Humana Healthy Horizons in Indiana
Indiana PathWays for Aging Program
Joining Humana's Network Resource Guide

February 2024

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

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Introduction

Thank you for deciding to become a part of the Humana Healthy Horizons® in Indiana provider network. The goal of this document is to offer a step-by-step overview of the provider journey including a review of the provider enrollment, credentialing/certification and contracting processes, and define key words used during the provider journey.

Prior to consideration for eligibility in Humana Health Horizons' Indiana PathWays for Aging provider network, all providers must have an active Indiana Health Coverage Programs (IHCP) Medicaid provider ID. If you do not have an IHCP Medicaid provider ID, please complete the IHCP application on the IHCP provider enrollment website.

Key terminology

As you review the following document, please note the key terms used throughout.

Credentialing—the process of reviewing the qualifications and appropriateness of a provider to join Humana's network. Humana conducts credentialing and recredentialing activities utilizing guidelines established by the National Committee for Quality Assurance (NCQA) as required by the IHCP and Indiana's Family and Social Services Administration (FSSA). Humana credentials and recredentials all licensed independent providers including physicians, non-physicians 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 providers requiring credentialing 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 completely processes credentialing applications from all provider types within 30 days of receipt of a completed credentialing application, including all necessary documentation and attachments.

Certification—Home- and community-based services (HCBS) providers go through Humana's certification process, which verifies HCBS provider Medicaid eligibility and scope of services authorized by the Indiana Office of Medicaid Policy and Planning (OMPP).

More information can be found on the HCBS certification process on page 13 of this quick reference guide.

Contracting/negotiating—process by which the provider and managed care entity (MCE) formally execute an agreement for the provider to deliver medical services that outlines reimbursement rates, scope of services, etc.

Enrollment—the process of loading a contracted and credentialed provider to all MCE internal systems, loading for claims payment and loading to the provider directory (if applicable).

Please note: Providers are requested to hold submission of claims until the completion of the enrollment process.

Enrollment process overview

1. All providers must be enrolled with IHCP. If you haven't already done so, please complete the IHCP provider enrollment process at the IHCP provider enrollment website to obtain your IHCP Medicaid provider ID.
2. The enrollment requirements vary according to your provider type: individual provider, hospital/ancillary provider or HCBS provider. Details on the requirements for each provider type can be found in this document.
3. A completed enrollment application can be submitted online, through email, fax or mail, as needed. Certain documents are required when submitting the enrollment application. Details for each provider type, including a list of which documents are required, can be found under "Submitting your enrollment application" in this document with a link to each listed here: individual and groups, organizational and ancillary and HCBS.
4. Once submitted, Humana reviews your application. If complete, you receive a participation agreement for review and signature.
5. A review of your complete enrollment application is finished within 30 days of submission.
6. Your signed participation agreement is required to complete the enrollment process.
7. Humana updates all internal data systems and external provider directories with your information.
8. Providers receive a welcome letter from Humana, notifying that enrollment is complete. Our provider education/outreach representative will then reach out to begin the onboarding orientation.

Important contact information
If you have questions, experience issues or want to check the status of your enrollment, you can email the appropriate team listed below:

Medical providers	INProviderUpdates@humana.com
Behavioral health providers	INBHMedicaid@humana.com
HCBS providers	LTSSContracting@humana.com

Effective date policy
The effective date policy is as follows:

- A brand-new provider that is not part of an existing contract with Humana is effective the first of the month following the contract execution date.
- The effective date is no sooner than the IHCP effective date.
- A provider added to an existing contract is effective the first of the month following receipt of the network participation request from the provider.

Individual provider and provider group enrollment (non-HCBS)

Required information for enrollment
All providers must be actively enrolled with IHCP. If you haven't already done so, complete the IHCP provider enrollment process at the IHCP provider enrollment website to obtain your Indiana Medicaid provider ID.

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

1. 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 distinct and separate location or specialty.
   - CAQH number should be included for all providers listed on the roster. More information about how Humana utilizes the CAQH application and expectations for providers can be found below in the section titled "CAQH application for individual providers."
   - If you have specific questions about completing the roster, please email INProviderUpdates@humana.com.
2. A completed Behavioral Health Profiling form for providers offering behavioral health services
3. Disclosure of ownership form
4. W-9 tax form

Failure to submit a complete application will result in a delay in completing or beginning the credentialing and contracting process. Providers are notified via email within 5 days if the request to join the network is incomplete.

