written
What is the time frame to submit a grievance?	Unlimited
Is an appointment of representative (AOR) required?	Yes, when submitted by someone other than the member
Is an acknowledgment of the grievance required?	Yes, within three business days of receipt
What is the resolution time frame?	No later than 30 calendar days after receipt

The member has the right to request an expedited grievance when taking the time for a standard resolution would seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function, or by the member's request. Expedited grievances are resolved within 48 hours of receipt. If Humana Healthy Horizons denies the request for an expedited review, the grievance is then processed under the standard time frame. The member is then notified by phone and mail of the denial for an expedited review. A letter explaining the outcome of the grievance is sent within five business days of the date Humana Healthy Horizons resolves the grievance request.

Indiana Medicaid expedited grievance first-level review

Topic	Response
In what manner may the grievance be submitted?	Oral or written
What is the time frame to submit a grievance?	Unlimited
Is an AOR required?	Yes, when submitted by someone other than the member
Is an acknowledgment of the grievance required?	No
What is the resolution time frame?	48 hours

Appeal review timelines

A member must file the appeal either verbally or in writing within 60 calendar days of the date on the notice of adverse action. The date of the oral notice will be considered the date of receipt. Humana Healthy Horizons resolves the appeal as quickly as the health condition requires. A letter telling the member the outcome of the appeal is sent within 30 days of the date Humana Healthy Horizons receives the request. The member has the right to review the member's case before and during the appeal process.

Indiana Medicaid appeal

Topic	Response
In what manner may the appeal be submitted?	Oral or written If oral, the date of request is considered the date of receipt
What is the time frame to submit the appeal?	Within 60 days from the date on the notice of adverse action
Is an AOR required?	Yes, when submitted by someone other than the member
Is an acknowledgment of the appeal required?	Yes, within three business days of receipt of the appeal
What is the decision notification method?	Written notification within five business days of the decision
What is the decision time frame?	As expeditiously as the member's health condition requires but no later than 30 calendar days from receipt, whether received orally or in writing

Expedited appeal process

The member has the right to request an expedited appeal when taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function. The member or the member's legal representative can file an urgent or expedited appeal. These appeals are resolved within 48 hours. When making an appeal, the member or the representative need to notify Humana Healthy Horizons that this is an "urgent" or "expedited" appeal. An expedited appeal may be made by calling **866-274-5888 (TTY: 711)**. If it is determined that an expedited process is not required, the appeal will go through the normal process.

NOTE: Humana Healthy Horizons does not discriminate against a provider or take punitive action against a provider that requests an expedited resolution or supports a member's appeal, as required by 42 CFR 438.410(b).

Indiana Medicaid expedited appeal

Topic	Response
In what manner may the appeal be submitted?	Oral or written
What is the time frame to submit the appeal?	Within 60 calendar days of the date on the notice of action
Is an AOR required?	Yes, when submitted by someone other than the member
Is an acknowledgment of the appeal required?	Yes, within 48 hours of receipt of the appeal
What is the decision notification method?	Oral notification followed by written notification within five business days of the decision
What is the decision time frame?	As expeditiously as the member's health condition requires but not to exceed 48 hours after receipt, whether the request was submitted orally or in writing

External review by an independent review organization

If a member is dissatisfied with the Humana Healthy Horizons appeal decision or a determination that a requested service is experimental or investigational, the member can ask for an external review by an independent review organization (IRO).

A member who has exhausted Humana Healthy Horizons' appeal process may file a written request for an external review within 120 calendar days of the date on Humana Healthy Horizons' notice of resolution. With the member's permission, and a signed consent form, providers may act on the member's behalf and ask for an external review by an IRO.

An external review does not restrict or replace the member's right to appeal a Humana Healthy Horizons decision to a state fair hearing. A member may seek external review by an IRO, and this process can run concurrently with a state fair hearing.

The IRO will issue a decision to uphold or reverse Humana Healthy Horizons' decision within 72 hours for an expedited appeal or 15 business days for a standard appeal. The determination made by the IRO is binding.

State fair hearing

If a member is dissatisfied with Humana Healthy Horizons' appeal decision, the member can ask for a state fair hearing. With the member's permission and a signed consent form, providers may act on the member's behalf and ask for a state fair hearing from the Indiana Office of Administrative Law Proceedings.

A member may seek a state fair hearing after exhausting Humana Healthy Horizons' appeal process. A member who exhausts Humana Healthy Horizons' appeal process may file a request for a state fair hearing within 120 calendar days from the date on Humana Healthy Horizons' notice of resolution.

Members can mail the request for a state fair hearing to:
Office of Administrative Law Proceedings
FSSA Hearing
402 W. Washington St. Rm E034
Indianapolis, IN 46204

Phone: **317-234-3488** or **1-866-259-3573**
Fax: **317-232-4412**
Email: **fssa.appeals@oalp.in.gov**

Members have the right to continue services during the appeal and state fair hearing process. If a member wants services to continue, the following is required:

- The member must submit an appeal within 10 calendar days of the date on the notice of action or within 10 calendar days of the date the action will take place, whichever is later.
- The appeal must involve the termination, suspension or reduction of a previously authorized service.
- The service must have been ordered by an authorized provider.
- The original time period covered by the original authorization must not have expired.
- The member must request that benefits be continued.

If the state fair hearing officer agrees with Humana Healthy Horizons' appeal decision, then the member may have to pay for the services that were received while the appeal was pending.

If a member is not happy with the decision from the state fair hearing, the member can ask for an agency review within 10 days of the hearing decision.

Chapter 14: Credentialing and recredentialing

Provider credentialing is the process of reviewing the qualifications and appropriateness of a provider to join Humana Healthy Horizons' network. Humana Healthy Horizons conducts credentialing and recredentialing activities utilizing the guidelines established by the NCQA as required by the IHCP and FSSA. Humana Healthy Horizons credentials and recredentials all licensed, independent practitioners including providers, nonproviders and organizational providers with whom it contracts and who fall within its scope of authority and action. A senior clinical staff person is responsible for oversight of the credentialing and recredentialing program.

All practitioners requiring credentials should complete the credentialing process prior to appearing in the provider directory. All credentials must be current at the time of the credentialing committee decision. Humana Healthy Horizons completely processes credentialing applications from all provider types within 30 days of receipt of a completed credentialing application, including all necessary documentation and attachments.

CAQH application for practitioners

Humana Healthy Horizons is a participating organization with the Council for Affordable Quality Healthcare® (CAQH). You can confirm we have access to your credentialing application by completing the following steps:

- Sign in to the CAQH website at **https://proview.caqh.org/**.

Sign in utilizing your account information.

- Select the Authorization tab.
- Confirm Humana Healthy Horizons is listed as an authorized health plan; if not, please check the box to add.

