Humana Healthy Horizons®

PathWays FOR AGING

Provider Orientation and Training

Information for Indiana PathWays for Aging Network providers

About Humana Healthy Horizons® in Indiana

Indiana PathWays for Aging is a new health delivery model in Indiana that begins July 1, 2024.

Members include:

- Hoosiers aged 60 and older who meet income requirements.
- Hoosiers who qualify for Medicaid based on age, blindness or disability.*

Program goal: To promote living in the member's setting of choice, receiving person-centered care and addressing social determinants of health (SDOH).

Caring for our Hoosier population

- Clinical documentation system suggests population-specific interventions based on assessment results
- Member incentive programs (e.g., getting active, becoming involved and receiving follow-up care)

Person-centered standards

- The transition coordination staff works to prioritize person-centered needs and timely supports and services and to avoid disruption in care.
- The care planning process is a strengths-based approach informed by person-centered thinking.
- Person-centered planning emphasizes relationship building and promotes member and family engagement.

* Eligibility is determined by Family and Social Services Administration (FSSA); full criteria is defined on the **Indiana FSSA website**.

Humana is honored to serve Hoosiers statewide for decades

For decades, 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 support our network providers, including Home and Community-Based Services (HCBS) entities, in delivering person-centered care to our members in the setting of their choice. Our range of clinical capabilities, combined with our member programs and resources, produce a simplified experience that makes healthcare more effective and easier to navigate.

Today, Humana covers **more than 350,000 lives in Indiana** across all lines of business, including some of your current patients and residents eligible for both Medicare and Medicaid.

Humana has forged, and continues to build, innovative, local community partnerships in Indiana focused on addressing priorities, such as **health equity and workforce development**.

Humana **employs 2,600 Indiana-based associates** with a deep understanding of the state's needs and long-standing relationships with Indiana providers and community-based organizations.

Humana works closely with **HCBS providers** in other Medicaid markets, giving us the experience to support you all in your transition to and success in the Indiana PathWays for Aging program.

Humana Healthy Horizons deploys a concierge provider services team enabling a transparent and seamless provider experience

Providers are essential in delivering person-centered care to Hoosiers in their communities.

Dedicated and local support

Every provider will have a dedicated provider education/outreach representative with experience in long-term services and supports to help you do business with Humana Healthy Horizons.

Ease of doing business

Our processes are developed to be clear and intuitive. We will educate you on how to submit claims, manage authorizations and more.

Accessible tools and resources

We will help you access Humana tools and resources, as well as partner with you to help you thrive in the Indiana PathWays for Aging program.

Provider Relations and services

Provider Relations representatives

- Provide local, high-touch assistance, regionally assigned by provider type
- Serve as day-to-day, front-line relationship management
- Conduct ongoing meetings and technical assistance in one-on-one or group settings
- Triage provider inquiries and facilitate resolution

Provider Services contact information

- **866-274-5888,** Monday through Friday, 8 a.m. to 8 p.m., Eastern time

Notification of demographic changes

More information regarding notification of demographic changes can be found in your **provider manual**.

Humana should be notified of changes including the following:

- Change to your Tax Identification Number (TIN)
- When any new providers are added to the group
- When any providers are leaving or have left the group
- Any changes to service address (e.g., new location, phone or fax).
- Access to public transportation
- Standard hours of operation and after hours
- Billing address changes or updates
- Any changes or updates to credentialing for any providers
- Panel status
- Interpretation services offered

Notification of demographic changes (cont'd)

Notifications to Humana of changes can be completed as follows:

Phone: **866-274-5888**

Providers/facilities/ancillary providers/Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs):

Email: **INProviderUpdates@humana.com**

Behavioral health:

- For address/location change:
  - Submit updated W-9 and a roster to **INBHMedicaid@humana.com**
- For nonaddress/location information:
  - Submit letter requesting change with provider name, TIN, National Provider Identifier (NPI), details for the change and a point of contact to **INBHMedicaid@humana.com**

HCBS:

Email: **LTSSContracting@humana.com** or call **866-274-5888**

Quick reference guide available at: https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=5406440

Member rights and responsibilities

More information regarding member rights and responsibilities can be found in your **provider manual**.