Submitting your enrollment application
You can submit you application online by visiting **Humana.com/HealthyIN** and selecting the Provider Online Enrollment Application (non-HCBS) or selecting the link in step 1. Submit your enrollment application via the following steps:

1) Open link to the Humana Healthy Horizons in Indiana Request to Join portal.
2) Download the required documents for submission of an individual provider or provider group, including:
   a. Provider/Group Roster Template
   b. W-9 tax form
   c. Disclosure of ownership form
   d. Behavioral Health Profiling form, if applicable
3) Save a copy of the completed enrollment documents for submission through the portal.
4) Once forms are complete and saved, return to the portal and select "New Network Request."
5) Fill out the Demographic and Basic Information, Service Address Demographics and Contract Contact fields listed.
   a. Items marked with a red asterisk are required to move forward with your application.

6) Upload your completed enrollment forms under the "Attachments" heading, ensuring all required documents are included.
7) Review the application for accuracy once completed. If satisfied, select Save to complete the submission.
8) After submitting, you should receive an automated message that includes a tracking number. The assigned contractor will follow up with you within in 5 days, advising whether the application was complete or additional information is required, along with the next steps in the enrollment process.

Other methods to submit the enrollment application
Providers also may submit the enrollment application along with the previously referenced credentialing materials directly to Humana using the following email addresses:

- Medical providers: INProviderUpdates@humana.com
- Behavioral health providers: INBHMedicaid@humana.com

If you are unable to submit your application electronically or via email, please call us at **800-626-2741** Monday through Friday, 9 a.m. to 6 p.m., Eastern time. Providers also may check enrollment status using these email addresses.

CAQH application for individual providers
Humana is a participating organization with CAQH. Prior to submitting your enrollment application, please ensure Humana is granted access to your credentialing application by completing the following steps:

- Log on to the CAQH website using your account information.
- Select the Authorization tab.
- Confirm Humana is listed as an authorized health plan; if not, please check the authorized box to add.

An up-to-date CAQH application, with status of complete or re-attested and access granted to Humana/ChoiceCare, is required. Please ensure the information supplied is complete and current on your credentialing application, including but not limited to:

- Practicing specialty
- National Provider Identifier (NPI)
- Contact name and email address used for credentialing purposes
- Current practice address, including suite number and fax number, if applicable
- Hospital privileges or coverage arrangements, as applicable by provider type
- Work history—at least 5 years of continuous work history experience

The following supporting documentation should be included in your CAQH application:

- Proof of current malpractice insurance with the minimum amount in accordance with state laws in which the provider provides care
- Disclosure of ownership form
- W-9 tax form
- Collaborative agreement for mid-level providers
- If practicing in one of the following specialties, attach 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 provider is serving as a primary medical provider (PMP), an on-site survey is required prior to beginning credentialing activities for the following specialties:
    - Internal medicine
    - General practice
    - Family medicine
    - Pediatrics
    - Gynecology, acting as a PMP
    - Endocrinology, acting as a PMP
    - Geriatrics
    - Advanced practice registered nurse (APRN)
    - Physician assistant (PA)

Provider helpful tips

What are the most common opportunities to reduce errors related to credentialing or recredentialing?

Provider credentialing		
Need	Most common opportunities	Recommendation

CAQH application	• Provider'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 provider's name, coverage amounts, and effective and expiration dates
		The information on CAQH must match the information you provide on your network participation request.
		• Log on to the CAQH website using your account information.
		• Select the Authorization tab.
		• Confirm Humana is listed as an authorized health plan; if not, please check the authorized box to add.
		
		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 correct and completed documents as required.

Response time for requested documentation	• Slow response time to requested information	Sign and return missing or incomplete documents as quickly as possible.

Organizational/ancillary provider

Required information for enrollment
All organizational providers must be actively enrolled with IHCP prior to submitting a facility enrollment application to Humana. If your organization hasn't already done so, complete the IHCP provider enrollment process by visiting the IHCP provider enrollment website to obtain the organization's IHCP Medicaid provider ID. Organizations must be enrolled with IHCP at the service location(s) applicable to your Humana Healthy Horizons agreement.