Request to join the network

All practitioners must be actively enrolled with IHCP. If you haven't already done so, complete the **https://www.in.gov/medicaid/providers/provider-enrollment/** to obtain your Indiana Medicaid provider ID number.

A completed credentialing application, including supporting documents, is necessary to verify a practitioner's credentials for network participation. A completed credentialing application must include the following:

- A completed provider/group enrollment roster.
- An active Medicaid ID obtained through IHCP. Providers must be enrolled with IHCP at the service location(s) applicable to your Humana Healthy Horizons contract.
- An up-to-date **https://proview.caqh.org/Login/Index?ReturnUrl=%2fPO**, with status of complete or reattested, and access granted to Humana/ChoiceCare. Please ensure the information supplied is complete and current on your credentialing application, including the following:
  - Practicing specialty
  - NPI
  - Contact name and email address for credentialing purposes
  - Current practice address including suite number and fax number, if applicable
  - Hospital privileges or coverage arrangements, as applicable by practitioner type
  - Work history: at least five years of continuous work history experience
- A copy of the following supporting documentation for your CAQH application:
  - Proof of current malpractice insurance with amounts at the minimum in accordance with state laws in which the practitioner provides care
  - A completed Behavioral Health Profiling form, for providers offering behavioral health services
  - Disclosure of ownership form
  - W-9 tax form
  - Collaborative agreement for midlevel practitioners
  - If practicing in one of the following specialties, a copy of your certification:
    - Certified registered nurse anesthetist (CRNA)
    - Board-certified behavior analyst (BCBA)
    - Licensed clinical addiction counselor (LCAC)

- A completed site visit: If the practitioner is serving as a PMP, an on-site survey is required prior to beginning credentialing activities for the following specialties:
  - Internal medicine
  - General practice
  - Family medicine
  - Gynecology
  - Endocrinology
  - Geriatrics
  - Advanced practice registered nurse
  - Provider assistant

Failure to submit a complete application may result in a delay in our ability to complete or begin the credentialing process. Practitioners are notified within five days in the event it is determined the request to join the network is incomplete.

Common credentialing or recredentialing mistakes

Practitioner credentialing		
Need	**Most common mistakes**	**Recommendation**
CAQH application	Practitioner's CAQH application status is incomplete or expired. We do not have authorization to access your CAQH application. Information in your completed CAQH profile is expired or outdated. For example, confirm the following information is up to date: Practice information Credentialing contact Malpractice insurance coverage face sheet including the practitioner's name, coverage amounts and effective and expiration dates	The information on CAQH must match the information you provide on your network participation request. Ensure your CAQH application is up to date before requesting to join the network.
Supporting documents	The incorrect document is provided. The document is expired or will expire within the next 30 days.	Provide all the correct and completed documents as required.
Response time for requested documentation	There is a slow response time to requested information.	Missing or incomplete documents are signed and returned as quickly as possible.

Organizational/ancillary providers

All organizational providers must be enrolled with IHCP prior to submitting a facility enrollment application to Humana Healthy Horizons. If your organization hasn't already done so, complete the IHCP provider enrollment process by visiting the https://www.in.gov/medicaid/providers/provider-enrollment/ to obtain the organization's Indiana Medicaid provider ID number.

A completed facility enrollment form, including supporting documents, is necessary to assess an organization for network participation. A completed facility enrollment form must include the following:

- The Organizational Provider Assessment form with an attestation signature date not more than 120 days old.
- A completed roster, dependent on provider type.
  - A complete FQHC/RHC roster template for FQHCs/RHCs.

  - A complete organizational provider roster template for all other provider types
- An active Medicaid ID obtained through IHCP. Organizations must be enrolled with IHCP at the service location(s) applicable to your Humana Healthy Horizons contract.
- A Behavioral Health Profiling form for providers offering behavioral health services.
- A copy of the following supporting documentation attached to the facility enrollment form:
  - The facility's license, as applicable
  - Accreditation letter, as applicable
  - CMS certification, as applicable
  - Malpractice insurance policy face sheet indicating effective and expiration dates and limits of liability within amounts at the minimum in accordance with state laws in which the organization provides care
  - CLIA, as applicable
  - Disclosure of ownership form
  - W-9 tax form

Failure to submit a complete application will cause a delay in our ability to begin or complete the credentialing process. Facilities will be notified within five days if we determine the request to join the network is incomplete.

Common credentialing or recredentialing mistakes

Organizational provider assessment		
Need	**Most common mistakes**	**Recommendation**
Facility enrollment form	The facility enrollment form is incomplete or expired.	Ensure the facility enrollment form is up to date before requesting to join the network.
Supporting documents	The required supporting documents are missing. The document is expired or will expire within the next 30 days.	Provide all the correct and completed documents as required.
Response time for requested documentation	There is a slow response time to requested information.	Missing or incomplete documents are signed and returned as quickly as possible.

HCBS providers

All HCBS providers must be actively enrolled with IHCP. If your organization hasn't already done so, complete the https://www.in.gov/medicaid/providers/provider-enrollment/ by visiting the IHCP provider enrollment website to obtain the organization's Indiana Medicaid provider ID number.

A complete HCBS/LTSS provider assessment application, including supporting documents, is necessary to assess an HCBS provider for network participation. A completed HCBS/LTSS provider assessment application must include the following:

- The HCBS/LTSS provider assessment application attestation signature date not more than 120 days old.
- An active Medicaid ID obtained through IHCP. HCBS providers must be enrolled with IHCP for provider type 32, specialty 350, and at the service location(s) appliable to your Humana Healthy Horizons contract.
- Disclosure of ownership form
- W-9 tax form
- HCBS certification from the FSSA Division of Aging.

Additional documentation and enrollment status

If you need to submit additional documents or would like to check the enrollment status, medical providers can email INMedicaidProviderRelations@humana.com and behavioral health providers can email INBHMedicaid@humana.com.

Failure to submit a complete application will delay the enrollment process with Humana Healthy Horizons. HCBS providers are notified within five days in the event it is determined the request to join the network is incomplete.

Common HCBS provider certification and recertification mistakes

HCBS/LTSS provider certification		
Need	**Most common mistakes**	**Recommendation**
HCBS/LTSS assessment application	The HCBS/LTSS provider assessment application is incomplete or expired.	Ensure the assessment application is up to date before requesting to join the network.
Supporting documents	Certification from the Division of Aging is missing. The document is expired or will expire within the next 30 days.	Provide all the correct and completed documents as required.
Response time for requested documentation	There is a slow response time to requested information.	Missing or incomplete documents are signed and returned as quickly as possible.

All provider types may submit a request to join the network via Humana Healthy Horizons' LTSS provider portal **https://humana-6853.quickbase.com/db/bsxaqn5yc** or the non-LTSS physical or behavioral health provider portal **https://humana-6853.quickbase.com/db/btnam42he**.

