

2026

Humana Healthy Horizons in Indiana

Provider Policy and Procedures Manual

Humana Healthy Horizons® | PathWays FOR AGING

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

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Contents

Welcome 10

About this manual 10

Manual updates and changes 11

Acronyms 11

Chapter 1: Introduction 15

General contact information 15

About Medicaid 16

Humana Healthy Horizons mission statement 16

About Humana Healthy Horizons in Indiana 16

About the Indiana PathWays for Aging program 17

Accreditation 17

Compliance and ethics 17

Provider websites 18

Availity Essentials provider portal 19

Humana Healthy Horizons Provider Education/Outreach Representative 20

Expected response times for provider inquiries 21

How to join our network 21

Chapter 2: Member eligibility and enrollment 22

Contact information pertaining to member eligibility and enrollment 22

Member enrollment and eligibility 23

Verifying member eligibility 23

Member ID cards 23

Automatic renewal 24

New member kits 24

Member services 24

Primary medical provider (PMP) assignment 25

Member-initiated PMP changes 25

Member request for a new provider 25

Member disenrollment 25

Involuntary dismissals 27

Referrals for release due to ethical reasons 28

Chapter 3: Member rights and responsibilities 29

Contact information pertaining to member rights and responsibilities 29

Member rights 29

PathWays member responsibilities 31

Primary medical provider (PMP) assignment 31

Member-initiated PMP changes 31

Chapter 4: Provider rights and responsibilities 32

Contact information pertaining to provider rights and responsibilities 32

Provider rights and responsibilities 32

Additional responsibilities of behavioral health service providers 35

Americans with Disabilities Act (ADA) compliance 36

Consideration and accommodation of member special needs 37

Nondiscrimination **37**
Affirmative action, diversity and cultural competency 37
PMP roles and responsibilities **38**
PMP responsibilities 39
PMP assignment **41**
PMP assignment and changes 41
Advance directives **41**
Provider responsibility 41
Other significant Humana Healthy Horizons policies affecting providers **42**
Appointment wait time and access standards and requirements **43**
Non-behavioral health providers 43
Requirements for after-hours availability **44**
Missed appointments **44**
Behavioral health appointment accessibility standards **44**
Behavioral health providers **45**
Provider accessibility monitoring **45**
Provider-based marketing activities **45**
Notification of demographic changes **46**
HIPAA compliance **47**
Personally identifiable information and PHI 47
Member privacy 47
Member consent to share health information 48
Confidentiality statement 48
Provider training **48**
Provider orientation 50

Chapter 5: Member health, safety and welfare **51**
Contact information pertaining to member health, safety and welfare **51**
Incident reporting **51**
Requirements 52
Time frame 52
Tool 52
Initial report processing 53
Follow-up 53
Critical events **53**
Non-reportable incidents 54
Member abuse, neglect and exploitation **55**
Who is an endangered adult? 55
What are the definitions of ANE in Indiana? 55
Definitions 59
Abuse 59
Neglect 60
Exploitation 60
Indicators 61
Behavioral 62
Neglect 63
Exploitation 63
Exploitation indicators for family/caregiver(s) 64
Reporting abuse, neglect or exploitation **64**
What is a mandated reporter? 64
General reporting requirements 65
Reporting critical incidents 65

Chapter 6: Cultural humility, health equity and interpreter services 67

Contact information pertaining to cultural humility, health equity and interpreter services 67

Cultural competency 67

Provide culturally appropriate decision aids 70

Cultural humility 70

Health equity 71

Factors affecting health equity 71

Linguistic services 72

Interpreter services 72

Cultural humility and health equity plan 73

Chapter 7: Covered services 74

Contact information pertaining to covered services 74

General services 75

Covered medical services 75

State Plan Medicaid package 76

General services 76

Dental services 82

Vision services 84

HCBS waiver package: General services 85

Non-emergency medical transportation 87

Noncovered services 87

Excluded services 90

Out-of-network services 91

Enhanced services 91

Go365 for Humana Healthy Horizons 94

Copays/coinsurance/member cost sharing requirements 96

Patient or waiver liability 96

Member billing 96

Emergency services 96

Telehealth services 97

Transplant services 98

Family planning 99

Chapter 8: Behavioral health 100

Contact information pertaining to behavioral health 100

Behavioral health overview 100

Provider coordination for behavioral health 102

Behavioral health provider expectations ... 102

Covered behavioral health services 103

Emergency behavioral health services 103

Behavioral health crisis hotline 103

Addiction 104

Opioid treatment program 105

Chapter 9: Case management 106

Contact information pertaining to case management 106

Our approach to case management 106

Case management services 106

Chronic and complex conditions 107

Referral to complex case management 107

Continuity of care requirements 107

Behavioral health coordination.....110
Care coordinator roles and responsibilities.....111
Disease management programs.....112
Telephonic disease management 112
Member reassessments..... 113
Model of care and care coordination 113
Stratification methodology..... 113
Member engagement 114
Assessments 114
Reassessments..... 115
Plan 116
Implement..... 116
Review and modification of the ICP as the member's healthcare needs change ... 117
Evaluate 118
Individualized care plans 118
Case management referrals.....119
Electronic visit verification and service gap reporting procedures for LTSS.....119

Chapter 10: Quality management and improvement..... 121
Contact information pertaining to quality management and improvement 121
Quality improvement program overview 121
Quality Management and Improvement Committee 123
Quality measures 123
HEDIS and other performance measures 124
Quality Assurance and Performance Improvement (QAPI) program..... 124
CAHPS 125
Encounter validation study..... 125
Provider participation in the Quality Management and Improvement Program 125
Evaluation of the Quality Management and Improvement Program 126
Medical record requirements..... 126
Minimum standards for member medical records 126
Medical record confidentiality requirements 127
Medical record storage requirements..... 127
Member rights related to medical records..... 128
Medical record reviews..... 128
Primary medical provider value-based payment programs..... 130
Compliance plan 130
Compliance and ethics..... 130
Member safety 131
Preventive guidelines and clinical practice guidelines 131
Provider and member satisfaction surveys 132
Peer review..... 132

Chapter 11: Utilization management 133

Contact information pertaining to utilization management 133

Utilization management program overview 134

Access to UM staff 135

Prior authorization 136

Services that require prior authorization 136

Requesting prior authorization 137

Time frames and notifications for responding to prior authorization requests 137

Standard PAs 137

Expedited PAs 138

Concurrent reviews 138

Retrospective review 138

Court-ordered services 139

Notification requirements for hospital admissions and hospice care 139

Observation requirements 139

Inpatient requirements 140

Hospice requirements 140

Medical necessity review 140

Prior authorization requests review process 141

Appeals 141

Services that do not require prior authorization 142

Medical necessity criteria and reviews 142

Peer-to-peer (P2P) discussions 143

External review by an independent review organization (IRO) 143

Requesting external review by an IRO 143

State Fair Hearing 144

Referrals 144

Self-referrals 144

Service plan authorization 146

Special considerations 146

LTSS service authorizations 146

HCBS 147

Specialized behavioral health services 147

Institutions for mental disease (IMDs) 147

SMI 147

SUD 147

Hospital admissions 148

PA in transitions of care 148

Discharge planning 150

Second opinions 150

Out-of-network services 151

Noncontracted services 151

Utilization management delegation 151

Right Choices Program 151

Chapter 12: Claims and billing 153

Contact information pertaining to claims and billing 153

Introduction 153

Claim submission 154

Required information 154

NPI, TIN and taxonomy 155

Location of provider NPI, TIN and member ID number 156

Claim submission 157
Electronic 157
Paper 157
5010 transactions 157
Electronic visit verification 157
Provider portal 158
EFT/ERA enrollment through Humana Healthy Horizons 158
Submitting electronic transactions 158
EDI clearinghouses 159
Procedure and diagnosis codes 159
Unlisted CPT/HCPCS codes 159
Common errors and reasons for denial or rejection 160
Code editing and payment policies 160
Claim processing 162
Claim compliance standards and time frames 162
Crossover claims 163
Claim status 164
Suspension of provider payments 164
Provider preventable conditions/never events 164
Out-of-network claims 164
Third-party liability 165
Coordination of benefits 165
COB overpayment 165
Member billing 166

Chapter 13: Complaints, grievances and disputes 168
Contact information pertaining to complaints, grievances and disputes 168
Overview 169
Process and timelines 170
Provider disputes 170
Provider claim payment dispute process 170
Informal claim dispute 170
Formal claim disputes (“claim appeal”) 171
Binding arbitration 172
Member grievances and appeals 172
Filing a grievance or appeal 172
Grievance review timelines 173
Indiana Medicaid grievance 173
Expedited grievance first-level review 174
Appeal review timelines 174
Indiana Medicaid appeal 174
Expedited appeal process 175
External review by an independent review organization 175
State Fair Hearing 176

Chapter 14: Credentialing and recredentialing 177
Contact information pertaining to credentialing and recredentialing 177
Overview 177
Provider recruitment and nondiscriminatory credentialing policy 178
Request to join the network 178
Credentialing process by provider type 179
Individual practitioners 179
Practitioner enrollment application 181
Credentialing application 181
Licensure 181

Drug Enforcement Administration and a controlled substance registration 181
Education and training 182
Board certification 182
Admitting privileges 182
Work history 182
Malpractice insurance 182
Malpractice history 183
NPI 183
IHCP enrolled provider 183
Site visit 183
In good standing with regulatory agencies 183
Performance indicators 183
Demographics 183
Common practitioner credentialing mistakes 184

Organizational/ancillary provider credentialing 184

Facility enrollment form 186
Licensure/business license/permit, as applicable 186
Insurance coverage 186
Eligible for Medicaid 186
Eligible for Medicare 186
Free from sanctions, exclusion or debarment 187
CLIA 187
On-site quality assessment 187
NPI 187
Disclosure of ownership 189

Common organizational/ancillary provider credentialing mistakes 189

HCBS/LTSS provider credentialing 190
FSSA certification 191
Eligible for Medicaid 191
Free from sanctions, exclusion or debarment 191

Common HCBS/LTSS provider credentialing mistakes 191

Additional documentation and enrollment status 192

Provider recredentialing and reassessment 192

Recredentialing process 192

Provider rights and responsibilities in credentialing process 193

Provider rights 193
Provider responsibilities 193

Delegation of credentialing/ recredentialing 193

Credentialing and recredentialing criteria 194

Recredentialing 194

Credentialing committee 194

Credentialing decision appeals and reconsideration of decisions 194

Ongoing provider monitoring 195

Chapter 15: Fraud, waste and abuse 196

Contact information pertaining to fraud, waste and abuse 196

Overview 197

Reporting FWA 198

Chapter 16: Pharmacy 199

Contact information pertaining to pharmacy 199

Covered medications 200

Appealing adverse decisions regarding medication coverage 201
Peer-to-peer (P2P) discussions 201
Dispensing limitations 202
UM for medications..... 202
Pharmacy copayments 202
Humana Healthy Horizons' pharmacy network..... 203
Continuity of care for new members..... 203
Continuity of medication coverage for newly enrolled members using nonparticipating pharmacies 203
Medication therapy management (MTM) 203
Medications administered in the provider setting 203
Electronic prescribing 203
340b provider billing 204

Chapter 17: Long-term services and supports 205
Contact information pertaining to long-term services and supports..... 205
Specific provider responsibilities..... 205
Level-of-care assessment and reassessment processes 206
Needs assessment service planning requirements 206
HCBS..... 207
Procedure..... 207
Service plan timeline requirements..... 208
Workforce development.....210
Definitions.....211

Welcome

Thank you for your participation 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). Our goal is to provide high-quality services to Humana Healthy Horizons in Indiana members.

Within this manual, key points are highlighted related to Humana Healthy Horizons policies and procedures. This manual is intended to inform both you and your staff of requirements for the Indiana PathWays for Aging plan(s), what Humana Healthy Horizons requires of you, and what you can expect from us. The guidelines set forth in this manual are designed to assist you in the provision of caring, responsive services to your patients who are Humana Healthy Horizons members.

You will be notified of updates to this manual via fax or U.S. mail. If you require further information about anything covered within this manual, please reach out to your Provider Education/Outreach Representative.

On behalf of everyone at Humana Healthy Horizons, we are looking forward to a lasting partnership with you and your team.

About this manual

This manual applies to those who provide services to our Humana Healthy Horizons members. Throughout the manual, all instances of “us,” “we” or “our” refer to Humana Healthy Horizons, and all references to “you” or “your” refer to you, the provider contracted with us.

All acronyms used within this provider manual are defined in the Acronyms section of this provider manual.

This manual furnishes you and your office staff with important information concerning Humana Healthy Horizons’ policies and procedures, claim submission and adjudication requirements, and other guidelines used to administer our health plans. This manual replaces and supersedes all previous versions as of Jan. 1, 2026. A paper copy of this manual can be obtained at any time upon request to your local Humana Healthy Horizons market office.

Except as may otherwise be set forth in the provider contract, providers are contractually required to comply with all provisions contained in this manual. Revisions to this manual reflect revisions to Humana Healthy Horizons’ policies and procedures.

Any requirements under applicable law, regulation or guidance that are not expressly set forth in the content of this manual are incorporated herein by this reference and shall apply to providers and/or Humana Healthy Horizons where applicable. Such laws and regulations, if more stringent, take precedence over the content in this manual. You are responsible for complying with all applicable laws and regulations.

We may deny payment for any services or supplies for which you failed to comply with Humana Healthy Horizons' policies and procedures.

Manual updates and changes

Updates to this manual as permitted by the provider contract are posted on the **Humana Healthy Horizons in Indiana provider website** and notification of changes may also be sent by U.S. mail and/or fax. Hard copies of this manual are available upon request, without cost, when you initially join the Humana Healthy Horizons network, when there are any changes in policies and procedures, and upon request. If you need further explanation about 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 **Humana Healthy Horizons in Indiana provider website**. We look forward to a long and productive relationship with you and your staff.

Acronyms

ADA	Americans with Disabilities Act
ADT	Admission, discharge and transfer
AI	Artificial intelligence
ALF	Assisted living facility
ANE	Abuse, neglect and exploitation
APS	Indiana's adult protective services
ASAM	American Society of Addiction Medicine
ASL	American Sign Language
BRFSS	Behavioral risk factor surveillance system
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective action plan
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHAT	Comprehensive Health Assessment Tool
CHW	Community health worker
CLAS	Culturally and Linguistically Appropriate Services
CLIA	Clinical Laboratory Improvement Amendments of 1988
CMS	Centers for Medicare & Medicaid Services

COPD	Chronic obstructive pulmonary disease
DDRS	Division of Disability and Rehabilitative Services
DFR	Division of Family Resources
DME	Durable medical equipment
DMHA	Division of Mental Health and Addiction
DSMT	Diabetes self-management training
D-SNP	Dual-eligible special needs program
EQRO	External quality review organization
ER	Emergency room
EVV	Electronic visit verification
FDA	Food and Drug Administration
FFS	Fee for service
FQHC	Federally qualified health center
FSSA	(Indiana) Family and Social Services Administration
HCBS	Home and Community-Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health information exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HME	Home medical equipment
HNS	Health needs screening
HRAC	Humana Rights Advocacy Committee
ICF	Intermediate care facility
ICP	Individualized care plan
ICT	Interdisciplinary care team
ID	Identification
IDOH	Indiana Department of Health
IFUR	Incident follow up reporting (system)
IHCP	Indiana Health Coverage Programs
IHS	Indian Health Service
IID	Individuals with intellectual disabilities
IMD	Institution for mental disease
LEP	Limited English proficiency
LOC	Level of care
LTAC	Long-term acute care
LTC	Long-term care
LTCOC	Long-term-care ombudsman council
LTSS	Long-term services and supports

MA	Medicare Advantage
MAT	Medication assisted treatment
MCE	Managed care entity
MLTSS	Managed long-term services and supports
MRO	Medicaid Rehabilitation Option
NCQA	National Committee for Quality Assurance
NEMT	Nonemergency medical transportation
NFLOC	Nursing facility level of care
NIH	National Institutes of Health
NPI	National Provider Identifier
OMPP	Office of Medical Policy and Planning
OT	Occupational therapy
OTP	Opioid treatment program
OTS	Opioid treatment services
PA	Preauthorization
PACE	Program of All-Inclusive Care to Elderly
PBM	Pharmacy benefits manager
PERS	Personal emergency response system
PHI	Protected health information
PII	Personally identifiable information
PMP	Primary medical provider
POC	Plan of care
PT	Physical therapy
QIC	Quality Management and Improvement Committee
QAPI	Quality Assessment and Improvement Program
RHC	Rural health clinic
SDOH	Social determinants of health
SFH	State Fair Hearing Process
SHCN	Special health care needs
SHI	Sensitive health information
SMI	Severe mental illness
SNAP	Supplemental Nutrition Assistance Program
SNP	Special needs plan
SSA	Social Security Administration
SSI	Supplemental Security Income
ST	Speech therapy
SUD	Substance use disorder

TANF	Temporary Assistance for Needy Families
TBI	Traumatic brain injury
TPL	Third-party liability
TTY	Teletype
UM	Utilization management
US	United States
USC	United States Code
VBP	Value-based program

Chapter 1: Introduction

General contact information

Contact name	Contact information	Hours of operation
Availity Essentials™	Phone: **800-282-4548** Website: **Availity Essentials**	8 a.m. to 8 p.m., Eastern time, Monday through Friday
Behavioral health contracting team	Email: **INBHMedicaid@humana.com** Website: **Availity Essentials**	
Dental contracting team (provided by DentaQuest)	Website: **DentaQuest**	
Home and community-based services (HCBS)/ long-term services and supports (LTSS) contracting team	Email: **LTSSContracting@humana.com** Website: **Availity Essentials**	
Home and vehicle modification contracting team	Website: **About Evolve**	
Member/Provider Services Contact Center	Phone: **877-274-5888 (TTY: 711)**	8 a.m. to 8 p.m., Eastern time, Monday through Friday
Nonemergency medical transportation (NEMT) contracting team	Website: **LCP Transportation**	
Pharmacy contracting team	Email: **PharmacyContractRequest@humana.com**	
Physical health contracting team	Email: **INProviderUpdates@humana.com** Website: **Availity Essentials**	
Vision contracting team (provided by EyeMed)	Phone: **844-961-2057** Email: **TSatterfield@eyemed.com** or **JDick@eyemed.com**	7 a.m. to 8 p.m., Eastern time, Monday through Friday

About Medicaid

Medicaid provides healthcare coverage for income-eligible children, seniors, disabled adults and pregnant women. Medicaid services have been offered in the state of Indiana for over 30 years. Medicaid is funded by both the state and federal governments and includes both capitated health plans and FFS coverage. Medicaid is a program for eligible individuals and/or families with low income and/or resources. It is a means-tested program jointly funded by the state and federal governments and managed by the state.

Humana Healthy Horizons mission statement

We offer a whole-person approach to delivering healthcare to Medicaid recipients in Indiana aiming to help improve the health and well-being of members across the state while helping you provide quality care.

About Humana Healthy Horizons in Indiana

Humana, headquartered in Louisville, Kentucky, is one of the nation's largest publicly traded full-service health, well-being solutions and supplemental benefits companies. Our affiliated health plans offer a wide array of health insurance and well-being products as well as government-sponsored plans. Over its more than 50-year history, Humana has consistently seized opportunities to meet changing customer needs. Today, Humana is a leader in consumer engagement.

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, refer to the **Indiana Medicaid Provider Information and Materials website** or reach out to the Member/Provider Services Contact Center. 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 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 the covered services chapter of this provider manual. Each MCE will contract with a network of providers to serve their Indiana PathWays for Aging members. 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 the **Indiana Medicaid website**. If you are not yet enrolled in IHCP and wish to do so, more information is available on the **Indiana Medicaid for Providers website**. Additional state resources can be found in the pages that follow.

Accreditation

We hold a strong commitment to quality, demonstrating our commitment through programs based on national standards, when applicable. Humana holds accreditation from the National Committee for Quality Assurance (NCQA) for our Medicaid lines of business.

Providers must agree to comply with Humana Healthy Horizons' quality assurance, quality investigation and peer review process, QI, accreditation, risk management, utilization review, utilization management (UM), clinical trial and other administrative policies and procedures established and revised by Humana Healthy Horizons.

Compliance and ethics

We comply with applicable state and federal regulations, along with applicable Humana Healthy Horizons policies and procedures, as are our contracted providers. We are committed to conducting business in a legal and ethical manner and we have an established compliance plan that:

- Formalizes our 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; and

  - noncompliance with our 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.

Our general compliance and ethics expectations for our contracted providers include:

- Acting according to professional ethics and business standards.
- Notifying us of suspected violations, misconduct or fraud, waste and abuse concerns.
- Cooperating fully with any investigation of alleged, suspected or detected violations of applicable state or federal laws and regulations.
- Notifying us if you have any questions or require 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.

Provider websites

You can obtain plan information from our **Humana Healthy Horizons in Indiana provider website**. This website also includes other information related to:

- Claim processing edits
- Clinical practice guidelines
- Compliance training
- Coverage and claims
- Credentialing
- Dental benefits
- Drug list
- Grievance and appeals
- Health programs
- Humana Community Navigator® directory
- In-person, video or telephonic interpretation services
- Language assistance resources
- Prior authorization (PA) lookup
- PA search tool
- Tutorial library
- Value-based care report

Indiana-specific educational resources are also available on the **Indiana Medicaid Provider Information and Materials website**. These resources include the following:

- Annual training information
- Communications and network notices
- Documents and forms
- Educational materials
- Pharmacy materials
- Quality resources

Providers may obtain plan information from **Humana Healthy Horizons' Provider Information** and **Humana's provider publications website**. This includes details for the following:

- Health and wellness programs
- Provider publications, including the provider manual, Humana Physician News (quarterly newsletter) and program updates
- Pharmacy services
- Claim resources
- Quality resources
- What's new

For help or more information regarding web-based tools, please contact the Member/Provider Services Contact Center.

Please refer to this manual's phonebook and other contact information section for more state-specific, FSSA-specific and Humana-specific resources.

Availity Essentials provider portal

We partner with Availity Essentials to allow providers to reference member and claim data for multiple payers using a single login. **Availity Essentials** provides access to the following:

- Certificates of coverage
- Claim submission and status
- Disputes and appeals
- Eligibility and benefits
- Electronic remittance advice (electronic remittance advice)/electronic funds transfer (EFT) enrollment
- Humana Healthy Horizons-specific applications, resources and news
- Medical record requests
- Member summary
- Overpayment management
- Plan of care

- Provider directory
- Referrals and authorizations
- Remittance advice
- Status of PA and referral requests

For more information, please reach out to **Availity Essentials**.

Humana Healthy Horizons Provider Education/Outreach Representative

We offer contracted providers access to a Provider Education/Outreach Representative who specializes in the following:

- Assisting all network providers in navigating available resources
- Helping providers access resources for billing and coding issues
- Educating providers regarding new policy changes, system updates and access and availability standards
- Providing instruction about resolution processes and assisting with escalated issues
- Communicating important information with the provider network via meetings, newsletters, network notices and emails
  - Your Provider Education/Outreach Representative will conduct a required yearly on-site visit to primary medical provider (PMP) offices to ensure compliance with and provide education on many requirements, including but not limited to:
    - Access and availability standards
    - Care management programs
    - Cultural humility and health equity
    - Encounter submissions
    - Grievance and appeals processes
    - Health Insurance Portability and Accountability Act (HIPAA) policies and procedures
    - Member disenrollment processes
    - Patient rights and responsibilities
    - Privacy practices
    - Provider resources

More information about your assigned Provider Education/Outreach Representative is available on the **Indiana PathWays for Aging provider website**. If you are unable to determine who your Provider Education/Outreach Representative is, please contact the Member/Provider Services Contact Center.

Medicaid claims-related inquiries can be directed to your Provider Education/Outreach Representative, the **Indiana PathWays for Aging provider claims and payments website** or **Availity Essentials**.

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 2 business days.

How to join our network

We are committed to offering accessible and high-quality care to our members. We would be honored to partner with you. If you are not yet participating in our network but are interested in joining, please visit the **Humana National Request to Join Portal**, or reach out to the relevant area:

Team	Contact Information
Behavioral health contracting team	INBHMedicaid@humana.com
Dental contracting team (provided by DentaQuest)	https://www.dentaquest.com/en/providers/join-our-network
HCBS and LTSS contracting team	LTSScontracting@humana.com
Home and vehicle modification contracting team (provided by Evolve)	NetDev@evolve-emod.com
Nonemergency medical transportation (NEMT) contracting team	INProviderUpdates@humana.com
Pharmacy contracting team	Email: PharmacyContractRequest@humana.com
Physical health contracting team	INProviderUpdates@humana.com
Vision contracting team (provided by EyeMed)	https://www.eyemed.com/en-us/provider

Chapter 2: Member eligibility and enrollment

Contact information pertaining to member eligibility and enrollment

Contact name	Contact information	Hours of operation
Grievance, appeal, and disputes	Phone (appeal requests): **866-274-5888 (TTY: 711)** Address: Humana Healthy Horizons in Indiana Grievance and Appeal Department P.O. Box 14169 Lexington, KY 40512-4169 Online: **Availity Essentials** Email: **INMedicaidClaimsResearch@humana.com** or **IndianaFormalDispute@humana.com** Address (State Fair Hearing): Office of Administrative Law Proceedings – FSSA Hearings 100 N. Senate Avenue, Room N802 Indianapolis, IN 46204 Address (provider informal claim dispute): Humana Healthy Horizons in Indiana Informal Claim Dispute P.O. Box 14169 Lexington, KY 40512-4169 Address (provider formal claim appeals): Humana Healthy Horizons in Indiana Attn: Formal Claim Appeals 201 N. Illinois St., Suite 1200 Indianapolis, IN 46204 Address (provider arbitration): Address (arbitration notice): Humana Healthy Horizons in Indiana Attn: Arbitration Notice 201 N. Illinois St., Suite 1200 Indianapolis, IN 46204	8 a.m. to 8 p.m., Eastern time, Monday through Friday

Contact name	Contact information	Hours of operation
Member/Provider Services Contact Center	Phone: **866-274-5888 (TTY: 711)**	8 a.m. to 8 p.m., Eastern time, Monday through Friday

Member enrollment and 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. Medicaid eligibility is determined by FSSA. Eligibility begins on the first day of each calendar month for members joining Humana Healthy Horizons.