The right to be treated with respect and due consideration for the member's dignity and privacy

The right to participate in decisions regarding the member's care, including the right to refuse treatment

The right to receive information on available treatment options and alternatives in a manner appropriate with the member's condition and ability to understand

For members receiving HCBS, the right to have and review their service plan of care

This list of member rights and responsibilities is **not all-inclusive**. Please refer to Chapter 4: Member rights and responsibilities of the Indiana Provider Manual for more details.

Provider requirements and responsibilities

More information regarding provider requirements and responsibilities can be found in your **provider manual**.

- Provide all covered services
- Respect member rights
- Participate in quality control
- Provide needed information promptly
- Submit timely, accurate and complete claims
- Maintain records for 10 years
- Provide medical record to member upon request
- Participate in provider reviews
- Comply with corrective action plans and program integrity requirements
- Advise members regardless of benefits for such care

Grievances and appeals

More information regarding grievances and appeals can be found in your **provider manual**.

Grievances

Members or their authorized representatives can file a grievance at any time, orally or in writing, if they are dissatisfied with Humana or any aspect of their care.

Appeals

Members or their authorized representatives can file an oral or written appeal request within 60 days of the date on the adverse benefit determination. Members can request assistance from Member Services.

Member grievances and appeals

Mail

Humana
P.O. Box 14546
Lexington, KY 40512-4546

Member Services

866-274-5888 (TTY: 711),
Monday
through Friday, 8 a.m. to 8 p.m.,
Eastern time

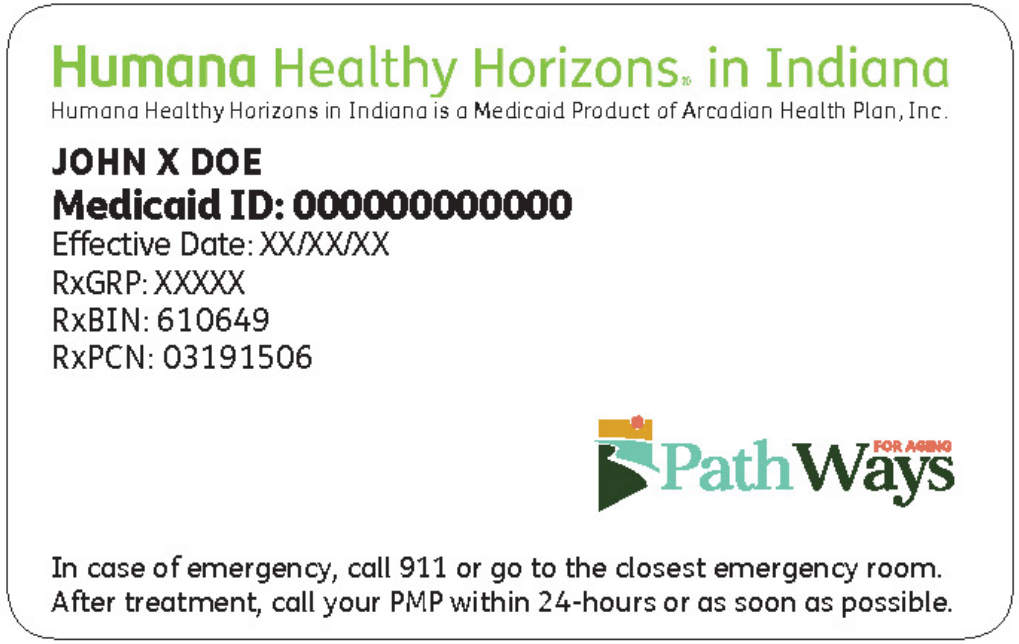
Additional training
Humana.com/provider/me dical-resources/indiana- medicaid/training