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

1. The Organizational Provider Assessment form with an attestation signature date no more than 120 days from the date inserted in the signature block.
2. A completed roster, dependent on provider type
    - Federally qualified health centers (FQHC) and rural health clinics (RHC), please complete the FQHC/RHC Roster template.
    - All other provider types, please complete the Organizational Provider Roster template.
3. A completed Behavioral Health Profiling form for providers offering behavioral health services.
4. W-9 tax form
5. A copy of the following supporting documentation attached to the facility enrollment application:
    - The facility's license, as applicable
    - Accreditation letter, as applicable
    - Centers for Medicare & Medicaid Services (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
    - Clinical Laboratory Improvement Amendments (CLIA), as applicable
    - Disclosure of ownership form

Failure to submit a complete application will delay our ability to complete or begin the credentialing and contracting process. Facilities are notified via email within 5 days if we determine the request to join the network is incomplete.

Submitting your enrollment application
You can submit you application online by visiting **Humana.com/HealthyIN** and selecting the Provider Online Enrollment Application (non-HCBS) portal or selecting the link in step 1. To submit your enrollment application through the portal:

1) Open link to the Humana Healthy Horizons in Indiana Request to Join portal.
2) Download required documents for submission:
    a. Organizational Provider Assessment form
    b. Facility specific roster template (select one)
        i. FQHC/RHC Roster template
        ii. Organizational Provider Roster template
    c. W-9 tax form
    d. Behavioral Health Profiling form, if applicable

3) Save a copy of the completed enrollment documents for submission through the portal.
4) Return to the portal once forms are complete and saved and select "New Network Request."
5) Fill out the Demographic and Basic Information, Service Address Demographics and Contract Contact fields listed.
    a. Items marked with a red asterisk are required in order to move forward with your application.
6) Upload your completed enrollment forms under the "Attachments" heading, ensuring all required documents are included.
7) Once complete, review the application for accuracy. If satisfied, select Save to complete the submission.
8) You will receive an automated message after submitting that includes a tracking number. The assigned contractor follows up within 5 days advising whether the application was complete or additional information is required along with describing next steps in the enrollment process.

Other methods to submit the enrollment application
For medical providers, submit your enrollment application along with referenced above credentialing materials directly to Humana through the following email addresses:

- Medical providers — INProviderUpdates@humana.com
- Behavioral health providers — INBHMedicaid@humana.com

Providers may check enrollment status with Humana using these email addresses.

Hospital and ancillary helpful tips
What are the most common opportunities to reduce errors related to facility credentialing or recredentialing?

Organizational provider assessment		
Need	Most common opportunities	Recommendation
Facility enrollment form	• Facility enrollment form is incomplete or is expired.	Ensure the facility enrollment form is up to date before requesting to join the network.
Supporting documentation	• The required supporting documents are missing. • The document is expired or will expire within the next 30 days.	Provide all correct and completed documents as required.

HCBS providers

Required information for enrollment
All HCBS providers must be enrolled with IHCP. If your organization hasn't already done so, complete the IHCP provider enrollment process by visiting the IHCP provider enrollment website to obtain the organization's Indiana Medicaid provider ID.

A complete HCBS/long-term services and supports (LTSS) provider enrollment application, including supporting documentation, is necessary to assess an HCBS provider for network participation. A completed HCBS/LTSS provider enrollment form must include the following:

1. The HCBS/LTSS provider assessment form (opens PDF) with a signature date not more than 120 days from the date inserted in the signature block
2. An active IHCP Medicaid provider ID obtained through IHCP
3. W-9 tax form
4. HCBS certification from OMPP or other applicable state division

Failure to submit a complete application will delay the enrollment process with Humana. HCBS providers are notified via email within 5 days of receipt if the request to join the network is incomplete.

Submitting your enrollment application
You can submit you application online by visiting **Humana.com/HealthyIN** and selecting the HCBS Provider Online Enrollment Application. Follow the below steps to submit your enrollment application through the portal:

1) Open link to the Humana Healthy Horizons in Indiana Request to Join portal.
2) To complete the application, select the Request to Join the Network button in the middle of the page.
3) Fill out the fields listed under Provider Identifiers, Contact Information and Confirmation.
    a. Items marked with a red asterisk are required to move forward with your application.
4) Download and complete the required documents for submission:
    a. HCBS/LTSS Provider Assessment form (opens PDF)
    b. W-9 tax form
5) Save a copy of the completed documents.
6) Upload your completed documents, including the following:
    a. HCBS/LTSS Provider Assessment form (opens PDF)
    b. W-9 tax form
    c. Division of Aging Waiver Certification letter
    d. Professional Licensing Agency license, if applicable
7) Once complete, review the application for accuracy. If satisfied, select Save and close to complete the submission.
    a. If a required field is not complete or a required document is not attached, the system will not allow you to proceed. Please provide the required information and select Save and close to complete the submission.
8) Once submitted, you should receive an automated message. The assigned contractor follows up within 5 days advising if the application was complete or additional information is required and describes the next steps in the enrollment process.