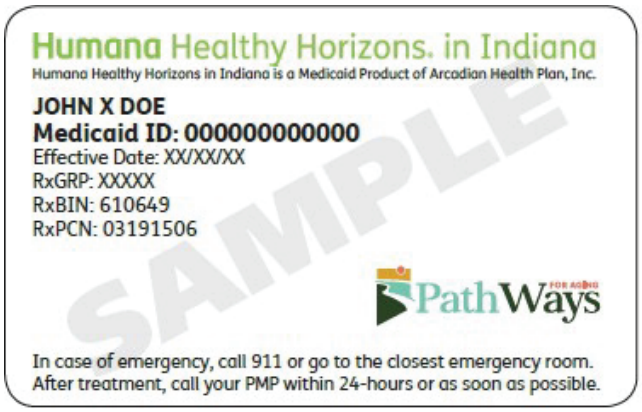
Verifying member eligibility

Before providing all non-emergency services, you must verify member eligibility. You should ask members to present an identification (ID) card each time services are rendered. If you are not familiar with the member seeking care and cannot verify the person as a Humana Healthy Horizons member, you should ask to see photo ID. Eligibility can be verified through **Availity Essentials** → Patient Registration → Eligibility and Benefits Inquiry.

Member ID cards

All new Humana Healthy Horizons members receive a member ID card. A new card is issued only if the information on the card changes, the card is lost or an additional card is requested. The member ID card is used to identify a Humana Healthy Horizons member but does not guarantee eligibility or benefits coverage because members may disenroll from Humana Healthy Horizons or lose Medicaid eligibility at any time.

Therefore, it is important to verify member eligibility prior to rendering any service. Providers should verify the member's coverage with Indiana PathWays for Aging through the Indiana provider portal.





Automatic renewal

If Humana Healthy Horizons members lose Medicaid eligibility but become eligible again within 2 months or less, they are automatically reenrolled in our plan and, if possible, are assigned the same PMP. As a reminder, you are encouraged to verify a patient's eligibility via **Availity Essentials** before providing services.

New member kits

Each new member household receives a new member kit and an ID card for each person in the family joining Humana Healthy Horizons in Indiana within 5 calendar days of enrollment. New member kits are mailed with the ID card.

The new member kit contains:

- A welcome letter, including education confirming the member's enrollment and information about coordination of care with current providers and how the member can receive care coordination assistance.
- A member handbook, including 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.
- A quick start guide, including information about enhanced services, confirming a provider, creating a Go365 for Humana Healthy Horizons® account and pharmacy benefits.
- Information on how to obtain a copy of our provider directory
- A health assessment survey
- Information about our digital tools, designed to improve member engagement

Optional forms regarding privacy and continuity of care are made available to PathWays members

Member services

Humana Healthy Horizons will assist members who have questions or concerns about benefits and services. Representatives are available by telephone through the Member/Provider Services Contact Center.

Representatives are not available 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. Humana Healthy Horizons observes the following holidays:

- New Year's Day
- Memorial Day
- Independence Day (4th of July)
- Labor Day
- Thanksgiving Day
- Christmas Day

Primary medical provider (PMP) assignment

A PMP will be assigned automatically to all PathWays-only members who do not self-select a PMP within 30 calendar days of their enrollment. Humana Healthy Horizons will utilize the PMP assignment history file for assignment. If a PMP is not provided, Humana Healthy Horizons' internal enrollment system will identify a member's previous PMP 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 Humana Healthy Horizons' provider directory. Members have the option to change to another participating PMP as often as needed. Members can initiate this change by contacting Humana Healthy Horizons' Member/Provider Services Contact Center. PMP changes are effective on the first day of the month following the requested change.

Member request for a new provider

Members have the right to choose a provider who meets their needs. To find a doctor, specialist, hospital, healthcare facility or other type of in-network service provider, the member can call the Member/Provider Services Contact Center or access Humana's **online provider directory**.

Member disenrollment

Indiana PathWays for Aging members can change to or from a Humana Healthy Horizons plan only at the following intervals:

- For just cause at any time.
- Without cause within 90 calendar days after initial enrollment or during the 90 calendar days following notification of enrollment, whichever is later.
- Without cause at least once every 12 months.
- Without cause when Humana Healthy Horizons does not meet substantive requirements in sections 1903(m) or section 1932(e)(2)(B)(ii) of the Social Security Act and 42 C.F.R. 438.56(b) – (d).
- Without cause upon reenrollment if a temporary loss of enrollment has caused the member to miss the annual disenrollment period.

Members may leave Humana Healthy Horizons for just cause. Determination about whether the member has met the conditions for just cause is solely the determination of the enrollment broker and the state. Valid just cause conditions 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 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 managed care entity (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 the 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 Humana Healthy Horizons 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 their managed care entity 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 Humana Healthy Horizons to ensure that the grievance and appeal process was exhausted. All enrollment broker reviews that result in a recommendation to approve disenrollment are then sent to the state, which makes the final determination on the request.

Members may be disenrolled from Humana Healthy Horizons for several reasons. If a member loses Medicaid eligibility, they are no longer eligible for coverage through Humana Healthy Horizons. Humana Healthy Horizons, the state or the member can initiate disenrollment, which may be initiated for the following:

- Unauthorized use of a member ID card
- Use of fraud or forgery to obtain medical services
- Disruptive or uncooperative behavior to the extent that it seriously impairs the ability to deliver care to the member or to other patients

Please notify our Member/Provider Services Contact Center if 1 or more of these situations occur. Procedures for dismissing noncompliant members from your practice are outlined in the involuntary dismissal section of this provider manual. Humana Healthy Horizons may counsel the member or, in severe cases, initiate a request to the state for disenrollment. It is at the state's discretion as to whether it will initiate disenrollment. Disenrollment from Humana Healthy Horizons always occurs at the end of the effective month.

Involuntary dismissals

Participating providers can request that a Humana Healthy Horizons member be involuntarily dismissed from their practice and assigned a new PMP for the following:

- Incompatibility of the provider/patient relationship
- Member has not used a service within 1 year of enrollment in the PMP's practice and the PMP has documented unsuccessful contact attempts by mail and phone on at least 6 separate occasions during the year
- The provider's inability to meet the medical needs of the member
- Member is incarcerated

You must follow the following Humana Healthy Horizons policy requirements to request involuntary dismissal of a member from your practice:

A. Attempt communication in person, by mail and/or by phone with the member, and document attempts within the member's medical record.
    a. Make 3 communication attempts regarding incompatibility of the provider/patient relationship where the member does not respond to recommended patterns of treatment or behavior, including:
        i. Noncompliance with medication schedules
        ii. Violating office no-show policies
        iii. Failing to modify behavior as requested
    b. Make 6 communication attempts when the member has not used a service within 1 year of enrollment in the PMP's practice.
    c. Communicate at least 1 time regarding your inability to meet the medical needs of the member.

B. Notify the member of their dismissal by certified letter, which must include the following details:
    a. The reason for which their disenrollment was requested
    b. The specific dates of the documented unsuccessful education/communications attempts and/or communication that you are unable to meet the member's needs
    c. If you are a PMP, notification of the phone number that the member must call to choose another PMP

C. Submit the member dismissal notice to Humana Healthy Horizons for review and approval prior to sending the notice to the member to ensure all requirements have been met.

A copy of this letter must be mailed or faxed to Grievances, Appeals, and Disputes.

Barring ethical or legal issues, the dismissing provider must serve the affected patient until a new provider can serve the patient.

When a member misses 3 or more consecutive appointments, providers may request assistance from Humana Healthy Horizons care management by sending an email to care management.

Providers do not have the right to request a member's disenrollment from their practice for the following:

- Change in the member's health status or need for treatment
- Member's utilization of medical services
- Member's diminished mental capacity
- Disruptive behavior that results from the member's special healthcare needs unless the behavior impairs the ability of the PMP to furnish services to the member or others

Transfer requests shall not be based on a member's race, ethnicity, sexuality, national origin, disability, age or gender.

Referrals for release due to ethical reasons

Humana Healthy Horizons has no moral or religious objections for providing any covered services. However, in accordance with 42 C.F.R. §438.102, you are not required to perform treatments or procedures contrary to your conscience, religious beliefs or ethical principles. 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.

You must refer the member to another provider who is licensed, certified or accredited to provide care for the individual service appropriate to the member's medical condition. The provider must be actively enrolled with the state to provide Medicaid services to beneficiaries and must also be in Humana Healthy Horizons' provider network.

In such circumstances, where your conscience, religious beliefs or ethical principles require involuntary dismissal of the member, your office must notify the member of the dismissal by certified letter.

- The letter must include:
- The reason for the disenrollment request.
- A referral to another provider that is licensed, certified or accredited to provide care for the individual service appropriate to the patient's medical condition.
- Instructions for the member to contact our Member/Provider Services Contact Center for assistance in finding a preferred in-network provider.

A copy of this letter must be mailed or faxed to Grievances, Appeals, and Disputes.

Please call Member/Provider Services Contact Center if you have questions about disenrollment reasons or procedures.

Chapter 3: Member rights and responsibilities

As a Humana Healthy Horizons provider, you are required to respect the rights of our members, who are informed of their rights and responsibilities via their member manual. We have also included the list of member rights and responsibilities below for your reference. Care coordinators provide members with information about their rights and responsibilities at the time of enrollment and annually.

Contact information pertaining to member rights and responsibilities

Contact name	Contact information	Hours of operation
Member/Provider Services Contact Center	Phone: **866-274-5888 (TTY: 711)**	8 a.m. to 8 p.m., Eastern time, Monday through Friday

Member rights

All members are encouraged to take an active and participatory role in their own health and the health of their family. Members have the right to:

- Be free from all forms of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion.
- Request and receive a copy of their medical records and request that they be amended or corrected, as per rules set forth in 45 C.F.R parts 160 and 164 subparts A and E, and as specified in 45 C.F.R § 164.524 and § 164.526.
- A candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.
- Be advised — before care is initiated — of the cost of services and the extent to which payment may be required by the member.
- Be afforded the opportunity to participate in the development of the care plan and to refuse treatment without retribution, while being fully informed of the possible medical consequences of refusal.
- Be assured of the confidentiality of records and to approve or refuse the release of information not authorized by law.

- Be assured that the member's right to appeal adverse action affecting services will be displayed in public areas of the 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 assured that qualified personnel will present proper identification at the time of a visit.
- Be fully informed by a physician of health status, unless medically contraindicated.
- Be fully informed in advance of all care and treatment to be provided by the service provider, changes in care or treatment and to receive a copy of their plan of care if they request.
- Be fully informed of services available from the service provider and how to access care.
- Be furnished healthcare services in accordance with 42 C.F.R 438.206
- Be informed of the state hotline number with hours of operation and purpose for obtaining information on home health agencies.
- Be served without regard to race, color, creed, sex, age, national origin, ancestry, or handicap/disability.
- Be treated with respect, dignity, privacy, confidentiality, accessibility and be free from discrimination.
- Direct their care with their own staff and/or providers.
- File a grievance without fear of discrimination or reprisal from the service provider.
- Make recommendations regarding the organization's member rights and responsibilities policy.
- Make recommendations to the Humana Healthy Horizons member rights and responsibilities policy.
- Receive home and community-based services in a home-like environment and participate in their communities regardless of their living arrangements.
- Receive information about Humana Healthy Horizons, its services, its providers, and member rights and responsibilities.
- Receive information about the plan, its services, its practitioners and providers and member rights and responsibilities.
- Receive information in accordance with 42 C.F.R § 438.10
- Take an active part in discussions about the member's healthcare unless it is not in their best interest.
- Voice complaints or appeals about the plan or the care it provides.

PathWays member responsibilities

Members have a responsibility to:

- Accept services of service provider staff, without regard to race, creed, color, religion, national origin, handicap, sex or age.
- Follow the advice and instructions for care which they have agreed upon with their healthcare provider.
- Have a PMP who will provide orders (as required) for skilled home-care treatments and services.
- Have a plan for management of emergencies and access the plan, if necessary for safety.
- Inform the service provider about changes in health status, medications, or treatments.
- Inform the service provider of the presence of advance directives and provide copies, as appropriate.
- Inform the state of any change in financial status that may affect reimbursement for home care.
- Participate in reaching goals that the member and their healthcare provider agree upon.
- Participate with the plan of treatment they have agreed, when possible, and make available an informal caregiver assume primary care, as appropriate.
- Provide accurate and complete medical and health history information as they understand it.
- Report fraud, abuse and overpayment.
- Understand as much as they can about their health issues.

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 Humana Healthy Horizons' provider directory. Members have the option to change to another participating PMP with cause as often as needed. Members initiate the change by contacting the Member/Provider Services Contact Center. PMP changes are effective on the first day of the month following the requested change.

Chapter 4: Provider rights and responsibilities

Contact information pertaining to provider rights and responsibilities

Contact name	Contact information	Hours of operation
Adult Protective Services State Hotline	Phone: **800-992-6978**	24 hours a day/7 days a week
Communication Assistance, Interpreters, and Alternative Formats	Phone: **877-320-2233** Email: **accessibility@humana.com**	8 a.m. to 8 p.m., Eastern time, Monday through Friday
Member/Provider Services Contact Center	Phone: **866-274-5888 (TTY: 711)**	8 a.m. to 8 p.m., Eastern time, Monday through Friday
PMP Referrals	Phone: **800-523-0023** Fax: **813-321-7220**	8 a.m. to 8 p.m., Eastern time, Monday through Friday

Provider rights and responsibilities

You are expected to treat members with respect. Our members should not be treated differently than patients with other healthcare insurance. Please refer to the member rights and responsibilities section of this provider manual for more information.

You are expected to make daily visits to your patients who are admitted as inpatient to an acute care facility, or you can arrange for a colleague to visit. Participating PMPs are also expected to have a system in place for following up with patients who miss scheduled appointments.

We expect you to verify member eligibility and ask for their healthcare insurance information before rendering services, except in an emergency. You can verify member eligibility and obtain information for other healthcare insurance coverage by accessing **Availity Essentials**, Humana's secure provider portal. For all Medicaid services provided by Humana Healthy Horizons that require the completion of a specific form (e.g., hospice, sterilization, early elective delivery, hysterectomy or abortion), the respective form must be completed and submitted with the procedure claim or initial hospice claim. Claims are not paid until you submit the completed form. The completed forms should be included in the member's chart in the event of audit and, on request, a copy should be submitted to the state. Please see the **Humana Healthy Horizons in Indiana provider website** for more information.

As a Humana Healthy Horizons participating provider, you agree to:

- Provide a health screening evaluation consisting of comprehensive health and developmental history, including past medical history assessment
- Provide developmental history behavioral health status
- Conduct a comprehensive unclothed physical examination
- Conduct developmental assessment
- Conduct nutritional assessment
- Immunize as required by the appropriate CDC Recommended Childhood Immunization Schedule
- Offer health education, including anticipatory guidance
- Conduct a dental screening, including a direct referral to a dentist for members beginning at 3 years of age or earlier as indicated
- Conduct a vision screening, including objective testing as required
- Conduct a hearing screening, including objective testing as required
- Provide diagnosis and treatment utilizing a trauma-informed care approach
- Provide referral to a specialist as needed and follow-up as appropriate
- Understand and agree that provider performance data can be used by Humana Healthy Horizons.
- Provide members with all covered services that are within the normal scope of and in accordance with the provider's licenses and/or certifications and members' access to those covered services through making appointment 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 the 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 **Indiana Health Coverage Programs Prior Authorization Request Form** 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 calendar 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 corrective action plans (CAP) 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. For more details, please see the health, safety and welfare section of this provider manual.
- Comply with the 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 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[1].
- Comply with Humana Healthy Horizons' operation of a unified appeals and grievance process with its companion Dual Eligible Special Needs Plan[2] (D-SNP), as applicable to the member's PathWays health benefit plan.

Please contact the Member/Provider Services Contact Center if you have any 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[4] or

- Discussing with members their 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

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 7 business days of the date of discharge.

1 Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, 122 Stat. 3765 (codified at 29 U.S.C. § 1185a); 42 C.F.R. § 438, subpart K.

2 405 Ind. Admin. Code 1.1 et al.; 42 C.F.R. §§ 422.629–422.634.

- Behavioral health network providers must notify the MCE within 5 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.

Americans with Disabilities Act (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 provider contract under Compliance with Regulatory Requirements. We develop individualized care plans (ICPs) that consider members' special and unique needs. Members in need of interpretation services can call the number on the back of their member ID cards or visit our **accessibility resources website** to schedule interpretation services at least 48 hours prior to an appointment. If your patient requires interpretive services, you may contact Communication Assistance, Interpreters, and Alternative Formats with date, time, your phone number and the appointment location. Please do not include patient health information when emailing. While interpreters may be available on demand, this cannot be guaranteed and thus scheduling interpretation services in advance is preferred. Oral interpretation services are provided free to you when communicating with Humana Healthy Horizons members.

If you have members who require interpretation services, please direct them to the number included on the back of their member ID card or visit our **accessibility resources website**.

Humana Healthy Horizons provides over-the-phone interpretation in over 150 languages at Humana touchpoints. Humana Healthy Horizons also provides TTY and alternative formats including braille, large print, audio, DAISY, screen reader accessible PDF, and reading over the phone of your written communications.

American Sign Language (ASL) interpreters are available in person or via video. Additional communication assistance support is detailed on our **communication assistance website**, via telephone or via email.

You are responsible for arranging 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 Communication Assistance, Interpreters, and 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:

- Provide physical access, reasonable accommodations and accessible equipment for members with physical or mental disabilities[3]
- Identify provider locations that provide physical access, accessible equipment and/or reasonable accommodations for members with physical or cognitive disabilities.

More details are available within your Humana Healthy Horizons provider agreement. Humana Healthy Horizons' provider directory contains information about:

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

Additional educational resources are available on our **accessibility resources 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, gender or any other factor protected by law.

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 cultural competency

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 free paper copy of Humana Healthy Horizons' Cultural Competency Plan, please contact the Member/Provider Services Contact Center or call your Provider Education/Outreach Representative.

Humana Healthy Horizons conducts site surveys of all office locations that include PMPs and gynecologists during initial credentialing and again every 3 years during recredentialing. Defined high-

3 2 C.F.R. § 438.206(c)(3).

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.

PMP roles and responsibilities

All Humana Healthy Horizons members choose or are assigned to a PMP upon plan enrollment. PMPs help facilitate a "medical home" for members, meaning that PMPs help coordinate healthcare for the member and provide additional health options to the member for self-care or care from community partners. PMPs are also required to screen and refer members for behavioral health conditions. Please refer to the behavioral health and substance use services section of this provider manual for more information.

Members select a PMP from our provider directory. Members have the option to transition to another participating PMP as often as needed. Members initiate the change by calling the Member/Provider Services Contact Center. PMP changes are effective on the first day of the month following the requested change.

When members change PMPs, the medical records or copies of medical records should be forwarded to the new PMP within 10 business days of receipt of the request. The PMP is required to have members sign a release of medical records before a medical record transfer occurs.

PMPs are responsible for:

- Supervising, coordinating and providing initial and primary care to members
- As needed, initiating referrals for specialty care
- Maintaining 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:

- Assisting with the coordination of a member's overall care, as appropriate
- Facilitating continuity of the member's total healthcare
- Providing early detection and preventive healthcare services
- Eliminating inappropriate and duplicate services

PMP care coordination responsibilities include the following (at a minimum):

- 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, 7 days a week (please refer to the appointment standards section of this provider manual for more details).
- Making referrals for specialty care and other medically necessary services.

  - When such services are not available within the Humana Healthy Horizons network, the PMP should refer the member to available out-of-network services.
- Following all prior authorization policies and procedures 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 calendar 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.

PMP responsibilities

PMPs are subject to the following roles and responsibilities as a Humana Healthy Horizons provider:

- Supervise, coordinate and provide initial and primary care to members
- Initiate referrals for specialty care as needed
- Maintain the continuity of patient care
- In addition, our PMPs play an integral part in coordinating healthcare for our members by providing:
  - Availability of a personal healthcare provider to assist 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, which include, at a minimum:
  - Treating our members with the same dignity and respect afforded to all patients—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 patient calls 24 hours a day, 7 days a week
- Refer to the PMP appointment waiting times and access standards and requirements section of this provider manual for more details.
- Referrals for specialty care and other medically necessary services, both in- and out-of-network (when such services are not available within our network)
- Following all referral and PA policies and procedures as outlined in this manual
- Complying with the quality assurance, quality investigation and peer review process, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures established and revised by Humana Healthy Horizons and as outlined in this manual
- Discussing advance medical directives with all 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 state specifications
- Obtaining patient records from facilities visited by Humana Healthy Horizons-covered patients for emergency or urgent care if notified of the visit
- Ensuring demographic and practice information is up to date for directory and member use (providers are strongly encouraged to provide their race and ethnicity for Humana Healthy Horizons to reference when a member requests a provider with the same race, ethnicity and language as themself)
- Referring members to behavioral health providers and arranging appointments, when clinically appropriate
- Serving as the ongoing source of primary and preventive care, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for members younger than 21
- Recommending referrals to specialists
- Participating in the development of care management and treatment plans, and notifying Humana Healthy Horizons of members who may benefit from care management
- 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 practice
- Providers understand and agree that provider performance data can be used by Humana Healthy Horizons.

PMP assignment

All Humana Healthy Horizons members choose or are assigned to a PMP on enrollment in the plan. PMPs facilitate a "medical home" for members. This means PMPs help coordinate healthcare for the member and provide additional health options to the member for self-care or care from community partners. PMPs also are required to know how to screen and refer members for behavioral health conditions. Please refer to the Behavioral Health section of this provider manual for more information.

PMP assignment and changes

Members select a PMP from our provider directory. Members have the option to change to another participating PMP as often as needed. Members initiate the change by calling our Member/Provider Services Contact Center. PMP changes are effective on the first day of the month following the requested change.

When members change PMPs, the medical records or copies of medical records should be forwarded to the new PMP within 10 business days of receipt of request. The PMP is required to have members sign a release of medical records before a medical record transfer occurs.

Advance directives

Provider responsibility

An advance directive is "a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provisions of health care when the individual is incapacitated."[4] Advance directives are essential for providing patient-centered care and should be charted in PathWays members' permanent medical record.[5] Humana Healthy Horizons providers are responsible for discussing advance directives during the first appointment with adult members of sound mind.

PMPs have the responsibility to discuss advance medical directives with members aged 18 or older who are of sound mind at the first medical appointment. The PMP should discuss potential medical emergencies with the member and document that discussion in the member's medical record. A copy of the advance directive should be included in the member's medical record inclusive of other mental health directives.[6]

- All member records shall contain documentation showing the member receiving written information concerning the member's rights regarding advance directives (written instructions for living will or power of attorney), including whether the member has executed an advance directive.[7]

4 42 C.F.R. § 489.100.
5 Ind. Code § 16-36-7-37.
6 Ind. Code § 16-36-1.7-1; Ind. Code § 16-36-1.7-2.
7 42 C.F.R. § 438.3(j)(3).

- Humana Healthy Horizons and its providers will not condition the provision of care or otherwise discriminate against a member based on whether the member has executed an advance directive.[8]
- Providers must inform individuals that complaints concerning the advance directive requirements may be filed with the Indiana Department of Health.[9]

Other significant Humana Healthy Horizons policies affecting providers

For more information about advance directives and available forms, please direct members to the **Advance Directives Resource Center website**.

- More information regarding CLIA certification requirements is available in the credentialing and recredentialing section of this provider manual.
- Humana Healthy Horizons will accept into the network:
  - Any skilled nursing facility (SNF) that agrees to Humana Healthy Horizons' standard provider agreement and meets all applicable state and federal participation requirements for the first 3 years of the program.
  - Any LTSS provider that agrees to the contractor's standard provider agreement and meets all applicable state and federal participation requirements for the first 3 years of the program.
- 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 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. Please refer to your provider agreement for more details.
- Members have a voice in the care they receive. Advance directives ensure members' healthcare needs are met if they are unable to communicate. Members are encouraged to communicate their wishes with their family and medical team.

8 Indiana Statement of Work (IN SOW); 42 C.F.R. § 489.102(a)(3); 42 C.F.R. § 422.128(b)(1)(ii)(F).
9 42 C.F.R. § 489.102(a)(4).

Appointment wait time and access standards and requirements

We have adopted service standards regarding the availability of participating provider services. You are expected to maintain these standards as outlined in your contract. Hours of operation should be identical to those that are offered to members with other health plans, such as commercial and Medicare.

Participating PMPs and specialists are required to ensure adequate accessibility for healthcare 24 hours a day, 7 days a week. An after-hours telephone number must be available to member (voicemail is not permitted). The member should have access to care for PMP services and the PMP should submit referrals to the plan so the member can see specialists for medical and behavioral health services available on a timely basis.

Considering the urgency of the need for services, you are expected to meet the following timely access to care standards:

Non-behavioral health providers

Provider type	Service	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 15 business days
	Urgent – without physical or behavioral symptoms	Within 24 hours
	Emergency	24 hours a day/7 days a week
	Routine gynecological exam/ new member	Within 15 business 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
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 adaptation	Home modifications	No more than 90 business days from time-of-service approval

Provider type	Service	Appointment standards
Consultative clinical and therapeutic services	For informal caregivers	No more than 60 business days from time-of-service approval

The PMP must arrange for coverage of primary care services during absences due to vacation, illness or other situations that require the PMP to be unable to provide services. A Medicaid-eligible PMP must provide coverage.

A PMP must submit referrals when necessary for members to see specialists for care. Referrals can be submitted or requested by phone, by fax or online. Please see the PMP referrals section of this provider manual for more details.

Compliance with availability and accessibility standards are monitored regularly through random sampling, review of member concerns, and member satisfaction surveys to ensure members have reasonable access to providers and services.

Requirements for after-hours availability

PMPs must provide after-hours coverage available 24 hours a day, 7 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.

The PMP must provide or arrange for coverage of services, consultation or approval for referrals 24 hours a day, 7 days a week by Medicaid-enrolled providers who will accept Medicaid reimbursement. This coverage must consist of an answering service, call forwarding, provider call coverage or other customary means approved by the state. The chosen method of 24 hours a day, 7 days a week coverage must connect the caller to someone who can render a clinical decision or reach the PMP for a clinical decision. The after-hours coverage must be accessible using the medical office's daytime telephone number

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. Members cannot be charged for missed appointments.

Behavioral health appointment accessibility standards

Please keep in mind the following behavioral health appointment accessibility standards. Participating providers are expected to have procedures in place to see members within these time frames and to offer office hours to their Humana Healthy Horizons-covered patients that are at least the equivalent of those offered to all other patients. Humana Healthy Horizons will monitor appointment time compliance using secret shopper surveys in accordance with contractual requirements.

Behavioral health providers

Patients with	Should be seen
Care for non-life-threatening emergencies	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 behavioral symptoms
Outpatient follow-up appointment	Within 7 business days following discharge for the inpatient behavioral health hospitalization

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, 7 days a week for emergent and urgent needs, including holidays.

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. You must remain aware of and in compliance with the following requirements:

LTC facilities are permitted to provide materials in admission packets announcing all contractual relationships with managed care plans.

- You may not orally or in writing compare benefits or provider networks among health plans, other than to confirm whether providers participate in a health plan's network. If you can assist a recipient in an objective assessment of your needs and potential options to meet those needs, you may do so. You may engage in discussions with members should a member seek advice. However, you must remain neutral when assisting with enrollment decisions.
- You may announce a new affiliation with a health plan through general advertising (e.g., radio, television, websites). You may also provide members a list of health plans with whom they are contracted.
- You may co-sponsor events, such as health fairs and advertise with the health plan in indirect ways, such as television, radio, posters, flyers, and print advertisements.
- You shall not furnish lists of your Medicaid members to Humana or any other entity.