Provider credentialing and recredentialing assessment of individual practitioners

Evaluation of practitioners included within the scope of credentialing for the Humana Healthy Horizons Indiana PathWays for Aging network include the following:

Physical health practitioners:

- Providers
- Oral surgeons
- Chiropractors
- Podiatrists
- Dentists
- Optometrists
- Allied health providers, including:
  - Advanced practice registered nurses
  - Clinical nurse specialists
  - Certified nurse midwives
  - Physician assistants
- Therapists, including:
  - Speech and speech/language pathologists
  - Occupational
  - Physical
- Audiologists
- Other licensed or certified practitioners, including provider extenders who act as a PMP or those that appear in the provider directory

Behavioral health practitioners:

- Psychiatrists and other providers
- LCACs
- Doctoral or master's level psychologists who are state licensed
- HSPPs
- Licensed, independent practice school psychologists
- Master's level clinical social workers who are state licensed
- Master's level clinical nurse specialists or psychiatric nurse practitioners who are state licensed
- Master's level licensed marriage and family therapists who are state licensed

- Master's level mental health counselors (LMHCs) who are state licensed
- ABA therapists
- Other behavioral health specialists who may be within the scope of credentialing and are licensed by the state to practice independently or as required by state regulations

Practitioner enrollment application

- Request to join Humana Healthy Horizons' network

Credentialing application

- Signed and dated CAQH credentialing application, including supporting documents and signature not more than 120 days old

Licensure

- Unrestricted license in the practicing state issued by the appropriate licensing board

Drug Enforcement Administration and a controlled substance registration

- Unrestricted Drug Enforcement Administration (DEA) in the practicing state, as applicable
- Unrestricted controlled substance registration (CSR) certificate issued by the state pharmaceutical licensing agency, as applicable

If the practitioner states in writing that the practitioner does not prescribe controlled substances and that in the practitioner's professional judgment, the members receiving care do not require controlled substances, the practitioner is therefore not required to have a DEA/CSR certificate but must describe the practitioner's process for handling instances when a member requires a controlled substance.

Education and training

- Successful completion of all training programs pertinent to one's practice:
  - For medical doctors and doctors of osteopathy, successful completion of residency training pertinent to the requested practice type
  - For doctors of chiropractic, proof from a chiropractic college for doctor of chiropractic medicine
  - For doctors of podiatric medicine, proof of graduation from podiatry school and completion of residency program for doctors of podiatric medicine
  - For Advanced Practice Registered Nurses, proof of graduation from an accredited master's degree program
  - For provider assistants, proof of graduation from an accredited master's degree program
  - For dentists and other providers who require or expect special training for services being requested, successful completion of training program

Board certification

- Proof of board certification if the practitioner's application states the practitioner is board-certified

Admitting privileges

- Practitioner holds current clinical privileges in good standing at a participating facility, as applicable
- If provider does not hold admitting privileges, an explanation of admitting arrangements applicable to the care the practitioner provides

Work history

- Work history that includes a minimum of five years via curriculum vitae (CV) or included on the application
- Gaps of six months or more to be explained

Malpractice insurance

- Current malpractice insurance coverage at the minimum amount in accordance with state laws in which the practitioner provides care

Malpractice history

- Explanation detailing any pending professional liability claims and claims resulting in settlements or judgements paid by or on behalf of the practitioner

NPI

- NPI verifiable via the National Plan and Provider Enumeration System (NPPES)

IHCP enrolled provider
- Currently enrolled with IHCP and has an active IHCP provider Medicaid ID number

Site visit
- PMP office location(s) must be surveyed prior to being credentialed.
- PMP and high-volume specialist office location(s) must be surveyed prior to being recredentialed.

Practitioners that may serve as a PMP include the following: internal medicine providers, general practitioners, family medicine providers, gynecologists, endocrinologists/internal medicine, geriatricians, advanced practice registered nurses and provider assistants. Providers that serve as "high-volume specialists" include the following: cardiology/cardiovascular disease, ophthalmology, oncology/medical oncology, orthopedic surgery and gastroenterology.

In good standing with regulatory agencies
- Provider, or an agent or managing employee of the provider, is in good standing with and not debarred, suspended or otherwise excluded by federal, state or local agencies including:
  - Medicaid agencies, including:
    - FSSA Termination of Provider Participation in Medicaid and Children's Health Insurance Program (CHIP) list
    - Medicare intermediary, including:
    - CMS Medicare preclusion list
    - CMS opt-out list
    - Health and Human Services Office of Inspector General (HHS-OIG)
    - General Services Administration (GSA, formerly Excluded Parties List System [EPLS])
    - State sanctions and restrictions on licensure

Performance indicators
- For recredentialing purposes only, practitioner should demonstrate an acceptable performance record related to Humana Healthy Horizons members with no evidence of quality issues.

Demographics
- Verify practitioners are appropriately linked to group(s), as applicable, and that practitioners are enrolled at the appropriate service locations.

Medical and behavioral health, hospital and ancillary providers
Organizational providers evaluated within the scope of credentialing for the Humana Healthy Horizons Indiana PathWays for Aging network include the following:
- Ambulatory surgical centers
- Clinical laboratories
- Dialysis centers/end-stage renal disease (ESRD) clinics
- Durable medical equipment/home medical equipment providers
- FQHCs
- Health departments
- Hearing aid dealers
- Home health agencies (LTSS)
- Hospice providers (LTSS)
- Hospitals
  - Acute care
  - Rehabilitation
- Mobile X-ray clinics/freestanding X-ray clinics
- Outpatient physical therapy and speech pathology facilities
- Pharmacies
- Rehabilitation facilities/comprehensive outpatient rehabilitation facilities
- RHCs
- Skilled nursing facilities/extended-care facilities (LTSS)

Behavioral health facilities providing mental health or substance use services in the following settings also are assessed:
- Inpatient

- Residential/extended care facilities
- Ambulatory

The following elements are evaluated when credentialing and recredentialing organizational providers:

Facility enrollment form
- Completion of a signed and dated application, signature not more than 120 days old

Licensure/business license/permit, as applicable
- As required by state, federal and local regulatory bodies, the provider is currently licensed. Providers requiring licensure must be in good standing with the appropriate licensing board.