Paper enrollment application
If you are unable to submit your application online or through email, please call us at **877-233-4705**. Our contracting representative can assist you with submitting enrollment documentation via mail or fax.

Additional documentation and enrollment status
HCBS providers may submit their completed HCBS/LTSS enrollment form and all supporting documentation directly to Humana or check the enrollment status by emailing LTSSContracting@humana.com. If you have questions, please call **866-274-5888** Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

HCBS providers helpful tips

What are the most common opportunities to reduce errors related to the HCBS provider enrollment process?

HCBS/LTSS provider assessment		
Need	Most common opportunities	Recommendation
HCBS/LTSS enrollment form	• HCBS/LTSS enrollment form is incomplete or expired.	Ensure the enrollment form is up to date before requesting to join the network.
Supporting documents	• Certification from OMPP is missing. • Documents submitted are expired.	Provide the correct and completed documents as required.
Response time for requested documentation	• Slow response time to requested information	Sign and return missing or incomplete documents as quickly as possible.

Humana contact information for HCBS providers

Email: LTSSContracting@humana.com
Phone: **866-274-5888** (customer service)/**877-233-4705** (HCBS/LTSS contracting)

Humana HCBS provider contracting region/territory

Region: Humana lead HCBS contracting associate
Region/territory 1 and 2 — Janine McDowell
Region/territory 3 and 4 — Sam Purchon
Region/Territory 5 — Greta Speights

Credentialing/certification and recredentialing/recertification overview

Medical and behavioral health: individual provider
The following section contains additional information regarding Humana's credentialing process for medical and behavioral health providers, including an overview of provider types requiring credentialing/certifications, elements evaluated as part this process, overview of delegated credentialing requirements and disclosure of certain provider rights and responsibilities.

Provisional credentialing

Provisional credentialing is valid for a maximum of 60 calendar days. A provider is permitted to be provisionally credentialed only once, after their first time joining the network. Provisionally credentialed providers are not included in the provider directory. Humana does not perform provisional credentialing for providers who were credentialed by a delegate. Provisional credentialing is not applicable to LTSS or HCBS provider types. Provisional credentialing shall be used when it is in the best interest of the member's care.

In instances when an individual provider is provisionally credentialed, the following elements are verified:

- Current, valid license to practice in the state(s) where members are treated
- Previous 5 years of malpractice history, verifiable via the malpractice carrier or National Practitioner Data Bank (NPDB) query
- A current and signed application including attestation to the following:
  - Inability to perform essential functions
  - Illegal drug use
  - History of loss of license
  - History of felony convictions
  - Limitation of privileges
  - Disciplinary actions
  - Current malpractice coverage
  - Correctness and completeness of the application

Individual providers
Evaluating providers included within the scope of credentialing for Humana's Indiana PathWays for Aging network includes, but is not limited to, the following:

Physical health providers:

- Physicians
- Oral surgeons
- Chiropractors
- Podiatrists
- Dentists
- Optometrists
- Allied health providers, including:
  - APRNs
  - Clinical nurse specialists
  - Certified nurse midwives

  - PAs
- Therapists, including:
  - Speech and speech and language pathologists
  - Occupational
  - Physical
- Audiologists
- Other licensed or certified providers, including physician extenders, who act as a PMP or those that appear in the provider directory

Behavioral health providers:

- Psychiatrists and other physicians
- State-licensed doctoral or master's level psychologists
- Licensed health service provider in psychology
- Licensed independent practice school psychologist
- State-licensed master's level clinical social workers
- State-licensed master's level clinical nurse specialists or psychiatric nurse practitioners
- Licensed clinical addiction counselors
- State-licensed master's level licensed marriage and family therapists
- State-licensed master's level mental health counselors
- Applied behavioral analysis 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

The elements Humana uses to evaluate providers during credentialing and recredentialing include:

Provider enrollment application

- Request to join Humana's network

Credentialing application

- Signed and dated CAQH credentialing application, including supporting documents, signature not more than 120 days from the date inserted in the signature block

Licensure

- Unrestricted license in Indiana issued by the appropriate licensing board

Drug Enforcement Agency and a controlled substance registration

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

If the provider states in writing that they do not prescribe controlled substances and that, in their professional judgment, the patients receiving their care do not require controlled

substances, they are not required to have a DEA/CSR certificate; but providers must describe their process for handling instances when a patient requires a controlled substance.