- You shall not furnish other health plans' membership lists to Humana; nor can you assist with health plan enrollment.
- For Humana Healthy Horizons, you may distribute information about non-health-plan specific healthcare services and the provision of health, welfare and social services by the state or local communities as long as inquiries from prospective members are referred to the Member Services/ Enrollee Services section of the health plan or the state.
- You may refer your members to other sources of information, such as the managed care plan, the enrollment broker or the local Medicaid area office. You may also share information with members from the state or CMS website.

You must not:

- Offer marketing/appointment forms
- Make phone calls or direct, urge or attempt to persuade members to enroll in a particular based on financial or any other interests you may have
- Mail marketing materials on behalf of a particular plan
- Offer anything of value to induce recipients/members to select you as their provider
- Offer inducements to persuade recipients to enroll in a particular plan
- Conduct health screenings as a marketing activity
- Accept compensation directly or indirectly from any managed care plan for marketing activities.
- Distribute marketing materials within an exam room setting
- Furnish lists of your Medicaid members or the membership of any managed care plan to a managed care plan

Notification of demographic changes

As a network provider, you are responsible for notifying us of demographic changes as outlined in this provider manual and under the terms of your contract with Humana Healthy Horizons.

Notify your Provider Education/Outreach Representative immediately of changes, such as:

- Demographic changes (e.g., telephone, fax, email or administrative staff changes)
- Name and ownership change (35-day notice)
- New member indicator
- Physical address change
- Tax identification/billing address change (W-9 required)

This notification will ensure your information is properly listed in the provider directory and all payments made are properly reported to the Internal Revenue Service. Failure to comply with this section could lead to a delay in payments. In the event there are changes that will affect your ability to provide services to our members, please notify your Provider Education/Outreach Representative immediately.

HIPAA compliance

The task of handling member records and related administration functions is accomplished in strict compliance with HIPAA. Member files are always kept confidential. Providers should take 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.

To be compliant with HIPAA, providers should make reasonable efforts to restrict access and limit routine disclosure of PHI to the minimum necessary to accomplish the intended purpose of the disclosure of patient information. If a Humana Healthy Horizons-covered member changes their PMP for any reason, you must transfer a copy of the patient's medical record to the patient's new PMP at the request of the plan or the patient. The contract states whether the original or a copy of the medical record must be sent. If you terminate, you are responsible for transferring the patients' medical records. Charges for copying medical records are considered a part of office overhead, and medical records are to be provided at no cost to Humana Healthy Horizons-covered patients and Humana Healthy Horizons, unless state regulations or the contract stipulate otherwise.

Personally identifiable information and PHI

In the day-to-day business of patient treatment, payment and healthcare operations, Humana Healthy Horizons and its providers routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, various standards and industry best practices guide how PII is appropriately protected when stored, processed and transferred while conducting normal business. As a provider, you should be taking measures to secure your patients' data.

You also are mandated by HIPAA to secure all PHI related to your patients. There are many administrative, physical and technical controls you should have in place to protect all PII and PHI.

Here are some important places to start:

- Utilize a secure message tool or service to protect data sent by email.
- Have policies and procedures in place to address the protection of paper documents containing patient information, including secure storage, handling and destruction of documents.
- Encrypt all laptops, desktops and portable media such as CD-ROMs and USB flash drives that may potentially contain PHI or PII.

Member privacy

The HIPAA Privacy Rule requires health plans and covered healthcare providers to develop and distribute a notice that provides a clear, user-friendly explanation of individuals' rights with respect

to their personal health information, as well as the privacy practices of health insurance plans and healthcare providers.

You must follow the HIPAA regulations and make only reasonable and appropriate uses and disclosures of PHI for treatment, payment and healthcare operations.

Member consent to share health information

Consent is the member's written permission to share their information. Not all disclosures require the member's permission. The following are consent requirements that pertain to sensitive health information (SHI) and substance use disorder (SUD) treatment:

- SHI is defined by the state (e.g., HIV/AIDS, mental health, sexually transmitted diseases).
- Confidentiality of substance use disorder patient records: 42 C.F.R Part 2 pertains to federal requirements that apply to all states. While all member data is protected under the HIPAA Privacy Rule Part 2 provides more stringent federal protections to protect individuals with SUDs who could be subject to discrimination and legal consequences in the event their information is inappropriately used or disclosed. The state requirements provide more stringent protections for the sharing of certain information determined to be SHI.
- When consent is on record, Humana Healthy Horizons displays all member information on **Availity Essentials** and any health information exchanges. Please explain to your patients that if they do not consent to let us share this information, the providers involved in their care may not be able to effectively coordinate their care. When a member does not consent to share this information, a message displays on the provider portal to indicate that all the member's health information may not be available to all providers.

Confidentiality statement

Humana Healthy Horizons maintains a policy to ensure that medical records, claim information, and grievances pertaining to members and providers remain confidential. The authorized release of information is used only for the resolution of medical problems or to enhance a member's health. We will ensure compliance with the privacy and security provisions of HIPAA.

Provider training

Humana Healthy Horizons requires adherence to all compliance-based training programs. This includes contract and assurance that all affiliated participating providers, along with supporting healthcare providers and staff with member interaction, receive training on the identified compliance material. Member interaction can involve face-to-face and/or over-the-phone conversation, as well as review and/or handling of correspondence via mail, email or fax.

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. Your Provider Education/ Outreach Representative will 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**.

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. Your Provider Education/Outreach Representative will work with you 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**.

As a Humana Healthy Horizons provider, you are required to complete all necessary training identified within your contract during your initial Humana Healthy Horizons orientation. All training must be completed within 30 calendar days of your Medicaid contract. You must also ensure that your affiliated participating providers and staff members are trained on mandatory compliance materials.

Annual compliance training must be completed on the following topics in compliance with federal laws[10], Humana Healthy Horizons' contract with the state and/or our compliance program:

- General compliance
- Combating fraud, waste and abuse
- Medicaid provider orientation training
- Cultural humility and health equity training for Medicaid providers
- Required critical incident training

You are required to complete compliance training and fraud, waste and abuse training as well as implement specific controls for the prevention and detection of potential or suspected fraud and abuse.[11] Providers and authorized users can access these online training modules 24 hours a day, 7 days a week via **Availity Essentials**. Sign in using your existing user ID and password.

Once logged in to **Availity Essentials**, click on Payer Spaces, then the Humana Learning Center.

- Select the category: Compliance trainings
- Search for the current year's training by state (for any state[s] in which you are contracted). Please refer to **Availity Essentials guidance** for steps on how to register with Availity Essentials.

For additional provider training, please see the **compliance training** section of our **Humana Healthy Horizons in Indiana provider website**. Our annual web-based training is delivered through Humana Healthy Horizons' provider portal and includes:

- Indiana PathWays for Aging program updates
- Updates to relevant Humana Healthy Horizons policies and procedures

10 Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6032, 120 Stat. 4, 72 (2006).
11 Ibid.

- Health, safety and welfare training on ANE, how to handle and report, as well as critical incident reporting
- Annual training on topics such as program integrity, compliance with ADA, advance directives and electronic visit verification (EVV)

Additional education and trainings are available to you on our **Humana Healthy Horizons in Indiana provider website** and through our CE program for medical and non-medical network providers via Relias, a web-based CE library. With more than 300 modules to choose from and over 500 hours of CE credits available, the training modules in Relias provide integrated information to support comprehensive care and address unique member needs. Relias offers courses designed to help you succeed in the emerging value-based healthcare delivery system.

We have also created a resource guide to support physicians, clinicians and care teams to screen and address member social health needs of members. This resource guide is available to network providers on the **compliance training** section of the **Humana Healthy Horizons in Indiana provider website**, and is designed to support network providers to:

- Understand the impacts of unmet health needs,
- Screen members using evidence-based screening tools
- Support the discussion of social determinants of health with members and provide member-specific resources and support
- Offer guidance for documentation and coding to monitor and follow up with members of resource referral, ultimately leading to improved health outcomes

Additionally, Humana Healthy Horizons supports providers in providing competent language services and offers additional training to practitioners on the provision of language services.

Provider orientation

All new providers will receive Humana Healthy Horizons' provider orientation. Your Contract Specialist is available to provide an initial orientation within 5 business days of completion of the credentialing process. This orientation reviews our policies and procedures. These personalized meetings are scheduled at your convenience and include staff you would like to attend. Additional educational trainings can be scheduled at any time by contacting your Provider Education/Outreach Representative.

Chapter 5: Member health, safety and welfare

Contact information pertaining to member health, safety and welfare

Contact name	Contact information	Hours of operation
Adult Protective Services State Hotline	Phone: **800-992-6978**	24 hours a day/ 7 days a week
FSSA OMPP Quality Improvement	Email: **OMPPQualityImprovement@fssa.in.gov**	
Member/Provider Services Contact Center	Phone: **866-274-5888 (TTY: 711)**	8 a.m. to 8 p.m., Eastern time, Monday through Friday

Incident reporting

Indiana PathWays for Aging incident reports are processed in accordance with 455 IAC 2-8-2, and the approved PathWays waiver provides a list of incident types that are required to be reported. We refer to these incidents as "reportable incidents." Indiana PathWays for Aging reportable incident types include, but are not limited to:

- Abuse, neglect and exploitation
- Death of an individual
- Environmental issues that compromise the health and safety of an individual
- Criminal activity
- Injuries of unknown origin
- Attempts of suicide or suicidal ideation
- Admission to a nursing facility
- Significant injury
- Injuries from the use of a restraint

- Police involvement when there is an arrest
- A missing person
- Inadequate staff with the potential for endangering the health and welfare of an individual

For a complete list of incident types, please refer to 455 IAC 2-8-2 and the approved PathWays waiver, previously known as the A&D waiver.

Requirements

All providers, including employees or contracted agents and Humana Healthy Horizons care and service coordinators or other designees, are mandated reporters. This means when the provider and/or the coordinator become aware of a reportable incident, the incident must be submitted to the state using the **State of Indiana Incident and Follow-Up Reporting (IFUR)** tool within the specified time frame. The provider responsible for an individual at the time of the occurrence of a reportable incident is responsible for submitting the incident report in the **IFUR tool**. If a provider or coordinator learns of an incident that has not been reported by the responsible party, the provider, coordinator or other designee should submit the incident report to the state using the state's **IFUR tool**. Anyone who submits an incident report will receive a copy if they include their email address with the form submission.

Providers are encouraged to prevent incident report duplication by verifying the incident was not previously submitted. One way to assist with this is to ensure the incident is communicated with all ICT members. The reporting entity must notify the individual's ICT by forwarding the PDF of the incident report. The information required to be shared is dependent upon incident type. Please reference 455 IAC 2-8-1 and 455 IAC 2-8-2 for more guidance.

Time frame

Reportable incidents involving abuse, neglect or exploitation are submitted to the state via the **IFUR tool** within **24 hours** of the incident or knowledge of the incident. All other incident types must be submitted within **48 hours** of the time the incident occurred or becoming aware of the incident.

Tool

Incident reports must be submitted in the **IFUR tool**. If the system is down, please **send an email to the Quality team** to notify them of the delay. The reporting individual should include as much detail as possible to include:

- A comprehensive description of the incident
- A description of the circumstances and activities occurring immediately prior to the incident
- A description of any injuries sustained during the incident
- A description of both the immediate actions that have been taken and actions that are planned but not yet implemented
- A list of each person's first name and last initial who were involved in the incident, including a description of the role and staff title (if applicable) of each involved individual

Initial report processing

Once the incident report is received through the **IFUR tool**, it will be processed by OMPP within 24 hours of receipt. Incident reports are processed 7 days a week, 365 days a year. An incident report may be closed by OMPP on initial receipt if all required information is provided and the narrative paints a clear story of what happened. If the incident is not closed during the initial processing, OMPP will send a request for follow-up to the entity responsible for incident follow-up.

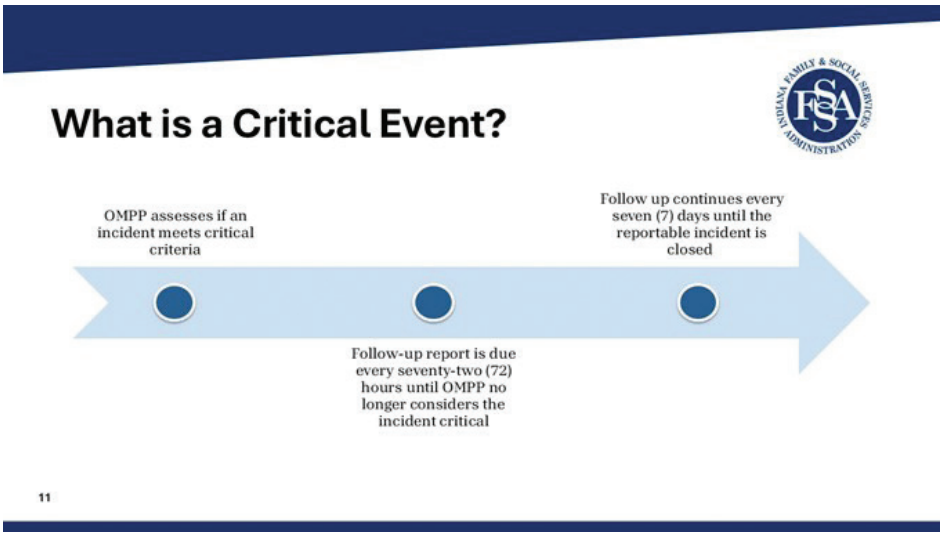
Follow-up

The entity responsible for incident follow-up is the individual's MCE. Typically the service coordinator will perform the follow-up, but this could also occur via another designee from the MCE's quality department.

OMPP will send the request for follow-up through the **IFUR tool**. The MCE should submit the requested follow-up via the **IFUR tool** within 7 calendar days of the date of the initial incident report and every 7 calendar days thereafter until the incident is resolved to the satisfaction of OMPP. Follow-up reports are processed by OMPP within 3 calendar days of receipt. Follow-up reports are processed Monday through Friday. When the MCE is identified as responsible for submitting the follow-up information, the individual's team is responsible for addressing and responding to the needs of the individual and requests for information, including documentation.

Critical events

At any point during the processing of an incident, it may be deemed a critical event. A critical event is an actual or alleged event that jeopardizes the health, safety or welfare of the individual receiving services. This includes cases of abuse, neglect and exploitation, death and significant injury. The critical part of an incident can be closed without the entire incident being closed. When the critical status remains open, follow-up is required within 72 hours and every 72 hours thereafter while the incident is considered critical to address those immediate health and safety needs most commonly confirming APS or DCS notification, staff suspension and investigation initiation. After the critical status is closed, the reportable incident may remain open and require follow-up to be submitted every 7 calendar days until OMPP closes the incident. This process is detailed in the image that follows.



Non-reportable incidents

On average, 23% of the submitted incident reports do not meet the reportable incident criteria outlined in 455 IAC 2-8-2. Non-reportable incidents are those incidents that do not meet the reportable incident criteria. While incidents may meet the reportable criteria for these incident types, the most common non-reportable incidents for the PathWays program fall into the following categories:

- Medical condition (change in/decline)
  - A change in medical condition or medical decline is non-reportable when treatment is received at an urgent care center. However, even in these cases, the incident becomes reportable when there is police involvement, an unexpected hospital visit or admission, or injuries determined to be critical.
- Falls
  - Based on 455 IAC 2-8-2 and OMPP reportable incident policy, a fall that results in no injuries is considered non-reportable.
  - A fall becomes a reportable incident when an injury is sustained. If the individual sustains any injury, no matter the severity, a fall is considered reportable and an incident report should be submitted.
  - Please note: An area of redness is not considered an injury for reporting purposes.
- Other
  - The “other” category is used when there is not a defined coding category into which the incident details fit. Examples of incidents coded as “other” include an individual refusing to attend an appointment or complete personal hygiene or refusing staff.
  - As incidents occur, those events that do not meet reportable criteria as outlined in 455 IAC 2-8-2 should still be documented through internal documentation and addressed as needed within the individualized care team.

- Duplicate reports of facility discharges
- Consensual relationships

Member abuse, neglect and exploitation

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:

- 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 resulting from neglect, battery or exploitation of the individual's personal services and property, including:
  - Mental illness
  - Intellectual disability
  - Dementia
  - Habitual drunkenness
  - Excessive drug use

What are the definitions of ANE in Indiana?

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

	Abuse/battery[12]	Neglect[13]	Exploitation[14]
Definition	A person who knowingly or intentionally touches another person in a rude, insolent or angry manner or places any bodily fluid or waste on another person in a rude, insolent or angry manner. 455 IAC 2-4-1	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. 455 IAC 2-4-23	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: (a) an endangered adult or (b) 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. 455 IAC 2-4-18
	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	Neglect: • Weight loss that cannot be explained by other causes • Lack of toileting that causes incontinence • Members sitting in their own urine and feces.	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

12 Centers for Medicare & Medicaid Services. "Glossary." Last modified 2024. **https://www.cms.gov/glossary?term=abuse&items_per_page=10&viewmode=grid**.

13 Ibid.

14 U.S. Department of Justice. "Elder Abuse and Elder Financial Exploitation Statutes." 2022. 22 M.R.S. § 3472. **https://www.justice.gov/elderjustice/prosecutors/statutes#:~:text=%C2%A7%203472.,for%20another%27s%20profit%2**

	Abuse/battery[12]	Neglect[13]	Exploitation[14]
	• 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)	• 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	• 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

	Abuse/battery[12]	Neglect[13]	Exploitation[14]
	• 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 toot 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 medical care – Signs of confinement (e.g., member is locked in a room)		• Show aggressive behavior toward the member – Threaten – Insult – Harass

Definitions

According to CMS, abuse occurs when another person does something on purpose that causes another individual mental or physical harm or pain.[15] Neglect occurs when a caretaker does not give a person they care for the goods or services required to avoid harm or illness.[16] Exploitation is the illegal or improper use of an incapacitated or dependent adult or that adult's resources for another's profit or advantage.[17] Please see the required critical incident training for more information.

Abuse

Abuse is the nonaccidental infliction of physical and/or emotional harm. This also includes sexual abuse on any child or adult by a relative, caregiver, household member or any other person. Abuse can also include active encouragement by a relative, caregiver or household member to commit an act that inflicts or could reasonably be expected to result in physical or psychological/emotional injury to a child or adult. Abuse can be:

- Physical:
  - The infliction of physical pain or injury to another person
  - Physical abuse of a member is the nonaccidental use of force that results in bodily injury, pain or impairment, including, but not limited to being:
    - Slapped
    - Burned
    - Cut
    - Bruised
    - Improperly physically restrained
- Sexual:
  - Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with a child, an adult with disabilities or any other person
  - Includes touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an older person when the older person is unable to understand, unwilling to consent, threatened or physically forced to engage in sexual activity
- Psychological:
  - Verbal
    - Includes (but is not limited to) name calling, intimidation, yelling and swearing; may also include ridicule, coercion and threats

15 Centers for Medicare & Medicaid Services. "Glossary." Last modified 2024. **https://www.cms.gov/glossary?term=abuse&items_per_page=10&viewmode=grid**.

16 Ibid, **https://www.cms.gov/glossary?term=abuse&items_per_page=10&viewmode=grid**.

17 U.S. Department of Justice. "Elder Abuse and Elder Financial Exploitation Statutes." 2022. 22 M.R.S. § 3472. **https://www.justice.gov/elderjustice/prosecutors/statutes#:~:text=%C2%A7%203472.,for%20another%27s%20profit%2**

  - Emotional
    - Includes verbal assaults, threats of maltreatment, harassment or intimidation intended to compel a child or adult to engage in conduct from which they wish and have a right to abstain
    - Includes verbal assaults, threats of maltreatment, harassment or intimidation intended to compel a child or adult to refrain from conduct in which they wish and have a right to engage

Neglect

Neglect is defined as repeated conduct or a single incident of carelessness that results or could reasonably be expected to result in serious physical or psychological/emotional injury or substantial risk of death. This can include:

- Self-neglect
  - Occurs when an individual does not attend to their own basic needs, such as personal hygiene, appropriate clothing, feeding or tending appropriately to medical conditions
- Passive neglect
  - Occurs when a caregiver fails to provide an eligible adult or child with the necessities of life including, but not limited to, food, clothing, shelter or medical care
    - This definition does not create a new affirmative duty to provide support to eligible adults, nor shall it be construed to mean that an eligible adult is a victim of neglect because of healthcare services provided or not provided by licensed healthcare professionals.
- Neglect of member
  - The failure of another individual to provide an adult or child with disabilities, or the willful withholding from a child or an adult with disabilities, the necessities of life including, but not limited to, food, clothing, shelter or medical care

Exploitation

Exploitation is the act of a person who stands in a position of trust and confidence with a disabled adult or an elderly person and knowingly, by deception, intimidation or force: (a) obtains control over the person's funds, assets or property, (b) deprives the person of the use, benefit or possession of funds, assets or property (temporary or permanent), or (c) uses the person's funds, assets or property for the benefit of someone other than the disabled adult or elderly person. Exploitation includes:

- Exploitation of member
  - The illegal use of assets or resources of an adult with disabilities, including (but not limited to) misappropriation of assets or resources of the alleged victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion or in a manner contrary to law
- Financial exploitation
  - The misuse or withholding of an older person's resources by another person to the disadvantage of the older person or the profit or advantage of person other than the older person

Indicators

Physical

Physical indicator	Description
Unexplained bruises or welts	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 Bruising in the shape of an object that may have been used to inflict injury Clustered bruising on the trunk or another area of the body Multicolored bruises that may indicate the person sustained multiple traumas over time (i.e., presence of old and new bruises at the same time) Wrap-around bruises encircling the member's arms, legs or torso that may indicate the individual was physically restrained
Unexplained fractures	Multiple or spiral fractures Sprains, dislocations To skull, nose, facial structure, in various stages of healing
Unexplained burns	Cigar or cigarette burns, especially on palms, legs, arms, back or soles of feet Immersion burns (sock-like or glove-like shapes on feet or hands, or a doughnut-shape on buttocks that indicate that the victim was held down in hot liquid) Patterned like objects (electric burner, etc.)
Unexplained lacerations	Cuts, lacerations or puncture wounds Mouth, lips, gums, eye or to external genitalia
Sexual abuse	Bruises on external genitalia, inner thighs, abdomen or pelvis Difficulty walking or sitting not explained by other physical conditions Inappropriate sex role relationships between victims and suspects Inappropriate, unusual or aggressive sexual behavior Sexually transmitted diseases Signs of psychological trauma, including excessive sleep, depression or fearfulness Stained or bloody underclothing Urinary tract infections Vaginal or anal pain, irritation or bleeding

Physical indicator	Description
Injuries	A history of similar injuries and/or numerous or suspicious hospitalizations A history of the member being brought to different medical facilities for treatment to prevent medical providers from observing patterns Delays between onset of injury and seeking medical care Inconsistent or conflicting information from family members about how injuries were sustained 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 • Injuries that are incompatible with the member's explanation
Other	Abrasions on arms, legs or torso that resemble rope or strap marks Emaciated (so that individual can hardly move or so thin bones protrude) Fleas, lice on individual Hair matted, tangled or uncombed Hair thin as though pulled out, bald spots Internal injuries evidenced by pain, difficulty with normal functioning of organs and bleeding from body orifices Lack of clothing Obvious illness that requires medical or dental attention Rash, impetigo, eczema Same clothing all the time Scars Severe or constant pain Signs of confinement Signs of traumatic tooth loss Unkempt, dirty Unusual lumps, bumps or protrusions under the skin

Behavioral

Behavioral indicator
Destructive behavior of victim
Other behavior of victim
Behavior of family or caregiver

Neglect

Neglect indicator
Weight loss that cannot be explained by other causes
Lack of toileting that causes incontinence
Member sitting in 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 indicators for victims
Visitors ask the member to sign documents the member does not understand
Unpaid bills (despite adequate financial resources, bills remain unpaid by the caregiver or other party)
Lack of affordable amenities for the member, such as personal grooming items or appropriate clothing
New “best friends” who take an interest in the member’s finances
Legal documents, such as powers of attorney, which the member did not understand at the time they signed them
Unusual activity in the member’s bank accounts, including large, unexplained withdrawals, frequent transfers between accounts or other activity the member cannot explain
Caregiver expresses excessive interest in the amount of money being spent on the member
Missing belongings or property
Suspicious signatures on checks or other documents (including signatures not matching the member’s and 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
Member is unaware of or does not understand financial arrangements that have been made for them

Exploitation indicators for family/caregiver(s)

Do not provide an opportunity for the member to speak for themselves
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
Show aggressive behavior toward the member (threaten, insult, harass)

Reporting abuse, neglect or exploitation

Although the law[18] requires all persons to report suspected abuse, neglect and/or exploitation, certain professionals have a specific responsibility to report. These include, but are not limited to:

- Physicians, osteopaths, medical examiners, chiropractors, nurses or hospital personnel engaged in the admission, examination, or care and treatment of elderly or disabled adults
- Health and mental health professionals not listed above
- Nursing home staff, adult-living facility staff, adult day-care-center staff, social worker or other professional adult-care, childcare, residential or institutional staff
- State, county or municipal criminal justice employees or law enforcement officers
- Humana Rights Advocacy Committee (HRAC) and Long-Term-Care Ombudsman Council (LTCOC) members
- Banks, savings and loan, or credit union officers, trustees or employees

What is a mandated reporter?

A mandated reporter is an individual who is required by law to report situations immediately if they suspect an adult or child may have been abused, neglected or exploited or is at risk of being abused, neglected or exploited. Most states allow for immunity from civil and criminal liability unless the report was made in bad faith or with malicious intent.[19] Most states also allow for identity protection such that mandated reporters must provide consent to have their identities revealed, although the court may order the identity of the reporter be revealed.[20] The court can then release confidential information without penalty.[21]

18 Laws differ across states, and specific requirements or protections may vary depending on the jurisdiction. For authoritative information, consult the relevant state statutes or government websites.

19 Laws differ across states, and specific requirements or protections may vary depending on the jurisdiction. For authoritative information, consult the relevant state statutes or government websites.

20 Laws differ across states, and specific requirements or protections may vary depending on the jurisdiction. For authoritative information, consult the relevant state statutes or government websites.

21 Laws differ across states, and specific requirements or protections may vary depending on the jurisdiction. For authoritative information, consult the relevant state statutes or government websites.

General reporting requirements[22]

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

Humana Healthy Horizons in Indiana market compliance team manages the reporting of Reportable and Critical Incidents that negatively impact the health, safety or welfare of our members. An adverse incident can include death, wrong surgical procedure, wrong site or wrong member, or a surgical procedure to remove s

If you identify an adverse incident, you should:

- Report the adverse incident to the appropriate entity (police, adult protective services, etc.).
- Call 911 if the member is in immediate danger.
- Report the adverse incident within 24 hours to Humana Healthy Horizons.
- Report suspected abuse, neglect and exploitation of a member immediately.