Insurance coverage
- Current general/comprehensive/malpractice liability insurance coverage or participation in the federal tort program as applicable per state requirements

Eligible for Medicaid

The organization, or an agent or managing employee of the provider, is in good standing and not debarred, suspended or otherwise excluded by federal, state and local agencies including:
- Currently enrolled with IHCP and has an active IHCP provider Medicaid ID number
- Must not be sanctioned, excluded or debarred from participation in any Medicaid program
- Must not appear on the FSSA Termination of Provider Participation in Medicaid and CHIP list

Eligible for Medicare

The organization, or an agent or managing employee of the organization, is in good standing with and not debarred, suspended or otherwise excluded by federal, state and local agencies including:
- Must not be sanctioned, excluded or debarred from participation in Medicare.
- Verification that the provider has not opted out of participation with Medicare.
- Verification that the provider does not appear on the CMS preclusion list.
- Must be Medicare-certified. Humana Healthy Horizons will verify an organizational provider's Medicare certification status.

Free from sanctions, exclusion or debarment

The organization, or an agent or managing employee of the organization, is in good standing with and not debarred, suspended or otherwise excluded by federal, state and local agencies including:
- Verification that the provider has not been sanctioned, excluded or debarred by the OIG, the System for Award Management (SAM) or any other disciplinary action by any federal, state or local entity identified by CMS.

CLIA
- Verification that all independent laboratories and organizations billing for lab services meet CLIA regulations defined in 42 CFR 493.1809

On-site quality assessment

Provider must supply evidence an on-site quality assessment has been conducted, as applicable:
- Accreditation body—The organizational provider must supply a copy of the accreditation report or evidence from an accreditation body where the provider is accredited.
- CMS or state quality review—If an organizational provider is not accredited, Humana Healthy Horizons may substitute a CMS or state review in lieu of performing its own on-site quality assessment. Humana Healthy Horizons verifies that an on-site quality assessment has been completed by a state agency or CMS by obtaining the assessment report or certification letter. The CMS or state review may not be more than three years old at the time of verification.
- Quality review conducted by Humana Healthy Horizons—If the CMS or state review is older than three years, Humana Healthy Horizons conducts its own on-site quality review. If the state or CMS has not conducted a site review of the provider and the provider is in a rural area (as defined by the U.S. Census Bureau), Humana Healthy Horizons may choose not to conduct a site visit.

NPI
- NPI verifiable via NPPES.

Opioid treatment program providers

In addition to the requirements listed above, OTP providers must provide:

- Evidence of active DEA certification
- Evidence of certification from the Division of Mental Health and Addiction (DMHA) as an OTP.

SUD addiction treatment providers

In addition to the requirements listed above, SUD providers must:

- Provide evidence of ASAM level of care
- Provide evidence of certification from the DMHA level-of-care designation
- Be an entity, not an individual.
- Have a primary physical address/location
- Be actively enrolled as an IHCP provider at the service location listed on the application
- Out-of-state providers
  - SUD residential treatment facilities located outside the state of Indiana may apply.
- Documentation required for new provider credentialing
  - Facility enrollment form (must be current and signature date will not expire within the next 30 days).
  - Behavioral Health Profiling form.
    - Facilities that have ASAM level-of-care designations of both 3.1 and 3.5 must include both designations on the Behavioral Health Profiling form.
  - Indiana Medicaid provider ID.
  - Copy of certification form (must be current and will not expire within the next 30 days).
    - Copy of DMHA certification as a sub-acute facility that includes ASAM level-of-care designation 3.1 or 3.5 residential services.
    - Proof of Department of Child Services licensing as a childcare institution or private secure-care institution with a DMHA addiction services provider regular certification that includes ASAM level-of-care designation 3.1 or 3.5 residential services.
  - Copy of DEA registration certificate.
  - CMS/Medicare certification letter, if certified.
  - Accreditation letter from an approved entity:
    - The Joint Commission
    - Council on Accreditation
    - Commission on Accreditation of Rehabilitation Facilities
  - Malpractice insurance face sheet showing effective and expiration dates and limits of liability coverage.
  - CLIA certificate, if applicable (must be current and will not expire within the next 30 days). CLIA address must match the address on the application.

Disclosure of ownership

- IHCP provider schedule C—disclosure information
- Disclosure Form CMS 1513
- Humana Healthy Horizons disclosure of ownership, business transactions and exclusions statement for providers

HCBS providers

HCBS providers evaluated within the scope of certification for the Humana Healthy Horizons Indiana PathWays for Aging network include the following:

- Adult day care
- Adult family home/community home share
- Assisted living facility
- Attendant care
- Community transportation
- Home and community assistance
- Home-delivered meals
- Home modifications
- Integrated healthcare coordination

- Nutritional supplements
- PERS
- Pest control
- Respite
- Specialized medical equipment
- Structured family care
- Vehicle modification

The following elements are evaluated when certifying and recertifying HCBS providers:

HCBS/LTSS provider enrollment form
- Completion of a signed and dated HCBS/LTSS assessment application, signature not more than 120 days old

FSSA certification
- HCBS providers must be certified by the FSSA Division of Aging.

Eligible for Medicaid
The HCBS or LTSS provider, or an agent or managing employee of the provider, is in good standing with, and not debarred, suspended or otherwise excluded by federal, state or local agencies.
- Currently enrolled with IHCP and has an active IHCP provider Medicaid ID number
  - HCBS providers must be enrolled with IHCP as provider type 32 and specialty 350.
- Must not be sanctioned, excluded or debarred from participation in any Medicaid program
- FSSA Termination of Provider Participation in Medicaid and CHIP list

Free from sanctions, exclusion or debarment
The organization, or an agent or managing employee of the organization, is in good standing with and not debarred, suspended or otherwise excluded by federal agencies.
- Verification that the provider has not been sanctioned, excluded or debarred by the OIG, SAM or any other disciplinary action by any federal, state or local entity identified by CMS

NPI
- NPI verifiable via NPPES

Please note: Atypical providers, such as waiver providers, are not required to have an NPI. If an HCBS waiver provider does not have an NPI, a Medicaid provider ID issued by IHCP is required in lieu of an NPI.
Provider recredentialing and reassessment

Network practitioners are recredentialed, and organizational, long-term care and HCBS providers are reassessed at least every three years. As part of the recredentialing process, Humana Healthy Horizons considers information regarding performance to include complaints, and safety and quality issues collected through the quality improvement program. Additionally, information regarding adverse actions is collected from the National Practitioner Data Bank (NPDB), Medicare and Medicaid sanctions, CMS preclusion list, OIG, GSA (formerly EPLS) and limitations on licensure.

Provider rights
Practitioners have the right to review, on request, information submitted to support their credentialing application to the Humana Healthy Horizons Credentialing Operations department. Humana Healthy Horizons keeps all submitted information secure and confidential.

Access to electronic credentialing information is password protected and limited to staff that requires access for business purposes.

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

Providers have the right to be informed of the status of their credentialing/certification or recredentialing/recertification application on written request to the Credentialing Operations department.

Provider responsibilities

Network providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. Humana Healthy Horizons initiates immediate action in the event the participation criteria are no longer met. Network providers are required to inform Humana Healthy Horizons of changes in status, including involvement in a medical malpractice suit; involuntary changes in hospital privileges, licensure or board certification; an event reportable to the NPDB; and federal, state or local sanctions, or complaints.