Education and training

- Successful completion of all training programs pertinent to one's practice
  - For M.D.s and D.O.s, successful completion of residency training pertinent to the requested practice type
  - For chiropractors, proof from a chiropractic college and completion of Doctor of Chiropractic medicine
  - For podiatrists, proof of graduation from podiatry school and completion of residency program for Doctor of Podiatric medicine
  - For APRNs, proof of graduation from an accredited master's degree program
  - For PAs, proof of graduation from an accredited master's degree program
  - For dentists and other providers who require or expect special training for requested services, successful completion of training program

Board certification

- Proof of board certification if the provider's application states he or she is board certified

Admitting privileges

- Provider holds current clinical privileges in good standing at a participating facility, as applicable
- If the provider does not hold admitting privileges, the provider must have an explanation of admitting arrangements applicable to their area of care.

Work history

- Work history that includes a minimum of 5 years via curriculum vitae (CV) or included on the application
- Explanation of gaps of 6 months or more

Malpractice insurance

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

Malpractice history

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

NPI

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

IHCP enrolled provider

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

Site visit

- PMP office location(s) must be surveyed prior to being credentialed.
    - Providers that serve as a PMP include the following: internal medicine, general practitioners, family medicine physicians, pediatricians, gynecologists, endocrinologists, geriatricians, APRNs and PAs.
- PMP and high-volume specialist office location(s) must be surveyed prior to being recredentialed.
    - Providers that serve as a high-volume specialist include the following: cardiologists/cardiovascular disease specialists, ophthalmologists, oncologists/medical oncologists, orthopedic surgeons and gastroenterologists.

In good standing with regulatory agencies

- Providers, or agents or managing employees of providers, are 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 intermediaries, including:
        - CMS Medicare preclusion list
        - CMS opt-out list
    - Health and Human Services – Office of Inspector General (HHS-OIG)
    - General Services Administration (GSA)
    - State sanctions and restrictions on licensure

Performance indicators

- For recredentialing purposes only: provider should demonstrate an acceptable performance record related to Humana members with no evidence of quality issues.

Demographics

- Verification providers are appropriately linked to group(s), as applicable, and are enrolled at the appropriate service locations

Disclosure of Ownership

- IHCP provider Schedule C – disclosure information
- CMS disclosure form CMS 1513
- Humana's disclosure of ownership, business transactions and exclusions statement for providers

Medical and behavioral health: hospital and ancillary provider

Evaluation of organizational providers included within the scope of credentialing for Humana's Indiana PathWays for Aging network include, but may not be limited to, the following:

- Ambulatory surgical centers
- Clinical laboratories
- Dialysis centers/end-stage renal disease clinics
- Durable medical equipment/home medical equipment providers
- FQHCs
- Health departments
- Hearing aid dealers
- Home health agencies (LTSS)
- Hospice providers (LTSS)
- Hospitals
- 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 healthcare facilities providing mental health or substance use services in the following settings are also 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 from the date inserted in the signature block

Licensure/business license/permit (as applicable)

- As required by state, federal and local regulatory bodies, the provider is currently licensed and in good standing with the appropriate licensing board

Insurance coverage

- Current general/comprehensive/malpractice liability insurance coverage or participation in 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 with and not debarred, suspended or otherwise excluded by federal, state, or local agencies, including:

- IHCP (and have an active IHCP Medicaid provider ID number)
- Any Medicaid program

The organization's employees must not appear on the FSSA Termination of Provider Participation in Medicaid and CHIP list.

Eligible for Medicare
To be considered eligible to provide Medicare services, 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, or local agencies. In addition, all of the following must be true:

- The organization and its managing employees must not be sanctioned, excluded, or debarred from participation in Medicare.
- The organization and its managing employees must verify that it has not opted out of participation with Medicare.
- The organization and its managing employees must verify that the provider does not appear on the CMS preclusion list.
- The organization and its managing employees must be Medicare-certified to participate in Humana's Medicare network(s).

Free from sanctions, exclusion or debarment
To be considered eligible to provide services, 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, or local agencies. The organization and its managing employees must verify 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.