Reporting critical incidents

A critical incident is defined as an adverse or critical incident that negatively impacts the health, safety or welfare of a member. If you determine whether a member meets the criteria for a critical incident, it must be reported immediately to the member's care coordinator. This could be a Humana Healthy Horizons associate or one of our contracted vendors. Humana Healthy Horizons has several contractual arrangements with vendors to serve as care coordinators in these states. Once the member's care coordinator is notified of the critical incident, the care coordinator must report it to Humana Healthy Horizons' risk management department for review and reporting to the respective state.

22 Laws differ across states, and specific requirements or protections may vary depending on the jurisdiction. For authoritative information, consult the relevant state statutes or government websites.

Critical incidents may include occurrences involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing or major medication incidents. Assisted living facilities (ALF) and skilled nursing facilities (SNF) need to report abuse, neglect or exploitation incidents to Humana Healthy Horizons. Critical incidents involving abuse, neglect or exploitation also must be reported by you to the FSSA.

You are expected to work with our care management team to resolve all identified critical incidents involving our members in a timely manner and support the safety and well-being of our members.

Chapter 6: Cultural humility, health equity and interpreter services

Contact information pertaining to cultural humility, health equity and interpreter services

Contact name	Contact information	Hours of operation
Communication Assistance, Interpreters, and Alternative Formats	Phone: **877-320-2233** Email: **accessibility@humana.com** Humana Healthy Horizons provides over-the-phone interpretation in over 150 languages at Humana touchpoints. Humana Healthy Horizons also provides TTY and alternative formats including braille, large print, audio, DAISY, screen reader accessible PDF, and reading over the phone of your written communications. American Sign Language (ASL) interpreters are available in person or via video. Additional communication assistance support is detailed on our communication assistance website, via telephone or via email.	8 a.m. to 8 p.m., Eastern time, Monday through Friday
Member/Provider Services Contact Center	Phone: **866-274-5888 (TTY: 711)**	8 a.m. to 8 p.m., Eastern time, Monday through Friday

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.[23]

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.[23]

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.

Humana Healthy Horizons recognizes cultural differences and the influence that race, ethnicity, language, and socioeconomic status have upon the member healthcare experience and health outcomes. Thus, we are committed to developing strategies that eliminate health disparities while addressing gaps in care. Racial and ethnic disparities in health and healthcare are well-documented. The COVID-19 pandemic highlighted these inequities, which are rooted in structural and systemic racism.

23 42 C.F.R. § 438.206

Data across 64 measures show significant differences in health outcomes and access to care between people of color and White individuals.[24] The Commonwealth Fund 2024 State Health Disparities Report found that Black members received worse care than White members on 52% of quality measures in 2023.

Communication is paramount in delivering effective care. Achieving mutual understanding may be difficult during cross-cultural interaction between members and their providers. Some disparities may be attributed to miscommunication between members and their providers, 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 making efforts to improve communication with diverse members.

We offer several initiatives to deliver services to all members regardless of ethnicity, socioeconomic status, culture or primary language, including language assistance services, race and ethnicity data collection and analysis, internal staff training and resources offered in Spanish. Other initiatives provide you with additional resources and materials including tools from health-related organizations that support awareness of gaps in care and information on culturally competent care.

Enhance your ability to provide inclusive, respectful care to individuals from diverse cultural and social backgrounds. 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.

A Cultural Broker is someone who helps bridge the gap between individuals or groups from different cultural backgrounds to promote understanding, effective communication, and respectful interaction. Cultural brokers may be community members, trained professionals, or staff with lived experience who understand both the dominant culture (e.g., healthcare system norms) and the cultural context of the individuals being served. 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.

24 Ndugga, N., Hill, L., and Artiga, S. "Key Data on Health and Health Care by Race and Ethnicity." Kaiser Family Foundation, June 11, 2024. **https://www.kff.org/key-data-on-health-and-health-care-by-race-and-ethnicity/?entry=executive- summary-introduction.**

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 patients about their learning preferences so you can present information better during shared decision making. Find out if your patients prefer you to offer materials in print, video or audio format. Ask your patients 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 patients 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 patients 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.

Cultural humility

Cultural humility means admitting what we do not know about patients and being willing to learn from their experiences, while also being aware of our own embedded cultural beliefs.[25] Cultural humility in healthcare looks like self-reflexivity and assessment, appreciation of the patients' expertise in the social and cultural context of their lives, openness to establishing power-balanced relationships with patients, and a lifelong dedication to learning.[26]

Balancing power and privilege means:

- Advocating to address power and privilege within healthcare institutions and doing the individual work needed to overcome them
- Recognizing patients bring valuable insight and knowledge to the equation of their medical care (Multiple studies show there is increased mistrust and unequal treatment in vulnerable communities.)
- Realizing medical systems hold scientific knowledge and power, while patients hold power in personal history and preferences along with the cultural context of expressing these

Institutional accountability means:

- Examining the relationships organizations have with the communities they serve

25 Lekas, H.-M., Pahl, K., and Lewis, C. F. "Rethinking Cultural Competence: Shifting to Cultural Humility." Health Services Insights 13 (2020): 1–4. **https://doi.org/10.1177/1178632920970580**.

26 Ibid.

- Making space for evolving knowledge about a cultural community and developing trusting relationships within the context of their beliefs and values
- Ensuring efforts are a top priority among leaders at the organization and understanding cultural humility is an active journey

Lifelong learning and self-reflection means:

- Continually being curious and open learning from patients, families and communities, which is necessary for growth
- Learning from patients, who are the experts and authorities in their own lives
- Examining one's own bias, beliefs and assumptions, which is critical as we continue our lifelong learning

Health equity

Health equity is the elimination of unjust, avoidable and unnecessary barriers in health and healthcare. According to the American Hospital Association's Institute for Diversity and Health Equity, health equity ensures that every individual has a fair and just chance to attain their best possible health. Health barriers can be based on background, where someone lives, the resources they have, or systemic factors such as racism and discrimination. The concept of health equity suggests everyone should have a fair opportunity to attain their full health potential and no one should be disadvantaged from achieving it.

Factors affecting health equity

Social determinants of health (SDOH) are the conditions in the places people live, learn, work, play and worship that can negatively affect health outcomes. Long-standing inequities in 6 key areas influence a wide range of health and quality-of-life risks and outcomes.[27] Examining these health and social inequities can help us better understand how to promote health equity and improve health outcomes.

Key areas include:

- Social and community context, including a patient's interactions with the places they live, work, learn, play and worship and their relationships with family, friends, coworkers, community members and institutions: This includes discrimination and racism.
- Healthcare access and use: People with disabilities, people from some racial and ethnic minority groups, people from rural areas, and populations with lower incomes are more likely to face multiple barriers to accessing healthcare.
- Neighborhood and physical environment, including crime, lack of access to healthy food, lack of safe and affordable housing, lack of public transportation, and limited infrastructure and resources.
- Poor quality or dangerous workplace conditions: Some people may face exposure to elements that can have negative impacts on their health in their workplace, such as secondhand smoke or loud noises.

27 Healthy People 2030. "Social Determinants of Health." Office of Disease Prevention and Health Promotion, 2023. **https://health.gov/healthypeople/priority-areas/social-determinants-health**.

- Education level: People who are historically marginalized, such as people from racial and ethnic minority groups, people with disabilities, and populations with lower incomes, are disproportionately affected by inequities in access to high-quality education.
- Income and wealth gaps: Individuals from some racial and ethnic minority groups and other historically marginalized groups also face greater challenges in getting higher-paying jobs with good benefits due to less access to high-quality education, geographic location, language differences, discrimination and transportation barriers.

Linguistic services

Humana Healthy Horizons offers several initiatives to deliver services to all 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, and health literacy
- All print resources available in English are also available in Spanish. Written materials available in languages other than English can be requested by you or the member by calling our Member/Provider Services Contact Center.

Our care coordinators are assigned to members based on their language needs, cultural compatibility and gender preference, to better align with the individual's choice.

All clinical associates complete cultural humility training.

Recognizing that complete and accurate provider data is foundational to ensuring an adequate and responsive network, we have an annual provider education campaign encouraging our network to self-report language, race and ethnicity data and educate providers on how we use this data to ensure culturally competent and equitable care. We seek to collaborate with other selected managed care entities on this campaign to promote systemwide accessibility for this important data.

Interpreter services

If you are assisting a member who needs interpretive services, please be aware that we provide 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 Communication Assistance, Interpreters, and Alternative Formats to schedule at least 48 hours in advance.

Linguistically trained interpreters for visually impaired customers—Call Communication Assistance, Interpreters, and Alternative Formats 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 you or the member by calling our Member/Provider Services Contact Center.

Please refer to the provider responsibilities section of this manual for more information.

Cultural humility and health equity plan

To request a printed copy of our cultural humility and health equity plan at no charge, please contact Humana Healthy Horizons Member/Provider Services Contact Center, or your Provider Education/ Outreach Representative. You may also review our cultural humility training in **Availity Essentials**.

Chapter 7: Covered services

Contact information pertaining to covered services

Contact name	Contact information	Hours of operation
Communication Assistance, Interpreters, and Alternative Formats	Phone: **877-320-2233** Email: **accessibility@humana.com** Humana Healthy Horizons provides over-the-phone interpretation in over 150 languages at Humana touchpoints. Humana Healthy Horizons also provides TTY and alternative formats including braille, large print, audio, DAISY, screen reader accessible PDF, and reading over the phone of your written communications. American Sign Language (ASL) interpreters are available in person or via video. Additional communication assistance support is detailed on our communication assistance website, via telephone or via email.	8 a.m. to 8 p.m., Eastern time, Monday through Friday
Go365 for Humana Healthy Horizons	Phone: **888-225-4669 (TTY: 711)** Website: **https://www.humana.com/medicaid/indiana/benefits/go365**	8 a.m. to 7 p.m., Eastern time, Monday through Friday
LCP Transportation	Phone: **800-508-7230** Website: **https://www.lcptransportation.com/**	
Member/Provider Services Contact Center	Phone: **866-274-5888 (TTY: 711)**	8 a.m. to 8 p.m., Eastern time, Monday through Friday

General services

Indiana PathWays for Aging provides benefit packages, and there are 2 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 can, 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 **Indiana Medicaid for Providers bulletins, banner pages, and reference modules website**.

Covered medical services

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

- Family planning services[28]
- Federally qualified health center services[29]
- Freestanding birth center services when licensed or otherwise recognized by the state[30]
- Home health services[31]
- Inpatient hospital services[32]
- Laboratory and X-ray services[33]
- Medication Assisted Treatment (MAT)[34]
- Nurse midwife services[35]
- Nursing facility services[36]

28 Social Security Act § 1905(a)(4)(C); 42 C.F.R. § 441.20.
29 Social Security Act § 1905(a)(2)(C).
30 Social Security Act § 1905(a)(28).
31 Social Security Act § 1905(a)(7); 42 C.F.R. § 440.70; 42 C.F.R. § 441.15.
32 Social Security Act § 1905(a)(1); 42 C.F.R. § 440.10.
33 Social Security Act § 1905(a)(3); 42 C.F.R. § 440.30; 42 C.F.R. § 441.17.
34 Social Security Act § 1905(a)(29).
35 Social Security Act § 1905(a)(17); 42 C.F.R. § 440.165; 42 C.F.R. § 441.21.
36 Social Security Act § 1905(a)(4)(A); 42 C.F.R. § 440.40; 42 C.F.R. § 440.155.

- Outpatient hospital services[37]
- Physician services[38]
- Routine patient costs of items and services for beneficiaries enrolled in qualifying clinical trials[39]
- Rural health clinic services[40]
- Transportation to medical care[41]

State Plan Medicaid package

General services

Service(s)	Coverage
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 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

37 Social Security Act § 1905(a)(2)(A); 42 C.F.R. § 440.20(a).
38 Social Security Act § 1905(a)(5); 42 C.F.R. § 440.50.
39 Social Security Act § 1905(a)(30).
40 Social Security Act § 1905(a)(2)(B); 42 C.F.R. § 440.20(b).
41 Social Security Act § 1902(a)(4); 42 C.F.R. § 431.53; 42 C.F.R. § 440.170.

Service(s)	Coverage
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 services	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 calendar days following a major surgical procedure and 10 calendar 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

Service(s)	Coverage
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
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 calendar 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

Service(s)	Coverage
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 1 of the following criteria also is met: • The service is not available in Indiana. However, the 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 non-legend drugs)	Covered
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

Service(s)	Coverage
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 year, 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 1 per provider within the last 3 years
Radiology services	Covered

Service(s)	Coverage
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
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 Cetner (FQHC) services	Covered
Speech pathology services	Covered for up to 1 hour per day
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

Service(s)	Coverage
Transportation services	Medical transportation: • Unlimited trips are covered • Trips are 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 • 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

Service(s)	Coverage
CROWNS	
Recement crowns	Covered
Stainless steel crown permanent	Covered
Steel crown primary	Covered
DENTURES AND PARTIALS	
Dentures	Covered
Partials	Covered
DIAGNOSTIC AND PREVENTIVE SERVICES	
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

Service(s)	Coverage
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 planing 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
Compound fracture of the mandible and maxilla	Covered
Drugs and medicaments	Covered
Excision of lesions and benign tumors (including oral biopsies)	Covered
Fracture simple stability	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

Service(s)	Coverage
Suturing	Covered
Therapeutic pulpotomy	Covered

Vision services

Service(s)	Coverage
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	Covered for up to 1 examination every 2 years unless more frequent care is medically necessary
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
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 $85.94 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
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 opthalmoscope	Covered if medically necessary

Service(s)	Coverage
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

HCBS waiver package: General services

Service(s)	Coverage
Adult day services	Covered for up to 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 $2,500 per lifetime for setup expenses
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	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

Service(s)	Coverage
Home modification assessments	Covered for members receiving services. Covered for up to $628 annually
Home modifications	Covered for members who would require institutionalization without physical home adaptations Installation costs covered for a lifetime cap of $20,000 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
Transportation services— nonmedical transportation	Covered
Vehicle modifications	Covered for up to $15,000 for 1 vehicle every 10 years

Non-emergency medical transportation

Coverage	How to schedule	Vendor contact
Members may receive rides to and from: • Any provider visit or healthcare appointment • Eligibility redetermination appointments with the state • Recurring appointments • Approved urgent appointments Please direct members to contact the Member/ Provider Services Contact Center for more information.	Rides must be scheduled at least 2 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.	Non-emergency medical transportation is provided by LCP Transportation.

Noncovered services

Humana Healthy Horizons must provide covered services under current administrative regulations. The scope of services may be enhanced with approval of Indiana and as necessary to comply with federal mandates and state laws. Certain Medicaid services are currently excluded from our benefits package but continue to be covered through the traditional fee-for-service Medicaid program. We are familiar with these excluded services, designated Medicaid "wrap-around" services, and coordinate with PathWays providers in the delivery of these services to members.

We may access information relating to these excluded service programs from Indiana to aid in the coordination of services.

Under federal law, Medicaid does not receive federal matching funds for certain services. Some of these excluded services are optional services that Indiana may or may not elect to cover. We are not required to cover services that Indiana elects not to cover for members.

The following services currently are not covered by the Indiana Medicaid program:

- All laboratory services performed by a provider without current certification, in accordance with the Clinical Laboratory Improvement Amendment (CLIA). **NOTE: This requirement applies to all facilities and individual providers of any laboratory service.**
- Cosmetic procedures or services performed solely to improve appearance
- Hysterectomy procedures, if performed for hygienic reasons or for sterilization only

- Medical or surgical treatment of infertility (e.g., the reversal of sterilization, in-vitro fertilization, etc.)
- Induced abortion and miscarriage performed out-of-compliance with federal and Indiana laws and judicial opinions
- Paternity testing
- Personal service or comfort items
- Post-mortem services
- Services including drugs that are investigational and for research purposes or experimental in nature
- Gender-affirming surgical services
- Sterilization of a mentally incompetent or institutionalized member
- Services provided in countries other than the United States, unless approved by Indiana
- Services or supplies more than limitations or maximums set forth in federal or state laws, judicial opinions and Indiana Medicaid program regulations referenced herein
- Services for which the member has no obligation to pay and for which no other person has a legal obligation to pay

The services detailed below are not covered by the Indiana Medicaid program.[42] Information regarding non- covered 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

42 405 IAC 5-29-1.

- 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. **NOTE: 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 trans telephonic monitor
- Otoplasty for protruding ears unless 1 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 1 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.

Out-of-network services

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.

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 by the Indiana Medicaid State Plan and the Indiana Medicaid fee schedules. These added benefits are more than the amount, duration and scope of covered services listed in this manual.

In instances where an enhanced service is also 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 • Bathmat • 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

Enhanced service	Details and limitations
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 1 year provided total spend remains within the $200 allowance.
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.

Enhanced service	Details and limitations
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.
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 a member resides with a caregiver, a 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

Enhanced service	Details and limitations
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.

*Humana Healthy Horizons publishes billing guidelines online for these benefits/services

Go365 for Humana Healthy Horizons

Go365 for Humana Healthy Horizons is a well-being and rewards program available to our Humana Healthy Horizons members. For each eligible Go365 activity completed, members can earn rewards and redeem them for gift cards in the Go365 in-app mall.

Most rewards are earned by Humana Healthy Horizons' receipt of the provider's claim for services rendered. Humana Healthy Horizons recommends that all providers submit their claims on behalf of a member by March 15, 2027. This allows members time to redeem their rewards. Members have 90 calendar days from one plan year to another to redeem their rewards, assuming they remain continuously enrolled.

Unless otherwise stated, all rewards are offered to Medicaid-only members. Members can qualify to earn rewards by completing 1 or more of the activities in the chart below.

Enhanced service	Details and limitations
Annual Wellness Visit	Annual $25 reward for completing an annual wellness visit
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 $15 reward for diabetic members who complete a retinal eye exam
Diabetic screening	Annual $15 reward for diabetic members who obtain a screening with their PMP for HbA1c and blood pressure
Fall prevention video	Annual $10 reward for members who watch the health education video in the Go365 app about how to reduce falls

Enhanced service	Details and limitations
Flu vaccine	Annual $10 reward for members who receive an annual flu vaccine from their provider or at the pharmacy (Members can also self-report through the Go365 app if they receive a vaccine from another source.)
Follow-up visit after high- intensity care for SUD	$25 reward for members who receive follow-up care within 30 days of an inpatient hospital discharge, residential treatment or detoxification visit for a diagnosis of substance use disorder (SUD)
Follow-up visit after hospitalization for behavioral health diagnosis	$25 reward for members who complete a follow-up visit within 30 days after discharge for a behavioral health diagnosis
Health Needs Screening (HNS)	$20 in rewards for members who complete their CHA (Comprehensive Health Assessment) HNS within 90 days of enrollment with Humana Healthy Horizons; 1 reward per lifetime
Nutritional Coaching	Members who participate in Nutritional Coaching earn $15 for completing enrollment $15 for completing 6 coaching calls with a Wellness Coach (Members must opt in to Go365 to be eligible for the reward.)

How to redeem rewards

To earn and redeem rewards, members must:

- Download the Go365 for Humana app from iTunes/Apple Shop or Google Play on a mobile device.
- Create an account to access and engage in the program. (If the member has a MyHumana account, they can use the same login information to access Go365, after they download the app.)
- If they are 18 and older, register to create a Go365 account. They must have their Medicaid Member ID.
- If they are under the age of 18, have a parent or guardian register on their behalf to participate and engage with the program. The person completing the registration process on behalf of a minor must have the minor's Medicaid Member ID.

If members have questions about the Go365 program, they can call the number on the back of their Humana ID card.

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 non-transferable 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.

Copays/coinsurance/member cost sharing requirements

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

Patient or waiver 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

Please refer to the member billing section of this manual for more information.

Emergency services

Humana Healthy Horizons providers are required to ensure adequate accessibility for healthcare 24 hours a day, 7 days a week. Humana Healthy Horizons members should contact their PMP if they experience an emergency, but should go to the closest ER or any other emergency setting if they have any of the following:

- Heavy blood loss
- Heart attack
- Severe cuts requiring stitches
- Loss of consciousness
- Poisoning
- Severe chest pains
- Loss of breath
- Broken bones

Members are instructed to call their PMP as soon as possible when they are in a hospital or have received emergency care. When a member arrives at a hospital seeking emergency services and care, the determination that an emergency medical condition exists shall be made, for the purposes of treatment, by a provider of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a hospital physician.

If the ER physician treating the member determines that the visit is not an emergency, the member will be given the choice to stay and receive medical treatment or follow up with their PMP.

If the member's PMP responds to the hospital's notification, and the hospital physician and the PMP discuss the appropriate care and treatment of the member, the managed care plan may have a member of the hospital staff with whom it has a participating provider contract participate in the treatment of the member within the scope of your hospital staff privileges.

If the member is treated for an emergency and the treating doctor recommends treatment after the member is stabilized, the member is instructed to contact their Humana Healthy Horizons PMP.

Members who are away from home and have an emergency are instructed to go to the nearest ER or any emergency setting of their choice. In such situations, members should contact their PMP as soon as possible.

Telehealth services

Humana Healthy Horizons reimburses providers for telehealth services, which refers to services provided by using interactive telecommunications equipment that includes, at a minimum, audio equipment permitting two-way communication between a member and provider. Telehealth is defined as the practice of healthcare delivery by a provider who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis or treatment. This applies to any person or entity prescribing or reviewing a request for Indiana Medicaid services and to all providers of Indiana Medicaid services that are enrolled in or registered with the Indiana Medicaid program.

Humana Healthy Horizons will not reimburse the following:

- Chart review(s)
- Electronic mail messages
- Facsimile transmissions
- Equipment required to provide telemedicine services

When providing telehealth services, you must include modifier GT on the CMS-1500 claim form, incorporated by reference in Rule 59G-4.001, F.A.C.

Providers who will be offering and/or facilitating telehealth services in their practices must remain aware of the state guidelines to ensure they are informed of their responsibilities, requirements and criteria for telemedicine. Offering these services may include a review of the practice by Humana Healthy Horizons' legal designee to ensure all considerations for the practice of telehealth have been met.

If you are approved by Humana Healthy Horizons to provide services through telehealth, you must implement telehealth fraud and abuse protocols to prevent fraud and abuse that address:

- Authentication and authorization of users
- Authentication of the origin of the information
- The prevention of unauthorized access to the system or information
- System security, including the integrity of information that is collected, program integrity and system integrity
- Maintenance of documentation about system and information usage

Providers offering these services to members with Medicaid coverage must address each of the following requirements:

- Telecommunication equipment and telehealth operations meet the technical safeguards required[43], where applicable.
- Administration of telehealth services complies with HIPAA and other state and federal laws pertaining to member privacy.
- Telehealth services provided are documented in the member's medical/case record.
- Telehealth services are offered to the member as a choice of whether to access services through face- to-face or telehealth encounters. This must be documented in the member's medical/ case records.
- Telehealth services must be performed by licensed practitioners within the scope of their practice.

NOTE: Humana Healthy Horizons does not reimburse for the costs or fees of any of the equipment necessary to provide services through telehealth, including telecommunication equipment and services.

Providers are encouraged to contact their Provider Education/Outreach Representative if they are offering or plan to offer these services to members covered by Humana Healthy Horizons.

If your practice is using telehealth with a hearing-impaired member, please call Communication Assistance, Interpreters, and Alternative Formats. Many telehealth platforms do not allow for an interpreter to participate. If this is the case with your telehealth platform, please call Communication Assistance, Interpreters, and Alternative Formats to utilize Humana Healthy Horizons' secure Doxy portal with the member, yourself and an interpreter. Please keep in mind that when using telehealth with a disabled member, nothing can be downloaded to the member's phone.

Transplant services

Medically necessary transplants and related services are covered. PA and other limits may apply.

43 45 C.F.R. § 164.312

Family planning

FSSA requires that family planning services be furnished on a voluntary and confidential basis. Humana Healthy Horizons provides family planning services to help members make comprehensive and informed decisions about family size and/or spacing of births.

The following services are provided:

- Planning and referral
- Education and counseling
- Initial examination
- Diagnostic procedures
- Routine laboratory studies
- Contraceptive drugs and supplies
- Follow-up care in accordance with the Medicaid Practitioner Services Coverage and Limitations manual

This information should be documented in the member's medical record to meet the contractual requirement. Humana Healthy Horizons or FSSA may audit medical records to confirm compliance with this contractual clause.

Members can choose from any Medicaid doctor for family planning services. Prior approval is not required.

NOTE: The above content is informational only and does not constitute clinical advice or recommendations. This information is not intended to interfere with, or prohibit, clinical decisions made by prescribers or communication between prescribers and members regarding clinical care and all available options.

Chapter 8: Behavioral health

Contact information pertaining to behavioral health

Contact name	Contact information	Hours of operation
Behavioral Health Contract Teams	Email: **INBHMedicaid@humana.com**	
Behavioral Health Crisis Line	Phone: **855-254-1758**	24 hours a day, 7 days a week
Case Management	Email: **INPathWaysCareManagement@humana.com**	
Member/Provider Services Contact Center	Phone: **866-274-5888 (TTY: 711)**	8 a.m. to 8 p.m., Eastern time, Monday through Friday
National Suicide Prevention Line	Phone: **800-273-8255**	24 hours a day, 7 days a week

Behavioral health overview

Behavioral health and substance-use disorder (SUD) services are covered services for Humana Healthy Horizons members. We recognize that behavioral health and physical health function as a part of the whole person, and one can affect the other. Therefore, we use a holistic approach to addressing behavioral health and substance use.

Humana Healthy Horizons covers a comprehensive range of behavioral health services, including:

- Outpatient coverage for:
  - Medication management
  - Therapy services, including individual, group and family therapy
  - Care management offered through key providers
- A broad range of services for both behavioral health and SUDs, including:
  - Intensive outpatient
  - Partial hospitalization

  - Crisis stabilization
  - Inpatient or residential treatment based on medical necessity
- Access to community-based resources

Providers, members or other responsible parties can call behavioral health services to verify available behavioral health and substance-use benefits and to seek a referral or direction for obtaining behavioral health and substance-use services. The Humana Healthy Horizons network focuses on improving the health of our members through efforts aimed at increased well-being, using member-centered, evidence-based practices.

Our goal is to provide the level of care needed by the member in the least restrictive setting—the right care, at the right time, in the right setting.