Delegation of credentialing/recredentialing (applicable to medical and behavioral health providers only)

Humana Healthy Horizons only enters into agreements to delegate credentialing and recredentialing if the entity that wants to be delegated is accredited by NCQA for these functions or utilizes an NCQA-accredited credentials verification organization (CVO) and successfully passes a pre-delegation audit demonstrating compliance with NCQA federal and state requirements. A pre-delegation audit must be completed prior to entering into a delegated agreement. All pre-assessment evaluations are performed utilizing the most current NCQA and regulatory requirements. The following are included (at a minimum) in the review:

- Credentialing and recredentialing policies and procedures
- Credentialing and recredentialing committee meeting minutes from the previous year
- Credentialing and recredentialing file review

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

Reconsideration of credentialing/recredentialing decisions

Humana Healthy Horizons' credentialing committee must notify a practitioner of a denial based on credentialing criteria. The notice must inform the practitioner of the reasons for the denial and, in the case of a denial based on credentialing criteria eligible for credentialing committee reconsideration, provide notice of such opportunity to request reconsideration of the decision in writing within 30 days of the notice or sooner as required by state or federal regulations. Unless otherwise noted, denials based on a failure to meet administrative criteria are final with no reconsideration rights. Where applicable, in the event such reconsideration is timely requested, the credentialing committee may affirm, modify or reverse the initial decision.

Humana Healthy Horizons should notify the applicant in writing of the credentialing committee's reconsideration decision within 60 days. Practitioners who were denied are eligible to reapply for network participation once they meet the minimum health plan credentialing criteria. To submit a reconsideration request, mail the request to the senior medical director. A reconsideration request must be in writing and include all additional supporting documentation. Send it to:

Humana
Attn: Shoba Srikantan, M.D.
101 E. Main St.
Louisville, KY 40202

Please note: Practitioner denials due to missing DEA and/or hospital privileges have 30 business days to provide missing documentation to Humana Healthy Horizons for review as a Category I file.

After reconsideration, the credentialing committee may affirm, modify or reverse its initial decision. Humana Healthy Horizons notifies the applicant, in writing, of the credentialing committee's reconsideration decision within 60 days. Reconsideration denials are final unless the decision is based on quality criteria; in these instances, a provider has the right to request a fair hearing. Providers who were denied are eligible to reapply for network participation once they meet Humana Healthy Horizons' minimum credentialing/certification criteria.

Chapter 15: Fraud, waste and abuse

Fraud is defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program.

Waste is overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the healthcare system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions but by the misuse of resources.

Abuse includes provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes beneficiary practices that result in unnecessary costs to the Medicaid program.

Both the federal government and the individual states that establish and monitor requirements for Medicare and Medicaid work to reduce fraud, waste and abuse in the Medicare and Medicaid programs. Healthcare fraud, waste and abuse can involve providers, pharmacists, members and even medical equipment companies. Success in combating healthcare fraud, waste and abuse is measured not only by convictions but also by effective deterrent efforts. Anyone who suspects or detects a fraud, waste and abuse violation is required to report it either to Humana Healthy Horizons or within their respective organization, which then must report it to Humana Healthy Horizons as outlined below.

You must integrate specific controls into your practice's policies and procedures to help ensure prevention and detection of potential or suspected fraud and abuse and subsequent correction of identified fraud or abuse. You must educate your employees about:

- The requirement to report suspected or detected fraud, waste or abuse
- How to make a report on the above
- The False Claims Act, which prohibits submitting false or fraudulent claims for payment and outlines the penalties for false claims and statements, whistleblower protections and each person's responsibility to prevent and detect fraud, waste and abuse.

Humana Healthy Horizons and FSSA should be notified immediately if you or your office staff:

- Is aware of any provider that may be billing inappropriately (e.g., falsifying diagnosis codes and/or procedure codes, or billing for services not rendered)
- Is aware of a member intentionally permitting others to use the member's ID card to obtain services or supplies from the plan or any network provider
- Is suspicious that someone is using another member's ID card
- Has evidence that a member knowingly provided fraudulent information on the member's enrollment form that materially affects the member's eligibility

Information can be reported via an anonymous phone call to Humana Healthy Horizons' fraud hotline at **800-614-4126**. All information will be kept confidential. Entities are protected from retaliation under 31 U.S.C. 3730(h) for False Claims Act complaints. Humana Healthy Horizons ensures no retaliation against callers through a zero-tolerance policy for retaliation or retribution against any person who reports suspected misconduct. You also may contact Humana Healthy Horizons at **800-4HUMANA (448-6262)**.

Phone	Email	Website
Special Investigations Unit Hotline: 800-614-4126 Hours of operation: Monday through Friday, 7 a.m. to 3 p.m. (24/7 voicemail access)	siureferrals@humana.com	
Ethics Help Line: 877-5-THE-KEY (584-3539)	ethics@humana.com	Ethics Helpline

Key features of methods for direct reporting to Humana Healthy Horizons

Anonymity: If the person making the report chooses to remain anonymous, that person is encouraged to provide enough information on the suspected violation (i.e., date(s) and person(s), system(s), and type(s) of information involved to allow Humana Healthy Horizons to review the situation and respond appropriately).

Confidentiality: Processes are in place to maintain confidentiality of reports; Humana Healthy Horizons allows confidential report follow-up. Humana Healthy Horizons strictly prohibits intimidation and/or retaliation against anyone who, in good faith, reports suspected or detected violation of ethical standards.

The Indiana OMPP also has Program Integrity staff who work to guard against fraud, waste and abuse of Medicaid program benefits and resources. If you have questions or concerns regarding fraud, waste and abuse, you can contact the Program Integrity department via phone (**800-457-4515**) or email **ProgramIntegrity.FSSA@fssa.in.gov**.

Chapter 16: Pharmacy

Covered medications

Humana Healthy Horizons and other health plans in the state are required to use a uniform Preferred Drug List (PDL) and Utilization Management, which are developed by FSSA. The PDL includes some preferred brands, as well as preferred diabetic supplies, such as blood glucose test strips, lancets, meters, syringes, etc.