Clinical Laboratory Improvement Amendments

- Verification 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 was conducted, as applicable.
- Accreditation body—Organizational provider must supply a copy of the accreditation report or evidence from the accreditation body with which the provider is accredited.

- CMS or state quality review—If an organizational provider is not accredited, Humana may substitute a CMS or state review in lieu of performing its own on-site quality assessment. Humana verifies an on-site quality assessment was 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 3 years old at the time of verification.
- Quality review conducted by Humana—If the CMS or state review is older than 3 years, Humana conducts its own on-site quality review. If the 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 may choose not to conduct a site visit.

NPI

- NPI verifiable via NPPES

Opioid treatment program providers

In addition to the requirements listed above, opioid treatment program (OTP) providers must provide:

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

Substance use disorder addiction treatment providers

In addition to the requirements listed above, substance use disorder (SUD) providers must provide:

- Evidence of American Society of Addiction Medicine (ASAM) level of care
- Evidence of certification from the DMHA level of care designation
- Evidence of the Department of Child Services (DCS) licensing as a childcare institution or private secure care institution with a DMHA addiction services provider, regular certification that includes ASAM designation offering either level 3.1 or level 3.5 residential services

Disclosure of ownership

- IHCP provider Schedule C – disclosure information
- CMS disclosure form CMS 1513
- Humana's disclosure of ownership, business transactions and exclusions statement for providers

HCBS providers

Certification and recertification overview

Evaluation of HCBS providers included within the scope of certification for Humana's Indiana PathWays for Aging network include, but may not be limited to 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
- Personal emergency response
- Pest control
- Respite
- Specialized medical equipment
- Structured family care
- Vehicle modification

Required documents for certification and recertification

- HCBS/LTSS provider enrollment
- Indiana OMPP certification

Medicaid eligibility

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.

- Providers and employees must currently be enrolled with IHCP and have an active IHCP Medicaid provider ID
  - HCBS providers must be enrolled with IHCP as provider type 32 and specialty 350.
- Providers and employees must not be sanctioned, excluded or debarred from participation in any Medicaid program.
- Providers and employees must not appear on the 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 the provider has not been sanctioned, excluded, or debarred by the OIG, the 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 recertification and reassessment

Network providers are recertified, and organizational, long-term care and HCBS providers are reassessed, at least every 3 years. As part of the recertification process, Humana 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 NPDB, Medicare and Medicaid sanctions, CMS Preclusion list, the HHS/OIG, GSA (formerly Excluded Parties List System), and limitations on licensure.

General credentialing/recredentialing and certification/recertification information

Provider rights

Providers have the right to review, on request, information submitted to support their credentialing/certification application to the Humana Credentialing Operations department. Humana keeps all submitted information secure and confidential. Access to electronic credentialing/certification information is password protected and limited to staff that require access for business purposes.

Providers have the right to correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the credentialing department prior to presentation to the credentialing committee. If information obtained during the credentialing/certification or recredentialing/recertification process varies substantially from the application, the provider 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 department.

Provider responsibilities

Network providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. Humana initiates immediate action in the event the participation criteria are no longer met. Network providers are required to inform Humana of changes in status, including but not limited to, involvement in a medical malpractice suit; involuntary changes in hospital privileges, licensure or board certification; an event reportable to the National Practitioner Data Bank (NPDB); federal, state or local sanctions; or complaints.

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

Humana 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 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 is required from the delegated entity, which is defined in an agreement between both parties.

Reconsideration of credentialing/recredentialing decisions

Humana's Credentials Committee must notify a provider of a denial based on credentialing/certification criteria. The notice must inform the provider of the reasons for the denial and, in the case of a denial based on credentialing/certification criteria eligible for Credentials 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 requested in a timely manner, the Credentials Committee may affirm, modify or reverse the initial decision. Humana notifies the applicant in writing of the Credentials Committee's reconsideration decision within 60 days. Providers who have been denied are eligible to reapply for network participation once they meet the minimum health plan credentialing/certification criteria. To submit a reconsideration request, mail the reconsideration request, including all additional supporting documentation, to the medical director at:

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

Please note: Providers who have denials due to missing DEA and/or proof of hospital privileges have 30 business days to provide the missing documentation to Humana for review as a Category I file.

After reconsideration, the Credentials Committee may affirm, modify or reverse its initial decision. Humana notifies the applicant, in writing, of the Credentials Committee's reconsideration decision within 60 days. Reconsideration denials are final unless the decision is based on quality criteria; in those 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's minimum credentialing/certification criteria.