For emergency mental health care within or outside the service area, please instruct members to go to the closest hospital ER or any other recommended emergency setting. Members should contact their PMP first if they are unsure whether they are experiencing an emergency. Emergency mental health conditions include:

- The member is a danger to themselves or others
- The member is unable to carry out actions of daily life due to functional harm
- The member is experiencing serious harm to the body that may cause death

In addition, the plan and the mental health provider shall ensure:

- The member has a follow-up appointment within 7 calendar days after discharge
- All required prescriptions are authorized at the time of discharge
- Coordination of care
  - Discharge planning begins upon admission and is designed for early identification of medical and/or psychosocial issues requiring post-hospital intervention.
  - Discharge plans from behavioral health inpatient admissions will be monitored to ensure that they incorporate the member's needs for continuity in existing behavioral health therapeutic relationships.
  - Behavioral health care providers should assign a mental health targeted care coordinator to oversee the member's care to ensure a smooth transition to a lower level of care.
  - The concurrent review clinician works with the attending provider, hospital discharge planner, family members, guardians, ancillary providers and/or community resources to coordinate care and post- discharge services to facilitate a smooth transfer of the member to the appropriate level of care.
  - An inpatient review nurse may refer an inpatient member with identified complex discharge needs to transitional care management for in-facility outreach.

Provider coordination for behavioral health

Network providers are required to coordinate care when PathWays members are experiencing behavioral health conditions that require ongoing care. 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 Case Management or the Member/Provider Services Contact Center.

Behavioral health provider expectations

PMPs are required to:

- Provide basic behavioral health services to members, including:
  - 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 unduplicated care to the member.
- Obtain a necessary signed release of information for the sharing of PHI, including compliance with requirements around behavioral health and SUD.[44] Behavioral health providers are required to:
- Notify the PMP when a member initiates behavioral health services with them.
- Obtain a signed release of information for the sharing of PHI in compliance with requirements around behavioral health and SUD prior to sharing information with the PMP.[45]
- Provide initial and summary reports to the PMP (after receiving 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 7 calendar days from the date of the member's discharge.

44 U.S. Department of Health & Human Services. "Fact Sheet: 42 CFR Part 2 Final Rule." Accessed [today's date]. **https://www.hhs.gov/hipaa/for-professionals/regulatory-initiatives/fact-sheet-42-cfr-part-2-final-rule/index.html**.

45 Ibid.

Humana Healthy Horizons assists with your 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.

Covered behavioral health services

Treatment for psychiatric and emotional disorders includes the following services:

- Children's behavioral healthcare services
- Counseling
- Day treatment services
- Evaluation and testing services
- Rehabilitation services
- Therapy and treatment services

Emergency behavioral health services

For mental or behavioral health services, members should call a contracted behavioral healthcare provider in their area. The behavioral healthcare provider can give the member a list of common problems with behavior health symptoms and talk to the member about how to recognize the problems. Members may contact the Member/Provider Services Contact Center for more information.

Behavioral health crisis hotline

For emergency behavioral health care within or outside the service area, please instruct members to go to the closest hospital emergency room or the closest recommended emergency setting. They should contact you first if they are not sure the problem is an emergency.

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, 7 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.

The National Suicide Prevention Line is staffed by trained personnel and available toll-free throughout the state. Crisis hotline staff includes or has access to qualified behavioral health services professionals to assess, triage and address specific behavioral health emergencies.

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 Emergency mental or behavioral health conditions include:
- Behaviors that are a danger to the member or others
- Inability to conduct actions of daily life due to functional harm
- Behaviors that cause serious harm to the body that may cause death

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.

If you encounter a member who 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 the Member/Provider Services Contact Center 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 Healthy Horizons 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 or request via **Availity Essentials**.

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
- 1 evaluation and management office visit every 90 calendar 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 18 years and older who have become addicted at least 1 year prior to admission and are placed in the Opioid Treatment Services (OTS) Level of Care according to all 6 dimensions of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.
- All members released from penal institution (within 6 months of release)
- Previously treated members (up to 2 years after discharge)

Chapter 9: Case management

Contact information pertaining to case management

Contact name	Contact information	Hours of operation
Case Management	Email: **INPathWaysCareManagement@humana.com**	
Member/Provider Services Contact Center	Phone: **866-274-5888 (TTY: 711)**	8 a.m. to 8 p.m., Eastern time, Monday through Friday
Population Health	Phone: **866-331-1577**	8 a.m. to 5:30 p.m., Eastern time, Monday through Friday

Our approach to case management

Humana Healthy Horizons provides comprehensive and integrated case management services through medical and behavioral health staff, social workers and outreach specialists, which include one-on-one personal interaction and support for members. Additionally, Humana Healthy Horizons coordinates with community- based resources to assist members with social determinants of health (SDOH), such as food, transportation to medical appointments, utilities and so forth. For help with members who need assistance with SDOH, please contact Population Health.

Our case management program provides a broad spectrum of educational and follow-up services for your patients. We offer individualized education and support for many chronic diseases. Case management is especially effective for reducing admission and readmission risks, managing anticipatory transitions, engaging noncompliant members, reinforcing medical instructions and assessing social needs.

Case management services

Humana Healthy Horizons' case management program is a fully integrated health management program, supporting a holistic approach to healthcare by integrating physical and behavioral health while also considering environmental factors that impact health, such as food insecurity, housing and other SDOH. We implement an integrated, personal approach, supporting members from their

initial assessment through the continuum of care with the goal of members taking an active part in their healthcare and making healthy lifestyle decisions. We take a member-centric approach, placing them at the center of the process and working to identify their health priorities to support them in meeting those goals. This approach also supports and enhances care and builds on the treatment you provide to your patient. We stress the importance of establishing a medical home, identifying early and ongoing barriers to care, and keeping appointments. When necessary, we assist in arranging transportation to the provider's office.

Humana encourages you to take an active role in your patient's case management program, and we invite and encourage you to direct and participate in the development of a comprehensive care plan as part of your patients' multidisciplinary care team. We believe communication and coordination are integral to ensure the best care for our members. Please contact Case Management for case management referrals and assistance with member needs.

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 non-preventive 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 visits and care.

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 should reach out to the Member/Provider Services Contact Center to refer members in need of case management assistance.

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 calendar days of continuity of care for authorized services and choice of providers.

- 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 calendar 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 calendar 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 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.

Providers' 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

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 5 business days (7 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 7 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 3 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 5 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 reach out to the member within 24 hours to help 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 5 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[46] without consent of the member as it pertains to the member's treatment. **NOTE: Consent is required when exchanging records that pertain to a 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 be released only 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

46 Ind. Code § 16-39-2-6(a)

All 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 5 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 calendar 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 can view the member holistically while also identifying members with emerging needs that may be at risk for negative health outcomes.

Care coordinator roles and responsibilities

The role of care coordinator includes utilizing a person-centered care approach to develop a member's personal goals and preferences during the care planning process. Care coordinators perform assessment visits with members, which are centered around conducting a comprehensive assessment of the member's needs and current supports to develop a person-centered care plan. Members are encouraged to include anyone they would like present in the care planning process, during which the care coordinator discusses the member's needs, preferences and goals.

The role of care coordinator also includes assisting the member with defining personal goals and aspirations, such as going back to school, going on a trip with friends, going to a dinner outing with family or obtaining desired living arrangements. In coordination with the care coordinator, the member and their authorized representative are required to develop, at a minimum, 2 goals that are specific to the member's situation and needs as identified in their comprehensive assessment. Additionally, they work collaboratively to identify a personal goal that focuses on the member's wellbeing and things that help them feel motivated or happy. The care coordinator, member and their authorized representative may also develop a care goal that focuses on their medical or physical health. The care goal will reflect a current issue and barrier found during the comprehensive assessment. Care goals are required for members who wish to transition to a different living environment. The member goals are documented in the plan of care. Goals are prioritized by numeric ranking. Priorities reflect the member and caregiver's input, preferences and why it is important to the

member. The care coordinator will assess and document the member's current ability to contribute toward goals, how the member prefers to participate in the activity, potential challenges with the member's achievement of goals and resources available to assist the member with meeting their goal in the plan of care. The care coordinator will also document the member's progress toward meeting their established goals upon each contact with the member.

Humana Healthy Horizons care coordinators are available to work with members to coordinate referrals to community-based organizations and other services provided through interagency agreements.

Disease management programs

Humana Healthy Horizons members with emerging conditions and those with chronic conditions are eligible for enrollment in our disease management programs. Members who choose to participate in these programs receive educational information on how to better manage their condition and care options for them to discuss with you. Members identified as high risk are assigned to a medical or behavioral health clinician who helps educate, coordinate and provide resources to the member to optimize their overall health.

Chronic and emerging conditions include:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Heart disease
- Diabetes
- Obesity
- Cancer
- Behavioral health and substance use disorder (SUD)
- Members with special healthcare needs
- And others as determined by Humana Healthy Horizons

If you have Humana Healthy Horizons-covered patients with any of these chronic conditions, and you believe they would benefit from this program, please contact Case Management.

Telephonic disease management

Low-risk members typically require support with care coordination and in addressing SDOH. These members have, at a minimum, quarterly telephonic outreach plan of care updates. Prevention and wellness messaging and condition-specific materials are also provided.

Moderate-risk members typically demonstrate rising risk and need focused attention to support their clinical care needs and to address SDOH. Focus is on interventions targeted at the member's specific problems and aims to improve overall health and prevent further illness/disease progression or

increase in risk. These members have, at a minimum, monthly telephonic outreach and plan of care updates.

High-risk members in intensive case management are those members who require the intensive, highly focused attention to support their clinical needs.

Member reassessments

The care coordinator evaluates 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 that 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 completes a timely full or partial reassessment and ICP after a trigger event or change in condition.

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 D-SNP information 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 4 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.

If 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 target 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, preventive 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 members' 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 5 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 1 or more areas of health or functional status
- A change in diagnosis that is not temporary or episodic and that impacts 1 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 6 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 case 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 case 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 2 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.

Individualized care plans

The care coordinator reviews 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) for the member. 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. The Humana Healthy Horizons care coordinator will contact providers to request member information or ask for your participation in ICT conversations. Your role is to cooperate and engage with our case management team.

Case management referrals

Humana Healthy Horizons members have access to care coordinators who provide a holistic approach to addressing the member's physical and behavioral healthcare needs as well as SDOH. We also offer chronic condition management programs for behavioral health and SUDs. Humana Healthy Horizons-contracted providers may contact us to refer members needing case management assistance by calling Case Management. Humana Healthy Horizons adheres to a "no wrong door approach" to case management referrals.

We encourage you to refer members who might need individual attention to help them manage special healthcare challenges to our case management programs. For direct access, please contact Case Management or Population Health.

Behavioral health service providers are required to 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 provide physical healthcare services only if they are licensed to do so.

Humana Healthy Horizons assists with your 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. Behavioral health providers are required to send initial and quarterly summary reports to the members' PMP and to refer members for PMP follow-up on untreated physical health concerns when identified.

Electronic visit verification and service gap reporting procedures for LTSS

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.[47]

Personal care services include:

- Respite care (skilled or unskilled)
- Attendant care
- Home and community assistance 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

47 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033 (2016).

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 Member/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.

Please refer to the claims and billing section of this provider manual for more information.

Chapter 10: Quality management and improvement

Contact information pertaining to quality management and improvement

Contact name	Contact information	Hours of operation
Member/Provider Services Contact Center	Phone: **866-274-5888 (TTY: 711)**	8 a.m. to 8 p.m., Eastern time, Monday through Friday
Quality Improvement	Address: Humana Healthy Horizons Quality Improvement 101 E. Main Street Louisville, KY 40202	

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 are 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 include:

- 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 outcome
- 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 Management and 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 QMIP 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

Humana Healthy Horizons monitors, measures and evaluates provider quality using identified standards, appropriateness of care and service delivery (or the failure to provide care or deliver services) to members, including members enrolled in specialty plans, through the following means:

Measure	Description
Medical record audits	Medical record audits are reviews of medical records to evaluate patterns of complaints regarding poor quality of service, poor quality outcomes and adherence to member record documentation standards.
Peer reviews	Peer reviews are reviews of the provider's practice methods, patterns and appropriateness of care.
Performance improvement projects	Performance improvement projects include ongoing measurements and interventions, significant improvement to the quality of care and service delivery, sustained over time, in both clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction.

Measure	Description
Performance measures	Performance measures include data collected on member outcomes as defined by the Healthcare Effectiveness Data and Information Set (HEDIS®) or otherwise defined by the state.
Surveys	Survey measures include the Consumer Assessment of Healthcare Providers and Systems (CAHPS®).

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 supplemental data submitted. There are 2 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 a single 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 your electronic medical record (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.

Quality Assurance and Performance Improvement (QAPI) program

Humana Healthy Horizons has a QAPI program that includes the following:

- Performance Improvement Programs
- Over- and underutilization measures
- Annual analysis of plan demographics, including clinical, geographical and cultural data points, to identify high-risk populations, areas of network need, member education opportunities and performance improvement opportunities

- Assessment of access and availability of network providers, including after-hours availability of PMPs
- Assessment of quality and appropriateness of care furnished to children with special healthcare needs
- Continuity and coordination of care
- HEDIS measurement
- CAHPS review
- Annual measurement of effectiveness review of the QAPI

We welcome healthcare providers' input regarding our QAPI program. Feedback can be provided in writing to Quality Improvement.

CAHPS

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey includes measures that reflect member satisfaction with your care and service. Each year surveys are sent to our members that ask multiple questions about how you and Humana Healthy Horizons are performing. Humana Healthy Horizons monitors and evaluates your quality, appropriateness of care and service delivery to members using this measure along with other measures of your satisfaction, behavioral health surveys and special surveys implemented to support quality/performance improvement initiatives.

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.

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[48] and rules and regulations promulgated thereunder[49] permit a covered entity (provider) to use and disclose PHI to health plans without member authorization for treatment, payment and

48 45 C.F.R. § 164.506.
49 45 C.F.R. Parts 160, 162, and 164.

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, case management and care coordination. Providers also must allow Humana Healthy Horizons to use their 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, the state and/or its designee within the time frame identified in the request and contain all information necessary for the utilization management of each Humana Healthy Horizons 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 Humana Healthy Horizons 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

A member's medical record must include the following information, at minimum[50]:

- 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

50 405 IAC 1-1.4-2.

- The date on which the service was rendered
- The diagnosis of the medical condition of the individual to whom service was rendered
- 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 7 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.[51] 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.

Medical record confidentiality requirements

For each medical record, you shall have a policy to ensure the confidentiality of medical records, including confidentiality of a minor's consultation, examination and treatment for a sexually transmissible disease.

The member or authorized representative must sign and date a release form before any clinical/medical case records can be released to another party. Clinical/medical case record release shall occur in a manner consistent with state and federal law.

You must ensure compliance with privacy and security provisions.[52] Humana Healthy Horizons and providers must agree to maintain the confidentiality of information contained in your records regarding healthcare services rendered to members as required by state or federal law, rule or regulation, including without limitation to HIPAA privacy and security requirements.[53]

Medical record storage requirements

Confidentiality of member information must always be maintained. Records are to be stored securely with access granted to authorized personnel only. Access to records should be granted to Humana

51 Ibid.
52 HIPAA; 42 C.F.R. Part 431, Subpart F.
53 42 C.F.R. Part 431, Subpart F; 42 C.F.R. § 438.224; 45 C.F.R. Parts 160 and 164.

Healthy Horizons, or its representatives, without a fee to the extent permitted by state and federal law. Providers must have procedures in place to permit the timely access and submission of health records to Humana Healthy Horizons upon request. Information from the health records review may be used in the recredentialing process as well as quality activities.

Member rights related to medical records

Humana Healthy Horizons members have the right to confidentiality and to be sure that others cannot hear or see them when receiving medical care. They have the right to get help with their medical records in accordance with applicable state and federal laws, and to be sure that their medical records are kept private. They have the right to ask for and receive a copy of their medical records and to be able to ask if their health records be changed or corrected if needed. Records should be retained for 5 years or longer as required by federal law.

Members also have the right to say yes or no to having their information given out unless Humana Healthy Horizons must provide it by law.

Medical record reviews

Authorized state and federal agencies and their authorized representatives may audit or examine your records.

This examination includes all records these agencies find necessary to determine whether state Medicaid payment amounts were or are due. This requirement applies to your records and records for which you are the custodian. You must give authorized state and federal agencies and their authorized representatives access to all state Medicaid recipient records and any other information that cannot be separated from state Medicaid- related records.

You must send, at your expense, legible copies of all state Medicaid-related information to authorized state and federal agencies or their authorized representatives upon request.

All records must be provided regardless of the media format on which the original records are retained by you at the time of the request. All medical records may be reproduced electronically or onto paper copies as authorized by the requestor.

You must maintain complete and accurate fiscal, medical, social and other administrative records for medical services rendered to Medicaid managed care plan members and are necessary to document the quality, appropriateness and timeliness of services performed under this contract and in compliance with applicable state and federal laws, rules and regulations, and the state contract. Such records must specifically include pertinent books, financial records, medical/case records and records of financial transactions.

You must agree to maintain and retain these records for a period of 10 years following the termination of Humana Healthy Horizons' contract with the state.

In addition to record retention requirements for your licensure, subcontractors are required to retain, as applicable, the following information[54]:

54 42 C.F.R. § 438.3(u).

- Member grievance and appeal records[55]
- Base data[56]
- MLR reports[57]
- Data, information and documentation[58]

The information listed above must be retained for a period not less than 10 years from the close of the contract and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by Humana Healthy Horizons if the subcontract is continuous.[59]

Humana Healthy Horizons requires that each member or their representative is entitled to 1 free copy of their medical record. Additional copies are made available to members at cost.

Medical records should be preserved and maintained by you for a minimum of 7 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).

Complete medical records include:

- Medical charts
- Prescription files
- Hospital records
- Provider specialist reports
- Consultant and other healthcare providers' findings
- Appointment records
- Other documentation sufficient to disclose the quantity, quality, appropriateness and timeliness of services

Humana Healthy Horizons periodically requests member medical records as part of our provider monitoring as described in the member medical record review section of this provider manual. Humana Healthy Horizons realizes that supplying medical records for review requires your staff's valuable time; your cooperation with our requests and associated timelines is appreciated.

Humana Healthy Horizons offers the following suggestions to ensure complete and accurate documentation of member services:

- Use legible handwriting for paper medical records.
- Consider dictated notes, which can improve comprehension of medical records while reducing the chance of misinterpretation.
- Include the patient's name on the front and back of every page of the medical record.

55 42 C.F.R. § 438.416.
56 42 C.F.R. § 438.5(c)
57 42 C.F.R. § 438.8(k).
58 42 C.F.R. § 438.604; 42 C.F.R. § 438.606; 42 C.F.R. § 438.608; 42 C.F.R. § 438.610.
59 42 C.F.R. § 438.3(h)

- Initial and date lab results in the medical record to indicate review by a provider.
- Record all patient visit dates and sign all chart entries.
- Consider using preprinted forms to document all aspects of comprehensive services, such as EPSDT exams.

Primary medical provider value-based payment programs

Humana Healthy Horizons is committed to reducing costs and improving quality of care in the communities we serve. We have developed value-based payment (VBP) programs that allow PMPs to earn financial incentives based on quality and clinical outcomes. The programs are designed based on your 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 2-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, 1 quarter in arrears to allow for reporting/data collection. Shared savings or two-sided arrangements are reconciled on a contract-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 QIC under the direction of the medical director and participation of contracted network providers. The guidelines can

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. You remain 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 your 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 Education/Outreach Representative. Clinical practice guidelines also are available to providers, members and the public on **Humana's clinical practice guidelines website**.

Provider and member satisfaction surveys

Humana Healthy Horizons conducts an annual provider satisfaction survey that includes questions to evaluate your satisfaction with our services, such as claims, communications, UM and provider services. We encourage you to participate in and respond to the survey as the results are analyzed and used to develop provider-related quality improvement initiatives.

Compliance with availability and access standards are monitored regularly through random sampling, review of member concerns, and member satisfaction surveys to ensure members have reasonable access to providers and services.

Peer review

Peer reviews are reviews of your practice methods, patterns and appropriateness of care. Providers are responsible for complying with the peer review process.

Chapter 11: Utilization management

Contact information pertaining to utilization management

Contact name	Contact information	Hours of operation
Availity	Phone: **800-282-4548** Website: **https://availity.com**	8 a.m. to 8 p.m., Eastern time, Monday through Friday
Clinical Intake Team	Phone: **800-523-0023**	24 hours a day, 7 days a week
Grievances and appeals	Phone: **866-274-5888** Fax: **800-949-2961** Address: Humana Grievance and Appeals Department P.O. Box 14163 Lexington, KY 40512-4163	8 a.m. to 8 p.m., Eastern time, Monday through Friday
Member/Provider Services Contact Center	Phone: 866-274-5888 (TTY: 711)	8 a.m. to 8 p.m., Eastern time, Monday through Friday
Office of Administrative Law Proceedings – FSSA Hearings	Address: Office of Administrative Law Proceedings – FSSA Hearings 100 N. Senate Avenue, Room N802 Indianapolis, IN 46204 Phone: 317-234-6689 or 317-232-8142 Fax: 317-232-4412 Email: **fssa.appeals@oalp.in.gov**	8:30 a.m. to 4:30 p.m., Eastern time, Monday through Friday

Contact name	Contact information	Hours of operation
Prior authorization requests	Phone (expedited requests): **866-274-5888 (TTY: 711)** For both physical and behavioral health authorizations, fax the IHCP Prior Authorization Request form to: Fax (Medicaid only): **502-324-6376** Fax (dual eligible): **502-405-5020**	8 a.m. to 8 p.m., Eastern time, Monday through Friday
Utilization management	Email (physical health): **INMCDUM@humana.com** Email (behavioral health): **INMCDBHUM@humana.com** Email (clinical criteria): **NABD_MCD_Letter_Review@humana.com**	

Utilization management program overview

Our utilization management program is designed to ensure that members receive access to the right care, in the right place, at the right time. Our goal is to optimize the members' 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. 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 members' ongoing need for such services and support. Authorization is not 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 ensure 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.

Utilization management helps maintain the quality and appropriateness of healthcare services provided to Humana Healthy Horizons members. Utilization review determinations are based only on appropriateness of care and service and existence of coverage.

Humana Healthy Horizons establishes measures designed to maintain quality of services and control costs that are consistent with our responsibility to our members; places appropriate limits on a service on the basis of criteria applied under the Medicaid state plan and applicable regulations, such as medical necessity; and places appropriate limits on a service for utilization control, provided the service furnished can reasonably be expected to achieve its purpose. Services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and support. The UM department performs all UM activities, including PA, concurrent review and discharge planning. Humana Healthy Horizons monitors inpatient and outpatient admissions and procedures to ensure appropriate medical care is rendered in the most appropriate setting, using the most appropriate resources. Humana Healthy Horizons also monitors the coordination of medical care to ensure its continuity. Referrals to the Humana Healthy Horizons case management team are made, if needed.

Humana Healthy Horizons completes an annual assessment of satisfaction with the UM process, identifying areas for improvement.

Access to UM staff

Providers may send an email to the UM staff with any UM questions.

- Medical and behavioral health inquiries can be directed to the Clinical Intake Team. Please keep the following in mind when contacting UM staff:
- Staff can receive in-bound communications regarding UM issues after normal business hours.
- Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- Staff are available to respond to email inquiries regarding UM issues.
- Staff are accessible to answer questions about the UM process.
- In the best interest of Humana Healthy Horizons members and to promote positive healthcare outcomes, Humana Healthy Horizons supports and encourages continuity of care and coordination of care between medical providers as well as between behavioral health providers.

Member health is always Humana Healthy Horizons' top priority. Provider reviewers from Humana Healthy Horizons are available to discuss individual cases with attending providers on request. Clinical criteria and clinical rationale or criteria used in making UM determinations are available at Medical and Pharmacy Coverage Policies (Humana.com), in the 'Humana Physician News' newsletter and upon request by email to one of the following UM departments:

- Medical and behavioral health inquiries can be directed to the Clinical Intake Team.

Upon request and at no cost to you, Humana Healthy Horizons supplies all documents, records and other information relevant to an adverse payment or coverage determination. If you want to request a peer-to-peer discussion on an adverse determination with a Humana Healthy Horizons provider reviewer, please contact Humana within 15 days of the determination.

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
- Ordering/providing/referring 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 quicker determination. If additional clinical information is required, a Humana Healthy Horizons representative will request the specific information needed to complete the authorization process.

CMS mandate requires the NPI is included for authorizations. As a result, your NPI will be required on authorizations submitted to Humana Healthy Horizons as of Dec. 9, 2023. This requirement applies to authorization submissions and inquiries (Inquiry 278 per the state) for all providers (requesting/referring provider, rendering/treating provider and rendering/treating facility) and lines of business, except atypical providers. Submissions that do not have an NPI will be returned for resubmission.

A list of Humana Healthy Horizons contracted **vendors who handle certain authorization types is available online**. As submission of such authorizations may vary from our regular processes, Humana Healthy Horizons asks that you check this page prior to submitting an authorization. For pharmacy, please refer to the Pharmacy section of this manual.

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. Providers may

contact the Member/Provider Services Contact Center to request a hard copy of the prior authorization list. **NOTE: The prior authorization list (PAL) is subject to change.**

Changes to the prior authorization requirements will be posted a minimum of 45 calendar days prior to the effective date of the change on Humana's **provider prior authorization notification lists website**.

Medical services and behavioral health/SUD services are evaluated for addition or removal from the PAL, utilizing the same factors in accordance with the Mental Health Parity and Addiction Equity Act (MHPAEA). Requests for preauthorization should be made as soon as possible but at least 14 calendar days in advance of the service date. If preauthorization is required and not obtained, it may result in a 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.

Requesting prior authorization

Healthcare providers should review the **PathWays Preauthorization and Notification List (PAL) online**. To initiate a prior authorization, notification or referral request, a provider may:

- Visit **Availity Essentials** (registration required). For many services that require prior authorization, you can answer a series of questions when requesting 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.
- Submit a B2B or batch Health Care Services Review and Response transaction (278) via electronic data interchange (EDI).
- Use our interactive voice response (IVR) system.
- Call the number for precertification on the back of the member's Humana Healthy Horizons ID card.
- Fax the **IHCP Prior Authorization Request Form** to prior authorization requests for both physical health and behavioral health authorizations.

If a request needs to be expedited due to the severity of a member's condition, contact the Member/Provider Services Contact Center. A copy of the **IHCP Prior Authorization Request Form** is available online.

Time frames and notifications for responding to prior authorization requests

Standard PAs

Humana Healthy Horizons will provide notice of decision as expeditiously as the member's health condition requires but no later than 5 business days, whichever comes first following receipt of the request for service. The member or the member's provider may request an extension up to 14

calendar days. 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 PA request not pertaining to medications within 5 business days of receiving the necessary documentation, the authorization is considered granted.

Expedited PAs

When you indicate 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 their 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 review

A retrospective review is a request for a review for authorization of care, a service or a benefit for which an authorization is required but not obtained before the delivery of care, service or benefit. Humana Healthy Horizons requires PA to ensure covered patients receive medically necessary and appropriate services. Claims not meeting the necessary criteria described below will be administratively denied.