Noncovered and excluded medications

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

- Agents used for anorexia, weight gain or weight loss
- Agents used to promote fertility
- Agents used for cosmetic purposes or hair growth
- Drugs for the treatment of erectile dysfunction
- Drug efficacy study implementation drugs or drugs that may have been determined to be identical, similar or related
- Investigational or experimental drugs
- Agents prescribed for any indication that is not medically accepted

Pharmacy and therapeutics committee

The pharmacy and therapeutics committee has a responsibility to review and make decisions about the appropriate use of drugs, biologicals and select nondrug pharmacy-related products. This charge may be relevant in many contexts, including but not limited to:

- Formulary development
- Clinical edits
- Drug utilization review
- Consumer programs

PDL

Humana Healthy Horizons may add or remove drugs on the PDL throughout the year as directed by FSSA. We also may change our Utilization Management requirements for covered drugs, or the FDA may provide new guidance or clinical guidelines about a drug. Examples include:

- Elect to require or not require prior authorization
- Elect to change the quantity limits
- Add or change step therapy restrictions
- Add a generic drug that is new to the market

We will notify you of negative impacts to the PDL at least 30 days in advance.

Please review the current formulary prior to writing a prescription to determine if the drug will be covered. The PDL is updated regularly; to view the current PDL, go to **http://humana.com/DrugLists**. To view current medical and pharmacy coverage policies, please visit **https://apps.humana.com/tad/tad_new/home.aspx?type=provider**.

Coverage determinations and exceptions

You may request coverage determinations, such as medication prior authorization, step therapy, quantity limits and formulary exceptions.

- Obtain forms at **Humana.com/PA**.
- Submit requests electronically by visiting **https://www.covermymeds.health/**.
- Submit requests by fax to **877-486-2621**.
- Call Humana Clinical Pharmacy Review at **800-555-CLIN (2546)**.

The coverage determination decision will be reviewed based upon medical necessity and our decision communicated within 24 hours after the request is received from the prescriber.

Appealing adverse decisions regarding medication coverage

If Humana Healthy Horizons denies the member's coverage determination or formulary exception, you can ask for a review of our decision by making an appeal on behalf of the member. Please review **Member grievance and appeals** in Chapter 13 of this manual for details on how to submit appeals.

Peer-to-peer discussions

If you prefer to have a discussion with one of our pharmacists or regional medical directors, you may initiate a P2P request by calling **844-330-7734**, Monday through Friday, 8 a.m. to 6 p.m., Eastern time, and leaving a message, including:

- Prescriber's contact information and best time to contact
- Referenced member name, date of birth and evidence of coverage information
- Prescription drug requested and reason for your call

The prescriber has 15 business days to request a peer-to-peer conversation.

Note: The P2P discussion is not considered part of the appeal process, and depending on the outcome, you may still request a formal appeal if necessary.

Dispensing limitations

Some drugs have limits on how much can be given to a member at one time. Quantity limits may be based on several factors, such as drug manufacturers' recommended dosing, member safety, the Indiana Medicaid Drug Utilization Review Board approved limits or FDA recommendations.

Utilization Management for medications

The PDL identifies covered drugs and associated drug Utilization Management requirements, such as prior authorization, quantity limits, step therapy, etc.

- Prior authorization: The medication must be reviewed using a criteria-based approval process prior to a coverage decision.
- Step therapy: The member must utilize medications commonly considered first line before using medications considered second or third line.
- Drug safety limits: The prescriber must facilitate the appropriate, approved label use of various classes of medications (e.g., drug-drug interactions, opioid limits, therapeutic duplication).
- Generic substitution: Generic drugs should be dispensed when available. If using a particular brand name is determined to be medically necessary, prior authorization must be obtained.

Pharmacy copayments

There are no pharmacy copayments.

Pharmacy network

Our Pharmacy Directory gives you a complete list of network pharmacies that have agreed to fill covered prescriptions for members. Providers and members can access our Pharmacy Directory on our website at **Humana.com/PharmacyFinder**, and members can use our Pharmacy Finder tool by signing in to **Humana.com**.

Members have access to a mail-order pharmacy, which will send their medications directly to their home. For additional information about this option, please visit: **https://www.humana.com/pharmacy/humana-mail-order-pharmacy**.

Continuity of medication coverage for new members

We want to make the enrollment or transition into our plan as easy as possible for our members. This helps members who have limited ability to receive their prescribed drug therapy by providing them with a temporary supply. For new members in need of drugs that require a coverage determination or formulary exception, Humana Healthy Horizons may allow a temporary supply of a drug during the first 90 days of enrollment, including an out-of-network pharmacy.

Medication Therapy Management (MTM)

Humana Healthy Horizons offers an MTM program that helps ensure members achieve the best possible outcomes from their medications. The member-centered MTM program promotes collaboration between the pharmacist, member and prescriber to optimize safe and effective medication use. The goal of this program is to optimize therapeutic outcomes by

focusing on safety, effectiveness, lower-cost alternatives and adherence.
Prescribers with questions about the program may call **888-210-8622 (TTY: 711)**, Monday through Friday, from 9 a.m. to 5:30 p.m., Eastern time.

Medications administered in the provider setting

Humana Healthy Horizons covers medications administered in a provider setting, such as a provider office, hospital outpatient department, clinic, dialysis center or infusion center. Prior authorization requirements exist for many injectables. Medicaid providers may:

- Obtain forms at **Humana.com/MedPA**.
- Submit a request by fax to **888-447-3430**.
- View preauthorization and notification lists at **Humana.com/PAL**.

Electronic prescribing

Through our participation in the Surescripts network, our pharmacy benefit manager, eligibility, formulary and member medication history is available through every major electronic health record or e-prescribing (eRx) vendor, including Allscripts, Epic, Oracle Cerner, athenahealth and DrFirst. Prescribers with electronic health records or eRx can view real-time clinical information about the formulary, safety alert messaging and prior authorization requirements.

Chapter 17: LTSS

Specific provider responsibilities

Humana Healthy Horizons uses an integrated care team (ICT) to support coordination of care for all members assigned to a complex case management level of service and care management as needed. Our ICT approach will use our companion D-SNP's CMS approved model of care to provide ICT services.

For members in our complex care management—intensive tier, we will increase ICT meeting frequencies, allowing us to work closely with the member's PMP, specialists, external care coordinator and others of the member's choosing to deliver highly coordinated, focused support.

We convene an ICT skilled in nursing, social work and behavioral health for members who qualify for an ICT. In addition to the minimum ICT participants (the member, the care coordinator, the service coordinator and any member-selected supports, including informal caregivers), the care coordinator will elicit the feedback of the member on who else the member would like to engage in the ICT.

As part of the minimum composition of every ICT and application of a person-centered approach to ICT membership, we incorporate additional expertise as needed based on the member's individualized needs and goals. The care coordinator may suggest adding participants to the ICT, including Humana Healthy Horizons associates, network providers, representatives from community-based organizations and other care coordinators, in reflection of the member's needs. However, the member has ultimate signoff on who is engaged in the ICT and reserves the right to invite others as the member deems necessary.

With the member's consent, the care coordinator includes the member's PMP, specialty providers and facility care team in the ICT. This connection ensures that the member's treatment plan is reflected in the individualized care plan (ICP), that the PMP and specialty providers can assist in the delivery of the services captured in the ICP and that the member receives a consistent message regarding the member's care across the care coordinator, the service coordinator and the member's providers.