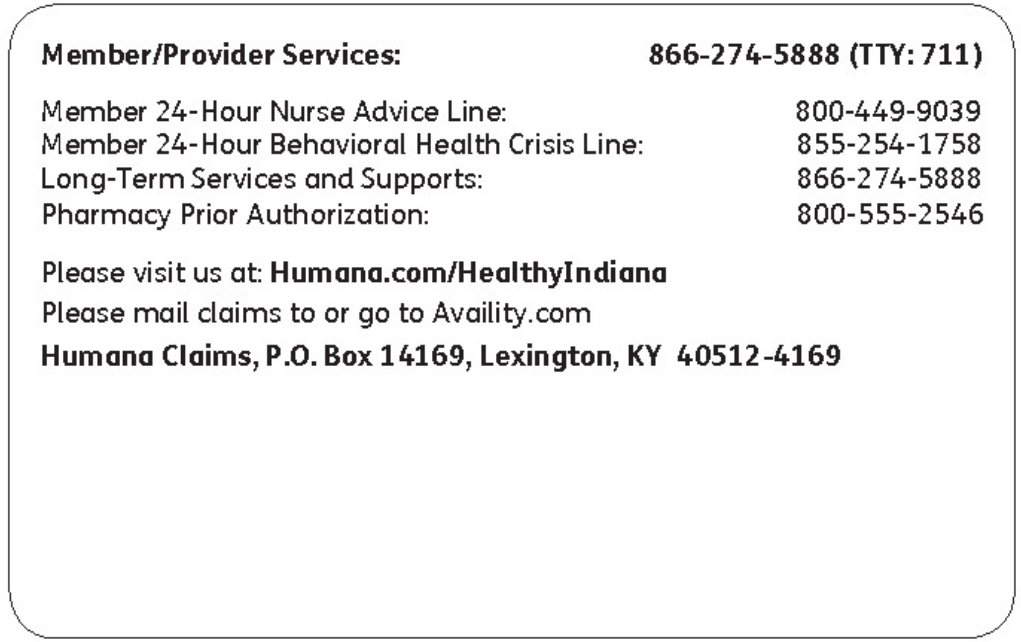
Member incentives

More information regarding member incentives can be found in your **provider manual**.

- Breast cancer screening
- Colorectal cancer screening
- Diabetic retinal eye exam
- Diabetic screening
- Fall prevention program
- Flu vaccine
- Follow-up after high-intensity care for substance use disorder
- Follow-up after hospitalization for mental illness
- Health needs screening
- Nutritional counseling
- Transitions of care
- Wellness visit

Sample ID card





Prior authorizations

More information regarding prior authorizations can be found in your **provider manual**.

Information required

- ✓ State Medicaid ID, date of birth and address
- ✓ Dates of service or hospital admission
- ✓ Requesting provider name, address, NPI and TIN
- ✓ Rendering provider name, address, NPI and TIN
- ✓ Ordering, prescribing or referring provider information
- ✓ Preparer's name, phone and fax number
- ✓ International Classification of Diseases diagnosis codes
- ✓ Procedure/service codes and description
- ✓ Modifiers
- ✓ Taxonomy
- ✓ Place of service
- ✓ Relevant clinical information

Requesting prior authorizations:

1. Review the **Indiana Medicaid prior authorization list.**
2. Initiate a prior authorization in Availity Essentials™.
   - Approved: immediate notification
   - Pended for further review: attach relevant clinical information

Expedited requests should be called in to 866-274-5888.

Second opinions

More information regarding second opinions can be found in your **provider manual**.

Providers or members may request a second opinion at no cost.

In accordance with 42 CFR 438.206(b)(3), all members have the right to a second opinion from a qualified professional. If the provider network does not include a provider who is qualified to give a second opinion, the member can obtain a second opinion from a provider outside the network, at no cost to the member.

Network

The provider must participate in the Humana Healthy Horizons network; if not, prior authorization must be obtained.

Affiliation

The provider must not be affiliated with the member's primary medical provider (PMP) or the specialist practice group from which the first opinion was obtained.

Specialty

The provider must be in an appropriate specialty area.