Humana may allow prior authorization requests after services have already been provided, or supplies delivered—but only in specific situations:

- **Member eligibility was pending or retroactive:** If the member wasn't yet eligible at the time of service but later received Medicaid coverage, you can submit the prior authorization request within 12 months of the date on their Medicaid card.
- **Office errors or delays:** Retrospective determinations may be available if there were mechanical or administrative issues on your end that caused a delay in submitting the request.
- **Out-of-state services:** Retrospective determinations may be available if you provided services outside Indiana and haven't yet received the Humana Healthy Horizons in Indiana provider manual.
- **Transportation services:** Retrospective determinations may be available if the request is for transportation services covered under 405 IAC 5-30, and it's submitted within 12 months of the service date.

- **Unaware of member's eligibility at time of service:** If you didn't know the member was eligible when services were provided, prior authorization may still be approved if:
  - Your records show the member refused or couldn't provide their Medicaid ID.
  - You can show that you tried to get payment from the patient until Medicaid eligibility was confirmed.
  - You submit the prior authorization request within 60 days of discovering the member's Medicaid eligibility.

Notice of decision is provided no later than 30 calendar days.

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 5 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 to authorizations submitted untimely by the provider.

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 5 business days before the date the indicated service would be terminated, suspended or reduced.

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 3 calendar 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 1 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 5 calendar days of the hospital inpatient admission or emergency treatment.

Hospice requirements

Humana Healthy Horizons requires notification within 10 calendar 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**.

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**, by faxing the form to the Clinical Intake Team or by calling Humana Healthy Horizons' Member/Provider Services Contact Center.

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. National clinical guidelines (InterQual or MCGs), MCE-developed PA-UM policy and criteria, IHCP policy

   a. Humana may choose to use either InterQual or MCG and may also customize those criteria.

   b. Humana may use IHCP policy and criteria.

   c. Humana may still choose to use Medicare NCDs and LCDs, when clinically appropriate

   d. Professional society guidelines – Guided by published peer-reviewed literature (can supersede national and MCE-developed PA-UM policy and criteria if specifically called out to be used in the Scope of Work, such as the American Society of Addiction Medicine [ASAM]). Professional references/Subject matter expert (SME) – Guided by published peer-reviewed literature. 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 UM determination is available upon request by contacting Utilization Management.

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 1 attempt is 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.

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/Provider Services Contact Center
- Writing a letter including the following information:
  - Member name
  - Member identification number from the front of the member's Humana Healthy Horizons Medicaid ID card
  - Member address and phone number
  - All information that will help explain the appeal Mail the form or letter to Grievance and Appeal Department.

Humana Healthy Horizons acknowledges receipt of the appeal within 3 business days of the day we received the appeal. If we extend the time frame for the appeal, we make reasonable efforts to provide prompt oral notice of the delay. We also send a 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 appeal 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 decides 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 5 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

Services that do not require prior authorization

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

Medical necessity criteria and reviews

All decisions are based on eligibility, coverage and medical necessity criteria. If a 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.

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member's needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational

- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not make such care, goods, or services medically necessary or a medical necessity or a covered service. Medically necessary or medical necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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 will be determined when the claim is received for processing.

Peer-to-peer (P2P) discussions

Providers may request a peer-to-peer (P2P) consultation when Humana Healthy Horizons denies a PA 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 peer- to-peer 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 peer-to-peer discussion on a determination with a Humana Healthy Horizons provider reviewer, please contact peer-to-peer (P2P) discussions. The P2P request must be made within 15 business days of the determination.

Upon request and at no cost to you, Humana Healthy Horizons supplies all documents, records and other information relevant to an adverse payment or coverage determination. If you want to request a peer-to-peer discussion on an adverse determination with a Humana Healthy Horizons provider reviewer, contact Humana within 15 days of the determination.

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 the Grievances and Appeals.

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 the Member/Provider Services Contact Center.

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 calendar days of the administrative law judge's decision.

To request a State Fair Hearing, the member or the member's representative should send the request to the Office of Administrative Law Proceedings – FSSA Hearings.

Referrals

Humana Healthy Horizons members may see any participating provider within our network, including specialists and inpatient hospitals.

Members may self-refer to any participating provider. PMPs do not need to arrange or approve these services for members if applicable benefit limits have not been exhausted. Exceptions to this policy apply to members who have been designated to participate in the pharmacy lock-in program.

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 services. 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.

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 chiropractic practice[60]

60 Ind. Code § 25-10-1-1; 846 IAC 1-1.

- Eye care services, except surgical services, by any IHCP-licensed provider (doctor of medicine, doctor of osteopathy, optometrist)[61]
- Routine dental services by any in-network, IHCP-licensed dental provider (dental hygienist, dentist)[62]
- Podiatric services by any IHCP-licensed provider (doctor of medicine, doctor of osteopathy, doctor of podiatric medicine)[63]
- Psychiatric services by any licensed provider[64]

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 the 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
- Advance practice nurses (APN)[65] 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 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 members' designated PMP if that provider is not a women's health specialist.)
- Immunizations, which are covered regardless of where they are received

61 Ind. Code § 25-22.5 (doctor of medicine, doctor of osteopathy); Ind. Code § 25-24 (optometrist).
62 Ind. Code § 25-13 (dental hygienist); Ind. Code § 25-14 (dentist).
63 Ind. Code § 25-22.5 (doctor of medicine, doctor of osteopathy); Ind. Code § 25-29 (doctor of podiatric medicine).
64 Ind. Code § 25-22.5 (doctor of medicine, doctor of osteopathy).
65 Ind. Code § 25-23-1-1(b)(3).

- 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, 7 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. Services may be rendered by any qualified provider, but for non-IHCP-providers, retroactive enrollment is required to facilitate payment).

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 need a course of treatment or regular care monitoring, to access a specialist to receive this treatment over a prolonged period.

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 2 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

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.

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.

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 the SUD section of this provider manual for determination time frames.

Institutions for mental disease (IMDs)

SMI

Humana Healthy Horizons 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 Indiana Medicaid State Plan in other settings. Humana Healthy Horizons may use IMD services in lieu of other behavioral health services when medically appropriate. Humana Healthy Horizons allows Indiana PathWays for Aging members between the ages of 60 and 64 an average length of stay not to exceed 30 calendar days for all IMD stays for SMI. If medically necessary, a maximum of 60 calendar days may be approved for short-term IMD stays for SMI.

SUD

Humana Healthy Horizons 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 Indiana Medicaid State Plan in other settings. Humana Healthy Horizons 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 calendar 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 calendar 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 calendar 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 Healthy Horizons 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 calendar days.

Humana Healthy Horizons 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 calendar days. A maximum stay of 60 calendar days can be approved, if medically necessary, for short-term IMD stays for SMI members.

Humana Healthy Horizons 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.

Hospital admissions

For hospital admission, you must use Availity Essentials or call the number listed on the back of the member's ID card. The following information is required for each hospital admission:

- Member's name
- Member's ID number, name and date of birth
- Date of actual or proposed admission
- Date of proposed procedure
- Bed type: inpatient or outpatient
- NPI of treatment facility or hospital
- Applicable ICD diagnosis code
- Caller's telephone number
- Attending physician's telephone number

For urgent PAs or notifications, you should call our Clinical Intake Team, which is available 24 hours a day, 7 days a week (excluding major holidays). Press "0" or say "representative" for live help and have your NPI available.

PA in transitions 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 UM clinician will initiate a referral to the assigned care coordinator. In addition, the clinician may initiate an interdisciplinary care team meeting if needed.

Humana Healthy Horizons will cover Medicaid Managed Assistance services until the member's PMP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the member's treatment plan no more than 90 calendar days after the effective date of enrollment, or the remainder of the prior authorized dates or service, or until the approved units of service are exhausted.

Providers should continue servicing Humana Healthy Horizons members during the 90 calendar day continuity of care period for any services that were previously authorized or scheduled, regardless of whether the provider is participating in Humana Healthy Horizons' network. Providers should keep previously scheduled appointments with new members during the transition.

The following services may extend beyond the continuity of care period with the member's current provider:

- Radiation and/or chemotherapy services (for the current round of treatment)
- Transplant services (through the first-year post-transplant)

If the services were arranged prior to enrollment with the plan, written documentation includes the following:

- Behavioral health services
- Prescriptions (including prescriptions at nonparticipating pharmacies)
- Prior existing orders
- Provider appointments (e.g., dental appointments, surgeries, etc.)

Although no additional authorization is needed for any ongoing treatment, written documentation for the provision of continued services may be needed for proper payment of the services provided.

Through the following process, we will ensure that transitioning members will still receive care even if Humana Healthy Horizons is not contracted with the member's current provider:

- Assign the member a new care coordinator
- Continue care plan as-is for up to 120 calendar days
- Contract with nonparticipating providers if possible
- Coordinate and build relationships with providers
- Determine unmet needs and put necessary services in place
- Emphasize the member's comfort and safety while addressing unmet needs
- Ensure there are no disruptions in care
- Identify members who desire to transition to another setting (provide continuity of care)
- Reassess and update the personalized plan of care

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 the 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 7 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 90 calendar days for the member's transfer out of the facility. Fewer than 90 calendar 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 90 calendar days of the date of the member's discharge.

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 members' PMP or the specialist practice group from which the first 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 services

An out-of-network provider is not directly contracted with the Humana Healthy Horizons plan. Humana Healthy Horizons is not responsible for payment of services provided by an out-of-network provider without written PA. 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.

Noncontracted services

Noncontracted services are services not defined on Schedule B of your contract. Humana Healthy Horizons is not responsible for payment of noncontracted services. If you or your staff identifies a service that a member may require that is not listed in your contract, please contact the member's Humana Healthy Horizons care coordinator to evaluate the member's needs and determine if the service can be authorized by Humana Healthy Horizons. If the care coordinator determines the service should be authorized by Humana Healthy Horizons, the care coordinator will contact your local Provider Education/Outreach Representative to discuss adding an addendum to your contract.

Utilization management delegation

Humana Healthy Horizons does not delegate physical health or behavioral health prior authorization functions to subcontractors, except for 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

More information about the RCP is **available on the Indiana Medicaid for Providers Right Choices Program website**.

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

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

- Call 866-274-5888 (Call Center), from 8 a.m. to 8 p.m., Eastern time, Monday through Friday. Alternatively, reach out to the Right Choices Program at 833-410-2496, from 8 a.m. to 5:30 p.m., Eastern time, Monday through Friday. After hours, please leave a voicemail with the member's name, Medicaid ID number, contact phone number and a detailed description of your request.
- Send a fax to 502-996-8184.
- Email **CPORM@humana.com**.

Chapter 12: Claims and billing

Contact information pertaining to claims and billing

Contact name	Contact information	Hours of operation
Availity Essentials	Phone: **800-282-4548** Website: **https://availity.com**	8 a.m. to 8 p.m., Eastern time, Monday through Friday
EVV data collection system	Phone: **800-457-4584, option 5** Email: **inxixevv@gainwelltechnologies.com** Website: **https://www.in.gov/medicaid/providers/files/Electronic_Visit_Verification_FAQs.pdf**	
Humana Claims	Address: Humana Claims P.O. Box 14169 Lexington, KY 40512-4169	
Member/Provider Services Contact Center	Phone: **866-274-5888 (TTY: 711)**	8 a.m. to 8 p.m., Eastern time, Monday through Friday
U.S. Government Printing Office	Phone: **202-512-1800** Fax: 2**02-512-2250**	8 a.m. to 5:30 p.m., Eastern time, Monday through Friday

Introduction

Humana Healthy Horizons maintains and complies with HIPAA standards for the submission and adjudication of claims. This section will provide information regarding the submission and payment process. If you have questions or would like training regarding submitting claims, please contact the Member/Provider Services contact center.

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. **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 both in-network and out-of-network providers. Corrected claims that were originally denied are considered initial claims, and they also must be submitted within 90 calendar days of the date of service or from discharge for both in-network and out-of-network providers. Corrected claims that were originally paid or partially paid must be submitted within 60 calendar days of the date of service or 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 may be mailed to Humana Claims. Providers must bill paper claims using the required claim type format (CMS-1500, UB-04 or Dental ADA) for the services rendered.

Required information

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.
- PA number, when applicable: A number is needed to match the claim to the corresponding PA information. This is only needed if the service provided required a PA.
- NPI: Please refer to the Location of Provider NPI, TIN and Member ID number section of this provider manual.
- 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
- Your signature or supplier: Your 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.
- Institutional claims for inpatient, outpatient, ambulatory surgical center (ASC) and long-term care (LTC) services must be billed with an attending NPI.

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

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 considered healthcare providers and include waiver providers, transportation providers (other than ambulances and air ambulances) and medical review team copy centers. Atypical providers are not required to have NPIs. Providers without an NPI should register with *Availity Essentials* as an atypical provider if they wish to submit electronic claims.

Waiver providers can avoid claim denials by ensuring they bill using their active IHCP-assigned Provider ID (Legacy Provider Identifier [LPI]) rather than an NPI when submitting claims as waiver or home- and community-based service providers. The IHCP does not permit waiver providers (type 32) to add an NPI to their profile, and claims submitted with an NPI will be denied.

To prevent claim denials:

- Always use the active IHCP-assigned Provider ID for billing.
- Do not use an NPI when billing as a waiver provider.
- Review IHCP billing guidelines regularly to stay updated on requirements.

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 attending provider NPI is required when submitting claims for inpatient, outpatient, ambulatory surgical center (ASC) and long-term care (LTC) services. The attending provider should always be an individual person, not the NPI of the group to which the rendering provider may be linked. A taxonomy for the attending provider is optional. The attending provider NPI should be in the following location:

- 2310A loop – attending provider name
- Identification code qualifier – NM108 = XX

- Identification code – NM109 = attending provider NPI The Humana Healthy Horizons member ID number should go on:
  - 2010BA loop = subscriber name
  - NM109 = member ID number

Claim submission

Electronic

To submit a claim via **Availity Essentials**, log in and choose Claims and Payments followed by Claims and Encounters.

For information regarding electronic claim payment, contact your local Provider Education/Outreach Representative or visit **the Indiana PathWays for Aging provider website** or **Availity Essentials**.

Paper

Please direct paper claims to Humana Claims. Providers must bill paper claims using the required claim type format (CMS-1500, UB-04 or Dental ADA) for the services rendered.

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 PA requests
- 834 Enrollment

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. Please reference IHCP's **Service Codes That Require EVV document**.

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.

Provider portal

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

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

To learn more, call Availity Essentials or visit **Availity Essentials** online.

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** provider portal. To access this tool:

1. Sign in to **Availity Essentials** (registration required).
2. From the Payer Spaces menu, select Humana.
3. From the Applications tab, select the ERA/EFT Enrollment app. (If you don't see the app, contact your Availity Essentials administrator to discuss your need for this tool.)

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

To learn more, call Availity Essentials or visit **Availity Essentials** online.

Submitting electronic transactions

To learn more about submitting electronic transactions online, contact **Availity Essentials** or visit Availity Essentials online and choose Claims and Payments.

To submit a claim via **Availity Essentials**, sign in to the provider portal and choose Claims and Payments, then select Claims & Encounters.

For more information regarding electronic claim payment, contact your Provider Outreach/Education Representative or visit Humana Healthy Horizons' **Indiana provider claims and payments website**.

EDI clearinghouses

EDI is a 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. Below are some commonly used clearinghouses. Please contact the clearinghouse of your choice to begin electronic claim submission; please note that some clearinghouses may charge a fee.

When filing an electronic claim, you will need to utilize payer ID 61101. Commonly used claim clearinghouses include:

- Availity, **www.availity.com**
- Trizetto, **www.trizettoprovider.com**
- McKesson, **https://mckesson.com**
- Optum, **https://www.optumrx.com/en/**
- The SSI Group, **http://thessigroup.com**

Procedure and diagnosis codes

Federal law establishes various standards for all covered transactions under HIPAA, including electronic medical claims. Those standards currently include these code sets:

- HCPCS, which includes:
  - CPT codes, available **from the American Medical Association (AMA)**
  - HCPCS Level II codes, available **from CMS**
- National Drug Codes (NDCs), available **from the U.S. Food and Drug Administration (FDA)**
- ICD-10-CM, available from the Centers for Disease Control and Prevention
- ICD-10, Procedure Coding System (ICD-10-PCS), available **from CMS**

Code sets also are typically available, in various media, from vendors licensed to publish them.
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 reduce 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.

Common errors and reasons for denial or rejection

Common reasons for rejected or denied claims include the following:

- Member not found
- Insured subscriber not found
- Member birthdate on the claim does not match that found in Humana Healthy Horizons' database
- Missing or incorrect information
- Providers submitting with incorrect NPI/ZIP code/taxonomy/address/NPI type
- Missing provider NPI/ZIP code/taxonomy
- Providers submitting encounters with zero-dollar values
- Rendering provider data missing for provider organizations
- Invalid HCPCS code submitted
- No authorization or referral found
- Billing/rendering/attending NPIs not enrolled/registered for Medicaid with the state

You can avoid these common errors by doing the following:

- Confirming that member information received and submitted is accurate and correct.
- Ensuring that all required claim form fields are complete and accurate.
- Obtaining proper authorizations and/or referrals for services rendered.
- Ensuring you have a valid Medicaid ID for the billing/rendering/attending NPIs and taxonomies submitted on claims exactly matching the applicable active PML record.
- Ensuring billed amounts are not zero dollar. Must submit billed charges.

Code editing and payment policies

Humana Healthy Horizons processes accurate and complete provider claims in accordance with Humana Healthy Horizons' normal claims processing procedures, including, but not limited to, **claim processing edits**, **claim payment policies**, and applicable state and/or federal laws, rules, and regulations. See the coverage and claims section of Provider.Humana.com to access a summary of changes to claims processing procedures; this summary of changes to claims processing procedures is not intended to be an exhaustive list.

Such claims processing procedures include review of the interaction of various factors. The result of Humana Healthy Horizons' claims processing procedures is dependent upon the factors reported on each claim.

Accordingly, it is not feasible to provide an exhaustive description of the claims processing procedures, but examples of the most commonly 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 any other provider who is billing independently is involved
- When a claim includes more than one claim line, whether any 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 claims 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:

- State 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 claims processing procedures.

These claims 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. Providers can access additional information on **the Humana Healthy Horizons in Indiana provider website**.

An adjustment in reimbursement as a result of claims processing procedures is not an indication that the service provided is a noncovered service. Providers can submit a dispute request for any adjustments produced by these claims processing procedures by submitting a timely request to Humana Healthy Horizons. For additional information, please refer to the provider disputes section of this manual.

Providers are required to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. Claims indicating provider-preventable conditions are not to be paid.

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**.

Claim processing

Claim compliance standards and time frames

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 7 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 calendar 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 calendar days after receiving a clean claim.

If Humana Healthy Horizons fails to pay or deny a clean claim within these time frames 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.

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 calendar 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)/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 a member has both a Humana Medicare Advantage and Humana Healthy Horizons plan, Humana will make every effort to enter the claim on both plans. If the claim is sent to the Humana Medicare Advantage plan, when the claim is completed, we will send that Humana Medicare Advantage claim disposition to the provider. We also will apply that claim to the Humana Healthy Horizons plan and coordinate it with the Humana Medicare Advantage plan and send out the final claim disposition.

The only exception to this is when Humana uses a delegated entity for a specific claim service for the Humana Medicare Advantage plan. In this scenario, the provider would then need to submit the claim with the disposition received by the delegated entity to the Humana Healthy Horizons plan using the Humana Healthy Horizons group number for adjudication.

If the claim is not copied over for any other reason, the provider must submit the claim and the Humana Medicare Advantage plan disposition to the Humana Healthy Horizons plan using the Humana Healthy Horizons group number on the claim.

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**. 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.

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.

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 about **provider enrollment with ICHP is available online**.

Authorization requests must be submitted via **Availity Essentials** 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.

Third-party liability

Medicaid serves as the payer of last resort, except when third-party liability cannot be reasonably established or when third-party benefits are unavailable to cover the member's medical expenses at the time a claim is submitted. In such cases, Humana Healthy Horizons will pay the provider initially and subsequently seek reimbursement from any potentially liable third party.

Providers are required to bill all other insurance carriers or applicable health coverage and obtain an Explanation of Benefits (EOB) before submitting claims to Humana Healthy Horizons.

If a claim submission results from a provider's efforts to determine the extent of third-party liability, Humana Healthy Horizons will waive timely filing requirements. Timely filing requirements will also be waived if there is a retroactive coverage change within 12 months of the member's eligibility with Humana Healthy Horizons, or if an error with another insurer has occurred.

For further information, please contact Humana Healthy Horizons Provider Services.

Coordination of benefits

Humana Healthy Horizons collects Coordination of Benefits (COB) information for its members to ensure accurate claims payment and compliance with federal regulations, which require Medicaid programs to act as the payer of last resort. While every effort is made to maintain current COB information, updates are received from multiple sources at varying intervals, and some changes may not be immediately reflected on Availity Essentials.

When processing claims, Humana Healthy Horizons will pay up to the Medicaid allowable amount, according to the applicable payment schedule, after subtracting any payments made by other insurance carriers. If the member responsibility amount identified by the other insurer is less than the difference between the Medicaid allowable amount and the amount paid by the other insurance, Humana Healthy Horizons will pay the member responsibility amount as indicated by the other carrier.

For additional guidance, please contact Humana Healthy Horizons Provider Services.

COB overpayment

When you receive 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 you at least 30 calendar days before an adjustment for overpayment is made. If a dispute is not received from you, adjustments to the overpayment are made on subsequent reimbursement.

Providers can issue refund checks to Humana Healthy Horizons for overpayments and mail them to coordination of benefits (COB) overpayment.

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 calendar 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 2 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.

COB requires a copy of the appropriate remittance statement from the primary carrier. For electronic and paper claims, the primary carrier's payment information and EOB from primary carrier is required. 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 calendar days of the date of the claim's recovery or recoupment notice from the previous payer.

Member billing

State requirements and federal regulations prohibit providers from billing Humana Healthy Horizons members for services except under extremely 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. Members cannot be billed and will be held harmless for services that are administratively denied. A Humana Healthy Horizons member can only be charged if a service is not covered or a prior authorization is denied prior to the service.

If a Humana Healthy Horizons member attempts to receive a non-covered service, the provider must inform the member of the cost of the service and how much they may be billed. The provider must notify the member prior to providing the service. The member must agree 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 financial responsibility.

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

1. Authorization has been requested and denied prior to rendering the service.
2. The provider has requested a review of the denial decision or the time for requesting such review has passed.
3. If the decision is made, the provider must inform the member that the service requires authorization and has been denied. For out-of-network providers, the member must also be informed that covered services may be authorized for an in-network provider without cost.
4. The provider must inform the member of the member's responsibility for payment if the member still chooses to receive the services without authorization.
5. 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
6. Member must be informed of the right to contact Humana to file an appeal if the member disagrees with the prior authorization denial. Please refer to the member grievance and appeals section of this manual for more details.
7. The provider must have the right to appeal any denial of payment by Humana for denial of authorization.

Please refer to the prior authorizations section of this manual for more details.

Providers should call Humana Healthy Horizons Member/Provider Services Contact Center for guidance before billing members for services.

Chapter 13: Complaints, grievances and disputes

Contact information pertaining to complaints, grievances and disputes

Contact name	Contact information	Hours of operation
Binding arbitration	Address: Humana Healthy Horizons in Indiana 201 N. Illinois St., Suite 1200 Indianapolis, IN 46204	
Formal claim disputes	Email: **IndianaFormalDispute@humana.com** Address: Humana Healthy Horizons in Indiana 201 N. Illinois St., Suite 1200 Indianapolis, IN 46204	
Grievance and appeals department	Phone (expedited appeal requests): **866-274-5888 (TTY: 711)** Standard appeal requests can be sent via paper to the following mailing address or fax number. Address: Humana Healthy Horizons in Indiana Grievances and Appeals Department P.O. Box 14169 Lexington, KY 40512-4169 Fax: **800-949-2961**	8 a.m. to 8 p.m., Eastern time, Monday through Friday
Member/Provider Services Contact Center	Phone: **866-274-5888 (TTY: 711)**	8 a.m. to 8 p.m., Eastern time, Monday through Friday

Contact name	Contact information	Hours of operation
Informal claim disputes	Email: **INMedicaidClaimsResearch@humana.com** Address: Humana Healthy Horizons in Indiana Informal Claim Dispute P.O. Box 14169 Lexington, KY 40512-4169 Website: **www.availity.com**	
Office of Administrative Law Proceedings	Phone: 317-232-4412 or 866-259-3573 Email: **fssa.appeals@oalp.in.gov** Address: Office of Administrative Law Proceedings FSSA Hearings 100 N. Senate Avenue, Suite N802 Indianapolis, IN 46204	8 a.m. to 3 p.m., Eastern time, Monday through Friday

Overview

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

You have the right to file a grievance or appeal with Humana Healthy Horizons regarding a healthcare service, claim for reimbursement, provider payment or a contractual issue.

A grievance is a complaint. An appeal is a request to review a previous decision made by Humana Healthy Horizons to deny, suspend or terminate the services.

For purposes of this section, coverage denial is Humana Healthy Horizons' determination that a treatment or service is specifically limited or excluded under the member's specified health benefit plan. When a coverage denial is involved, you may request an internal appeal.

You can file grievances and appeals on your own behalf. You can file an appeal on behalf of a member if you have the member's written consent. Humana Healthy Horizons ensures that no punitive or retaliatory action is taken against a member or provider who files a grievance or appeal or a provider who supports a member's grievance or appeal.

Process and timelines

All inquiries, complaints, grievances and disputes should be directed to the Grievances and Appeals Department or your Provider Education/Outreach Representative. Based on the type of issue or complaint, your inquiry will be reviewed by a Humana Healthy Horizons associate with the designated authority to resolve your issue or complaint.

Your complaint, grievance or dispute may be filed verbally or in writing.

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 2 internal steps. You are not penalized for filing a claim dispute, and no action is required by the member:

Step 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.
Step 2	Formal claim dispute	This is the second step in the provider payment dispute 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 the 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 decide within 30 calendar days

You can submit a written informal claim dispute by mail, through the **Availity Essentials** provider portal or via email. Please reference the contact information for informal claim disputes for more details.

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.

If it is determined that a claim was processed or denied incorrectly, all affected claims will be reprocessed within 7 to 14 business days following the resolution of the informal claims dispute. . To submit an informal dispute about a finalized claim, sign in to **Availity Essentials**. Then, use the Claim Status tool to locate the claim and select the Dispute Claim button. You should then navigate to 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 determination by Humana Healthy Horizons for claim disputes submitted electronically via **Availity Essentials** can be viewed in the Appeals worklist. For training opportunities, please refer to Humana's **provider web-based training and resources** site. Please refer to the contact information for informal claim disputes for more details about submitting informal claim disputes via mail or email.

Formal claim disputes ("claim appeal")

If you are dissatisfied with the determination of the informal claim dispute, you may request a formal claim review, also referred to as a claim appeal.[66] All claim 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 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. The process for filing a formal claim dispute follows:

- 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.