Level-of-care assessment and reassessment processes

NFLOC assessments are performed by the state's designated entity. Humana Healthy Horizons incorporates the level-of-care assessment results from the assessment into the comprehensive health assessment tool (CHAT). If the member's circumstances have substantially changed since the level-of-care assessment was completed, or if more than three months have elapsed between completion of the level-of-care assessment and completion of the CHAT, the member's Humana Healthy Horizons care coordinator reviews the level-of-care assessment responses with the member to confirm their accuracy.

Care and service coordinators will jointly conduct the annual CHAT reassessment for members in service coordination residing in a home and community-based setting. The applicable CHAT results will be sent to the entity or entities designated by the state for an updated NFLOC determination as required. For members residing in nursing facilities, the results of the member's annual level-of-care reassessment conducted by the state's designated entity will be incorporated into the member's record, after which the member's care coordinator and service coordinator will conduct a joint visit to the member to review and update the member's ICP and complete any other needed reassessments. As with the initial assessment process, the care coordinator and service coordinator encourage the member to invite the member's caregivers, natural supports and other chosen ICT participants in the ICT process. The care coordinator and service coordinator ensure that the updated assessments and ICP are shared with ICT participants via our CDS or another participant-preferred method of data sharing.

Needs assessment service planning requirements

Humana Healthy Horizons performs strengths-based, LTSS-specific service planning processes for these members, rooted in the principles of person-centered thinking, trauma-informed care and the "4Ms" of age-friendly care (what matters, medication, mentation and mobility), and based on the results of the member's CHAT and/or level-of-care assessment. As with our CHAT completion process, we will encourage members completing LTSS-specific assessments to include their informal caregivers, family members and other individuals in the member's circle of support in the assessment conversations.

To reduce member abrasion and support a cohesive and streamlined assessment process, the service coordinator will complete the LTSS-specific assessments during the same visit as the CHAT. This dual visit, with both the care coordinator and service coordinator participating, also ensures that both the care coordinator and service coordinator get the full picture of the member's needs, preferences and goals, across all service types.

The service coordinator uses the information gathered via the LTSS assessments to develop the member's service plan, working in collaboration with the member and the member's supports and ICT to identify those services and supports that best meet the member's needs and goals, including a goal to transition to a less restrictive setting. As with the CHAT, we design our CDS platform to directly link the LTSS assessments with the service plan. The service coordinator will be prompted to add a service or intervention for each identified need, ensuring that all member needs are addressed with a service that fits the member's preferences and desires.

HCBS

During service planning, service coordinators leverage their experience, training and expertise to evaluate individual member needs and recommend appropriate services and supports. Service coordinators enter authorizations into our CDS platform during the CHAT and LTSS-specific assessment process and the creation of the member's person-centered service plan. The member's service plan serves as the authorization for LTSS and HCBS services. Humana Healthy Horizons' CDS platform eases member and provider burden by automatically reviewing requested services against our clinical review criteria (as approved by FSSA) in real time and auto-approving services that meet our predetermined thresholds.

Procedure

1. Humana Healthy Horizons uses our CDS platform to create automated authorizations for LTSS.
2. Humana Healthy Horizons has built into our CDS system logic that recommends services based on individual assessment results. Each recommendation is presented with a total number of hours according to service type and the decision-making guidelines or tools approved by FSSA.
3. Recommended services can be approved by the service coordinator in real time if the member agrees. All member requests that differ from the recommendation are sent to our Utilization Management team for review.
4. Our Utilization Management program is evidence based and guided by a set of clinical practice guidelines adopted from clinically sound and reputable agencies.
5. All decisions to deny a service authorization request for a service in an amount, duration or scope that is less than requested are made by a medical director.
6. All member-initiated decisions to authorize a service authorization request for a service in an amount, duration or scope that is less than recommended are auto-approved and indicated that the member declined the additional services.
7. Once the service plan is created and authorizations are approved, service authorizations are automatically delivered to the provider.
8. Humana Healthy Horizons aligns authorizations with the services documented and agreed upon by the member/representative on the member's plan of care. The authorized services will be ongoing according to the time frames specified in the agreed-upon service plan.
9. The service request/authorization sent to the provider contains an authorization number and an effective date. Service authorizations that include service type, frequency and duration as specified in the service plan are sent to contracted and noncontracted providers within 24 hours of the initial face-to-face visit.
10. The service plan provided to the member includes a listing of the services and items that will be authorized by Humana Healthy Horizons, detailing the name of each service or item to be furnished; the frequency and duration of each service, including the start and stop date; for LTSS, the units authorized; and for each service, the provider's name.
11. Humana Healthy Horizons typically authorizes HCBS services for a duration of 12 months, which will update when the member's condition changes.
12. Continuing authorization of services occurs via the process described above.
13. Humana Healthy Horizons does not delay service authorization if written documentation is not available in a timely manner. Covered services are not denied based on an incomplete service plan. However, Humana Healthy Horizons is not required to approve claims for which written authorization is not available.

14. Humana Healthy Horizons measures compliance with standards for processing authorization requests in a timely manner.

Service plan timeline requirements

We will adhere to the following timeline requirements for completion of the service plan:

Service coordinators conduct an initial face-to-face visit and include any LTSS assessments within 90 days of implementation when the member has already been determined to meet NFLOC and is receiving HCBS.

At enrollment, when a member is determined to meet NFLOC and already receiving HCBS prior to implementation, the member's service coordinator will conduct an initial face-to-face visit, administering any LTSS assessments and updating the member's service plan with any modifications to the HCBS needs.

Service coordinators will conduct a face-to-face visit with NFLOC members receiving short-term nursing facility care on the effective date with Humana Healthy Horizons prior to the expiration date of the approved nursing services but no more than 90 days after implementation.

If there is an increase in the member's needs before the initial CHAT or LTSS assessment can occur and the member is already determined to meet NFLOC and receiving HCBS/short-term nursing facility care, the service coordinator will immediately conduct a functional needs assessment. The service plan also will be updated accordingly.

The service coordinator will conduct a face-to- face in-facility visit within 90 days of implementation and conduct a needs assessment when the member resides in a nursing facility for less than 90 days at enrollment.

The service coordinator will conduct quarterly face-to-face visits every 90 days at the facility to assess the member's needs and/or transition the member.

For members who are determined to meet NFLOC by the state-designated entity(ies) following a referral by or on behalf of a member, regardless of referral source, the service coordinator will conduct a face-to-face visit with the member and complete and approve a service plan within five business days of receiving the member's NFLOC determination notification from the state-designated entity.