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Coordination of care and relevant roles

Care coordinator

Responsibilities include assessing, planning, implementing, reassessing, and evaluating members for, at a minimum, the list of State-defined conditions. Additionally:

- Provides education to member and/or caregiver specific to disease process, behavioral health crisis line, member portal and details within
- Educates and coordinates available benefits to include enhanced benefits
- Assistance in navigating the health care system
- Provides overall ownership of ICP and ensures compliance of ICP with SOW;
- Primary point of contact for ICT;
- Develops, implements, and maintains ICP;
- Coordinates medical and behavioral health across Medicare and Medicaid;
- For members not in Service Coordination, coordinates services to meet HRSN needs
- Facilitates Transition of Care activities as needed
- Works with Service Coordinator as applicable

Service coordinator

- Service Coordinator Develops, implements, and maintains service plan;
- Coordinates LTSS and services to meet HRSN needs
- Participates in all ICT discussions and meetings.
- The Service Coordinator facilitates discussion of the member's LTSS and social services.
- Supports the Care Coordinator with Transition of Care activities as needed
- Monitors service initiation and assists in closing gaps associated
- Administers initial and ongoing LTSS-related assessments through person-centered thinking approaches.
- Contacts both telephonically and/or in-person to establish goals and priorities, evaluate resources, and develop plan of care, and identify LTSS providers and community partnerships to best meet the needs and goals of members and caregiver
- Coordination of home- and community-based services.

Referral process

Humana's policies and procedures ensure timely and appropriate care for a member's condition when the member is referred by a PMP.

Members are permitted to self-refer, at minimum, to the following services:

- Behavioral health services
- Chiropractic services
- Diabetes self-management services
- Emergency services
- Eye care services
- Family planning services
- Family planning supplies
- Immunizations
- Podiatric services
- Psychiatric services
- Routine dental services
- Urgent care services

Continuity of care

First and subsequent years

- 90 days from the date of member enrollment for the authorization of services and choice of providers

Home- and community-based services level of care with approved care plan

- 90 calendar days from the date of enrollment

Skilled nursing facility

- Duration of the program if the member chooses to remain in the facility

Humana transition coordinator

- Oversees Indiana member transition and continuity of care process to prioritize members individualized and person-centered needs
- Provides timely support and service to members to avoid disruptions in care

Transition coordination support staff

Share and/or obtain information needed to ensure continuity of care, including member transition data transfer files (claims/encounter history and prior authorization data) and member-specific socioclinical information

Details about provider roles and responsibilities related to care coordination and care transitions are included in your provider manual.

Clinical management programs

- Humana coordinates care and population health services to our members.
- Care plan is person-centered, strengths-based and holistic, addressing:
  - **Physical care**
  - **Behavioral health**
  - **Community and social support needs**

Provide person-centered and strengths-based care

Deliver coordinated care across the delivery system and care continuum

Coordinate services across the totality of the member's needs

Ensure member choice

Promote caregiver support and skill development

Submitting electronic and paper claims

Humana accepts electronic claims through the following clearinghouses:

Availity

TriZetto

McKesson

Change Healthcare

The SSI Group

When filing an electronic claim, you will need to use one of the following payer ID:

- **61101** for fee-for-service and HCBS claims

Paper claims can be submitted on:

- CMS-1500, formerly HCFA 1500 form — AMA universal claim form also known as the National Standard Format (NSF)
- CMS-1450 (UB-04), formerly UB92 form, for facilities

Use the **most current version** designated by Centers for Medicare & Medicaid Services (CMS) and the National Uniform Claim Committee (NUCC).

Paper claims mailing address:
Humana Claims
P.O. Box 14169
Lexington, KY 40512-4169

Provider secure portal: Availity Essentials

Availity Essentials (Humana's provider portal) supports your access to:

- ✓ Patient management
- ✓ Claims management
- ✓ Provider engagement
- ✓ Authorization and referral management
- ✓ Credentialing
- ✓ Claims tracking

Would you like to get paid faster and reduce paperwork? If so, enroll with electronic funds transfer (EFT) and electronic remittance advice (ERA).

Additional resources:

- Humana's ERA/EFT enrollment tool is available on the **provider portal**.

Claims processing for physical health and behavioral health only

Humana will process accurate and complete provider claims in accordance with Humana's normal claims processing procedures, including **claims processing edits**, **claims payment policies**, and applicable state and/or federal laws, rules and regulations.

Humana pays or denies clean, electronically-filed, non-HCBS claims for services within 21 calendar days of the date of receipt. Clean, electronically-filed HCBS claims are paid or denied within 7 calendar days of the date of receipt.

Timely filing requirements

Initial claims must be submitted within 90 calendar days of the date of service or discharge (waived in cases of member retroactive coverage).