66 405 IAC 1-1.6.

- A resolution letter is mailed within 45 calendar days of receipt of the appeal.

Provider claim appeals can be submitted via mail or email using the formal claim dispute contact information.

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[67] 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.

Binding arbitration notices should be mailed using contact information for binding arbitration.

Member grievances and appeals

Information about member grievances and appeals is provided to you so that you may assist Humana Healthy Horizons' members in this process, should they request it. You can also refer members to their **member handbook** or you may reach out to your Provider Outreach/Education Representative for more information.

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

Filing a grievance or appeal

If members have questions or issues, please refer them to the Member Services Contact Center. If they are dissatisfied with the answers provided by the Member Services Contact Center, members can then file a grievance via mail or online using contact information for the grievance and appeals department.

Members can call the Member Services Contact Center to file a grievance or appeal. To file a grievance or appeal in writing, the member can mail a letter, complete a form obtained from our website or simply call Member/Provider Services Contact Center to request a form. When filing a grievance or appeal, the member can request help from Humana Healthy Horizons associates via the Member Services Contact Center. Members may also request assistance from an ombudsman and/or independent advocacy services when filing grievances and appeals.

The grievance or appeal submission should include the following:

- Name, address, telephone number and state Medicaid ID number

67 Ind. Code § 34-57-2.

- Facts and details about the actions taken to correct the issue
- What action would resolve the grievance or appeal
- Member's signature
- Date

All grievances and appeals will be considered. The member can have someone act on their behalf during the process, whether it is a provider or someone else. A provider, acting on behalf of the member, 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 request within 60 calendar days of the date on the notice of action.
- The member must request continuation of benefits within 10 calendar days of the date on the notice of action or by the intended effective date of the 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.

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.

Grievance review timelines

Indiana Medicaid grievance

The member has the right to file a verbal or written grievance at any time. The grievance process may take up to 30 calendar 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 5 business days of the date Humana Healthy Horizons resolves the grievance request.

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

Topic	Response
Is an acknowledgment of the grievance required?	Yes, within 3 business days of receipt
What is the resolution time frame?	No later than 30 calendar days after receipt

Expedited grievance first-level review

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 expedited grievance is sent within 5 business days of the date Humana Healthy Horizons resolves the grievance request.

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 3 business days
What is the resolution time frame?	48 hours

Appeal review timelines

Indiana Medicaid appeal

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 calendar days of the date Humana Healthy Horizons receives the request. The member has the right to review their case before and during the appeal process.

Topic	Response
In what manner may the grievance be submitted?	Oral or written; if oral, the date of request is considered the date of receipt
What is the time frame to submit a grievance?	Within 60 calendar days from the date on the notice of adverse action

Topic	Response
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 3 business days
What is the resolution time frame?	Written notification within 5 business days of the decision

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 their 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 that this is an "urgent" or "expedited" appeal. An expedited appeal may be made by calling the Provider/Member Services contact center. If it is determined that an expedited process is not required, the appeal will go through the standard appeal process. **NOTE: Humana does not discriminate against a provider or take punitive action against a provider who requests an expedited resolution or supports a member's appeal.**

Topic	Response
In what manner may the grievance be submitted?	Oral or written
What is the time frame to submit a grievance?	Within 60 calendar days from the date on the notice of action
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 48 hours of receipt of the appeal
What is the resolution time frame?	Oral notification followed by written notification within 5 business days of the decision

External review by an independent review organization

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 the Office of Administrative Law Proceedings.

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 a request for a State Fair Hearing within 120 calendar days of the date on the appeal resolution letter.
- The member must request that benefits be continued within 10 calendar days of the date on the appeal resolution letter or by 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 covered by the original authorization must not have expired.

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 calendar days of the hearing decision.

Chapter 14: Credentialing and recredentialing

Contact information pertaining to credentialing and recredentialing

Contact name	Contact information	Hours of operation
Credentialing decision appeals	Address: Humana Attn: Shoba Srikantan, M.D. 101 E. Main Street Louisville, KY 40202	
Member/Provider Services Contact Center	Phone: 866-274-5888 (TTY: 711)	8 a.m. to 8 p.m., Eastern time, Monday through Friday
Provider Education/ Outreach Representatives	Email (medical providers): **INMedicaidProviderRelations@humana.com** Email (behavioral health providers): **INBHMedicaid@humana.com** Fax: **317-808-6099**	

Overview

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 state. Humana Healthy Horizons credentials and recredentials all licensed, independent practitioners including providers, non-providers 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 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments.

Provider recruitment and nondiscriminatory credentialing policy

Humana Healthy Horizons makes every effort to recruit and retain providers of all ethnicities to support the cultural preferences of its members. Humana Healthy Horizons' provider networks are open to review new provider participation, barring your willingness to accept contractual requirements, contractual rates and satisfy all credentialing and regulatory requirements. Humana Healthy Horizons reviews and accommodates all provider nomination requests, when appropriate, from both members and providers to ensure all providers are equally represented in Humana Healthy Horizons' provider network.

As part of this process, Humana Healthy Horizons collects and publishes spoken languages in our Physician Finder provider directory. Please be sure to accurately indicate all languages spoken in your office(s) on your Humana Healthy Horizons recredentialing application and/or CAQH application or contact your Provider Education/Outreach Representative to request updates.

Request to join the network

All practitioners must be actively enrolled with IHCP. If you haven't already done so, complete your enrollment using the **Indiana Medicaid for Providers Provider Enrollment website**. You can obtain your Indiana Medicaid provider ID number through this process.

All provider types may submit a request to join the network via **Availity Essentials**.

1. Sign in to **Availity Essentials** (registration required).
2. Select **Payer Spaces** then select **Humana** in the top header.
3. Select the **Applications** tab in the middle of the page.
4. Scroll down to select **Join Our Network**, then follow the prompts to complete the form and submit your application.

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 **CAQH application**, 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 5 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 a 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 mid-level 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
  - Advance 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 5 business days in the event it is determined the request to join the network is incomplete.

Credentialing process by provider type

Individual practitioners

CAQH application for providers

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** using your account information (registration required).
- Select the **Authorization** tab.
- Confirm Humana Healthy Horizons is listed as an authorized health plan. If it is not listed as an authorized health plan, please select the checkbox to add it.

Humana Healthy Horizons is a participating organization with the CAQH, a nonprofit alliance of leading health plans, networks and trade associations. A catalyst for positive change, CAQH members collectively develop and implement administrative solutions that produce meaningful, concrete benefits for physicians, allied health professionals, their staffs, members and plans. Humana Healthy Horizons requires use of CAQH ProView® for gathering credentialing information for all network providers.

Be sure to include your CAQH provider ID number when submitting credentialing documents. It is essential that all documents are complete and current. Please include copies of the following documents:

- Current Malpractice Insurance Face Sheet
- A current DEA certificate
- All buprenorphine prescribers must have an "X" DEA number
- Explanation of any lapse in work history of 6 or more months
- CLIA certificate, as applicable
- ECFMG, if you have a foreign medical degree
- If you are acting as a PMP, attestation that your total member load is not more than 3,000 members
- Disclosure of Ownership, as applicable

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	Behavioral health practitioners
Providers	Psychiatrists and other providers
Oral surgeons	LCACs
Chiropractors	Doctoral or master's level psychologists who are state licensed
Podiatrists	HSPPs
Dentists	Licensed, independent practice school psychologists
Optometrists	Master's level clinical social workers who are state licensed
Allied health providers, including: – Advance practice registered nurses – Clinical nurse specialists – Certified nurse midwives – Physician assistants	Master's level clinical nurse specialists or psychiatric nurse practitioners who are state licensed
Therapists, including: – Speech and speech/language pathologists – Occupational – Physical – Audiologists	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 licensed or certified practitioners, including provider extenders who act as a PMP or those who appear in the provider directory.	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

Please see the request to join the network section of this provider manual for more details.

Credentialing application

The CAQH credentialing application should be signed and dated and include supporting documents and signature not more than 120 calendar days old.

Licensure

Practitioners must have an unrestricted license in the practicing state issued by the 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 of handling instances when a member requires a controlled substance.

Education and training

Successful completion of all training programs pertinent to one's practice:

Medical doctors and doctors of osteopathy	Doctors of chiropractic medicine	Doctors of podiatric medicine	Advance practice registered nurses	Provider assistants	Dentists and other providers
Successful completion of residency training pertinent to the requested practice type	Proof from a chiropractic college for doctor of chiropractic medicine	Proof of graduation from podiatry school and completion of residency program for doctors of podiatric medicine	Proof of graduation from an accredited master's degree program	Proof of graduation from an accredited master's degree program	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 the 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 5 years via curriculum vitae (CV) or included on the application
- Gaps of 6 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 judgments 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, advance 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.

Common practitioner credentialing mistakes

Need	Most common mistakes	Recommendation
CAQH application	Your 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 your 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 calendar 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 provider credentialing

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

- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting
- Diabetes education
- Dialysis centers
- Federally qualified health centers
- Free standing ambulatory surgery centers
- Free-standing birthing centers
- Home health agencies
- Hospice providers

- Hospitals
- Pharmacies
- Physical, occupational therapy and speech language pathology (PT/OT/SLP) facilities
- Portable X-ray suppliers
- Rehabilitation hospitals (including outpatient locations)
- RHCs
- SNFs
- Urgent care clinics

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

- Inpatient
- Residential/extended care facilities
- Ambulatory

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 **Indiana Medicaid for Providers Provider Enrollment website**. You can obtain your Indiana Medicaid provider ID number through this process.

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 calendar days old (Please refer to the "Provider Classification, Type and Specialty" section of the **Complete an IHCP Provider Enrollment Application website**.)
- 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 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 5 business days if we determine the request to join the network is incomplete.

Facility enrollment form

Completion of a signed and dated application, signature not more than 120 calendar 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[68]

On-site quality assessment

The 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 3 years old at the time of verification.
- **Quality review conducted by Humana Healthy Horizons:** If the CMS or state review is older than 3 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.

68 42 C.F.R. § 493.1809

Opioid treatment program providers	SUD addiction treatment 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	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 calendar days). • Behavioral Health Profiling form – Facilities that have ASAM residential level-of-care designations 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 calendar 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

Opioid treatment program providers	SUD addiction treatment providers
	• 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 calendar 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

Common organizational/ancillary provider credentialing mistakes

Need	Most common mistakes	Recommendation
HCBS/LTSS assessment application	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 calendar 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/LTSS provider credentialing

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

All HCBS/LTSS providers must be enrolled with IHCP prior to submitting an enrollment application to Humana Healthy Horizons. If your organization hasn't already done so, complete the IHCP provider enrollment process by visiting the **Indiana Medicaid for Providers Provider Enrollment website**. You can obtain your Indiana Medicaid provider ID number through this process.

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 calendar 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 OMPP Certification Team

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

When certifying and recertifying HCBS providers, evaluation includes a complete, signed, and dated HCBS/LTSS assessment application, with a signature not more than 120 calendar days old.

FSSA certification

HCBS providers must be certified by OMPP Certification Team.

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

Common HCBS/LTSS provider credentialing mistakes

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 IHCP Certification Team is missing. The document is expired or will expire within the next 30 calendar 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.

NOTE: Waiver and Home-and-Community-Based providers are classified as atypical providers and are not required to obtain a National Provider Identifier (NPI). Atypical providers should not include an NPI number on claims submitted for waiver services. An active Legacy Provider Identifier (LPI) is required for all atypical providers submitting claims for services.

Additional documentation and enrollment status

If you need to submit additional documents or would like to check the enrollment status, medical providers can reach out to their Provider Education/Outreach Representative. Failure to submit a complete application will delay the enrollment process with Humana Healthy Horizons. HCBS providers are notified within 5 business days in the event it is determined the request to join the network is incomplete.

Failure to submit a complete application may result in a delay in Humana Healthy Horizons' ability to complete or begin the credentialing process. You can confirm Humana Healthy Horizons' access to your credentialing application by completing the following steps:

- Sign in to the **CAQH website** using your account information (registration required).
- Select the **Authorization** tab.
- Confirm Humana Healthy Horizons is listed as an authorized health plan. If it is not listed as an authorized health plan, please select the checkbox to add it.

Provider recredentialing and reassessment

Network practitioners are recredentialed, and organizational, long-term care and HCBS providers are reassessed at least every 3 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.

Recredentialing process

Network providers, including practitioners, organizational and LTSS providers, are recredentialed at least every 3 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 QI program.

Additionally, information regarding adverse actions is collected from the NPDB, Medicare and Medicaid Sanctions, CMS preclusion list, the HHS/OIG and GSA (formerly EPLS), and limitations on licensure. A notification will be sent to you for reverification of credentialing. All network providers must submit updated documents as they expire. Failure to provide updated documentation may delay payment. Your contract may be terminated at any time if it is determined the credentialing requirements are no longer being met or you fail to complete the recredentialing process.

Provider rights and responsibilities in credentialing process

Provider rights

You have the right to review, on request, information submitted to support your 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 require 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, you are 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

NOTE: Applicable to medical and behavioral health providers only.

Humana Healthy Horizons only enters contracts 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 a delegated contract. 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 a contract between both parties.

Credentialing and recredentialing criteria

Recredentialing

Network providers, including practitioners, organizational and LTSS providers, are recredentialed at least every 3 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 QI program.

Additionally, information regarding adverse actions is collected from the NPDB, Medicare and Medicaid Sanctions, CMS preclusion list, the HHS/OIG and GSA (formerly EPLS), and limitations on licensure. A notification will be sent to the provider for reverification of credentialing. All network providers must submit updated documents as they expire. Failure to provide updated documentation may delay payment. Your contract may be terminated at any time if it is determined the credentialing requirements are no longer being met or you fail to complete the recredentialing process.

Credentialing committee

The credentialing committee is overseen by a Humana Healthy Horizons CMO and is responsible for making determinations for all credentialing and recredentialing decisions. The credentials committee meets monthly and comprises participating providers in both primary care and specialty disciplines, including behavioral health, pharmacy and mid-level practitioners. The credentialing committee has the responsibility to establish and adopt, as necessary, criteria for your participation and termination. The committee also directs credentialing procedures, including your participation, denial and termination. Failure of an applicant to adequately respond to a request for assistance may result in termination of the application process.

Credentialing decision appeals and reconsideration of decisions

Humana Healthy Horizons' credentialing committee must notify you of a denial based on credentialing criteria. The notice must inform you 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 within 30 calendar 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 calendar 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. Reconsideration requests can be sent via mail to Credentialing Decision Appeals.

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 calendar days. Reconsideration denials are final unless the decision is based on quality criteria; in these instances, you have 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.

Ongoing provider monitoring

Humana Healthy Horizons monitors provider sanctions, complaints and quality issues between credentialing cycles and ensures corrective actions are taken to address occurrences of poor quality. Ongoing monitoring and appropriate interventions including removal from the network are implemented by collecting and reviewing the following information within 30 calendar days of its release:

- Medicare and Medicaid sanctions and exclusions, available online
- LEIE/OIG
- EPLS/SAM
- Sanctions or limitations on licensure
- Complaints
- Identified Adverse Events

Chapter 15: Fraud, waste and abuse

Contact information pertaining to fraud, waste and abuse

Contact name	Contact information	Hours of operation
Ethics Help Line	Phone: **877-5-THE-KEY (877-584-3539)** Website: **www.ethicshelpline.com** Email: **ethics@humana.com**	
Humana Customer Service	Phone: **800-4-HUMANA (448-6262)**	8 a.m. to 8 p.m., Eastern time, Monday through Friday
Indiana fraud reporting	Phone: **800-403-0864** Email: **reportfraud@fssa.in.gov**	
Member/Provider Services Contact Center	Phone: **866-274-5888 (TTY: 711)**	8 a.m. to 8 p.m., Eastern time, Monday through Friday
Program integrity department	Phone: **800-457-4515** Email: **programintegrity.fssa@fssa.in.gov**	
Special investigations unit	Phone (hotline): **800-614-4126** Email: **siureferrals@humana.com** Fax: 920-339-3613 Address: Humana Special Investigations Unit 1100 Employers Blvd. Green Bay, WI 54344	24 hours a day, 7 days a week

Overview

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 over utilization 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 the state 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' Special Investigations Unit. All information will be kept confidential. Entities are protected from retaliation[69] 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 customer service.

Reporting FWA

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.

Please contact the Special Investigations Unit or Ethics Help Line to report fraud, waste or abuse.

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 may contact the Program Integrity department.

69 31 U.S.C. § 3730(h)

Chapter 16: Pharmacy

Contact information pertaining to pharmacy

Contact name	Contact information	Hours of operation
CenterWell Pharmacy	Phone: **800-379-0092 (TTY: 711)** **To submit electronic prescriptions, select "CenterWell Pharmacy Mail Delivery" in your ePrescribing software. The NCPDP ID numbers is 0353108.** Website: **https://www.centerwellpharmacy.com/documents-forms.html** Physician fax form (English): **http://apps.humana.com/marketing/documents.asp?file=675636** Physician fax form (Spanish): **https://apps.humana.com/marketing/documents.asp?file=1214538** Fax: **800-379-7617**	8 a.m. to 11 p.m., Eastern time, Monday through Friday and 8 a.m. to 6:30 p.m., Eastern time, Saturday
CenterWell Specialty Pharmacy	Phone: **800-486-2668 (TTY: 711)** Website: **https://www.centerwellpharmacy.com/prescriber-specialty-forms.html** Fax: **877-405-7940**	8 a.m. to 11 p.m., Eastern time, Monday through Friday and 8 a.m. to 6:30 p.m., Eastern time, Saturday
Humana Clinical Pharmacy Review	Phone: **800-555-CLIN/800-555-2546** Fax: **877-486-2621** Obtain forms via Humana prior authorization tool online: **https://provider.humana.com/pharmacy-resources/prior-authorizations** Submit requests via CoverMyMeds® website: **https://www.covermymeds.health/**	8 a.m. to 8 p.m., Eastern time, Monday through Friday
Humana Clinical Programs	Phone: **888-210-8622 (TTY: 711)**	9 a.m. to 5:30 p.m., Eastern time, Monday through Friday

Contact name	Contact information	Hours of operation
Medication intake team	Fax: **888-447-3430** Provider prior authorization notification lists: **https://provider.humana.com/coverage-claims/prior-authorizations/prior-authorization-lists** Prior authorization for professionally administered drugs: **http://humana.com/MedPA**	
Member/Provider Services Contact Center	Phone: **866-274-5888 (TTY: 711)**	8 a.m. to 8 p.m., Eastern time, Monday through Friday
Peer-to-peer (P2P) discussions	Phone: **844-330-7734**	8 a.m. to 6 p.m., Eastern time, Monday through Friday

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

- Clinical edits
- Consumer programs

- Drug utilization review
- Formulary development Preferred drug list

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

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

Please review the current formulary prior to writing a prescription to determine if the drug will be covered. You can review the PDL online. The PDL is updated regularly. We will notify you of the negative impacts to the PDL at least 30 calendar days in advance. Current medical and pharmacy coverage policies are available online for your review.

Coverage determinations and exceptions

You may request coverage determinations, such as medication PA, step therapy, quantity limits and formulary exceptions through Humana Clinical Pharmacy Review.

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 the member grievance and appeals section of this provider manual for more details on how to submit appeals.

Peer-to-peer (P2P) discussions

If you prefer to have a discussion with one of our pharmacists or regional medical directors, you may initiate a P2P request by contacting Peer-to-peer (P2P) discussions and leave 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 a single 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.

UM for medications

The PDL identifies covered drugs and associated drug UM requirements, such as PA, quantity limits, age limits, etc.

- PA: 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: 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, PA must be obtained.
- Quantity limits: Quantity limits have been implemented for various classes of drugs to facilitate the appropriate, approved label use of these agents to help members obtain the optimal dose required for treating their conditions. If a member's medical condition warrants an additional quantity, the pharmacist should ask the prescriber to submit a request to Humana Clinical Pharmacy Review (HCPR).
- Age limits: Age limits have been implemented for various classes of drugs to facilitate the appropriate, approved label use of these agents to help members receive appropriate care for the member's age. If a member's medical condition warrants an exception to an age limit, the pharmacist should ask the prescriber to submit a request to HCPR.

You can review the PDL online.

Please review the current formulary prior to writing a prescription to determine if the drug will be covered. The PDL is updated regularly. The current PDL can be **viewed online**. To view current medical and pharmacy coverage policies, please see our Medical and Pharmacy Coverage Policies.

Pharmacy copayments

There are no pharmacy copayments.

Humana Healthy Horizons' 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** online, 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. More information about this **mail-order pharmacy option** is available online.

Continuity of care for new members

Continuity of medication coverage for newly enrolled members using nonparticipating pharmacies

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 calendar days of enrollment, including an out-of-network pharmacy.

Medication therapy management (MTM)

Humana Healthy Horizons offers a 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 Humana Clinical Programs.

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. PA requirements exist for many injectables. Medicaid providers may contact the Medication Intake Team for more details.

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 PA requirements.

340b provider billing

The IHCP instructs providers to follow Medicare guidance regarding the proper billing procedure and use of modifiers, as follows:

- For physician-administered claims (CMS-1500 or UB-04), modifiers:
  - TB – Drug or biological acquired with 340b drug pricing program discount, reported for informational purposes

For more information about 340b provider billing, please reference the Humana 340b claims processing information section of the **Indiana PathWays for Aging Provider Resources website**.

Chapter 17: Long-term services and supports

Contact information pertaining to long-term services and supports

Contact name	Contact information	Hours of operation
Humana Healthy Horizons Workforce Development	Email: **HumanaINWorkforce@humana.com**	
Member/Provider Services Contact Center	Phone: **866-274-5888 (TTY: 711)**	8 a.m. to 8 p.m., Eastern time, Monday through Friday

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 case 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 case 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 comprehensive health assessment tool (CHAT). If the member's circumstances have substantially changed since the level-of-care assessment was completed, the member's Humana Healthy Horizons care coordinator reviews the level-of-care assessment responses with the member to confirm their accuracy and reassesses if necessary.

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 reassessment is conducted every third year and will be incorporated into the member's record, after which the member's service coordinator will conduct a visit with the member to review and update the member's ICP and complete any other needed reassessments. As with the initial assessment process, the service coordinator will encourage the member to invite the member's caregivers, natural supports and other chosen ICT participants in the ICT process. The service coordinator will ensure that the updated assessments and ICP are shared with ICT participants via our care delivery system 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 care coordinator will complete the LTSS-specific assessments during the same visit as the CHAT. This gives the care coordinator a full picture of the members' needs, preferences and goals, across all service types.

The care 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 care 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, care coordinators leverage their experience, training and expertise to evaluate individual member needs and recommend appropriate services and supports. Care 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 care 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 indicate 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.

Care coordinators conduct an initial face-to-face visit and include any LTSS assessments within 90 calendar 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 care 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.

Care 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 calendar 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 care coordinator will immediately conduct a functional needs assessment. The service plan also will be updated accordingly.

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

The care coordinator will conduct quarterly face-to-face visits every 90 calendar 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 care coordinator will conduct a face-to-face visit with the member and complete and approve a service plan within 5 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 business days of receiving a notification from the service coordinator, as indicated on the service plan. The care coordinator will verify all HCBS included in the member's service plan, except home modification and vehicle modification, which are started or delivered within 30 calendar 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 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

Humana Healthy Horizons is committed to supporting the workforce development needs of its provider network, recognizing the vital role providers play in effective case management, and the impact of a qualified and dependable workforce on member outcomes. To this end, Humana has established a comprehensive Workforce Development program that offers resources for professional development, retention strategies and building a strong talent pipeline for Indiana's managed care workforce.

Furthermore, Humana Healthy Horizons is collaborating with key partners to advance the Indiana Direct Care Workforce initiative, addressing the critical shortage of direct service workers in the state. Through this partnership, Humana supports recruitment, retention and data initiatives that are essential to strengthening care teams.

Workforce development is regarded as a long-term partnership, fundamental to delivering high-quality, person-centered care. Humana Healthy Horizons is dedicated to working closely with providers now and in the future to promote excellence in service delivery. Providers seeking more information or wishing to participate in workforce development initiatives are encouraged to contact the Humana Healthy Horizons workforce development team at **HumanaINWorkforce@humana.com**.

Definitions

Term	Definition
Abuse	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 health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program, per 42 C.F.R. § 455.2.
Abuse, neglect and exploitation (ANE)	Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.
Adjudicated claim	A claim that has been received and processed which resulted in a payment or denial of payment.
Adverse benefit determination	Per 42 C.F.R. § 438.400(b), an adverse benefit determination means, in the case of an MCO, PIHP, or PAHP, any of the following: The denial or limited authorization of a requested service, including determinations based on the type or level of service requirements for a medical necessity, appropriateness, setting or effectiveness of a covered benefit. The reduction, suspension, or termination of a previously authorized service. The denial, in whole or in part, of a payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at 447.45(b) is not an adverse benefit determination. The failure to provide services in a timely manner, as defined by the State. The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network. The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Term	Definition
Aged and disabled waiver	Allows Indiana to provide an alternative to nursing facility admission for adults and persons of all ages with a disability. The waiver is designed to provide services to supplement informal supports for people who would require care in a nursing facility if waiver or other supports were not available. Waiver services can be used to help people remain in their own homes, as well as assist people living in nursing facilities to return to community settings such as their own homes, apartments, Assisted Living or Community Home Share.
Aligned enrollment	Refers to enrollment in a Dual Eligible SNP of full-benefit Dual Eligible Beneficiaries whose Medicaid benefits are covered under the managed care entity Medicaid contract and the Dual Eligible D-SNP's MA organization, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization
Americans with Disabilities Act (ADA)	Refer to Public Law 101-336. The ADA prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, state and local government services, public accommodations, commercial facilities, and transportation. It also mandates the establishment of TDD/telephone relay services.
Appeal	Per 42 C.F.R. § 438.400, a request for a review of an action. An appeal is a special kind of complaint a member may make if they disagree with a decision to deny a request for health care services or payment for services they've already received. A member may also make a complaint if they disagree with a decision to stop the services that they are receiving. For example, a member may ask for an appeal if Medicare doesn't pay for an item or service they think they should be able to get. There is a specific process that a member's health plan must use when they ask for an appeal.
Area Agencies on Aging	A public or private nonprofit agency designated by the state to address the needs and concerns of all older persons at regional and local levels.
Assessment	An analysis of a patient's needs to determine which services shall be provided to the patient.
Behavioral health services	Mental health and/or substance abuse services collectively.
Benefits	The package of health care services, including physical health, behavioral health, and long-term care services, that define the covered services available to enrollees assigned to the Contractor pursuant to the Contract with Indiana.
Business day	Monday through Friday, except for State of Indiana holidays.