Providers should begin services as soon as possible and within 20 days of receiving a notification from the service coordinator, as indicated on the service plan. The service coordinator will verify all HCBS included in the member's service plan, except home modification and vehicle modification, are started or delivered within 30 days of the initial service plan.

For requests related to HCBS, once a decision to deny has been made, a notice to the member will be provided within 24 hours.

Our care coordinators and service coordinators ensure that the requisite level of support is provided for ensuring that the member directs the person-centered planning and ICT process to the maximum extent possible and is empowered to make informed choices and decisions.

Our person-centered service planning process will include, but is not limited to, the following requirements:

- Identifying, coordinating and supporting members in gaining access to LTSS services and other covered services
- Identifying, coordinating and assisting members in gaining access to noncovered medical, social, housing, educational, financial and other services and supports, including services provided by other community resources
- Informing members about available LTSS, required assessments, the person-centered service plan, service alternatives and service delivery options, including participant direction, risks and responsibilities
- Protecting a member's health, welfare and safety, including developing an emergency plan
- Facilitating member access to locating, coordinating and monitoring needed services and supports
- Collecting additional necessary information, including, at a minimum, member preferences, strengths and goals
- Reassessing a member's level of care annually
- Assisting in identifying and choosing willing and qualified providers
- Coordinating efforts and prompting the member to complete activities necessary to maintain LTSS eligibility
- Exploring coverage of services to address member-identified needs through Medicaid and other services such as Medicare, private insurance, Veterans Affairs services and other informal unpaid supports

- Actively coordinating with other individuals and entities essential in the physical and social care delivered for the member to provide for seamless coordination
- Referring to all training, education and resources for informal caregivers as required in the Informal Caregiver Supports and Informal Caregiver Coaching section of the contract

Workforce development

Requirements

In addition to the training listed in the section above, Humana Healthy Horizons is committed to supporting our provider network in meeting overall workforce development needs. Our providers are an integral part of our care management team, and we are extremely focused on supporting the capacity and professional development needs of the people who are providing care for our members. For this reason, we have invested in a Center of Excellence for Workforce Development that functions as a nexus to bring together industry, community and government entities with the common goal of understanding workforce needs and gaps, delivering professional development and retention initiatives, and building a talent pipeline for the Indiana managed care workforce ecosystem.

As part of this work, Humana Healthy Horizons is partnering with the **https://www.in.gov/fssa/ompp/files/2022DSWReport_FINAL.pdf** to address the critical workforce shortage of direct service workers throughout Indiana, which we know is a major obstacle for many of our providers. Through this work, Humana Healthy Horizons will support the recruitment, retention and data needs necessary to fuel this important part of the care team.

Workforce development is a long-term partnership that will make all the difference in delivering high-quality, person-centered care to our members, and Humana Healthy Horizons will work closely with our providers to address needs now and in the future, as we work together to deliver services with excellence. If you have questions or would like to participate in Humana Healthy Horizons' workforce development efforts, please reach out to **HumanaINWorkforce@humana.com**.

Chapter 18: Frequently asked questions

Below is a collection of frequently asked questions that you may find useful.

Providers

Question	Answer
What is considered a complete credentialing application?	A complete application must include the following: • A completed provider/group enrollment roster. Complete all fields applicable to your practice and the individual provider. - If a provider has multiple addresses or specialties, a new row should be used for each additional location or specialty. • The CAQH number. This should be included for all providers listed on the roster. More information about how Humana Healthy Horizons utilizes the CAQH application and expectations for providers can be found in the credentialing section of this manual. If you have specific questions about completing the roster, please email INProviderUpdates@humana.com. • A completed Behavioral Health Profiling form (for providers offering behavioral health services). • W-9 tax form.
What is the turnaround after a complete credentialing application is received?	Complete applications will be processed within 30 days of receipt.
Will I receive an update if my credentialing application is incomplete?	Yes. Providers will receive notification within 5 business days.
When will I receive notification after credentialing is complete?	Yes. Humana Healthy Horizons distributes a welcome letter within 5 days of the network participation process completion. This welcome letter outlines the effective date of the contract schedule of onboarding activities and the online resources available to providers, including the provider manual and self-guided pre-orientation modules. This welcome letter also includes a direct phone number and email address for providers to reach their assigned Provider Education/Outreach Representative to request any additional information.
Who can I contact if I have questions or concerns?	Provider Services Contact Center at **866-274-5888 (TTY: 711)** or your dedicated Provider Education/Outreach Representative.

Hospital/ancillary providers

Question	Answer
What is considered a complete application?	A complete facility application must include the following: • The Facility and Ancillary Assessment form with an attestation signature date no more than 120 days from the date inserted in the signature block • The Behavioral Health Profiling form, for providers offering behavioral health services - A copy of the following supporting documentation attached to the facility enrollment form: • Facility's license, as applicable • Accreditation letter, as applicable • CMS certification, as applicable • Malpractice insurance policy face sheet showing effective and expiration dates and limits of liability within amounts at the minimum amount in accordance with state laws in which the organization provides care • CLIA, as applicable. • Disclosure of ownership form • W-9 tax form
What is the turnaround after a complete credentialing application is received?	Complete applications will be processed within 30 days of receipt.
Will I receive an update if my credentialing application is incomplete?	Yes. Providers will receive notification within 5 business days of application receipt.
When will I receive notification after credentialing is complete?	Humana Healthy Horizons distributes a welcome letter within 5 days of the network participation process completion. This welcome letter outlines the effective date of the contract schedule of onboarding activities and the online resources available to providers, including the provider manual and self-guided pre orientation modules. This welcome letter also includes a direct phone number and email address for providers to reach their assigned Provider Education/Outreach Representative to request any additional information.
Who can I contact if I have questions or concerns?	Provider Services Contact Center at **866-274-5888 (TTY: 711)** or your dedicated Provider Education/Outreach Representative.

HCBS providers

Question	Answer
What is considered a complete application?	A complete application must include the following: • A complete and up-to-date HCBS/LTSS assessment form • Current supporting documentation • Certification from the Division of Aging • Site survey, if applicable
What is the turnaround after a complete HCBS/LTSS assessment form is received?	Complete applications will be processed within 30 days of receipt.
Will I receive an update if my HCBS/LTSS assessment form is incomplete?	Yes. Providers will receive notification within 24 hours.
When will I receive notification after my assessment is approved?	Humana Healthy Horizons distributes a welcome letter within 5 days of the network participation process completion. This welcome letter outlines the effective date of the contract schedule of onboarding activities and the online resources available to providers, including the provider manual and self-guided pre orientation modules. This welcome letter also includes a direct phone number and email address for providers to reach their assigned Provider Education/Outreach Representative to request any additional information.
Who can I contact if I have questions or concerns?	Provider Services Contact Center at **866-274-5888 (TTY: 711)** or your dedicated Provider Education/Outreach Representative.