Corrected claims must be submitted within 90 calendar days of the date of service or discharge for in-network providers or 6 months from the date of service or discharge for out-of-network providers.

Claims will not be paid if they have incomplete, incorrect or unclear information.

Coordination of benefits overpayment

- When a provider receives a payment from another carrier after receiving payment from Humana Healthy Horizons for the same item or services, we consider this an overpayment.

- Humana provides written notice to the provider at least 30 business 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 can issue refund checks for overpayments to Humana:

Humana Healthcare Plans

P.O. Box 931655
Atlanta, GA 31193-1655

Balance billing a member

- **Do not balance bill members.**
- State requirements and federal regulations prohibit you from billing Humana members for medically necessary covered services except under very limited circumstances. 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 of 1935.
- Humana monitors this billing policy activity based on complaints of billing from members. Failure to comply with regulations after intervention may result in both termination of your agreement with Humana and criminal charges.
- For more information on member billing, please refer to your **provider manual**.

Provider claim payment dispute process

The provider payment dispute process consists of 2 internal steps. You are not penalized for filing a claim payment 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.

If you disagree with the outcome of a claim, you may begin the Humana Healthy Horizons provider claim payment dispute process.

Examples of denials that may constitute a dispute:

- Timely filing
- Coding issues

The following do not constitute a dispute:

- New claims
- Corrected claims
- Medical records
- Attachments (e.g., consent forms, invoices)
- Recoupments

Formal claim appeals

Filing a formal claim appeal:

1. A provider's request for informal claim dispute is required before requesting a formal provider claim appeal.
2. Providers or their authorized representatives have the option to submit a formal claim appeal following the informal claim dispute process. The provider must submit all documentation from the informal claim dispute request when submitting a provider appeal.
3. If the appeal is on behalf of a member, written authorization from 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.
4. In all instances when a provider claim is denied, the consent of the member who received services is not required for the provider to dispute the denial of the claim.
5. Additional or new clinical documents sent to Humana are reviewed by the medical director to determine if the additional clinical documents support the claim appeal in meeting medical necessity.
6. A resolution letter is mailed within 45 calendar days of receipt of the appeal. If Humana fails to respond to the formal appeal within 45 calendar days, this will result in an approval of the formal appeal.

Informal claim dispute:

This is the first step in the provider payment dispute process and represents your initial request for an investigation into the outcome of the claim. Informal disputes about finalized claims may be submitted by providers online via **Availity Essentials**.

If you are dissatisfied with the determination of the informal claim dispute, you may request a formal claim review ("claim appeal").

- Submit a formal claim appeal within **60** calendar days of the date on the determination letter.
- Humana will review and provide a determination within **45** calendar days.

Providers can file an appeal in writing to:

Humana Healthy Horizons in Indiana
Attn: Formal Claim Appeals
201 North Illinois Street Suite 1200
Indianapolis, IN 46204
IndianaFormalDispute@humana.com

Fraud, waste and abuse defined

Fraud

- Fraud is intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Waste

- Waste is the overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program; generally, this is not considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse

- Abuse involves provider practices that are inconsistent with sound fiscal, business or medical practices and result in 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.

Overview of provider website

More information can be found in your **provider manual**.

Availity Essentials	Claims and payments	Contact information: contracting	Contact information: credentialing
Contact information: Provider Relations	News and announcements	Pharmacy	Prior authorization
Provider Manual	Provider resources	Training calendar	Transportation

Required training and annual compliance

More details about required annual training and compliance requirements are available on our **provider compliance** webpage.

- Fraud, waste and abuse
- Abuse, neglect and exploitation
- Cultural competency

Provider compliance webpage:

- ✓ Detailed information about required annual training and compliance requirements
- ✓ Direct links to the training
- ✓ Directions for completing the training annually
- ✓ Required attestation

Provider manual references

Provider availability and accessibility

Chapter 5: Provider rights and responsibilities

Care management participation and referrals

Chapter 9: Care management

Chapter 11: Utilization management

Access to care requirements

Chapter 5: Provider rights and responsibilities

Credentialing

Chapter 14: Credentialing and recredentialing

Thank you

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