Term	Definition
Care coordinator	A professional responsible for assisting Medicaid members in accessing, coordinating, and managing their healthcare services. The care coordinator works with the member, their family, healthcare providers, and other support systems to develop and implement a person-centered care plan. Their duties often include conducting assessments, identifying member needs, arranging necessary services, monitoring progress, and ensuring effective communication among all parties involved in the member's care. The goal is to improve health outcomes and help members navigate the healthcare system efficiently.
Caregiver supports	Training, education, and resources that will equip the Informal Caregiver with the necessary knowledge and skills to promote safe and appropriate services and supports to the member and to continue living in the community.
Carved-out services	As defined by the State, include services that are carved out of managed care program coverage, meaning that they are the financial responsibility of the State to provide to managed care members via fee-for-service (FFS) Medicaid benefits. This definition also includes services that could potentially require a managed care member to be disenrolled from a managed care plan and instead be reenrolled into traditional Medicaid to obtain the FFS benefit.
Case management	A level of direct-contact services tailored to the member that is intended to provide members with assistance with care coordination activities, making preventive care appointments, and/or accessing care for needed health or social services to address a member's chronic health condition(s). Case management entails a purposeful plan to reach members and impact their health and health care utilization and to coordinate all services provided to members.
Centers for Medicare and Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (HHS), which administers the Medicare (Title XVIII) and Medicaid (Title XIX) programs, and the State Children's Health Insurance Program (Title XXI).
CFR	Code of Federal Regulations. The general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.
Claim dispute	A dispute, filed by a provider or MCE, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.
Clean claim	A claim received by the MCE or adjudication that requires no further information, adjustment, or alteration by the provider of the services to be processed and paid.
Coinsurance	The portion of an allowed charge that a member would be required to pay for a covered medical service after the deductible has been met if the member did not have Medicaid coverage. The coinsurance or a percentage amount is paid by Medicaid if the member is eligible for Medicaid.

Term	Definition
Complex case management	A level of service available to high-need/high-risk members who are determined Nursing Facility Level of Care (NFLOC) and are receiving LTSS in a home or community-based setting; or members with 3 or more disease states which require the ongoing involvement of sub-specialists to manage and deliver disease-appropriate care; or members with 2 or more "uncontrolled" disease states, which are defined as disease states requiring immediate attention, for which the member is not currently receiving disease- appropriate screening, follow-up appointments, care, therapy, and/or medication; or members who have had an inpatient hospital stay in the last 90 days; or members with high dollar claims of over fifty thousand dollars ($50,000) in 6 months. Complex case management services include all of the services and benefits from case management as well as additional benefits.
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Patient experience surveys that ask patients (or in some cases their families) about their experiences with, and ratings of, their health care providers and plans, including hospitals, home health care agencies, doctors, and health and drug plans, among others.
Copayment or copay	Per Ind. Code § 27-13-1-7, copayment means an amount, or a percentage of the charge, that an enrollee must pay to receive a specific service that is not fully prepaid.
Corrective action plan (CAP)	A written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions/tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the MCE and/or its providers, to enhance Quality Assessment and Performance Improvement activities and the outcomes of the activities, or to resolve a deficiency.
Covered services	Pursuant to a contract, services individuals in the respective program will receive include all traditional Medicaid services. A limited number of services are carved out of the capitated arrangement. See also benefits.
Credentialing	The process of obtaining, verifying and evaluating information regarding applicable licensure, accreditation, certification, educational and practice requirements to determine whether a provider has the required credentials to deliver specific covered services to members.
Critical incident	Critical incidents in the HCBS setting are defined in accordance with 455 IAC 2-8-2 (Protecting Individuals: Unusual Occurrence; Reporting). Also known as incidents falling in the category of unusual occurrences.

Term	Definition
Cultural competency	The ability for the MCE, healthcare professionals, and social support providers to demonstrate cultural competence toward members/patients with diverse values, beliefs, and feelings that allows for a process that includes consideration of the individual social, cultural, and psychological needs of patients for effective cross-cultural communication with their health care providers in order to reduce health disparities and to provide optimal care to patients regardless of their race, gender, ethnic background, native, and religious or cultural beliefs.
Days	Calendar days unless otherwise specified.
Deductible	For health insurance, the amount a person must pay toward medical expenses before insurance plan begins paying.
Disenrollment	The discontinuance of a member's eligibility to receive covered services through an MCE.
Division of Aging	A division of the Family and Social Services Administration. Supports the development of alternatives to nursing home care by coordinating and funding Home and Community-Based Services coordinated through a network of Area Agencies on Aging.
Division of Family Resources (DFR)	A division of the Family and Social Services Administration. The State agency that offers help with job training, public assistance, supplemental nutrition assistance, and other services. The DFR make Medicaid eligibility determinations based on federal and state policy.
Division of Mental Health and Addiction (DMHA)	A division of the Family and Social Services Administration. The DMHA assists people with mental illness or addiction who are uninsured or underinsured to receive treatment and re-integrate into their community. The Division operates 6 state hospitals and partners with Indiana's Community Mental Health Centers (CMHC) to provide treatment in communities across Indiana.
Drug formulary	List of drugs that includes therapeutic classes for both generic and brand-name medications. Within the formulary, a drug or dosage form may be designated as "preferred" or "non-preferred." Preferred drugs generally require minimal or no prior authorization; non- preferred drugs require prior authorization and may also require periodic regimen review or specific billing requirements.
Dual eligible member	A member who is eligible for both Medicare and Medicaid. There are two types of Dual Eligible Members: A Qualified Medicare Beneficiary (QMB) Dual Eligible Member (a QMB Plus or a QMB Only) and a Non QMB Dual Eligible Member (a Special Low-Income Beneficiary [SLMB] Plus or an Other Full Benefit Dual Eligible).

Term	Definition
Durable medical equipment (DME)	Per 42 CFR § 414.202, equipment that is necessary for ongoing medical issues. Durable medical equipment includes purchased or rented items such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a health care provider to be used in a patient's home which are covered by Medicaid.
Electronic visit verification (EVV)	A computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.
Eligibility determination	The process of determining, through an application and required verification, whether an applicant meets the criteria for Title XIX/ XXI funded services.
Eligible member	A person certified by the State as eligible for medical assistance.
Eligible providers	Person, organization, or institution approved by the State as eligible for participation in Medicaid.
Emergency medical condition	Per 42 C.F.R. § 438.114, emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part.
Emergency medical transportation	Per 836 IAC 1-1-1, emergency medical transportation means the transportation of emergency patients by ambulance and the administration of basic life support to emergency patients before or during such transportation.
Emergency room care	Per 42 C.F.R. § 405.440, includes care given for a medical emergency when a member believes that their health is in serious danger and every second counts.
Emergency services	Per 405 IAC 5-2-9, emergency services are defined as a service provided to a member after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.
Encounter	A record of a health care-related service rendered by a provider or providers to a member who is enrolled with an MCE on the date of service.
Enrollee	Per 42 C.F.R. § 438.2, a Medicaid recipient who is currently enrolled with a Contractor.

Term	Definition
Enrollee encounter data	Per 42 C.F.R. § 438.2; 42 C.F.R. § 438.818, the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between the State and an MCE that is subject to the codified requirements.
Enrollment	The process by which an enrollee becomes a member of the MCE.
Enrollment broker	Per 42 C.F.R. § 438.810(a), an individual or entity that performs choice counseling or enrollment activities, or both.
Excluded services	Defined by the State as services that are not covered under Indiana Medicaid. See also 405 IAC 5-29-1.
External quality review	Per 42 C.F.R. § 438.320 and as used in CFR part 438 subpart E, the analysis and evaluation by an external quality review organization (EQRO), of aggregated information on quality, timeliness, and access to the health care services that an MCE described in 42 C.F.R. § 438.310(c)(2) or their contractors furnish to Medicaid beneficiaries.
Family and Social Services Administration (FSSA)	Indiana Family and Social Services Administration is a health care and social service funding agency with 8 care divisions established by Indiana to consolidate and better integrate the delivery of human services by state government. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs; includes the Office of Medicaid Policy and Planning, the Division of Aging, the Division of Family Resources, the Division of Mental Health and Addiction, and the Division of Disability & Rehabilitative Services.
Federally qualified health center (FQHC)	A federally qualified health center (FQHC) is a community-based health care provider that receives funds from the Health Resources & Services Administration (HRSA) Health Center Program to provide primary care services in underserved areas. FQHCs offer services on a sliding fee scale based on ability to pay and operate under a governing board that includes patients. They must meet specific criteria set by the federal government to ensure access to comprehensive, quality health care for all individuals, regardless of their insurance status or ability to pay.
Fee-for-service (FFS)	A method of making payment for health services based on a fee schedule that payment for defined services. Also includes Indiana Medicaid program for members not enrolled with an MCE.
Fraud	Per 42 C.F.R. § 455.2, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to an individual or another person. It includes any act that constitutes fraud under applicable Federal or State law.

Term	Definition
Grievance	Per 42 C.F.R. § 438.400(b), a complaint or an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as the rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision. A grievance is a complaint about the way a member's health plan is giving care. For example, a member may file a grievance if the member has a problem calling the plan or if the member is unhappy with the way a staff person at the plan has behaved toward them. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (refer to appeal).
Grievance and appeal system	Per 42 C.F.R. § 438.400(b), the processes the Contractor implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.
Habilitation services and devices	Per 42 C.F.R. § 156.115, habilitation services and devices include health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples may include therapy for a child who is not walking or talking at the expected age. These services may also include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Health care professional	A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist, licensed professional counselor, and licensed mental health counselor (LMHC).
Health care services	Per 42 C.F.R. § 438.320 and as used in CFR part 438 subpart E, all Medicaid services provided by an MCE, PIHP, or PAHP under contract with the state Medicaid agency in any setting, including but not limited to medical care, behavioral health care, and LTSS.
Health equity	Ensuring that everyone has the chance to be as healthy as possible considering factors outside of a person's control that can prevent them from achieving their best health.

Term	Definition
Health insurance	Per 45 C.F.R. § 144.10, health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.
Health Insurance Portability and Accountability Act (HIPAA)	Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended at 42 U.S.C. § 1320d et seq.).
Healthcare Effectiveness Data and Information Set (HEDIS)	A widely used set of standardized performance measures used in the managed care industry, designed to allow reliable comparison of the performance of managed health care plans. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance.
High-risk member	An Indiana Medicaid member who is enrolled with Aged and Disabled (A&D) Waiver services.
Home- and community-based services (HCBS)	Services that are provided, pursuant to the Indiana Section 1915(c) waiver, as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility.
Home health care	Per 42 C.F.R. § 440.70, limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.
Home health services	Per 42 C.F.R. § 440.70, nursing services, home health aide services, therapy services, medical supplies, equipment, and appliances when provided to a member at their place of residence and on his or her physician's orders, or beginning March 1, 2020, ordered by the member's nurse practitioner, physician assistant, or clinical nurse specialist, as a part of the plan of care and is reviewed by the practitioner annually as part of a written plan of care.
Home medical equipment (HME)	The Ind. Code § 25-26-21-2 defines home medical equipment as equipment that is prescribed by a healthcare provider; sustains, restores, or supplants a vital bodily function; and is technologically sophisticated and requires individualized adjustment or regular maintenance.
HoosierRx	A qualified State Pharmaceutical Assistance Program. For more information, please refer to the **HoosierRx website**.

Term	Definition
Hospice	Per 42 C.F.R. § 418.3, a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Hospital Insurance.
Hospitalization	Per 40 C.F.R. § 159.153, hospitalization means admission for treatment to a hospital, clinic, or other health care facility. Treatment as an out-patient is not considered to be hospitalization.
In lieu of services	Per 42 C.F.R. § 438.3(e)(2)(iii), services or settings used in place of services and settings covered under the state plan. In Lieu of Services must be medically appropriate and cost effective as determined by the State.
Indiana health care provider	Per 42 C.F.R. § 438.15(a) and as defined in 25 U.S.C. § 1603, a health care program operated by the IHS or by an I/T/U as those terms are defined in section 4 of the Indian Health Care Improvement Act.
Indiana PathWays for Aging	Indiana's health care program for Medicaid enrollees who are aged 60 and older and are eligible for Medicaid on the basis of age, blindness, or disability. Enrollees include members who have a full Medicare benefit, those in a nursing facility, and those who are receiving long-term care services and supports in a home or community-based setting.
Indiana State Department of Health	The State agency is responsible for promoting health and for providing guidance on public health issues. For more information, please refer to the **Indiana Department of Health website**.
Individualized care plan	A plan of care, with contractually defined minimum components, developed for each member based on the results of the member's initial screening and health risk assessment(s) to ensure that the care of members is adequately coordinated and appropriately managed.
Informal caregiver	Family members, partner, friends, or neighbors who provide care for a member and is routinely involved in providing unpaid support and assistance to the member.
In-network provider	Any provider that is directly or indirectly employed by or has a provider agreement with the MCE or subcontractor to the MCE pursuant to the contract between the MCE and the State of Indiana.
Institution for mental disease (IMD)	Per 42 C.F.R. § 435.1010, a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases (including substance abuse disorders), including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases and whether it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases.

Term	Definition
Interdisciplinary care team (ICT)	A team of individuals that are responsible for the initial assessment and ongoing reassessment and evaluation of qualified members, that is skilled in nursing, social work and behavioral health, with knowledge of local community resources to implement protocol-driven care modules for members. At a minimum, a member's ICT must include the member, the member's Care Coordinator, the member's Service Coordinator (as applicable), any member-selected supports including informal caregivers, and additional expertise as needed based on the person's medical and needs.
Legacy provider identifier (LPI)	The 9-digit numeric code plus one alpha character used to identify atypical providers, including all Home and Community-Based Services (HCBS) waiver providers
Level-of-care (LOC)	A level of care determination is the outcome of the measure of an individual's care needs. This includes a determination of nursing home or institutional placement level of care need of an individual.
Limited English Proficiency (LEP)	Per 42 C.F.R. § 438.10, individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may have LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.
Long-term care (LTC) ombudsman program	A statewide program that advocates for residents of long-term care facilities, which includes nursing facilities and licensed assisted living facilities, to promote and protect the resident rights guaranteed to residents under federal and state law.
Long-term care program	A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
Long-term services and supports (LTSS)	Per 42 C.F.R. § 438.2, services and supports provided to individuals of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.
Managed care	An arrangement whereby a single provider or organization oversees the overall care of a patient to ensure cost-efficient quality health care to its members.
Managed care entity (MCE)	Organization contracted with the state of Indiana for this contract that meets all applicable requirements of Medicaid managed care organizations under Sections 1903(m) and 1932 of the Social Security Act, as well as the implementing regulations set forth in 42 C.F.R. § 438, and Ind. Code § 12-15 as may be amended.

Term	Definition
Managed care program	Per 42 C.F.R. § 438.2, a managed care delivery system operated by a State as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act.
Managed long-term services and supports (MLTSS)	Managed Long-Term Services and Supports refers to the delivery of long- term services and supports through capitated Medicaid managed care programs.
Mandated or required services	Services a state is required to offer to categorically needy clients under a state Medicaid plan (medically needy clients may be offered a more restrictive service package). Mandated services include the following: hospital, nursing facility care (21 and over), home health care, family planning, physician, nurse midwives, dental (medical/surgical), rural health clinics, certain nurse practitioners, federally qualified health centers, renal dialysis services, EPSDT (under age 21), and medical transportation.
Mandatory report state	Indiana mandatory reporting law establishing a legal, enforceable duty for those who have contact with vulnerable populations to report suspected neglect, battery, or exploitation of an endangered adult to an APS unit or law enforcement. All reports are secured and kept confidential.
Marketing materials	Per 42 C.F.R. § 438.104(a), materials that (1) are produced in any medium, by or on behalf of an MCE; and (2) can reasonably be interpreted as intended to market the MCE to potential enrollees.
Medicaid	A Federal/State program authorized by Title XIX of the Social Security Act, as amended.
Medicaid buy-in	This is an optional Medicaid program that allows individuals with a disability who work to retain Medicaid coverage. Individuals may pay a premium on a sliding fee scale based on their income. In Indiana, this program is called M.E.D. Works.
Medicaid-covered service	A service provided or authorized by a Medicaid provider for a Medicaid enrollee for which payment is available under the Medicaid program. A list of covered services is referenced in Ind. Code § 12-15-5-1.
Medicaid-Medicare eligible	Also called Dual Eligible: - Member who is eligible for benefits under both Medicaid and Medicare; also called dually eligible. Members in this category are bought-in for Part B coverage of the Medicare Program by the Medicaid Program.
Medical expenses	Amounts paid to providers for the provision of covered physical health, behavioral health, and/or long-term care or other covered services to members.

Term	Definition
Medical necessity	Per 42 C.F.R. § 438.210(a)(5), services or supplies that are proper and needed for the diagnosis or treatment of the member's medical condition, are provided for the diagnosis, direct care, and treatment of the member's medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of the member or the member's doctor. Medically necessary services include covered services that are required for the care or well-being of the patient and are provided in accordance with generally accepted standards of medical or professional practice to prevent disease, disability or other adverse conditions or their progression, or to prolong life.
Medical records	All communications related to a patient's physical, mental health or long-term care condition that are recorded in any form or medium and that are maintained for purposes of evaluation or treatment, including records that are prepared by a health care provider or by other providers. Records do not include materials that are prepared in connection with utilization review, peer review, or quality assurance activities.
Medically needy	Individuals whose income and resources equal to or exceed the levels for assistance established under a state or federal plan but are insufficient to meet their costs of health and medical services.
Medicare	The federal medical assistance program for people aged 65 and older, for persons eligible for Social Security disability payments, and for certain workers or their dependents who require kidney dialysis or transplantation as defined under 42 U.S.C. § 1395 et seq.
Medicare Advantage (MA)	The managed care program established for beneficiaries of Medicare Part A and enrolled under Part B, pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified as amended in scattered sections of 42 U.S.C.).
Medicare Advantage Plan (MA Plan)	Per 42 C.F.R. § 422.2 and 42 C.F.R. § 422.304(b)(2), health benefits coverage offered under a policy or contract by an MA organization, that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the Service Area of the MA plan (or in individual segments of a Service Area.
Medicare Advantage Special Needs Plan (MA SNP)	Per 42 C.F.R. § 422.2 and 42 C.F.R. § 422.4(a)(1)(iv), a Medicare Advantage Plan that exclusively enrolls, or enrolls a disproportionate percentage of, special needs Enrollees and provides Part D benefits under 42 C.F.R. Part 423 to all Enrollees; and has been designated by CMS as meeting the requirements of a MA SNP as determined on a case-by-case basis using criteria that include the appropriateness of the target population, the existence of clinical programs or special expertise to serve the target population, and whether the proposal discriminates against sicker members of the target population.

Term	Definition
Medicare Prescription Drug Program (Part D Drug Benefit)	Per 42 C.F.R. Part 423, the prescription drug benefit for Medicare beneficiaries.
Member	An eligible individual who is enrolled in Indiana Medicaid. Also referred to as enrollee, Title XIX Member or Medicaid Member.
Mental health services	The diagnosis, evaluation, treatment, residential care, rehabilitation, counseling, or supervision of persons who have a mental illness.
National Committee for Quality Assurance (NCQA)	An independent 501c nonprofit organization that works with policymakers, employers, doctors, patients and health plans to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.
National provider identifier (NPI)	The 10 digit10-digit number issued by CMS which is the standard unique identifier for health care Providers in standard transactions.
Network	A list of the doctors, other health care providers, and hospitals that a Contractor contracts with directly, or employs through a subcontractor, to provide medical care to its members. These providers are called “network providers” or “in-network providers.” A provider that isn’t contracted with the Contractor is called an “out-of-network provider.”
Network provider	Per 42 C.F.R. § 438.2, any provider, group of providers, or entity that has a network provider agreement with the MCO or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render Covered Services as a result of the MCE contract. A network provider is not a subcontractor by virtue of the network provider agreement.
Non-participating provider	A provider who does not accept assignment on all Medicaid claims.
Nursing facility	An institution that provides organized and ongoing nursing care and related services for residents who require medical or nursing care, rehabilitation, or health-related care and services above the level of room and board. Medicaid-certified nursing facilities must meet federal and state requirements for resident care, staffing, and safety, and are licensed by the state to provide these services. Medicaid covers care in a nursing facility for eligible individuals who meet both financial and medical criteria.
Nursing facility level of care (NFLOC)	Nursing Facility Level of Care determined through an assessment by a level of care vendor for determination.

Term	Definition
Office of Medical Policy and Planning (OMPP)	The Office of Medical Policy and Planning is under the Indiana Family and Social Services Administration (FSSA).
Out-of-network provider	Any provider that is not directly or indirectly employed by or does not have a provider agreement with the Contractor or any of its subcontractors pursuant to the Contract between the Contractor and the State of Indiana.
Participating provider	Per Ind. Code § 27-13-1-24, a participating provider means a provider who, under an express or implied contract with: (1) the health maintenance organization; or (2) a contractor of the health maintenance organization or any subcontractor of a contractor of the health maintenance organization; has agreed to provide health care services to enrollees with an expectation of directly or indirectly receiving payment, other than copayment or deductible, from the health maintenance organization.
Person-centered planning process	Per 42 C.F.R. § 441.301(c)(1), person-centered planning is a process for selecting and organizing the services and supports that an older adult or person with a disability may need to live in the community. Most important, it is a process that is directed by the person who receives the support.
Pharmacy benefits manager (PBM)	An entity responsible for the provision and administration of pharmacy services.
Plan of care (POC)	A formal plan developed to address the specific needs of an individual. It links clients with needed services.
Population health	The health outcomes of a group of individuals, including the distribution of such outcomes within the group.
Preauthorization	Per 42 C.F.R. § 419.81, preauthorization (or prior authorization) means the process through which a request for provisional affirmation of coverage is submitted to CMS or its contractors for review before the service is provided to the beneficiary and before the claim is submitted for processing. Through this process the MCE authorizes, in advance, the delivery of covered services based on factors, including but not limited to, medical necessity, cost effectiveness, in, and in compliance with any applicable contract or policy provisions.
Prescription drug	Per 21 C.F.R. § 2023.3, prescription drug means any drug (including any biological product, except for blood and blood components intended for transfusion or biological products that are also medical devices) required by Federal law (including Federal regulation) to be dispensed only by a prescription, including finished dosage forms and bulk drug substances subject to Social Security Act § 503(b).

Term	Definition
Prescription drug coverage	Per 42 C.F.R. § 423.100, prescription drug coverage means coverage of Part D drugs that is either standard prescription drug coverage or basic alternative coverage.
Primary care	Per 42 C.F.R. § 438.2, all health care services, and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes the service.
Primary medical provider (PMP)	Is a primary care physician or other licensed health practitioner practicing in accordance with State law who is responsible for providing preventive and primary health care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. At a minimum, providers allowed to serve as PMPs must include physicians, physician assistants, and advanced practice registered nurses. Also known as a Primary Care Provider (PCP) or primary care doctor.
Program of All-Inclusive Care to Elderly (PACE)	A program of all-inclusive care for the elderly that is operated by an approved PACE organization and that provides comprehensive and coordinated healthcare services to enrollees in accordance with a program agreement.
Protected health information (PHI)	Individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium (and collectively defined in IC 4-1-6-1 and Ind. Code § 4-1-11-3, "PII") on the State's behalf pursuant to and consistent with the services performed by the Contractor under the Contract with Indiana.
Provider	A provider is defined as any individual, organization, or institution (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, ambulatory surgical centers, outpatient clinics, or other entity that is licensed or otherwise authorized to provide any of the covered services in the State in which they are furnished) that provides medical services to beneficiaries covered under this Contract. Per 42 C.F.R. § 438.2, provider does not include consumer-directed workers (refer to Consumer-Directed Worker); nor does provider include the FEA (refer to Fiscal Employer Agent)
Provider agreement	An agreement between the MCE and a provider or between the MCE's subcontractor and a provider describing the conditions under which the provider agrees to furnish covered services to the MCE's members.

Term	Definition
Quality management	The evaluation and assessment of member care and services to ensure adherence to standards of care and appropriateness of services. Services can be assessed at a member, provider, or population level.
Referral	A verbal, written, telephonic, electronic, or in-person request for health services.
Reportable unusual occurrence	An incident of suspected abuse, neglect, or exploitation or other situations that place at risk an adult or child receiving HCBS.
Rural health clinic (RHC)	An outpatient facility that is primarily engaged in furnishing physician and other medical and health services and that meets other requirements designated to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically under-served area that is not urbanized as defined by the U.S. Bureau of Census.
Service authorization	Per 42 C.F.R. § 431.201, a managed care enrollee's request for the provision of a service.
Service coordination	A process of assessment, discovery, planning, facilitation, advocacy, collaboration, and monitoring of the holistic LTSS and related environmental and social needs of each individual to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence.
Service coordinator	Individuals meeting Indiana residential, educational and/or experience requirements responsible for the development and continuous modification of the Service Plan for members who are determined NFLOC and receiving LTSS, to establish goals and priorities, comprehensively assess needs, evaluate available resources, and develop a plan of care; and to identify LTSS providers as well as other community partners to provide a combination of services and supports that best meet the needs and goals of the member and caregiver.
Service gap	A delay in initiating any long-term care service and/or a disruption of a scheduled, ongoing HCBS that was not initiated by a member, including late and missed visits.
Service plan	LTSS-specific, person-centered support plan, developed utilizing the person-centered minimum service planning process for assisting members in gaining access to long term care services, as well as medical, social, housing, educational, and other services regardless of the funding source for the services to which access is gained to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement.
Significant change in medical condition	A deterioration in health, mental, or psychosocial status in either life-threatening circumstances or clinical complications.

Term	Definition
Skilled nursing care	Per 42 C.F.R. § 409.44, a level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).
Specialist	A doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems. A specialist is a board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.
State Fair Hearing process (SFH)	Per 42 C.F.R. § 438.400(b), the State process set forth in Subpart E of Part 431, Chapter IV, Title 42, which allows members the opportunity to appeal the MCE's decisions to the State. Refer to 405 IAC 1.1 for the appeal procedures for applicants and recipients of Medicaid.
Substance use disorder (SUD) services	The assessment, diagnosis, treatment, detoxification, residential care, rehabilitation, education, training, counseling, referral, or supervision of individuals who are using or have abused substances.
Temporary Assistance for Needy Families (TANF)	Needy families with dependent children eligible for benefits under the Social Security Act, Title IV-A, 42 U.S.C. § 601 et seq.
Third party liability (TPL)	A member's medical payment resources, other than Medicaid, available for paying all or part of the cost of services for the enrollee.
Treatment	A procedure or method to cure, improve, or palliate an individual's medical condition or behavioral health issue.
Unusual occurrence	Defined in 455 IAC 2-4-27. It means an incident of suspected abuse, neglect, exploitation, or other situations that place at risk an adult or child receiving HCBS.
Urgent care	Per 42 C.F.R. § 405.400, urgent care services mean services furnished to an individual who requires services to be furnished within 12 hours in order to avoid the likely onset of an emergency medical condition.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

